



FXB Center
for Health & Human Rights
at Harvard University

FROM THE WAR ON DRUGS TO HARM REDUCTION: IMAGINING A JUST OVERDOSE CRISIS RESPONSE

Expert Recommendations for the
Use of Opioid Settlement Funds for
Policy Makers and Advocates

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In April 2020, the FXB Center for Health and Human Rights at Harvard University, Doris Duke Charitable Foundation, First Focus on Children, and Open Society Foundations convened a group of experts in public health, harm reduction, drug policy, and child welfare. The experts shared ideas on how to direct the opioid litigation settlement funds toward structural and policy reform that advances public health and health equity. The recommendations found in this position paper reflect the views of the following participants:

Leo Beletsky

Professor of Law and Health Sciences
Northeastern University School of Law

Kassandra Frederique

Executive Director
Drug Policy Alliance

Sandro Galea

Dean and Robert A. Knox Professor
Boston University School of Public Health

Tracie Gardner

Vice President of Policy Advocacy
Legal Action Center

Robert Green

Director of Policy Reform and Advocacy
Annie E. Casey Foundation

Robin Koval

CEO/President
Truth Initiative

Zachary Laris

Director, Federal Advocacy and Child Welfare
Policy American Academy of Pediatrics

Lindsay LaSalle

Managing Director of Public Health Law and
Policy Drug Policy Alliance

Christine Minhee

Soros Justice Fellow/Visiting Scholar
University of Washington School of Law

Mike Moore

Mike Moore Law Firm

Steven Pacheco

John Jay College of Criminal Justice
Vera Institute of Justice Opportunity Fellow

Meredith Rosenthal

Professor, C. Boyden Gray
Professor of Health Economics and Policy
Harvard TH Chan School of Public Health

Movement for Family Power

Lisa Sangoi, Co-Founder/Co-Director

Erin Miles Cloud, Co-Founder/Co-Director,
Movement for Family Power

Monique Tula

Executive Director

Harm Reduction Coalition

The Doris Duke Charitable Foundation

Lola Adedokun, Program Director for Child Well-
being

Karimita Bah, Program Associate

Rumeli Banik, Program Officer

First Focus on Children

Messellech Looby, SVP, Development and
Strategy

Averi Pakulis, VP, Early Childhood and Public
Health

FXB Center for Health and Human Rights

Mary T. Bassett, Director

Tori Cowger, Graduate Fellow

Griffin Jones, Graduate Fellow

Natalia Linos, Executive Director

Sam Peisch, Project Manager

Open Society Foundations

Sarah Evans, Unit Manager, Public Health
Program

Bisola Falola, Program Officer, Public Health
Program

Jeanie Kim, Consultant, Public Health Program

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INTRODUCTION

The overdose crisis is a health equity crisis. Over the past two decades, overdose-related fatalities have reached devastating numbers across the country. From urban epicenters to rural counties, the hardest hit communities are a stark reminder that the current ‘drug crisis’—like the ones preceding it—was not an accident.¹

Long before the overdose crisis entered the national spotlight, structural inequalities across race, ethnicity, and class created the societal conditions that lead to opioid use and have amplified the health disparities that increase the risks of overdose-related mortalities and morbidities.²

In 2014, local, state, and tribal jurisdictions began pursuing legal action against pharmaceutical manufacturers and distributors in hopes of recovering a range of costs associated with opioid-related overdose.³ While there is growing consensus within the opioid litigation community that funds should be used solely for overdose-related issues, settlement negotiations have been complicated by differing priorities among plaintiffs. These tensions will likely continue even after settlements are reached, as government officials begin distributing settlement funds amid economic strain and historic depletion of government revenue due to the COVID-19 pandemic.

This position paper offers recommendations for policymakers, community organizations, funders, and other stakeholders on effective and evidence-based ways to use opioid settlement funds to promote public health and health equity. In addition, it reflects on broader policy reforms that would create an enabling environment for the best use of settlement funds. As a potential global settlement may be modest in comparison to the landmark Tobacco Master Settlement Agreement in 1998,⁴ the opioid settlement funds are even more precious and require coordination and thoughtful utilization to maximize their impact.

The opioid settlement funds must not replace what government agencies should already be doing, but rather, catalyze bolder initiatives that may not be possible with current sources of opioid-related funds, particularly in addressing structural determinants of the overdose crisis. The funds present a critical opportunity to work in synergy with other available resources. Since 2016, the federal government has awarded around \$11.7 billion in opioid-related grants to states, territories, and localities, and most states now have the infrastructure to direct funds to areas that are most impacted by the opioid crisis.⁵ However, federal opioid-related grants impose

1 Grantmakers in Health. “Responding to the opioid and drug overdose epidemic.” (2020). Available at <https://www.gih.org/publication/responding-to-the-opioid-and-drug-overdose-epidemic/>

2 Substance Abuse and Mental Health Services Administration (SAMHSA). “The opioid crisis and the Black/African American population: an urgent issue.” Publication No. PEP20-05-02-001. (2020). Available at https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf

3 Minhee, C. The Opioid Settlement Tracker. <https://www.opioidsettlementtracker.com>

4 Heaton, C. “Tobacco master settlement agreement—strategic lessons for addressing public health problems.” *New England Journal of Medicine*, 379, 997-1000. (2018). doi: 10.1056/NEJMp1802633

5 Bipartisan Policy Center. “Tracking federal funding to combat the opioid crisis.” (2019). Available at <https://bipartisanpolicy.org/wp-content/uploads/2019/03/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf>

conditions, such as prohibitions on addressing co-dependence with other substances. These restrictions have hindered a more meaningful response that reflects the realities faced by people at risk of overdose, and, at times, overlooks inequities.

From the criminalization of “illicit opioids” that has enabled state-sanctioned violence against Black, Indigenous, and People of Color (BIPOC) communities to the aggressive marketing tactics that have fueled the overprescribing of ‘pharmaceutical opioids’ in rural or working-class areas, the drivers of the overdose crisis are deeply entrenched in inequitable systems of power.⁶ Even before the COVID-19 pandemic, when overall overdose-related deaths were beginning to decline, the number of fatal overdoses among BIPOC individuals continued to rise in many cities across the country.⁷ The pandemic has also disproportionately surged through these communities and has only compounded these disparities. People at risk of overdose are facing greater social isolation and disruption of treatment and access to safer use supplies and support systems.⁸ To address the crisis in a meaningful way, policymakers, regulators, community organizations, and funders must work together to adopt solutions that distribute wealth, care access, and resources to the communities and individuals impacted by the crisis. The need for an equitable and structural response to the overdose crisis is more urgent and critical than ever.

SUMMARY OF RECOMMENDATIONS

The following recommendations are centered on two key principles: (1) supporting the full range of care, services, and support for people who use drugs and people with opioid dependence, and (2) rethinking prevention to address the underlying determinants of opioid use and dependence. The recommendations emerge from the point of view that the overdose crisis is rooted in health disparities, racially motivated drug policies, class inequalities, sustained disruption of social safety nets, loss of economic opportunities, and other long-standing structural barriers and violence. This framing opens a broader range of solutions integrated across health care, mental health, housing, employment, child welfare, and criminal justice, as posited in our two categories of proposals.

First, policymakers should prioritize the health and well-being of people who use drugs and people with opioid dependence, particularly those who are most at risk of overdose. The lack of access to overdose reversal medication, safer use supplies, long-term substitution treatment, and basic health care—due to cost, stigma, and other barriers—heightens the risk of overdose. Opioid use disorder (OUD) is a complex chronic, relapsing medical condition that often requires life-long care. Episodes of relapse should be anticipated and

6 Murch, D. “How race made the opioid crisis.” *Boston Review*. (2019). Available at <http://bostonreview.net/forum/donna-murch-how-race-made-opioid-crisis>

7 Katz, J., Goodnough, A., & Sanger-Katz, M. “In shadow of pandemic, U.S. drug overdose deaths resurge to record.” *New York Times*. (2020). Available at <https://www.nytimes.com/interactive/2020/07/15/upshot/drug-overdose-deaths.html?referringSource=articleShare>

8 Misha Gajewski. “States scramble to deal with the compounding Covid and opioid epidemic.” *Forbes*. (2020). Available at <https://www.forbes.com/sites/mishagajewski/2020/07/29/states-scramble-to-deal-with-the-compounding-covid-and-opioid-epidemic/amp/>

should not be considered a failure or a reason to discontinue treatment. Furthermore, not every individual who uses opioids develops OUD, and many seek other health or social services to maintain their well-being. The “continuum of care” should encompass the broad range of evidence-based services, treatments, and support, not as a linear pipeline, but as a long-term outlook that reduces the harms associated with opioid use and is responsive to individual health goals—whether it is to stop use or to stabilize.⁹

Second, prevention strategies for the overdose crisis should address the structural determinants that lead individuals to use and the inequities that worsen the consequences of use. Historically, substance use ‘prevention’ has been centered on curbing youth use—a strategy largely shaped by tobacco control efforts. However, youth prevention campaigns have fallen short in addressing the racial, social, and economic inequalities that drive substance use. While reports show that national tobacco control efforts have led to a decline in overall tobacco use, glaring disparities in tobacco use and tobacco-related health conditions continue to exist across race, ethnicity, sexual orientation, education, income, health insurance coverage, geographic regions, and mental health.¹⁰

Policymakers can draw useful lessons from tobacco control efforts, but these lessons should be informed by important distinctions between opioid and tobacco use, including with respect to both ‘pharmaceutical opioids’ and ‘illicit opioids.’¹¹ Opioids are essential medicines for controlling and reducing pain, so not all supply suppression strategies utilized by tobacco control efforts translate to the opioid space. Furthermore, opioids have been criminalized in ways that tobacco products have not (i.e., people do not end up in prison for smoking tobacco). These distinctions highlight pressure points for prevention strategies that consider structural disparities in opioid dependence and overdose. Addressing the former—the overprescribing of pharmaceutical opioids—without responding to the latter—the criminalization of illicit opioids—will only perpetuate racist and structurally inequitable drug policies.¹²

9 United for Survival & Beyond. (2020, June 1). <https://survivalandbeyond.info/platform/>

10 Truth Initiative. “Achieving health equity in tobacco.” (2015). Available at <https://truthinitiative.org/sites/default/files/media/files/2019/03/Achieving%20Health%20Equity%20in%20Tobacco%20Control%20-%20Version%201.pdf>

11 Murch, D. “How race made the opioid crisis.” Boston Review. (2019). Available at <http://bostonreview.net/forum/donna-murch-how-race-made-opioid-crisis>

12 53% of White individuals who have opioid dependence began with prescription opioids while only 26% of Black individuals with opioid dependence began with prescription opioids. S. S. Martins, A. Sarvet, J. Santaella-Tenorio, T. Saha, B. F. Grant, & D. S. Hasin, “Changes in US lifetime heroin use and heroin use disorder: prevalence from the 2001-2002 to 2012-2013 National Epidemiologic Survey on Alcohol and Related Conditions.” *JAMA Psychiatry* 74(5), 445-512. (2017).

EXPERT RECOMMENDATIONS FOR THE USE OF OPIOID SETTLEMENT FUNDS FOR POLICY MAKERS AND ADVOCATES

PRIORITIZING THE HEALTH AND WELL-BEING OF PEOPLE WHO USE DRUGS AND PEOPLE WITH OPIOID DEPENDENCE

1

Set up a bulk purchasing fund to procure overdose reversal medication (naloxone) and Medications for Addiction Treatment (MAT) at lower prices

2

Increase community-based distribution of overdose reversal medication (naloxone) to reach people at risk of overdose

3

Increase community-based distribution of safer use supplies and low-threshold services to reduce the risk of death, overdose, and other harms associated with opioid use

4

Expand access to evidence-based and non-coercive Medications for Addiction Treatment (MAT) and other treatment programs for opioid use disorder

5

Provide naloxone training, MAT, and related care for individuals who are arrested, detained, incarcerated, or post-incarcerated

6

Expand Medicaid to ensure access to quality health care and increase funding for other health and social services tailored for people who use drugs or are at risk of overdose

PREVENTING OPIOID USE AND ADDRESSING STRUCTURAL DRIVERS OF OPIOID USE AND DEPENDENCE

7

Create a national campaign to address stigma and misconceptions around drug use and treatment both in the general public and among clinicians

8

Monitor the pharmaceutical opioid supply while promoting evidence-based and compassionate pain management for individuals, including people who use drugs

9

Divest from punitive and carceral approaches to addressing drug use and reform the criminal legal system and corollary systems

10

Invest in community development programs and remove abstinence-only conditions that further punish drug use

11

Allocate funds to create a non-profit foundation that coordinates a national-level response and serves as a non-governmental watchdog

Recommendation 1: Set up a bulk purchasing fund to procure overdose reversal medication (naloxone) and Medications for Addiction Treatment (MAT) at lower prices

The rising costs of pharmaceuticals have become a major barrier for individuals and communities to access life-saving overdose reversal medication and long-term substitution treatment. Naloxone is a medication that is highly effective in reversing opioid overdose and reducing the risk of long-term brain damage and other overdose-related morbidities. However, depending on the specific naloxone product, prices have skyrocketed 244% to 3797% between 2006 and 2017,¹³ creating an access barrier for individuals who are most likely to experience or witness an overdose. For example, the first auto-injector version of naloxone (Evzio), which contains a few cents worth of the medicine, was listed at \$690 for a twin-pack shortly after FDA approval in 2014.¹⁴ By 2017, the same twin-pack cost \$4,500, a 550% increase. While the nasal spray version of naloxone is significantly more affordable, it is still priced at \$140 for a two-bottle supply.

Similarly, the prices of Medications for Addiction Treatment (MAT) for opioid use disorder (OUD) have sharply increased in the past several years. The World Health Organization (WHO) considers methadone and buprenorphine as the ‘gold standard’ for the long-term treatment and stabilization of OUD, including reducing the risk of fatal overdose in cases of relapse.¹⁵ However, newer MAT pharmaceuticals are entering the market with higher costs but less evidence of safety and efficacy. For example, naltrexone (Vivitrol) has recently become the fastest growing medicine for opioid dependence even though it is considerably more expensive than methadone and buprenorphine and is backed by less research on its adverse effects, its efficacy in managing withdrawals or cravings, and its ability to reduce the risk of fatal overdose following discontinuation.¹⁶

Recognizing this concern, some of the plaintiffs in the opioid litigation have called for the pharmaceutical defendants to provide naloxone and MAT in addition to settlement dollars, and at least one defendant has

13 Rosenberg, M., Chai, G., Mehta, S., & Schlick, A. Trends and economic drivers for United States naloxone pricing, January 2006 to February 2017. *Addictive Behaviors*, 86, 86-89. (2018). doi: 10.1016/j.addbeh.2018.05.006

14 Banerjee, A. “Senators question Kaleo’s \$4,500 tag on opioid overdose treatment.” Reuters. (2017). Available at <https://www.reuters.com/article/us-kaleo-evzio-prices/senators-question-kaleo-4500-tag-on-opioid-overdose-treatment-idUSKBN1502RI>

15 Wakeman, S., Larochele, M., Ameli, O., et al. “Comparative effectiveness of different treatment pathways for opioid use disorder.” *JAMA Network Open*, 3(2), e1920622. (2020). doi:10.1001/jamanetworkopen.2019.20622

16 Wakeman, S., Larochele, M., Ameli, O., et al. “Comparative effectiveness of different treatment pathways for opioid use disorder.” *JAMA Network Open*, 3(2), e1920622. (2020). doi:10.1001/jamanetworkopen.2019.20622

agreed to provide \$25 million worth of MAT pharmaceuticals.¹⁷ However, several state attorneys general have raised concerns about defendants contributing these products as part of the settlement terms.¹⁸ Such a framework would risk placing an inflated value on those medicines, particularly when many pharmaceutical manufacturers of naloxone and MAT have engaged in price gouging since the opioid crisis was declared a ‘public health emergency.’

As an alternative, policymakers should consider using a portion of the settlement funds to create a trust fund dedicated to purchasing naloxone and MAT in bulk. State legislators, health officials, and attorneys general in particular can leverage their bargaining power and negotiate more affordable drug prices to meet local and community needs.¹⁹ While the implementation of such a fund would depend on the political processes within each state, the Massachusetts’ Municipal Naloxone Bulk Purchase Trust Fund provides a useful blueprint. In 2015, the Massachusetts attorney general reached an agreement with a manufacturer of naloxone (Narcan) to settle claims of price gouging. With the \$325,000 settlement, the Massachusetts attorney general partnered with the state legislature and Department of Public Health to set up a trust fund.²⁰ As a show of collaboration, lawmakers provided an initial funding of \$150,000 for the trust fund in the state budget, and the Department of Public Health now administers the trust fund to purchase naloxone at a wholesale price and directly sells to cities and towns at a heavily discounted rate. Furthermore, to ensure that the funds are used solely for their intended purpose, the legislature enacted a law that allows money remaining at the end of the fiscal year to stay in the trust fund and not revert to the general fund.

A government procurement system has the potential not only to tackle a major barrier to treating overdose and OUD, but also to set a precedent in countering rising pharmaceutical prices more broadly. Several larger states and consortium of states have explored government-funded generic production, with California being the first to create a state-sponsored generic drug label.²¹ Furthermore, one of the reasons that pharmaceutical companies have been able to increase the prices of naloxone and MAT pharmaceuticals is through the patenting of newer formulations, packaging, and delivery methods—a common industry practice to extend the lifetime of pharmaceutical patents. The Defense Production Act allows for the federal government to issue compulsory licenses to bypass patents and authorize generic production by providing reasonable compensation to patent holders.²² Invoking this law, which has largely been underutilized for public health

17 In the multi-district opioid litigation, Teva Pharmaceutical agreed to provide an additional \$25 million worth of Suboxone, a MAT treatment that combines buprenorphine and naloxone. Minhee, C. The Opioid Settlement Tracker. Available at <https://www.opioidsettlementtracker.com>

18 Hals, T., & Raymond, N. “Several states wary of \$48 billion opioid settlement proposal.” Reuters. (2019). Available at <https://www.reuters.com/article/us-usa-opioid-lawsuits/several-states-wary-of-48-billion-opioid-settlement-proposal-idUSKBN1X315P>

19 National Conference of State Legislature. Pharmaceutical Bulk Purchasing. (2020, March 2). Available at <https://www.ncsl.org/research/health/bulk-purchasing-of-prescription-drugs.aspx>

20 Office of Attorney General Maura Healey. “AG Healey announces \$325K agreement with naloxone manufacturer, dedicates funds to help first responders statewide access life-saving drug.” [Press release]. (2015, August 31). Available at <https://www.mass.gov/news/ag-healey-announces-325k-agreement-with-naloxone-manufacturer-dedicates-funds-to-help-first>

21 Office of Governor Gavin Newsom. “Governor Newsom signs legislation advancing California’s fight to lower prescription drug prices.” [Press release]. (2020, Sept. 28). Available at <https://www.gov.ca.gov/2020/09/28/governor-newsom-signs-legislation-advancing-californias-fight-to-lower-prescription-drug-prices/>

22 Defense Production Act of 1950. 28 U.S.C. § 1498(a).

purposes, would allow the federal government to procure generic versions of naloxone and MAT that are still covered under patent protection and decrease the costs of those medicines. (In theory, it may be the threat of issuing a compulsory license that gives the government negotiating power and would force pharmaceutical companies to lower prices, as opposed to actual government-funded generic production.) Thus, in addition to state-level generic production, state leaders can call upon federal agencies to issue compulsory licenses for patented versions of naloxone and MAT.

Recommendation 2: Increase community-based distribution of overdose reversal medication to reach people at risk of overdose

Despite evidence that naloxone is most effective when it is available at the time of overdose and administered in time to reverse respiratory depression, current distribution practices fall short in reaching people who are most at risk of overdose or are likely to witness an overdose.²³ Naloxone is often given to first responders, such as police and emergency medical technicians, leaving people in need of immediate overdose reversal assistance to call on authorities for help. This is something individuals may be unwilling to do given the risk of criminal charges or other penalties associated with drug use, particularly as drug-induced homicide charges have become more widespread.

For this reason, the WHO recommends community-based distribution of naloxone—putting the medicine in the hands of people who use drugs and their social networks—as the first line of defense against overdose.²⁴ A review of various naloxone distribution strategies found that Opioid Education and Naloxone Distribution (OEND) programs where existing and trusted community organizations directly train and distribute naloxone to high-risk individuals are the most effective in preventing overdose deaths and more impactful than other distribution sites, such as pharmacies and hospitals.²⁵ One study showed that community-based naloxone distribution through syringe exchange programs resulted in an approximately 65% reduction in overdose fatalities over a six month period compared to the baseline.²⁶ Similarly, another study found that distributing naloxone to people released from prison reduced opioid-related deaths by 36% in the four weeks following release.²⁷

23 Leonard Davis Institute of Health Economics. "Expanding access to naloxone: a review of distribution strategies." (2019). Available at <https://di.upenn.edu/brief/expanding-access-naloxone-review-distribution-strategies>

24 World Health Organization. "Community management of opioid overdose." (2014). Available at <https://www.who.int/publications-detail/9789241548816>

25 Leonard Davis Institute of Health Economics. "Expanding access to naloxone: a review of distribution strategies." (2019). Available at <https://di.upenn.edu/brief/expanding-access-naloxone-review-distribution-strategies>

26 Keanu, C., Egan, J., & Hawk, M. "Effects of naloxone distribution to likely bystanders: results of an agent-based model." *International Journal of Drug Policy*. 55:61-69. (2018). Available at <https://pubmed.ncbi.nlm.nih.gov/29524734/>

27 Bird, S., McAuley, A., Perry, S., & Hunter, C. "Effectiveness of Scotland's National Naloxone Programme for reducing opioid-related deaths: a before (2006-10) versus after (2011-13) comparison." *Addiction*. 111(5):883-891. (2016). Available at <https://pubmed.ncbi.nlm.nih.gov/26642424/>

In addition to allocating funds, state and local policymakers should develop policies that support community-based distribution and protect organizations and laypeople who use naloxone and report overdoses. By 2017, all 50 states and the District of Columbia passed legislation to improve naloxone access for laypeople and organizations, including non-profits and syringe exchange programs, and by 2018, 46 states and the District of Columbia passed Good Samaritan laws that provide varying degrees of protection for bystanders reporting an overdose.²⁸ Naloxone access laws and Good Samaritan laws are linked to overall reductions in opioid overdose fatalities by about 14% and 15%, respectively.²⁹ For Black communities that face disparate policing and criminalization, the laws reduced opioid-related overdose deaths by 23% and 26%, respectively.³⁰ Policymakers can expand these laws to offer wider protection from arrest and prosecution for possession, paraphernalia, and other violations, such as violating parole conditions, as well as ensure that first responders implement the protections. To remove barriers to community-based distribution of naloxone even further, policymakers should support federal-level efforts to convert individual naloxone products from prescription to over-the-counter.³¹

Recommendation 3: Increase community-based distribution of safer use supplies and low-threshold care to reduce the risk of death, overdose, and other harms associated with opioid use

In addition to naloxone, there is a broad array of safer use supplies that reduce the harms and health risks associated with drug use. Abstinence-only interventions that are aimed at ‘stopping’ drug use miss contact with people who continue to use drugs—the very population most at risk of fatal overdose, including people in closed settings (e.g., prisons, jails, detention centers, in-patient treatment centers) or released from them. Distributing safer use supplies directly to high-risk individuals and providing low-threshold services can offer care and counseling without coercing or controlling the individual’s intake of drugs, particularly as individuals may be reluctant to use conventional services despite their increased health care needs.

The most commonly cited examples of ‘harm reduction’ care include access to sterile syringes, safer smoking supplies, and drug checking technologies—all of which have been shown to reduce health risks associated with drug use, including overdose, HIV and Hepatitis C Virus (HCV) transmission, and skin and soft tissue infections.

28 The Network for Public Health Law. “Legal interventions to reduce overdose mortality: naloxone access and overdose Good Samaritan Laws.” (2017). Available at <https://www.networkforphl.org/wp-content/uploads/2020/01/legal-interventions-to-reduce-overdose.pdf>

29 McClellan, C., et al., “Opioid-overdose laws associated with opioid use and overdose mortality”. *Addictive Behaviors* 86(90) (2018). doi: 10.1016/j.addbeh.2018.03.014

30 McClellan, C., et al., “Opioid-overdose laws associated with opioid use and overdose mortality”. *Addictive Behaviors* 86(90) (2018). doi: 10.1016/j.addbeh.2018.03.014

31 The U.S. Food and Drug Administration Commissioner has the authority to initiate and approve an over-the-counter switch, and FDA regulations require that the Commissioner remove the prescription requirements when such requirements are not necessary to protect the public health and the drug is safe and effective for self-use as directed by the labeling. 21 CFR § 310.200(b).

Policymakers should tailor distribution strategies to reach high-risk individuals and invest in community-led or peer-led models that serve people who use drugs, including people in sex work and people who are houseless. In addition, policymakers should support the distribution of safer use supplies by passing legislation or setting forth policies to remove legal barriers. For example, drug checking technologies, like test strips, are a cheap and cost-effective way to reduce the risk of overdose and death by allowing individuals to check for contaminants in the drug supply—particularly fentanyl, which has become increasingly responsible for overdose deaths. However, many states have anti-drug checking laws that prohibit the distribution of testing strips or other more advanced drug checking technologies, like infrared spectrometers or mass spectrometers.³²

In addition to community-based distribution of safer use supplies that reach individuals and their social networks, policymakers should invest in drop-in centers, clinics, ‘one-stop shops,’ and other in-door services where people can access supplies, wound treatment, therapy, and follow-up care with ease. The criminalization of drug use and the fear of penalties have driven drug use ‘underground,’ increasing the risk of overdose and deterring individuals from seeking care. Access to physical spaces can provide an environment that not only minimizes the risk of overdose and death, but also opens the possibility of therapeutic relationship-building, education and follow-up care. Policymakers should support such sites that have been proven to reach individuals effectively, such as syringe exchange programs. Settlement funds can support syringe exchange programs increase their capacity and build out their services to include HCV treatment, wound care, and low-threshold treatments.

The opioid settlement funds can also pilot new interventions, such as overdose prevention centers (OPCs), where people can use illicit substances under medical supervision and access on-site initiation of Medications for Addiction Treatment (MAT), wound care, and referrals to primary care, social services, and housing services. While OPCs do not yet exist in the US due to legal and political barriers, supervised observation units (which offer clinical supervision immediately after consumption) have operated successfully in the US for years. Further, various models of OPCs or drug consumption rooms (DCRs) have been in operation for many years in other countries, including Canada, Germany, Denmark, and the Netherlands, and have succeeded in reducing the likelihood of overdose and overdose fatalities and connecting individuals to care. Funding a pilot OPC would be a visionary use of the opioid settlement funds.

Note: As mentioned in the Introduction to this paper, the opioid settlement funds should not replace what government agencies could already be doing, but rather, catalyze bolder initiatives that may not be possible with current sources of opioid-related funds. Recommendations 4-6 contain a mix of broader policy recommendations, initiatives that states could and should already be pursuing in order to have an impact on overdose death rates and to create an enabling, together with some specific ways in which opioid settlement funds should be used to advance towards those broader policy aims.

32 In North Carolina, the legislation that supports drug checking was written so narrowly that it protects checking with test strips, but not with mass spectrometers.

Recommendation 4: Expand access to evidence-based and non-coercive Medications for Addiction Treatment (MAT) and other treatment programs for opioid use disorder

Medications for Addiction Treatment (MAT) with methadone or buprenorphine/naloxone are the world standard for long-term treatment and stabilization of opioid use disorder (OUD).³³ Multiple studies show that these therapies reduce the risk of fatal overdose, minimize the severity of relapses, and even decrease incarceration rates for drug-related crimes³⁴ to the point where “treatment actually saves society money” with respect to costs associated with emergency response, health services, and the criminal legal system.³⁵ But it is important to underscore that settlement funds should only be used for expanding access through voluntary means, as coercive practices and undue restrictions are harmful and perpetuate disparities in access to quality care for opioid dependence.

Policymakers should dedicate settlement funds to expanding newly relaxed treatment practices. As a response to COVID-19, the federal government has temporarily relaxed rules on opioid treatments in ways that were not possible before. In March 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) released guidance on opioid treatment programs, which permit states to request blanket exceptions for patients to receive 14 to 28 days of take-home doses of OUD medication, including methadone.³⁶ Methadone clinics are now able to provide four weeks’ worth of the methadone, rather than requiring individuals to come in for daily visits and dispensing, and physicians are able to evaluate patients via telemedicine. Policymakers should make it a priority to implement these welcome enhancements in all jurisdictions, and to make them permanent to further alleviate the barriers to MAT access, including expanding prescribing clearances to meet individuals’ health needs.

Additionally, in order to prescribe some forms of MAT, providers must opt to submit to additional training and credentialing simply to receive an “X Waiver” (a requirement entirely absent prior to the same providers prescribing opioids). This regulatory hurdle has led to treatment access shortages, especially in BIPOC and poor communities, where the overdose epidemic has hit hardest. Efforts should be made to use settlement funds to address these shortages, either through policy changes to remove this additional credentialing or to incentivize more providers in doing so.

33 Wakeman, S., Larochele, M., Ameli, O., et al. “Comparative effectiveness of different treatment pathways for opioid use disorder.” *JAMA Network Open*, 3(2), e1920622. (2020). doi:10.1001/jamanetworkopen.2019.20622

34 Wilson, D., et al. “The cost-effectiveness of harm reduction.” *International Journal of Drug Policy* 26(1):S5-S11. (2015). <https://doi.org/10.1016/j.drugpo.2014.11.007>

35 Frakt, A. “Spend a Dollar on Drug Treatment, and Save More on Crime Reduction” *The New York Times*. (2017). Available at <https://www.nytimes.com/2017/04/24/upshot/spend-a-dollar-on-drug-treatment-and-save-more-on-crime-reduction.html>

36 Substance Abuse and Mental Health Services Administration (SAMHSA). “Opioid treatment program guidance – updated 3/19/2020.” Available at <https://www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf>

Recommendation 5: Provide naloxone training, MAT access, and related care for people who are arrested, detained, incarcerated, post-incarcerated, or otherwise involved in the criminal legal system.

While the specific percentage varies from city to city, around 25% of people who inject drugs report being incarcerated,³⁷ and 90% of detained or incarcerated individuals with opioid dependency do not receive MAT or other medical treatment during their time in prison or jail.³⁸ Due to the racially-determined criminalization of drug use, individuals from poor and BIPOC communities face harsher arrests, prosecutions, and sentencing for drug-related offenses and more traumatic consequences in corollary punitive systems, including immigration and child welfare systems—all of which impedes access to care and further heightens the risk of overdose and death following release.

While a goal of these funds should be to shift away from punitive approaches, policymakers should concurrently ensure access to naloxone, all FDA-approved forms of MAT, and other services and support systems during incarceration and post-incarceration.³⁹ Discontinuing MAT during incarceration leads to the detrimental effects of withdrawal and contributes to the high risk of relapse and opioid overdose upon release. Furthermore, a recent study found that distributing naloxone to people released from prison reduced opioid-related deaths by 36% in the four weeks following release.⁴⁰ Prisons and jails should employ health professionals to assess incarcerated individuals for opioid dependence and where voluntarily elected by the individual, should provide MAT and arrange for continued MAT, naloxone access, and overdose prevention training to prepare individuals to re-integrate into their communities.⁴¹ Opioid settlement funds could support pilot programs to advance these approaches.

Because of the criminalization of drug use, and lack of understanding of the chronic relapsing nature of OUD, policymakers and others sometimes call for programs that “mandate” abstinence. Law enforcement agencies have acted as gate-keepers that mandate or coerce treatment and impose non-evidence-based outcome metrics, particularly for BIPOC communities, people in sex work, and individuals facing poverty and housing insecurity.⁴² For their part, family and drug court judges often fail to align court-ordered treatments with the clinically accepted standards for MAT.⁴³ Policymakers should take care to ensure that settlement funds are not used to prop up these practices, and should ensure that any support goes to voluntary and non-coercive

37 Centers for Disease Control and Prevention (CDC). “HIV and People Who Use Drugs.” (2019). Available at <https://www.cdc.gov/hiv/group/hiv-idu.html>

38 Katz, J. “How a police chief, a governor, and a sociologist would spend \$100 billion to solve the opioid crisis.” *New York Times*. (2018). Available at <https://www.nytimes.com/interactive/2018/02/14/upshot/opioid-crisis-solutions.html>

39 Rhode Island and many municipalities have made all three forms of FDA-approved MAT available for incarcerated people.

40 Bird, S., McAuley, A., Perry, S., & Hunter, C. “Effectiveness of Scotland’s National Naloxone Programme for reducing opioid-related deaths: a before (2006-10) versus after (2011-13) comparison.” *Addiction*. 111(5):883-891. (2016). Available at <https://pubmed.ncbi.nlm.nih.gov/26642424/>

41 National Advocates for Pregnant Women (NAPW). “Re: In re Purdue Pharma Debtors’ Emergency Fund Expenditures – Proposed Guidelines.” (2020).

42 Physicians for Human Rights. “Neither justice nor treatment.” (2017). Available at https://phr.org/wp-content/uploads/2017/06/phr_drugcourts_report_singlepages.pdf

43 National Advocates for Pregnant Women (NAPW). “Re: In re Purdue Pharma Debtors’ Emergency Fund Expenditures – Proposed Guidelines.” (2020).

models, where treatment plans are tailored to the goals of the individual—whether it is to stop substance use or to stabilize by managing withdrawals or cravings.

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Recommendation 6: Expand Medicaid to ensure access to quality health care, and increase funding for other health services and care tailored for people who use drugs or are at risk of overdose

While some states did use tobacco settlement funds to increase enrollment in Medicaid or SCHIP,⁴⁶ we recommend that states who wish to have the maximum impact on overdose rates should already move forward with Medicaid expansion in order to create an enabling environment and allow the settlement funds to be used more effectively.

Many of the medical conditions associated with drug use, such as tissue infections, abscesses, and even overdose itself, are preventable and perpetuated by the criminalized context in which drug use is taking place. Yet, despite urgent and long-term health needs, people who use drugs face challenges to accessing quality health care, including significant barriers related to lack of insurance coverage. Around 16% of people who inject drugs reported having no health insurance,⁴⁷ and the number is likely higher among users in Black communities where one in five Black Americans in general are uninsured, compared to about one in eight white Americans.⁴⁸ Of the 30 million people who remain uninsured, approximately half are people of color, and among the 14 states that have refused to expand Medicaid, many have the largest populations of Black

44 Physicians for Human Rights. “Neither justice nor treatment.” (2017). Available at https://phr.org/wp-content/uploads/2017/06/phr_drugcourts_report_singlepages.pdf

45 National Advocates for Pregnant Women (NAPW). “Re: In re Purdue Pharma Debtors’ Emergency Fund Expenditures – Proposed Guidelines.” (2020).

46 Relatedly, thirty-five states used a significant portion of their tobacco MSA funds to health care, including expanding Medicaid, with several states allocating more than 90 percent of their MSA funds. U.S. Government Accountability Office (GAO). “Tobacco Settlement: states’ use of Master Settlement Agreement payments.” (2001). Available at <https://www.gao.gov/new.items/d01851.pdf>

47 Centers for Disease Control and Prevention (CDC). “HIV and People Who Use Drugs.” (2019). Available at <https://www.cdc.gov/hiv/group/hiv-idu.html>

48 Young, C. “There are clear-race-based inequalities in health insurance and health outcomes.” USC-Brookings Schaeffer on Health Policy. (2020). Available at <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/02/19/there-are-clear-race-based-inequalities-in-health-insurance-and-health-outcomes/>

Americans.⁴⁹

Medicaid the largest payor for MAT. Expanding coverage and removing restrictions on OUD treatment and related care are critical to stemming overdose and promoting quality basic health care for people who use drugs. A bipartisan report on the impact of opioid-related federal grants found that states that had expanded Medicaid, such as Ohio, were better equipped and more effective in providing access to MAT, in responding to the opioid and overdose crisis in general, and in addressing corollary health issues, such as HCV infections from shared needles.⁵⁰ Policymakers should join ongoing movements for health equity and racial justice to expand Medicaid, eliminate bureaucratic obstacles, such as pre-authorization and work search requirements, and bolster documentation, reporting, and analysis on race and ethnicity.

In addition, policymakers should increase funding for other services and care for people who are at risk of overdose, such as expanding screening, testing, and treatment for HCV, HIV, and other infectious diseases from intravenous opioid use. In 2017, people who inject drugs accounted for 9% of new HIV diagnoses in the U.S.,⁵¹ with many more cases undiagnosed because of limited or no access to health care. Finally, policymakers should focus on supporting services that reach the unmet health needs of specific groups, such as care and counseling for young people or pregnant and post-partum individuals, telehealth services for individuals in rural areas with strained health systems or individuals with disabilities, and mental health, behavioral, and social therapies and counseling for those who request it. Opioid settlement funds might support these efforts through funding pilot programs and evaluations.

49 Young, C. "There are clear-race-based inequalities in health insurance and health outcomes." USC-Brookings Schaeffer on Health Policy. (2020). Available at <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/02/19/there-are-clear-race-based-inequalities-in-health-insurance-and-health-outcomes/>

50 Bipartisan Policy Center. "Tracking federal funding to combat the opioid crisis." (2019). Available at <https://bipartisanpolicy.org/wp-content/uploads/2019/03/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf>

51 Centers for Disease Control and Prevention (CDC). "HIV and People Who Use Drugs." (2019). Available at <https://www.cdc.gov/hiv/group/hiv-idu.html>

PREVENTING OPIOID USE AND ADDRESSING STRUCTURAL DRIVERS OF OPIOID USE AND DEPENDENCE

Recommendation 7: Create a national campaign to address stigma and misconceptions around drug use and treatment both in the general public and among clinicians

Stigma and misconceptions around drug use and treatment pose a significant barrier to timely and effective treatment and care of OUD. It is not only individuals and families that may be reluctant to acknowledge the need for support, but stigma also plays into community conversations, and at times, opposition to the expansion of services. Misconceptions among health care workers can also impact the quality of care. At the same time, many of the regulatory restrictions governing MAT are based on stigma and misinformation, rather than clinical evidence. For example, 16 states in the country still prohibit Medicaid coverage of methadone maintenance care, and some private insurance companies have preauthorization requirements for MAT coverage.⁵² Removing these barriers will require de-stigmatizing drug use and promoting science-based regulations and high-impact treatment programs with evidence-based outcomes. It will also require public education and trainings for service providers, clinicians, and the public to socialize a compassionate and equitable response to opioid use.

A mechanism should be introduced to pool settlement funds to support a national campaign on a compassionate and equitable response to drug dependency and to de-stigmatize effective responses, including the use of medication for addictions treatment (MAT). Specifically, funds could be used to support the creation of a national public communications strategy to address stigma and misconceptions among the general population about MAT and drug use. Many states have already initiated their own campaigns—for example, North Carolina’s “More Powerful NC” was established by the state attorney general and state Department of Health and Human Services to raise awareness around the opioid crisis. However, rather than each state developing its own campaign (something that can be prohibitively expensive), states should pool some settlement funds to be used for a national media mechanism. This would enable limited resources to reach a larger audience, and the national campaign messaging could be well-tested and evidence-based.

A national campaign to address misconceptions among clinicians may be particularly valuable in parallel to other efforts to expand clinical education. For example, there is still enormous stigma around pregnant individuals with opioid use disorder, and a campaign that can help providers understand that buprenorphine

⁵² More Powerful NC. <https://www.morepowerfulnc.org/>

and methadone are safe and effective treatments for OUD during pregnancy⁵³ could ensure that pregnant individuals are encouraged and not penalized by the criminal legal or child welfare system for using these treatments. While babies exposed to these medications may experience Neonatal Abstinence Syndrome (NAS), it is less severe than in the absence of treatment during pregnancy.⁵⁴ Furthermore, NAS is a transitory set of conditions that are treatable with protocols that involve keeping the parent and baby together, reducing time in the NICU and hospital, and chest feeding, which is safe and recommended even while taking methadone or buprenorphine. As a cost-effective way to address maternal opioid use or potential prenatal exposure, hospitals and child welfare agencies should provide staff on best practices for “rooming-in,” which has been shown by growing evidence to promote positive outcomes for maternal and neonatal health.⁵⁵

Recommendation 8: Monitor the pharmaceutical opioid supply while promoting evidence-based and compassionate pain management for individuals, including people who use drugs

To address the role of pharmaceutical opioids in fueling the overdose crisis, policymakers should support strategies better to monitor the promotion, prescribing, and dispensing of such products. However, given racial and gender disparities in health professionals’ perceptions of patient pain, blanket attempts to restrict prescription opioids backfire and cause more harm for people who use drugs or have opioid dependence, and can even drive those requiring pain management to illicit opioid use, increasing their overdose risk.⁵⁶ Policymakers should adopt approaches that prevent overprescribing while promoting evidence-based standards for compassionate and equitable pain management.

While more thoughtful implementation and improvements are needed, prescription drug monitoring programs, including data monitoring, can offer a new interface between doctors, pharmacists, patients, and regulatory agencies and promote accountability for industry practices. In the late 1990s, pharmaceutical manufacturers of opioid painkillers began using prescribing data from data mining companies to target doctors in working-class areas with higher proportions of disability claims and workplace injuries and promote broader uses of painkillers, fueling the demand for pharmaceutical opioids. In 2019, the federal judge overseeing the opioid litigation lifted the protective order on a database maintained by the Drug Enforcement Administration (DEA). It then finally revealed to the public that the DEA had data tracking every prescription opioid in the U.S., but

53 National Institute on Drug Abuse. “Risk of opioid misuse during pregnancy.” (2017). Available at <https://www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy#ref>

54 National Institute on Drug Abuse. “Risk of opioid misuse during pregnancy.” (2017). Available at <https://www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy#ref>

55 National Advocates for Pregnant Women (NAPW). “Re: In re Purdue Pharma Debtors’ Emergency Fund Expenditures – Proposed Guidelines.” (2020).

56 Substance Abuse and Mental Health Services Administration (SAMHSA). “The opioid crisis and the Black/African American population: an urgent issue.” Publication No. PEP20-05-02-001. (2020). Available at https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf

for decades, regulators failed to act on the surge of painkillers that fueled the opioid crisis in certain parts of the country.⁵⁷ If overseen by a non-governmental watchdog (see Recommendation 11), a data monitoring system can promote greater accountability and transparency for opioid distribution and prescribing practices. It will also require policymakers to address legal and ethical concerns, including patient privacy and the risk of public and private actors improperly accessing patient information, for example, to terminate parental rights or determine employment eligibility.

Furthermore, to prevent overprescribing without creating burdens for those who need pharmaceutical opioids, policymakers should allocate funds to educate and train clinicians through counter-detailing programs, or “academic detailing,” and to develop a stronger clinical evidence base for compassionate chronic pain management. Suppressing access to prescription opioids—for example, restricting the use of painkillers during labor for pregnant individuals who use drugs—can worsen problems and go beyond intended restrictions on over-prescribing,⁵⁸ particularly as many individuals who face barriers to accessing prescription opioids also face broader health access barriers because of racism and socioeconomic discrimination.⁵⁹ Guidelines on opioid prescription for clinicians have been shown, not only to be more effective at reducing the percentage of opioid prescriptions for emergency department patients and doses of morphine compared to prescription monitoring programs,⁶⁰ but also to promote a more evidence-based practice for managing the pain of poor and BIPOC patients.⁶¹

Recommendation 9: End punitive and carceral approaches to addressing drug use and reform the criminal legal system and corollary systems

The criminalization of drug use has justified and sustained state-sanctioned violence against BIPOC communities and individuals living in poverty—ranging from arrest, detention, prosecution, incarceration, and surveillance to family separation, loss of employment, and housing insecurity. Punitive approaches to drug use only exacerbate the conditions that lead to overdose and create barriers to health and other social safety nets that are just as necessary as treatment. Thus, policymakers should not use any of the opioid settlement funds for approaches that expand the reach of the law enforcement, the criminal justice system, and other corollary

57 Higham, S., Horwitz, S., & Rich, S. “76 billion opioid pills: newly released federal data unmask the epidemic.” *The Washington Post*. (2019). Available at https://www.washingtonpost.com/investigations/76-billion-opioid-pills-newly-released-federal-data-unmasks-the-epidemic/2019/07/16/5f29fd62-a73e-11e9-86dd-d7f0e60391e9_story.html

58 Rothstein, M. “The opioid crisis and the need for compassion in pain management.” *American Journal of Public Health*. (2017). Available at <https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.303906>

59 Substance Abuse and Mental Health Services Administration (SAMHSA). “The opioid crisis and the Black/African American population: an urgent issue.” Publication No. PEP20-05-02-001. (2020). Available at https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf

60 Fink, B., Uyttebroeck, O., & Larson, R. “An effective intervention: limiting opioid prescribing as a means of reducing opioid analgesic misuse and overdose deaths.” *Journal of Law, Medicine & Ethics* (2020). <https://doi.org/10.1177/1073110520935336>

61 Substance Abuse and Mental Health Services Administration (SAMHSA). “The opioid crisis and the Black/African American population: an urgent issue.” Publication No. PEP20-05-02-001. (2020). Available at https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf

systems. Rather, funds should be used to pilot, evaluate, or otherwise catalyze a range of depenalization and decarceration approaches and encourage the creation of community-based crisis response teams that can respond to drug-related crises, including:

- Depenalizing (both criminal and civil penalties) drug use, personal possession,⁶² and social conditions associated with drug use, such as poverty and houselessness
- Implementing guidelines for prosecutorial and law enforcement discretion to reduce arrests (for example, for minor traffic violations) and requiring police to collect racial and ethnic data from all traffic stops and arrests and make this information publicly available in order to track disparities⁶³
- Ending forced or coercive OUD treatment, often mandated by family or drug courts
- Eliminating mandatory minimum sentencing
- Ending cash bail and pretrial confinement
- Expanding Good Samaritan laws for overdose reversal, rejecting recent laws on drug-induced homicide, and ending involuntary manslaughter charges against people at the scene of an overdose
- Scaling back policies on fetal assault, child removal, termination of parental rights, and related policies that amplify generational trauma for families of opioid dependent people
- Supporting “clean slate” policies that automatically expunge or seal dismissed charges, not-guilty verdicts, and qualifying (usually nonviolent) criminal convictions to reduce the punitive effects of a criminal record, particularly for finding housing and meaningful employment

Policymakers should acknowledge the urgency of depenalizing drug use and respond to the growing demands for racial justice, anti-racist policies, and divesting from or meaningfully reforming the policing and mass incarceration system pervasive in prisons, jails, home detention, juvenile detention, immigration detention, foster system, parole, schools and hospitals.⁶⁴ Furthermore, policymakers should prevent funds from being allocated to corollary systems that penalize drug use without addressing underlying causes that lead to use or use non-evidence-based perceptions of drug use to justify policies that punish people of color and people living in poverty. Similar to the criminal legal system, these oppressive approaches exacerbate the conditions that lead to drug use.⁶⁵

62 Some states like Washington have decriminalized personal possession through prosecutorial discretion (<https://mynorthwest.com/912497/drug-users-snohomish-county/>), whereas other states like Oregon have decriminalized personal possession by statute (<https://www.washingtonpost.com/news/post-nation/wp/2017/07/11/oregon-legislature-passes-bill-decriminalizing-heroin-cocaine-meth-possession-hoping-to-curb-mass-incarceration/>).

63 Through the Open Data Policing project, North Carolina, Maryland, and Illinois collect and makes public stop, search, and use-of-force data, including data on race and ethnicity. <https://opendatapolicing.com/>

64 Drug Policy Alliance. Tweet: “Ending the drug war will not end racism. It will, however, dismantle one excuse the police use to justify their violence and killings.” (June 24, 2020). Available at <https://twitter.com/DrugPolicyOrg/status/1275825910327934979>

65 Movement for Family Power. “Whatever they do, I’m her comfort, I’m her protector: how the foster system has become ground zero for the U.S. Drug War.” (2020). Available at <https://static1.squarespace.com/static/5be5ed0fd274cb7c8a5d0cba/t/5eead939ca509d4e36a89277/1592449422870/MFP+Drug+War+Foster+System+Report.pdf>

For example, the child welfare system has separated countless families and has employed excessive interventions in response to stigma-based and unsubstantiated claims around prenatal exposure and parental drug use.⁶⁶ Families subject to the child welfare system’s investigations, surveillance, and control are overwhelmingly low-income and disproportionately BIPOC and female-presenting. Policymakers should support non-punitive, integrated, and harm reducing interventions that promote the rights and health of parents and children and shift towards a framework that decouples parental use of substances and “parental fitness.”⁶⁷ These interventions focus on resourcing families, reducing the harms associated with problematic drug use, increasing access to health care, preventing out-of-home placement, and family-based recovery counseling—all while keeping the family together. Most child abuse and neglect allegations do not stem from maltreatment by parents, but rather reflect the result of being forced to live under conditions of poverty and social inequalities. Thus, it is far more impactful on the health and well-being of children to allocate resources and support families through housing⁶⁸, health care, childcare, cash assistance, and other social safety nets.

Recommendation 10: Invest in community development programs and remove abstinence-only conditions that further punish drug use

Starting with communities of color and low-income communities that have faced underinvestment of public resources and infrastructure, policymakers should strengthen and invest in community development programs to tackle the racial, social, and economic disparities that lead to drug use and to create an environment for individuals to achieve their health goals—whether it is to stabilize or to stop using drugs. A wide range of non-punitive initiatives include affordable housing, job training, trauma services, anti-violence programs, child care, family services, youth programming, income support, social worker support, de-escalation training, and conflict mediations, and non-police alternative first responders, such as rapid response teams. Furthermore, community development programs and related safety net systems should not be preconditioned on abstinence, which only perpetuates the barriers and lack of access that drive overdose-related harms and fatalities. \

- 1. Housing:** According to the CDC, 56% of people who inject drugs have reported facing housing insecurity.⁶⁹ In many cases, punitive public housing policies conditioned on abstinence present a

66 **Movement for Family Power.** “Whatever they do, I’m her comfort, I’m her protector: how the foster system has become ground zero for the U.S. Drug War.” (2020). Available at <https://static1.squarespace.com/static/5be5ed0fd274cb7c8a5d0cba/t/5eead939ca509d4e36a89277/1592449422870/MFP+Drug+War+Foster+System+Report.pdf>

67 National Advocates for Pregnant Women (NAPW). “Re: In re Purdue Pharma Debtors’ Emergency Fund Expenditures – Proposed Guidelines.” (2020).

68 30% of children in the foster system could go home if their parents had access to housing. Movement for Family Power. “Whatever they do, I’m her comfort, I’m her protector: how the foster system has become ground zero for the U.S. Drug War.” (2020). Available at <https://static1.squarespace.com/static/5be5ed0fd274cb7c8a5d0cba/t/5eead939ca509d4e36a89277/1592449422870/MFP+Drug+War+Foster+System+Report.pdf>

National Advocates for Pregnant Women (NAPW). “Re: In re Purdue Pharma Debtors’ Emergency Fund Expenditures – Proposed Guidelines.” (2020).

69 Centers for Disease Control and Prevention (CDC). “HIV and People Who Use Drugs.” (2019). Available at <https://www.cdc.gov/hiv/group/hiv-idu.html>

major barrier to housing stability and deepen the inequalities faced by people who use drugs and people with opioid dependence. Policymakers should support housing models and policies that offer a compassionate, equitable, and individualized support system for individuals to meet their basic needs. Housing First is a homeless assistance movement that prioritizes providing permanent housing “without prerequisites or conditions beyond those of a typical renter.”⁷⁰ There is growing evidence that the Housing First approach is an effective solution to homelessness,⁷¹ and residents of low-barrier or no-barrier housing programs that implement Housing First—many of which are at the city and county level—are more likely to achieve long-term housing retention as well as participate in optional job training, education, and health services.⁷² As a corollary, 9% of federal funding for HIV/AIDS goes towards cash and housing assistance, reflecting an understanding that housing security is critical to health and stability.⁷³

- 2. Employment:** Meaningful employment is an important factor for many individuals who use drugs or have opioid dependence to maintaining health and well-being. However, many drug users, particularly those who have a criminal record or listed in child neglect registries for drug use, are unable to participate in the job application process. To address this barrier, Fair Chance Hiring policies delay questions regarding a job applicant’s criminal record until after the applicant has had a chance to demonstrate their skills and qualifications for the position.⁷⁴ “Ban the Box” legislation and policies removes questions asking applicants whether they have ever been convicted of a crime or been incarcerated at the initial stage of the employment process. Such policies are proven to help formerly incarcerated people obtain stable, meaningful employment—a significant deterrent to recidivism, drug use, and fatal relapse and overdose.

Recommendation 11: Allocate funds to create a non-profit foundation that coordinates a national-level response and serves as a non-governmental watchdog

There have been calls for a portion of the opioid settlement proceeds to be earmarked for national action and to establish an independent nonprofit public health foundation, like the Truth Initiative.⁷⁵ Such a foundation can coordinate national strategies that can support and amplify local or state action. Experts have suggested a

70 National Alliance to End Homelessness. Housing First. (2016). Available at <https://endhomelessness.org/resource/housing-first/>

71 National Alliance to End Homelessness. Housing First. (2016). Available at <https://endhomelessness.org/resource/housing-first/>

72 Barnett, E. “After 15 years, Seattle’s radical experiment in no-barrier housing is still saving lives.” Crosscut. (2019). Available at <https://crosscut.com/2019/09/after-15-years-seattles-radical-experiment-no-barrier-housing-still-saving-lives>

73 Kaiser Family Foundation. “U.S. federal funding for HIV/AIDS: trends over time.” (2019). Available at <https://www.kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hiv-aids-trends-over-time/>

74 National Employment Law Project. “Ensuring people with convictions have a fair chance to work.” Available at <https://www.nelp.org/publication/the-fair-chance-ban-the-box-toolkit/>

75 As a promising sign, the state of Oklahoma has allocated 38% of its opioid settlement funds from Purdue for a national foundation for addiction treatment and research (along with 7% for treatment medications and 4% for localities).

range of roles and activities that such a foundation could play at the national level, including:⁷⁶

- Guide and oversee the settlement’s implementation and fund distribution
- Prevent and respond to future drug and overdose crises, not just those involving opioids⁷⁷
- Increase political power and research capacity to keep regulators, health officials, and other government actors accountable in monitoring opioid supply practices
- Set up a federal procurement system or support state-based procurement for overdose reversal medication or MAT through bulk purchasing or generic production (Recommendation 1)
- Support evidence-based programs that reduce the risk of overdose and increase access to treatment (Recommendations 2 to 5)
- Fund newer, pilot interventions, including overdose prevention centers (OPCs), and evaluate effectiveness of programs (Recommendations 3)
- Coordinate national information campaigns and policy adaptations and support state-based efforts to depenalize drug use and invest in community development (Recommendations 7, 9-10)
- Serve as a non-governmental watchdog over the pharmaceutical industry and supply chain to monitor prescribing and distribution of prescription painkillers (Recommendation 8)

In thinking about using settlement funds for national-level coordination and action, it is critical to ensure that the voices of affected communities, particularly BIPOC communities, are structurally placed in the national conversation without falling into the pitfalls of tokenism and perpetuating the same inequities. For example, prompted by HIV/AIDS activists, the Ryan White legislation contains explicit language requiring local governments and public health agencies to incorporate input from impacted communities and to hold government actors accountable in the distribution of HIV-related funds. Specifically, the law requires planning councils, which are legislatively tasked with distributing HIV-related funds and creating strategies for responding to HIV in localities, to include representation from people living with HIV, community-based organizations serving people living with HIV, mental health providers, social services providers, formerly incarcerated people, housing shelters, and more.⁷⁸ Relatedly, any national-level action must incorporate community mobilization, wealth redistribution, knowledge transfer, and data access, so that groups led by and working directly with people who use drugs can effectively engage in the national sphere.

76 Khalik, F., Parmet, W., & Beletisky, L. “Learning From the Lessons of Tobacco: A Public Health Approach to the Opioid Settlement.” *Health Affairs*. (2019). Available at <https://www.healthaffairs.org/doi/10.1377/hblog20190925.554104/full/>

77 “Empirical data do show ... that more than 50% of deaths with an opioid positive toxicology include alcohol, and the average number of drugs identified in mortality toxicologies is 6.” Christo, P. “Opioids May be Appropriate for Chronic Pain.” *Journal of Law, Medicine & Ethics*. (2020). Available at <https://journals.sagepub.com/doi/abs/10.1177/1073110520935335>

78 Ryan White HIV/AIDS Treatment Extension Act of 2009. Section 2602(b)(2). Available at <https://hab.hrsa.gov/sites/default/files/hab/Global/happartmanual2013.pdf>

FXB Center for Health and Human Rights at Harvard University
651 Huntington Avenue, 7th Floor, Boston, MA 02115 USA
Email: fxbcenter_info@hsph.harvard.edu

fxb.harvard.edu



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for Health & Human Rights
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