

**We are
the Drug
Policy
Alliance.**

DPA COVID-19 Policy Recommendations



The Drug Policy Alliance (DPA) advances drug policies grounded in science, compassion, health, and human rights that are aimed at reducing harms of both drug prohibition and drug use. DPA is deeply concerned about our community members who are most vulnerable during the COVID-19 crisis, including people of color, people in jails, prisons, and immigrant detention centers, people otherwise entangled in the criminal legal system, people without housing, and people who use drugs, are accessing treatment, or are in recovery.

These communities face unique challenges that put them at increased risk of various public health harms, including contracting and spreading COVID-19 and other infectious diseases or dying from preventable drug overdose, due to a number of intersecting social and structural risk factors. Racism, stigma, discrimination, and an inadequate social safety net, including barriers to healthcare, were impacting these communities long before COVID-19 but are amplified and compounded amid the current pandemic.

People who use drugs will face even more challenges to accessing life-saving harm reduction services and medications for treatment than before. The racialized punishment of people who use drugs has not stopped, and additional policing, surveillance, and criminalization can be expected. People who are incarcerated and detained will remain stuck in crowded, unsanitary spaces. And people without housing will struggle to manage risks without adequate services, resources, or medical care.

Immediate policy action is needed. DPA offers a place to start—a set of COVID-19 drug policy priorities to protect public health, individual rights, and the dignity and well-being of those in our communities who are most harmed by structural inequities.

In order to be most effective, equitable, and sustainable, all policy responses must:

- Address structural racism and systemic inequities;
- Ensure access to benefits and services regardless of immigration status;
- Reflect the differing needs of communities across the country;
- Research and measure the social, racial, economic, and health impacts of COVID-19 and the policy responses to COVID-19; and
- Be supported and maintained beyond the COVID-19 crisis.

Though many of the recommendations outlined here are those that DPA has advanced for decades, COVID-19 makes their implementation imperative.

Substance Use Disorder Treatment

1. Increase access to buprenorphine and methadone.

- **Expand methadone access by waiving in-person examination requirement for new patients.** The Substance Abuse and Mental Health Services Administration (SAMHSA) has waived the federal requirement for new buprenorphine patients to receive an in-person examination before starting treatment so that it can now be conducted via telehealth or over the phone, thereby making the medication more accessible to patients. However, SAMHSA has explicitly stated this change does not apply to new methadone patients, so they will still need to complete an in-person examination, potentially placing themselves and their providers at risk for COVID-19 exposure. We are still in the midst of an overdose crisis, and people with opioid use disorders need safe and less restrictive access to both of these life-saving medications.
- **Expand implementation of SAMHSA guidance allowing 14 and 28 days of take-home medications.** SAMHSA issued guidance allowing opioid treatment programs (OTPs) to give “stable” patients 28 days of take-home methadone or buprenorphine and 14 days of take-home doses for “less stable” patients. This is a positive development that would allow patients to minimize in-person contact, thereby reducing their risk of COVID-19 transmission from congregating in large groups. Implementation of this new guidance, however, has been inconsistent due to a number of factors. Some states have more restrictive methadone policies than the new federal guidelines, making it challenging or impossible to implement the new loosened guidelines. Ohio, for example, has issued a policy capping the take-home limit at 14 days for any patient. Some states have requirements that take-home medications be accompanied by take-home naloxone, which may not be readily available. Beyond this, there also appears to be a great deal of variability from clinic to clinic, so that while some programs are now allowing more patients take-home doses, there are others that still require daily or frequent program attendance.

Some ways to address this include:

- States and OTPs remove requirements for patients to purchase their own secure lockbox in order to receive take-home doses;
 - States issue guidance to OTPs to maximize the doses allowed for take-home medication;
 - States allow reimbursement for take-home medications in state Medicaid programs;
 - States suspend prior authorization requirements or other barriers to take-home medications in state Medicaid programs;
 - States waive any barriers preventing take-home medications (e.g., co-prescribing naloxone: this should be encouraged if naloxone is available but lack of availability should not prevent take-home medication);
 - States and OTPs waive in-person drug testing requirements; and
 - States and OTPs suspend counseling requirements.
- **Suspend restrictive OTP requirements, allowing physicians to prescribe methadone and community pharmacies to fill methadone prescriptions.** The only way to access methadone for opioid use disorder treatment is through an OTP registered with the Drug Enforcement Administration (DEA), where methadone doses are dispensed on site (the majority of these doses are often observed and monitored by staff). In many less densely populated parts of the country, patients have to travel long distances on a daily or near-daily basis in order to receive treatment at the nearest OTP. As a general matter, providers cannot write a methadone prescription for opioid use disorder that can be filled at a pharmacy. Waiving some of the OTP requirements during the COVID-19 pandemic would allow methadone prescriptions to be filled at a pharmacy. This would reduce traffic and gatherings at OTPs, while also minimizing travelling long distances during shelter-in-place guidelines. This change would allow people to safely access their medications through neighborhood pharmacies or mail-order pharmacies which currently have

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protocols and equipment to protect themselves and their customers. Changes allowing pharmacies to dispense methadone should be accompanied by changes to allow for methadone to be Medicaid reimbursable under outpatient prescription benefits.

- **Expand provision of mobile methadone and buprenorphine, including home delivery.** Mobile clinics can play an important role in increasing access to methadone and buprenorphine, particularly for those who live in less densely populated areas and/or areas with limited public transportation infrastructure. COVID-19 guidelines for sheltering-in-place that deter long-distance travel can prevent patients from travelling to access their medications, so mobile programs may be especially helpful for these patients. In addition, home delivery should be available for symptomatic and coronavirus-positive patients who must remain in quarantine. The DEA is already considering a new rule that would allow established OTPs to operate a mobile component without separate DEA registration. This will give the authority for OTPs to begin operating mobile programming. The startup costs, however, will be significant. Federal and state governments should:
 - Provide financial assistance to OTPs to scale up mobile methadone and buprenorphine;
 - Relax barriers to home delivery, including allowing couriers to deliver medications to people's homes and exploring delivery by mail;
 - Provide personal protective equipment to OTP staff to reduce likelihood of COVID-19 transmission while providing mobile services.
- **Ensure methadone and buprenorphine access in criminal legal system settings.** Access to methadone and buprenorphine is extremely limited in criminal legal system settings even though a disproportionate number of people involved with the system have opioid use disorder. Many drug courts do not allow all three FDA-approved medications for opioid use disorder, and only a handful of jails and prisons provide access for incarcerated people (other than pregnant women). Access to methadone and buprenorphine can improve facility operations

and reentry, reduce the likelihood of further system involvement, and reduce the high risk of death due to overdose upon release. It may also help to facilitate decarceration efforts by stabilizing people and preparing them for release. All sectors of the criminal legal system should ensure access to methadone and buprenorphine for those who could benefit. Drug courts should not prohibit use of any of these medications, allowing participants to choose any of the three medications. Jails and prisons should ensure people who were using these medications prior to incarceration are maintained and that those who need the medications can begin these treatments.

- **Suspend X waiver requirements for prescribing buprenorphine.** Physicians, nurse practitioners, and physicians' assistants can prescribe buprenorphine for opioid use disorders outside of an OTP (e.g., from a doctor's office) if they have completed the requirements delineated by SAMHSA to receive a DATA 2000 waiver (also called an X waiver). Currently, the providers must complete a set number of training hours (eight for physicians, 24 hours for physicians' assistants and nurse practitioners). Once waived, providers can only treat up to 30 patients for the first year, then can apply to increase their limit to 100 patients thereafter. Providers can also eventually apply to have the 100-patient limit raised to 275 after at least one year. These restrictions limit how many providers are qualified to prescribe this life-saving medication, so that patients must seek a waived provider to start treatment. These providers, however, can be difficult to find. A recent study found that over half of counties in the U.S. did not have a single waived buprenorphine physician. DPA has long advocated for removing these barriers, but it is especially important during the COVID-19 pandemic because more people may be motivated to seek treatment since telehealth inductions will make buprenorphine more accessible. Suspending the training requirement needed to obtain an X waiver would likely require Congressional action. SAMHSA could waive the patient limit using its emergency powers, however, which would allow waived providers to serve unlimited patients.

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2. Expand outpatient and remote access to evidence-based treatment (versus residential).

- **Prioritize outpatient treatment.** Evidence suggests that residential treatment is not more effective than outpatient treatment, yet it is still a widely-used form of treatment. COVID-19 is more likely to spread in facilities where people are in sustained close contact with each other, such as residential treatment facilities. These facilities may go into lockdown to prevent transmission, but this means that people will not be able to see loved ones for an indefinite amount of time. Treatment providers should prioritize outpatient services and work to reduce inpatient or residential populations. Individuals who are mandated to residential treatment should be allowed to transfer to outpatient services, or if not available, to leave treatment with referrals to appropriate community resources. States can help to facilitate this by:

- Developing guidance for treatment providers to prioritize outpatient services;
- Utilizing housing subsidies made available through the CARES Act and other financial resources if people need places to live (e.g., unbooked hotel rooms);
- Working with providers to ensure quick approvals of licenses or other necessary approvals for changes in delivery of services;
- Modifying Medicaid reimbursement to make outpatient more financially attractive to providers; and,
- Providing additional financial support to community outpatient service providers.

- **Suspend drug treatment requirements, such as drug testing, that require in-person gatherings.** Many drug treatment facilities require consistent attendance and drug testing. This is especially true if an individual is mandated to be in treatment by the criminal legal system (see paragraph six under “decarceration” for additional recommendations). For people who are mandated to treatment, the

requirement that they attend in person should be waived for the duration of the emergency. Individuals who are mandated to residential treatment should be allowed to transfer to outpatient services, or if not available, to leave treatment with referrals to appropriate community resources. No one should be required to complete in-person drug tests. Doing so puts the individual and the provider at risk. Individuals should not be violated for failing to attend treatment in person or submit to drug tests during the emergency.

- **Expand telehealth (including internet and device access).** Telehealth has become more important than ever for providing outpatient services to people with substance use disorders. Many of the federal government agencies have loosened restrictions and encouraged telehealth during the COVID-19 pandemic. Many states have their own laws and regulations, however, that may prevent providers from using telehealth. These can include states that have not waived state privacy laws to allow use of non-compliant platforms (e.g., Zoom), state Medicaid programs that do not reimburse for telehealth, and lack of access for low-income communities. Solutions include adjusting state Medicaid programs to reimburse for telehealth and providing funding for increasing telehealth, including subsidizing internet and devices (e.g., phones) for lower-income communities (e.g., people who already receive some form of government benefit). During this time, telehealth should be used as widely as possible to continue to provide services without having people congregate or requiring travel. Access to internet and electronic devices should also be made available to people in recovery so they can remotely attend support groups, even if these would not be billable as telehealth services.

3. Ensure treatment funding requires adherence to evidence-based principles.

Estimates suggest that more people may develop substance use disorders during and after the public health emergency, due in part to increased isolation and economic stressors. Several treatment providers and advocacy organizations have called for increases in funding to ensure that providers have the financial resources to survive and meet the expected increase in need. However, treatment has long lacked oversight and accountability, allowing many providers to implement treatment modalities that have not been shown to be effective and in fact may cause harm. Any funding that is disbursed in response to the COVID-19 pandemic (and in general) should require treatment providers to adhere to evidence-based principles of substance use disorder care. Such principles include:

- Providing access to methadone and buprenorphine, or, at the bare minimum, not prohibiting participants from using these medications;
- Prohibiting expulsion based on relapse;
- Not requiring abstinence;
- Not requiring participation in or refraining from certain services to gain access to other services;
- Prohibiting the use of degrading tactics;
- Using participant's goals to define success;
- Making harm reduction supplies available to those who desire them; and
- Implementing evidence-based behavioral therapies, such as contingency management.

1. Expand availability and accessibility of harm reduction services.

- **Explicitly designate sterile syringe and naloxone access services as “essential” and staff providing these services as “essential” providers/businesses.** States and/or localities that have issued “stay at home” orders during the COVID-19 pandemic have deemed some businesses and services as “essential” or “life-saving,” which means that these services can continue, the service providers may remain open, staff can travel to provide services, and individuals in need of the services can travel to receive them. At this point, only a handful of states and county departments have made clear that syringe and/or naloxone access services and staff fall under the designation of “essential.” Access to sterile syringes and naloxone is vitally important during the COVID-19 pandemic to ensure people who use drugs have the harm reduction tools necessary to decrease risk of both COVID-19 as well as other infectious diseases. Moreover, overdose deaths have already started to increase in some areas as a result of the COVID-19 pandemic and access to naloxone is critical. Every state that has issued a “stay at home order” should also issue an explicit statewide order making clear that sterile syringe and naloxone access programs are “essential services” and their staff are “essential service providers,” or language to similar effect under that state’s original directive to reduce the spread of COVID-19.¹
- **Provide federal and state funding for personal protective equipment (PPE) for people who provide harm reduction services.** While providing adequate PPE for healthcare providers has been the primary focus at the national level, there has not been similar advocacy to assure that PPE is provided to people who perform essential functions, including harm reduction services. Staff at these programs need PPE to continue providing services in a way that protects their own health as well as

¹ Wisconsin’s order provides a good model and is comprehensive, covering both syringe and naloxone access. However, each state will need to tailor its recommended order and approach to the existing order(s) and state context.

Harm Reduction

reduces transmission of COVID-19 to the vulnerable populations they serve. Community-based harm reduction providers should not be expected to compromise their health and safety, and that of their families and loved ones, to provide vital health services to people who use drugs.

- **Increase access to sterile syringe and naloxone access programs.** Beyond calling for harm reduction programs to be designated “essential” during the COVID-19 pandemic, it is also critically important that access to these services be expanded and unnecessary barriers be eliminated. Access to naloxone and sterile syringes is limited even absent additional challenges posed by COVID-19, particularly in rural communities across the country. States or localities that have policies requiring a one-to-one exchange of syringes should immediately be changed to allow for broader access without the requirement to “exchange” a used syringe for a sterile one, for example. New methods of distribution should also be explored and funded, such as mobile or mail-order options and secondary syringe exchanges. Providing funding to ramp up mail distribution of critical harm reduction supplies is one way to ensure that people still have the tools necessary to protect themselves from preventable transmission of infectious diseases and overdose deaths. NEXT Harm Reduction, which operates NEXT Distro and NEXT Naloxone, is one example of a mail-order service providing harm reduction equipment and supplies while also engaging in drug user health education.

2. Implement Overdose Prevention Centers.

The fight to establish Overdose Prevention Centers (OPCs), also known as Supervised Consumption Sites, and protect them from federal enforcement efforts should remain a priority during the COVID-19 pandemic. OPCs provide a space for people to consume pre-obtained drugs in controlled settings under the supervision of trained staff and receive access or referrals to health care

and social services, including drug treatment. OPCs are uniquely effective at engaging highly marginalized communities, including people who use drugs and who are homeless or marginally housed, who are at particular risk for health-related harms, whether it be COVID-19 transmission or overdose death. As with other health care services, with appropriate safeguards in place, OPCs could operate successfully during the COVID-19 pandemic to improve the health and well-being of people who use drugs.

3. Ensure housing accommodations prioritize harm reduction and safe supply.

As more homeless and marginally housed people are provided accommodations as a result of COVID-19, we must prioritize “housing first” policies for people who use drugs, which do not have preconditions and barriers to entry, such as sobriety or treatment requirements. And to the extent possible, necessary substances and services for stability should be provided along with housing. The San Francisco Department of Public Health, for example, is administering alcohol, tobacco, medical cannabis, and other substances in an effort to prevent people quarantined or isolating in city-leased hotels from going outside to get the substances themselves. They are also providing substance use disorder treatment, such as buprenorphine dispensing, directly to the people they have housed.

1. Reduce new entries into the incarceration pipeline.

- **End criminal penalties for drug possession.**

Drug possession is the leading cause of arrest in the United States and a major driver of people into the criminal legal system. States should decriminalize possession of drugs for personal use as a tool for reducing unnecessary interpersonal contacts that increase the spread of physical disease, as well as the psychological and social harms that flow from overcriminalization. While short-term measures described below may temporarily have some effect in reducing the criminalization of people who use drugs, legislative changes to repeal criminal statutes is the most effective, comprehensive, and humane way of eliminating risk of COVID-19 infection for those who otherwise are criminalized by the drug war.

- **Implement “lowest law enforcement priority” policies at the local and state level for drug possession and use.**

In seeking to arrest fewer people during the crisis and better protect the health of police personnel, those detained, and the general public, city leaders can make clear that enforcing drug laws should not be a priority for their police forces during and after the COVID-19 emergency, and that police should not be seeking to investigate, stop, detain, or arrest individuals for drug use and possession. Even prior to the pandemic, certain cities established policies or passed resolutions stating that police resources should not be used for enforcing laws prohibiting certain substances (e.g., marijuana or psilocybin). As state and national emergencies were declared in response to COVID-19, some leaders made clear (or implied) that police would reduce or even halt enforcement of certain offenses, including drug offenses. Under the present circumstances, such resolutions should go even further and make clear that drug possession and use is “deprioritized,” acknowledging that drug arrests do more harm than good. As a result of the pandemic, some agencies have deprioritized drug possession and other misdemeanor offenses. Moving forward, local governments and police agencies should

start codifying these priorities, developing policies to categorically reduce arrests for offenses related to possession, use, public consumption, and paraphernalia. Additionally, governors should provide statewide guidance to encourage the reduction of arrests.

- **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.

- Police are typically unable to effectively handle physical and mental health crises, too often responding with force and violence. During the COVID-19 crisis, some law enforcement officers have been reluctant to administer naloxone due to fear of potentially contracting the virus. Professionals trained in crisis intervention could better provide the initial response to many calls for service. Some communities have established programs to diversify 911 response protocols and dispatch crisis intervention teams that do not include police. Expansion of funding to pilot additional programs, and policy changes that reflect the deprioritization of police response, are critical to providing a higher level of service in addressing physical and mental health needs and channeling fewer people into harmful criminal legal processes.
- When police are the first responders to situations relating to alleged drug offenses, it is similarly far more effective to directly facilitate service connections for those in need of supportive services rather than into detention and the criminal legal pipeline. Existing pre-arrest diversion programs nationwide served a critical role during the early months of the COVID-19 health emergency by

Criminal Legal System Pre-Entry / Arrest / Technical Violations

leveraging existing relationships with clients to help ensure safety and facilitate access to healthcare, housing, and other services. States and the federal government should expand available funding for “pre-arrest” or “pre-booking” diversion programs that better meet individual needs rather than wasting criminal legal resources, delaying delivery of services, exposing individuals to viral exposure in booking facilities, jails, and courthouses, and causing further collateral consequences. Such programs should prioritize the reduction of police involvement (including eliminating “booking” procedures), employ harm reduction principles, be consistently voluntary rather than coercive, and be based on broad community partnerships among stakeholders.

- **Stop prosecutions for possession of drugs for personal use as well as paraphernalia.** Where arrests are made, prosecution offices should establish clear policies to not file charges in cases involving possession and sale of “personal-use” quantities of prohibited drugs. Forward-thinking prosecutors in Santa Clara County, California, even prior to the epidemic, had enacted a policy to not file charges against individuals arrested for possession of small quantities of controlled substances and offering to refer any such individuals to behavioral health services voluntarily if desired. Since the COVID-19 pandemic, other offices, including the Baltimore State Attorney’s office and San Francisco District Attorney’s office, have enacted similar policies.
- **Limit arbitrary prosecution of “possession with intent” offenses.** In many states and localities, prosecutors have enormous discretion in charging alleged drug violations. Broad statutes prohibiting possession of drugs with the intent to distribute or sell permit prosecutions based on allegations that an individual possessed, for example, multiple separate bags of a substance packaged individually. The inference suggested by prosecutors is that even when no evidence of a sale exists, the circumstances of packaging alone suggest that the possessor intended a sale. In some jurisdictions, prosecutors

can increase the likelihood of pretrial detention by simply charging a felony “possession with intent” offense rather than simple possession, even where the amount of a substance may be consistent with possession for personal use. Particularly at a time when many drug users have lost access to regular suppliers and are likely to maintain larger-than-normal supplies for personal use, courts should protect against overreaching prosecutions and refuse to issue pretrial detention orders in drug possession cases.

- **Suspend enforcement and repeal statutes on public intoxication and use of controlled substances.** While non-arrest and non-prosecution policies are vital to immediately slow the entry of individuals into police facilities and jails and reduce contacts between police and residents, legislators and elected officials should also quickly take action to make clear that police should not simply substitute drug possession or low-level sales arrests to other code violations, such as “public intoxication” or “public consumption” offenses. Additionally, while states and localities seek to enforce public health orders requiring residents to stay home, many unhoused individuals or others living in public housing or group settings may face an elevated risk of interaction with police due to unnecessary enforcement of public use and intoxication statutes. The enforcement of public use statutes is particularly unfair for those who are unhoused or who live in apartments or group settings where they could face the loss of shelter for use of marijuana, even where possession and use of the substance is lawful.
- **Withdraw or suspend outstanding warrants for drug offenses, other misdemeanor and traffic offenses, and bench warrants.** When an individual is temporarily detained or arrested, the police typically check state and federal databases for any outstanding warrants. Even when police do not intend to make an arrest for a new offense, statutes and policies usually require that the individual be brought to a judge before any outstanding warrants may be cleared. Warrants may be related to an offense that has been charged and never

prosecuted, or issued by a judge when an individual failed to appear in court for a pending case.

Sometimes a person may have had a warrant issue by error, or in relation to a missed appearance at a hearing they never knew about, or the individual arrested may not in fact be the same person sought by the warrant. Regardless of the circumstances, it is common for an individual to remain detained while awaiting a hearing in court. Such outstanding warrants related to drug offenses and crimes of poverty can and should be withdrawn by prosecutors and courts during the COVID-19 emergency to reduce unnecessary admissions into jails.

2. Reduce the number of people taken into custody and detained pending trial.

- **Cite and release from the point of contact for drug possession, use, and paraphernalia offenses, and low-level drug sale offenses, if enforcement of drug offenses continues.** It is clear that we have to reduce “jail churn” to slow the spread of COVID-19, and to do that we have to stop admitting people into facilities as we work to decarcerate more of those detained. This includes bringing individuals to jails or police precincts simply for “booking” prior to release. To reduce the number of contacts between those arrested, police personnel, and others detained or incarcerated, stopped individuals should be released from the location of initial contact with police. Many local police have established orders mandating that those accused of most misdemeanor offenses should be given a citation to appear in court at a later time or await information about whether and when they must report to court. While legislation may be necessary to allow for such procedures in some states, “cite and release” policies can and have been enacted quickly by many localities throughout the U.S. during the crisis.
- **Prohibit the imposition of monetary bail for offenses with no public safety risk, particularly drug offenses.** COVID-19 brings greater urgency to the bail reform debate. To reduce churn of jail populations, judges and state and local governments

need to prioritize reducing jail counts in all lower-level offense categories, particularly drug-related offenses. In response to the COVID-19 crisis, the California Judicial Council adopted an emergency bail schedule that sets bail at \$0 for most misdemeanor and lower-level felony offenses. These policies should extend beyond the crisis, and other jurisdictions should replicate the California model.

3. Reform probation and parole supervision practices.

- **Suspend drug testing and in-person meetings for people on probation or parole.** Many probation offices have already suspended in-person meetings for those on supervision. Where face-to-face meetings have not ended, there should be an immediate cessation of all in-person appearance and drug testing requirements. Permanent reforms of community-supervision systems are also needed, including eliminating drug testing and other arbitrary requirements that bear no relationship to recidivism.
- **Suspend issuance of violation reports and revocation warrants for drug test violations.** In 2016, approximately 60,000 people were incarcerated in state prisons because of technical violation of probation and parole rules. Returning to jail those alleged to have only committed technical violations, particularly positive drug tests, serves no productive purpose in reintegrating those who have served sentences of incarceration. Placing a moratorium on the issuance of new violation reports where no new offense has been committed is a fast way of reducing jail churn and beginning a policy reorientation to a more productive, assistance-oriented model of probation/parole supervision.
- **End probation/parole early for those under supervision solely for drug offenses.** The supervision of people who are nearing the end of the community-supervision portion of any sentence should be terminated early during the COVID-19 crisis (through executive clemency, parole board discretion, or judicially-ordered resentencing where

supervision is conducted by courts) to free up resources for parole agencies, but also to lift the burden and the anxiety from many individuals at a time when they should be able to focus solely on health, employment, family, and housing.

4. Monitor drug arrests in light of shelter-in-place order enforcement.

To establish more informed criminal legal policies during and after the COVID-19 pandemic, we need to better understand how many people are being arrested for drug-related offenses, and the nature of the offenses alleged. While some agencies provide real-time data for violent and serious property crimes, few provide transparency and recency in data surrounding drug offenses. During the pandemic and afterward, we need more jurisdictions to provide more detailed and more timely information on drug-related arrests so that communities can better understand how law enforcement resources are being allocated and make sensible policy reforms.

5. Suspend and limit immigration enforcement operations.

- **Suspend new detentions of suspected non-citizens and proactive enforcement operations, especially enforcement operations in or around hospitals or medical clinics and those targeting people deemed removable for drug-related offenses.** In the initial weeks of the COVID-19 emergency, Immigration and Customs Enforcement (ICE) engaged in aggressive enforcement practices such as conducting raids, setting up additional check points, and increasing Border Patrol presence in communities, causing increased fear and anxiety for immigrants. Immigrant families may be especially vulnerable to COVID-19 since many immigrants are working in industries deemed “essential” during the pandemic and are having to work outside of their homes. As a result of these vulnerabilities, many immigrants avoid seeking necessary medical attention out of fear of detection by ICE.

- **Support the adoption of model policies to increase the number of safe locations for immigrants in the workplace, community care clinics and hospitals, and schools.** To further reduce the number of people held in ICE detention facilities, local jurisdictions and law enforcement agencies must stop collaborating with ICE and local resources should not be used to further federal immigration enforcement. Various model policies and guidelines have been developed for interacting with ICE agents or officials.²
- **Protect against expanded surveillance powers, especially those that disparately impact people of color, immigrants, and other at-risk groups.** The COVID-19 crisis has led many governments around the world to expand or seek expansion of surveillance powers to enable tracking of personal data. Technology is being used to track location data for contact tracing and enforcement of quarantine orders. The federal government has reportedly sought aggregated location data from companies such as Facebook and Google to predict the spread of the virus. Overbroad surveillance programs can expose, intentionally or by mistake or negligence, private information to police or others who may prey on vulnerable populations. Surveillance practices can also chill speech and association and raise inferences relating to personal matters involving health or criminal allegations. All too often technology-driven policing technologies have been used unconstitutionally to track, burden, and oppress people of color. The use of policing technologies generally, and the expansion of technological surveillance in the context of the pandemic, must be monitored carefully and resisted where inadequate safeguards ensure the protection of individual rights. And any public health information collected must not be shared with ICE, Border Patrol, or joint federal task force for the purpose of arresting, detaining, or transferring any individual into ICE custody.

² See, e.g., [sample model policy for local law enforcement](#); [sample model Sanctuary Ordinance policy](#) for cities and counties; [sample model workplace sanctuary policy](#); [sample model school sanctuary policy](#); [safe locations for health care providers](#).

Decarceration

DPA stands with our allies in the criminal justice field who are calling for the broad-scale release of people currently incarcerated in institutions and settings that cannot possibly follow Centers for Disease Control and Prevention (CDC) directives on safe practices for reducing risk of COVID-19 transmission and so are putting people at unnecessary risk of harm. Our priorities simply reflect the calls we have fought for historically and those we organizationally find even more urgent today.

1. Reduce prison populations by releasing vulnerable people who are at greater risk of suffering severe health impacts from exposure to COVID-19 and those who have nearly completed sentences.

- **Release people who are especially vulnerable to contracting COVID-19.** Many of those held in jails and prisons have chronic illnesses, complex medical needs, or inadequate nutrition, and tend to be more vulnerable to contracting COVID-19 and becoming severely ill. Many are older and already have compromised immunity. People with respiratory conditions, cancer, HIV, asthma, and other chronic conditions must be released. This can be achieved through state and federal executive action (clemency or commutation of sentence) or by judicial order.
- **Release incarcerated people who are near the completion of their sentence.** Many individuals serving short sentences and those near the end of longer sentences should be released by commuting sentences, issuing amended judgment orders to resentencing, or allowing them to serve the remainder of sentences in home confinement.

2. Reduce incarcerated populations by releasing non-citizens held in detention centers.

- **Release more people held in administrative immigration detention and local jails.** An estimated

30,000 non-citizen individuals are held in immigrant detention facilities. In mid-March, ICE officials released enforcement guidance³ stating that they would delay arresting non-citizens who are not “public safety threats,” but it is not clear yet whether that policy is being honored. Continued decarceration of those held for removal, including those held in federal facilities and local jails, and the suspension of new detentions, particularly based on drug offenses, are necessary. Additionally, immigration detention facilities and other local jails and detention centers should flag “high-risk” individuals for release and allow for individuals and non-profit organizations the ability to post bond remotely and allow in-person bond payments where permitted by public health recommendations.

- **Release non-citizens in a responsible manner so that individuals do not end up in ICE detention.** In addition to releasing individuals from jails and prisons, law enforcement, including police, sheriff, and probation departments, must suspend all communication with ICE regarding non-citizen’s release from custody. This recommendation includes the departments and agencies above and their interaction with juvenile detention facilities. It is critical to not engage in facilitating immigration arrests, which includes prohibiting ICE transfers in jails or state prisons, prohibiting ICE from entering jails to make arrests, and prohibiting ICE access to any databases, files, or information. Communication with ICE must also prohibit sharing release dates, home addresses, or work addresses with Department of Homeland Security (DHS) agents or personnel.
- **Law enforcement and state agencies must suspend all collaboration with ICE, including ICE contractors, Border Patrol, and any other local collaboration agreements with ICE.** Collaboration with ICE and Border Patrol in both formal and informal agreements and informal cooperation should be ceased. Law enforcement and local or

³ ICE Guidance on COVID-19, March 15, 2020: <https://www.ice.gov/coronavirus>.

Decarceration

state agencies, including probation departments, must not respond to subpoena requests for information on individuals from ICE since these requests are non-binding and they are not legally required to respond. Law enforcement should avoid conducting joint operations with ICE to arrest people for immigration violations. Law enforcement should also not use local resources to support federal prosecution for immigration-related offenses, especially during the pandemic when resources are extremely limited.

3. Reduce jail populations by releasing those held prior to trial.

As noted previously in relation to criminal legal system reforms, it is essential that courts order the release of those held pre-trial who have not been convicted of an offense but are detained because they are unable to pay monetary bail. People held for bail and others detained without bail who are awaiting trial for offenses that pose no significant risk to public safety should be released and ordered to appear for proceedings at a later time.

4. Reduce prison and jail populations by releasing more people incarcerated for drug and other offenses.

Through executive orders or resentencing, people incarcerated for drug offenses, particularly possession, paraphernalia, “quality of life” offenses,⁴ misdemeanor, and low-level felony offenses should be pardoned or receive clemency to facilitate their immediate release. Although clemency processes typically involve individualized petitions, it would be reasonable to call for clemency for a class of individuals convicted of a range of drug-related offenses.

4 The Alternatives to Incarceration workgroup with the Los Angeles Board of Supervisors recently adopted the following recommendation to decriminalize quality of life crimes: Decriminalize drug use, public intoxication, fare evasion, driving without a license, licensing suspensions, licensing revocation and/or other quality-of-life crimes and survival crimes.

5. Reduce prison and jail populations by releasing those incarcerated for parole or probation violations, and those detained on technical violation warrants.

Far too often individuals on community supervision (either parole or probation) are rearrested not because they committed a new offense, but because they missed an appointment with a parole officer. Many of those supervised have health vulnerabilities and significant social service needs, including in some cases substance use disorders warranting treatment. People who are incarcerated merely for parole, probation, or technical warrant violations should immediately be released.

6. Permit people court-ordered into inpatient drug treatment to withdraw when necessary and desired.

For those mandated by courts to participate in drug treatment, counseling, drug testing, and other obligations, they may be faced with the choice of either remaining in a facility with insufficient health protections or violating a court order and risking incarceration. Courts should issue orders giving discretion to those ordered to treatment or other residential facilities to withdraw from such inpatient settings where desired to protect their health without facing sanctions.

7. Protecting people who remain incarcerated.

While release from incarceration is ultimately the priority objective, the protection of those who remain incarcerated should still be an essential priority. All levels of government should be held accountable for insufficient COVID-19 testing, inadequate protective equipment and hygiene supplies, and deficiencies in facility cleaning and living conditions. States and the federal government must ensure that all incarcerated individuals have immediate access to medical care without copays or other costs.

Reentry

1. Provide people being released from incarceration with necessary social supports.

- **Provide naloxone to all people being released from jails and prisons.** Jails and prisons across the country are releasing more people in order to reduce overcrowding and the likelihood of transmission of COVID-19 inside their facilities. Overdose risk among people recently released from incarceration is exceedingly high because individuals without access to opioids and other drugs during incarceration leave with a lower tolerance level and then are likely to overdose when they return to use in the community. This is a deadly combination in an environment where stay-at-home orders may reduce access to naloxone in the community and other safeguards such as using drugs with other people. Naloxone should accordingly be made universally available to people being released from federal and state prisons and county jails. A successful model in San Francisco has demonstrated that when naloxone is distributed upon release, overdose deaths in the community are reduced. Additional programs that provide wide scale and anonymous distribution have been successful because they do not require people to request naloxone from corrections personnel, which can be stigmatizing and inhibit adoption.
- **Shift criminal legal funding to reentry services.** People are being released from federal, state, and local incarceration settings into the community, but without the support they need to make a successful reentry 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 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 SNAP and TANF. Such conviction bans on access to federally supported benefits and resources should not occur during the COVID-19 epidemic. Federal and state officials are taking unprecedented actions to provide relief from regulations and other barriers that otherwise impose undue hardship on people struggling to get by during the epidemic. People with criminal convictions who would otherwise be eligible to receive need-based supports should have unimpeded access during the national emergency.
- **Ensure that released people have financial assistance.** Congress should provide COVID-19 federal cash assistance to individuals who are released from custody during the pandemic. Individuals impacted by the criminal legal system and their families need direct cash assistance to help them with lost wages, access to food, housing, and other basic needs.

2. Ensure people released from incarceration settings have access to healthcare.

- **Suspend Medicaid coverage for the duration of incarceration and facilitate smooth reinstatement prior to release.** States have the ability to suspend Medicaid coverage, as opposed to terminating it, when a person is incarcerated. Thirty-one states and D.C. have policies to suspend coverage in some capacity, though most are time-limited (i.e., coverage is terminated after a certain period of suspension has expired). Ensuring people are enrolled in Medicaid upon release is crucial to ensure access for health services, including COVID-19 care and substance use disorder treatment. States should implement an indefinite suspension policy and clear protocols to ensure that individuals leaving incarceration have their Medicaid coverage reinstated upon release.

Reentry

- **Support pre-release Medicaid enrollment for individuals leaving incarceration.** Incarcerated people tend to have more serious health needs than the general population. Ensuring people are enrolled in Medicaid upon release is crucial for accessing for health services, including COVID-19 care and substance use disorder treatment. Jails and prisons should facilitate enrollment in Medicaid prior to release to ensure access to care in the community. Federal and state governments should provide resources to increase pre-release enrollment programs.
- **Repeal the Medicaid “inmate exclusion” to facilitate continuity of care.** Congress should immediately repeal Section 1905(a)(A) of the Social Security Act (commonly referred to as the “inmate exclusion” provision) (see the “Humane Correctional Health Care Act” – S. 2305/H.R. 4141) or waive on an emergency basis until at least six months after the COVID-19 crisis is over. This provision prohibits use of Medicaid funding (and other federal funds) for medical care provided to “inmates of a public institution.” This additionally applies to individuals who are incarcerated but have not been convicted of a crime (540,000 people are currently incarcerated in pre-trial detention). Waiving this exclusion would allow for Medicaid-certified providers to provide healthcare in incarceration settings and to bill for Medicaid reimbursement of those services. It would open the door for community providers to provide services in jails and prisons. It could possibly improve the level of care provided in incarceration settings because it would mean that the providers need to comply with Medicaid regulations, including quality improvement measures. It would create opportunities to coordinate care with Medicaid-certified providers

in the community to assist with care coordination and connection at entry and release. If done without nuance, however, eliminating the “inmate exclusion” could be a financial windfall for law enforcement and corrections without guaranteeing improvements in care or coordination with care in the community. It may weaken incentives to divert people into community-based care because the care in jails and prisons would be Medicaid reimbursable, too. It may create the inverse incentive to arrest and incarcerate people so that they can then be coerced into healthcare services, including substance use disorder and mental health treatment. Repealing the exclusion in a manner to address these concerns could help to improve continuity and quality of care while avoiding perverse incentives. Some possible ways to help ensure appropriate care is to only allow Medicaid reimbursement if provided by healthcare providers with independent decision-making authority and that incarcerated beneficiaries have the same rights as non-incarcerated beneficiaries, including use of established grievance processes.

Cannabis

1. Protect access to cannabis.

- **Declare that cannabis businesses are essential.** There are several million state-licensed medical cannabis patients in the U.S., including many who are medically vulnerable, in addition to people who use cannabis for other reasons. It is essential that they maintain uninterrupted access to safe, laboratory-tested cannabis products. To protect access, state and local governments should declare cannabis businesses “essential” as part of any orders that limit commercial activity to ensure that cannabis businesses do not have to cease operations as the result of shelter-in-place orders and that patients and consumers have continued safe access to cannabis.
- **Allow cannabis delivery, curbside delivery, suspension of purchase limits, and online and telephone ordering.** State and local governments should allow cannabis access for patients and consumers that does not require traveling to or entering a retail store. In order to further limit the spread of COVID-19, to comply with shelter-in-place orders, and to ensure that consumers and patients, especially medically vulnerable patients, continue to have safe access to cannabis, ordering and purchasing online and over the phone must be allowed along with cannabis delivery to homes and other accessible no-contact locations so that patients and others can protect themselves and the community by engaging in social distancing, as recommended by most public health departments, to the greatest extent possible. Purchase limits should be expanded to reduce the number of trips to a retail store or delivery interactions that are required.
- **Allow medical cannabis consultations to occur by telemedicine.** In order to limit in-person contact and protect medically vulnerable people, telemedicine should be expanded for medical cannabis patients for the purpose of medical cannabis authorizations and re-authorizations. During the duration of this crisis, in-person consultations and physical examinations requirements should be waived to allow patients to limit their exposure to hospitals and medical offices.

- **Extend the expiration date of medical cannabis cards.** In order to limit the number of patients who need to visit a medical office or the state regulatory agency (which may be closed or operating at limited capacity), states should extend the expiration date of medical cannabis cards for the duration of the COVID-19 crisis. Some states have taken this approach with driver’s licenses that are set to expire for people while state offices are at limited capacity so as to limit non-essential activity and further limit transmission of the virus. Additionally, due to the financial hardship that so many are now unexpectedly facing, recommendation and patient identification card fees should be waived or lower.

2. Protect patient and consumer health.

Provide harm reduction information. Cannabis businesses and regulators should proactively provide patients and consumers information related to consumption and COVID-19, including to not directly share bowls, bong, pipes, vape pens, etc., and to continually use 90%+ Isopropyl Alcohol to clear any germs or pathogens. Further, because COVID-19 is a respiratory illness, some consumers, particularly those that are medically vulnerable, may want to limit exposure to combustive smoke to avoid undue strain on the lungs. Alternative delivery devices, such as vaporizing, edibles, or tinctures that limit smoke exposure, should be allowed by state lawmakers and regulators and provided as an alternative to smoking for cannabis patients and consumers.

3. Protect cannabis businesses and employees.

- **Allow cannabis businesses access to small business loans and other economic programs to survive the current economic crises.** The state-licensed cannabis industry employs over 200,000 workers. Currently, these cannabis businesses are ineligible for economic/crisis relief or access to low-interest loans and are not eligible for Small Business Administration funded services and loans. Relief efforts and programs should be expanded to include cannabis

Cannabis

businesses so that they are able to withstand this financial crisis, continue to employ workers, generate tax revenue for state and local governments, and provide a safe and legal product to consumers.

- **Provide standard operating procedures and guidelines to cannabis businesses so they can implement best practices to protect public health.** States and localities should develop and provide guidance to cannabis companies to best protect health in the face of COVID-19, including requiring frequent sanitization of shelving and other public spaces, limits on the total number of customers permitted to congregate together at one time, and potentially imposing specific hours of operation for elderly or other higher-risk patients.
- **Ensure that cannabis business employees have access to paid sick leave and unemployment insurance.** COVID-19 has created an unprecedented demand and need for paid sick leave, paid medical family leave, and unemployment insurance. Cannabis industry workers should be entitled to these benefits, just as workers in any other industry, to protect both their individual and family health and livelihood and to protect the broader public health and limit the spread of COVID-19 through employees coming to work sick because they cannot afford to stay home or to lose their job.
- **Remove additional barriers for the cannabis business workforce.** Some states require that cannabis employees obtain identification cards issued by a state agency before they can begin employment. In the event employees become ill, states and localities should waive requirements that employees first receive or renew identification cards, so that businesses can maintain a sufficient workforce to be able to operate. Background checks and other barriers to employment (such as criminal history exclusions) should be suspended.

4. Enact federal and state laws to legalize, regulate, and tax cannabis.

- **Congress should enact the Marijuana Opportunity Reinvestment and Expungement (MORE) Act.** The MORE Act would de-classify cannabis as a controlled substance under federal law, expunge low-level federal cannabis convictions, reduce federal cannabis sentences, establish social equity programs for cannabis businesses, and create a five percent federal tax on all cannabis sales. The MORE Act will help alleviate both the public health challenges caused by COVID-19 in incarceration settings by reducing the number of people who are incarcerated and the economic hardship caused by COVID-19 by reducing barriers to employment resulting from prior criminal history and by generating hundreds of thousands of new jobs and billions of dollars in new tax revenue. Additionally, ending the federal criminalization of cannabis will allow state cannabis regulatory programs to flourish, generating additional new jobs and additional state and local revenue.
- **States should legalize, regulate, and tax cannabis.** States that have already legalized, regulated, and taxed cannabis under state law have reduced the number of people who are incarcerated, removed barriers to employment through expungement of prior cannabis convictions, created new businesses and thousands of new jobs, and generated millions of dollars in new tax revenue for state and local governments. States that have not legalized cannabis should do so now to stop wasteful government spending of limited resources on enforcing and punishing low level cannabis offenses, to reduce the numbers of people who are cycling through the courts and jails, exacerbating the spread of the virus, and to address the economic devastation caused by COVID-19 by reducing barriers to employment, creating new jobs, and generating state and local tax revenue at a time when both jobs and revenue are desperately needed.

