



February 2020

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# Changing Course in the Overdose Crisis: Moving from Punishment to Harm Reduction and Health

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## Director's Note

For almost half a century, the United States has waged a war on drugs and on people who use drugs, investing billions of dollars in the enforcement of punitive laws. The “war on drugs” has helped fuel mass incarceration and perpetuate racial disparities in the justice system, without any lasting, measurable impact on drug use or drug-related crime. Today, after decades of prioritizing arrest and incarceration, communities around the country are finding themselves ill-equipped to address spiking rates of drug use and overdose. In some jurisdictions, the police, courts, and corrections agencies are recognizing that drug use is primarily a public health problem and are supporting initiatives rooted in prevention, harm reduction, and treatment. However, in other places, justice agencies are doubling down on punitive, zero-tolerance policies that continue to stigmatize drug use, increase racial disparities, and drive people who need help away from harm reduction supports and treatment services.

This report from the Vera Institute of Justice, produced with support from the Robert Wood Johnson Foundation, is a resource for jurisdictions seeking to rethink how they respond to drug use. It describes a range of approaches that exist at the intersection of health and criminal justice, including practical examples from two jurisdictions: Ross County, Ohio and Atlanta, Georgia. It concludes with a series of recommendations for shifting practice and policy.

Addressing the drug overdose crisis is complex, but the lessons embodied in this report are relatively straightforward. In some cases, justice agencies can provide a bridge to treatment services and other forms of support. More often, they can remove barriers by stepping aside and letting health and harm-reduction entities intervene. History has demonstrated that the “war on drugs” has failed. We hope that the lessons contained in this report can help communities chart a path towards health and safety.



Jim Parsons, vice president and research director

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# Introduction

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For the first time in a century, life expectancy in the United States declined for three consecutive years from 2015 to 2017, driven largely by the staggering number of drug overdose deaths: 70,237 in 2017 alone.<sup>1</sup> Overdose death rates peaked in 2017 at 21.7 per 100,000 people before modestly declining in 2018.<sup>2</sup> These deaths exist alongside quieter, but no less devastating headlines; localized HIV outbreaks, increased hepatitis C diagnoses, and rising numbers of child welfare placements have all been tied to increases in problematic drug use.<sup>3</sup> And with the drug supply more dangerous and potent than ever—due to an influx of heroin and counterfeit pills adulterated with fentanyl and other synthetic opioids—there are signs that rates of opioid-related overdose deaths in particular could get worse before they get better.<sup>4</sup>

The roots of this drug overdose crisis are deep, spanning four decades of documented growth in drug-related deaths, though only in the past decade has it received significant attention nationally.<sup>5</sup> The current heightened focus has varied explanations: the sheer number of deaths; the lawsuits against the pharmaceutical industry related to the aggressive push to treat pain with powerful prescription medications; and the new visibility of overdoses in white, rural, and suburban communities.<sup>6</sup> But along with the reports and public dialogue about the opioid overdose crisis, there is increasing recognition that relying on criminalizing drug use and enforcement-led approaches does not work. Indeed, it is now firmly established that the long-running “war on drugs” in the United States has not only failed to reduce illicit drug use and associated crime but has also contributed mightily to mass incarceration and exacerbated racial disparities within the criminal justice system, with a particularly devastating impact on Black communities.<sup>7</sup>

Researchers at the Vera Institute of Justice (Vera) have long been working to provide accurate information about the latest evidence regarding justice system responses to problematic drug use and the opioid overdose crisis. In so doing, Vera has highlighted innovative strategies that justice system actors are using to move away from enforcement-led approaches to drug use.<sup>8</sup> Furthermore, Vera, like others, has pushed for a public health

approach to problematic drug use—one that simultaneously seeks to reduce contact with the justice system for people who use drugs and ensure that people who use drugs and do have such contact can access harm reduction, treatment, and recovery services to reduce the negative consequences of their drug use.<sup>9</sup>

This report provides a look at the current intersection of problematic drug use and the criminal justice system. It offers practical guidance for practitioners, policymakers, and funders by compiling the wide range of interventions that communities can consider to minimize justice system contact for people who use drugs and to improve public health and safety. In this report, Vera starts from the perspective that there is an urgent need to transform the criminal justice system's response to drug use and to implement policies and practices that advance health. The findings and recommendations in this report are guided by the principles of harm reduction—a set of practical strategies and ideas aimed at reducing the negative consequences of drug use without insisting on cessation of use—and by the conviction that problematic drug use should be addressed primarily as a public health problem rather than a criminal justice issue. This report addresses the long-standing history of racialized drug policies in the United States and highlights the ways they have fueled mass incarceration and racial disparities at every point along the justice continuum. It also shows that a new path forward requires not only bold leadership at the local level, where real change is more tangible, but also sustained investment in community organizations led by people who are directly impacted.

This report is organized into four main sections. To begin, it offers a brief overview of the context of the current drug overdose crisis and the ways that an enforcement-led approach to drug use has harmed people and communities. The report then outlines the spectrum of community-based and justice system-based interventions that are currently applied in response to drug use at the local level. The third section of the report describes how these interventions come together in two places: Ross County, Ohio, and Atlanta, Georgia. These case studies describe responses in two different contexts, highlighting successes, common themes, and ongoing challenges. The report concludes with key strategies and recommendations for changing the trajectory of justice system responses to drug use by drawing on these two case studies and interviews with advocates, scholars, and practitioners in the field.

## Methodology

The analysis, observations, and recommendations in this report are based on a review of the literature at the intersection of criminal justice, substance use, and harm reduction; interviews with experts; and site visits to Ross County, Ohio, and Atlanta, Georgia.

Vera researchers conducted phone and video interviews between February and April 2019 with experts in the fields of drug policy, harm reduction, public health, policing, corrections, law, and history. Researchers interviewed 19 people in 16 interviews (two interviews contained multiple people from the same organization; see Appendix, page 56). Interview questions covered the consequences of a criminal justice-based response to drug use and the policy changes and programmatic innovations needed for more effective responses across the health and justice systems. Experts were asked to identify the most important priorities in, and biggest barriers to, addressing the opioid overdose crisis today. All interviews were audio-recorded and transcribed. The research team then analyzed them for common themes.

The research team conducted site visits over four to five days each in Ross County, Ohio, and Atlanta, Georgia, in May 2019. The sites were chosen based on a number of specific criteria related to the magnitude of the problem of drug overdose deaths in each jurisdiction, the presence of clear programmatic or policy innovations, the geographic location, the demographic composition of the population, and the research team's ability to access a range of stakeholders. The researchers narrowed down a list of potential sites by focusing on one urban and one rural location with high rates of overdose deaths and that also demonstrate regional and racial diversity. At the time of selection, Georgia and Ohio ranked, respectively, 16<sup>th</sup> and second in the country for drug-related deaths (based on the Centers for Disease Control and Prevention's 2017 data). Demographic and drug overdose data from Atlanta and Ross County are reflected in Table 1 below. Additional details about the people interviewed in each location during the site visits are detailed in the respective case studies on page 20 and page 32.

Table 1

### Demographics and drug overdose data: Ross County, Ohio, and Atlanta, Georgia

Site	Population	Race	Total drug overdose deaths (2017)	Drug overdose death rate, per 100,000 (2017)
Ross County, Ohio	76,931	90.7% White 5.8% Black 0.6% Asian 2.6% Two or more races	28	36.2
Atlanta, Georgia	498,044	40.3% White 51.8% Black 4.2% Asian 2.4% Two or more races	164 (Fulton County)	15.7 (Fulton County)
United States	327,167,434	76.5% White 13.4% Black 5.9% Asian 2.7% Two or more races	70,237	21.7

Sources: United States Census Bureau Quick Facts, Centers for Disease Control and Prevention, National Center for Health Statistics, "Underlying Cause of Death 1999-2017" on CDC WONDER Online Database, <https://wonder.cdc.gov>.

# Contextualizing the current drug overdose crisis and its associated harms

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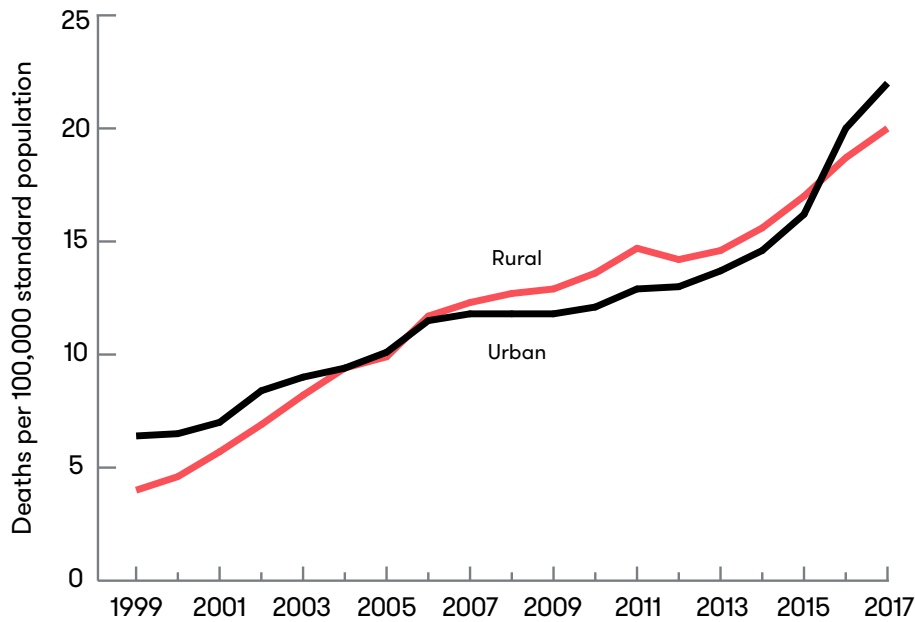
The current overdose crisis in the United States is unprecedented in scale, but drug overdose deaths have followed an exponential growth curve for 40 years.<sup>10</sup> Opioid-related overdose deaths (from drugs including prescription opioids, heroin, and synthetic opioids such as fentanyl) accounted for nearly 68 percent of drug overdose deaths in 2017 and increased almost sixfold from 1999 (8,048 deaths) to 2017 (47,600 deaths).<sup>11</sup> This trend has been described as a “triple wave” of opioid-related overdose deaths: from those attributed primarily to prescription painkillers (beginning in the 1990s); to those driven by heroin as tightened control of opioid prescribing and dispensing resulted in an expansion of street-based heroin markets (beginning in 2010); to those involving synthetic opioids, such as fentanyl, as adulterants of street drugs (beginning in 2013).<sup>12</sup> Although fentanyl has long been used in medical environments, the fentanyl analogs responsible for many of these deaths are illicitly manufactured and distributed, often being added to other drugs or sold as “heroin” or counterfeit opioid or benzodiazepine pills, but much more potent (30 to 40 times stronger than heroin and 80 to 100 times stronger than morphine).<sup>13</sup>

Since 2010, overdose mortality rates have been increasing for all drug types (except methadone and “unspecified drugs and narcotics”), and overdose deaths increased across all geographic regions and demographic groups between 2010 and 2016.<sup>14</sup> However, the types of drugs involved in overdose deaths vary by location and race.<sup>15</sup> For example, though the absolute number of overdose deaths is greatest in urban counties, where most Americans live (87 percent of overdose deaths in 2017), the counties with the highest overdose death rates have fluctuated over time between urban and rural areas. Drug overdose death rates were higher in rural counties from 2007 through 2015 before being overtaken by rates in urban counties in 2016 and 2017 (20.0 per 100,000 and 22.0 per 100,000 in rural and urban counties respectively in 2017; see Figure 1).<sup>16</sup> Drug overdose mortality rates



Figure 1

**Age-adjusted rates of drug overdose deaths, by urban and rural residence: United States, 1999–2017**



Source: Holly Hedegaard, Arialdi M. Miniño, and Margaret Warner, “Urban–rural Differences in Drug Overdose Death Rates, by Sex, Age, and Type of Drugs Involved, 2017,” National Center for Health Statistics(NCHS), NCHS Data Brief No. 345 (Washington, DC: NCHS, 2019). <https://perma.cc/MK8Q-SDJ7>.

are higher for men than women, and rates for white people exceed those for Black people for all opioids.<sup>17</sup> However, Black people experienced the largest percentage increase in opioid-involved deaths in 2017 (25.2 percent), and cocaine-related overdose death rates are higher for Black people.<sup>18</sup> Native Americans, Alaskan Natives, and Latinx Americans have also experienced large increases in overdose deaths in recent years.<sup>19</sup>

## Health-related, social, and economic harms

The rise in overdose deaths is but one devastating consequence of the drug epidemic. Additional health-related, social, and economic harms must be considered to capture its collective human toll. Along with the rise in drug overdose deaths, the United States is experiencing increases in hepatitis C virus (HCV) infections, increases in infective endocarditis, and localized HIV outbreaks in some communities related to lack of access to new syringes and subsequent syringe sharing among people who inject drugs.<sup>20</sup> For example, between 2004 and 2014, the incidence rate of acute HCV

infection doubled, with a 400 percent increase among people ages 18 to 29.<sup>21</sup> A 2018 study documented a nearly eightfold increase between 2000 and 2016 in hospitalizations for endocarditis.<sup>22</sup> Further, there are very real health impacts to nonfatal overdoses, including both acute outcomes stemming from respiratory depression and longer term outcomes associated with repeated opioid overdoses such as decreasing cognitive performance, increases in depression symptoms, and suicidal ideation.<sup>23</sup>

Dramatic social and economic costs of the current drug crisis have also compromised the stability of communities, especially those already afflicted by intergenerational poverty and diminishing economic mobility.<sup>24</sup> A recent report estimates costs of at least \$631 billion from 2015 through 2018 when accounting for lost wages to affected workers, lost productivity and health care costs borne by the private sector, and lost tax revenues and additional spending on health care, social services, education, and criminal justice for local, state, and federal governments.<sup>25</sup> From 2013 to 2017, the number of children in foster care nationwide increased 10 percent to nearly 442,995; parental drug use was cited as a factor in 36 percent of cases.<sup>26</sup>

## The harms of criminalizing and punishing drug use

Although there is increasing rhetoric around the notion that problematic drug use is primarily a health problem, punitive approaches to drug use remain widespread. The history and consequences of the “war on drugs” have been well documented and will not be covered in depth here.<sup>27</sup> Since the 1970s, the U.S. government has relied extensively on the criminal legal system to attempt to control the supply of drugs and deter their consumption. During the 1980s and 1990s, drug laws became harsher through legislation at the state and federal levels to establish mandatory minimum sentences, three-strikes rules, and “truth in sentencing” laws.<sup>28</sup> At the same time, police began aggressively targeting low-level, quality-of-life crimes that swept both users and dealers of illegal drugs into the criminal justice system.<sup>29</sup> Three major takeaways can be gleaned from this history of enforcement-led approaches to drug use.

- › **An enforcement approach to drug use has significantly contributed to mass incarceration.** From 1980 to 2016, drug-related arrests increased by 171 percent and now account for more than 1.6 million arrests annually—with the vast majority (86 percent) associated with drug possession charges.<sup>30</sup> The number of people in jail and prison for drug offenses has increased more than tenfold since 1980, though in recent years some systems have seen declines; people incarcerated for a drug conviction at the federal level account for nearly half of the federal prison population.<sup>31</sup>

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- › **Increased enforcement and incarceration have not significantly reduced drug use or drug crime.** There is considerable evidence that an enforcement-led approach to drug use has not significantly reduced drug use, substance use disorders, or drug-law violations. A 2017 study by the Pew Charitable Trusts found no statistically significant relationship between drug imprisonment and three measures of drug problems: self-reported drug use (excluding marijuana), drug arrests, and overdose deaths.<sup>32</sup> A recent study of the 96 largest U.S. metropolitan areas found no association between levels of per capita arrests, corrections spending, and police presence and changes in rates of intravenous drug use, suggesting that enforcement does not measurably reduce drug consumption.<sup>33</sup> As a committee of 19 leading criminologists concluded in a 2014 review of the research, “the best empirical evidence suggests that the successive iterations of the war on drugs—through a substantial public

policy effort—are unlikely to have markedly or clearly reduced drug crime over the past three decades.”<sup>34</sup>

- > **Enforcement of drug laws exacerbates racial disparities in the justice system.** It is well known that people of color experience discrimination at every stage of the justice system, and this is particularly true for drug law violations.<sup>35</sup> Although Black and Latinx people use drugs at similar rates to people of other races, they are disproportionately more likely to be stopped, searched, arrested, convicted, and incarcerated for drug law violations.<sup>36</sup> For example, in 2014, Black people were more than two-and-a-half times more likely than white people to be arrested for drug possession and almost six times more likely to be in prison for drug possession.<sup>37</sup> Their overrepresentation in the criminal justice system means that people of color are also more likely to face the collateral consequences of mass incarceration—fractured family structures; diminished access to housing, public assistance, education, and employment opportunities; and restricted voting access, to name a few.<sup>38</sup> In short, the hyperincarceration of communities of color via the drug war has perpetuated systematic racism and intergenerational economic injustices.

# Addressing drug use as a health problem

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With millions of Americans entangled in the criminal justice system every year as a result of drug law enforcement and a spiraling overdose crisis, policymakers and practitioners are increasingly adopting a range of harm reduction and public health strategies to address the harms associated with problematic drug use and substance use disorders. Internationally, support is growing for the four-pillar model to transform drug policies and improve public health, which comprises prevention, treatment, enforcement, and harm reduction.<sup>39</sup> Although any comprehensive strategy requires work in all of these areas, the focus in this report is on the specific interventions that communities can adopt to move their response to drug use upstream—ensuring low threshold access to a range of harm reduction, treatment, and recovery services; keeping people who use drugs out of the justice system altogether; and connecting people who do have justice-system contact to evidence-based care when needed.<sup>40</sup> Below, this report presents the current range of available interventions that exist both outside and within the criminal justice system.

## Community-based interventions

Transforming approaches to drug policy in the United States will require commitment to adopting, expanding, and sustaining proven community-based interventions. This section briefly summarizes a spectrum of public health and harm reduction interventions for reducing the health-related harms of drug use, some of which have been widely implemented in the United States and some of which lack a supportive legal framework and/or have not yet been brought to scale.

### Naloxone distribution

Naloxone distribution is key to reducing the number of opioid-related overdose deaths.<sup>41</sup> Naloxone, an intranasal or injectable antidote that

reverses respiratory depression from opioid overdose, can be administered with minimal to no training and has no addictive properties or potential for nonmedical use.<sup>42</sup>

Though all 50 states and the District of Columbia have passed laws expanding access to naloxone, specifics of each law vary across states.<sup>43</sup> Laws differ with respect to whether naloxone can be sold without a prescription, whether it can be prescribed to third parties (that is, to people who do not use opioids or are not personally at risk of experiencing overdose), and whether it can be dispensed through community organizations. Most states have laws that provide immunity from professional sanctions, criminal prosecution, and/or civil liability to health providers who prescribe or dispense naloxone, and some states extend immunity from criminal prosecution and/or civil liability to laypeople who administer naloxone.<sup>44</sup>

A national study of opioid overdose deaths from 2000 to 2014 found that states with Good Samaritan laws (which protect people reporting overdoses from criminal penalty) working in tandem with strong naloxone access laws had lower rates of overdose mortality, particularly among African Americans.<sup>45</sup> In light of this reduction, researchers estimate that, to have maximum impact, the number of naloxone doses distributed should be about 20 times the number of a region's opioid-related deaths.<sup>46</sup> Peer-led and community-based naloxone distribution is essential avenue for expanding access.<sup>47</sup> Naloxone distribution is often combined with overdose education (overdose education and naloxone distribution, or OEND)—about such topics as risk factors for overdose, how to recognize when an overdose is occurring, what to do in the event of an overdose, and an overview of relevant laws. And while this education is important, it should not be a barrier to or requisite for naloxone access.<sup>48</sup>

## Syringe service programs

Syringe service programs (SSPs) are highly effective at reducing the spread of blood-borne diseases like HIV and hepatitis C.<sup>49</sup> These programs can help connect people to social and health services, while increasing public safety by taking syringes off the streets.<sup>50</sup>

Though the exact number of programs is unknown, there are an estimated 376 formal SSPs in the United States as of November 2019.<sup>51</sup> Changes to the legal landscape in support of SSPs are crucial; SSPs are technically illegal in 12 states and, in many states where SSPs are legal,

there are significant barriers to opening and operating them.<sup>52</sup> Additional enhancements should include decriminalizing syringes and other injection equipment considered to be “drug paraphernalia”; increasing and sustaining funding for syringes, staffing, equipment, and services; and implementing regulatory frameworks that adhere to evidence-based distribution models supporting peer-led organizations to establish and implement SSPs.<sup>53</sup> Law enforcement practices must change in tandem with policies to support SSPs. Specifically, law enforcement personnel must cease policing practices that stigmatize SSP participants and conflate program engagement with criminality, including, but not limited to, confiscating syringes and making arrests on the basis of program participation.<sup>54</sup>

## Supervised consumption sites

Supervised consumption sites (SCSs; also called safe or supervised injection facilities, drug consumption rooms, and overdose prevention sites or centers) are places where people can bring their own drugs to use with new, sterile equipment, under the supervision of trained staff who are prepared to respond to overdose incidents and other emergencies.<sup>55</sup> SCSs can also provide people with information and supplies for safer drug use and connections to withdrawal management care and substance use treatment, health care, and other social services.<sup>56</sup> And when legal, SCSs are places where people can use illicit drugs without the risk of arrest and prosecution.<sup>57</sup>

Research studies evaluating the impacts of SCSs have shown positive benefits for public health, including reductions in HIV- and HCV-related risk behavior, increased connections to substance use treatment and primary health care, and reductions in the number of overdose deaths. (There has not been a single reported overdose death at any SCS worldwide.)<sup>58</sup> SCSs have also been associated with lower levels of public drug use and have not been found to increase drug use or crime in surrounding areas.<sup>59</sup> In addition, based on the fiscal savings from averted HIV and HCV infections, SCSs have been found to be a cost-effective use of public health resources.<sup>60</sup> More than 100 SCSs are operating worldwide—mostly in Europe, as well as in Australia and Canada.<sup>61</sup> A range of models has been implemented in recent years, including standalone storefronts, mobile vans, peer-run sites, gender-specific sites, and SCSs integrated into and located with other health or social services.<sup>62</sup>

Although no legally sanctioned SCSs are operating in the United States yet, health and social service providers, activists, organizers, and government officials in many jurisdictions have been working to change policies, build community support, and figure out the logistics to open a SCS.<sup>63</sup> Safehouse, the organization planning to open a SCS in Philadelphia, won a key victory in October 2019 when a federal court ruled that Safehouse's plans for a SCS do not violate the federal Controlled Substance Act, paving the way for other jurisdictions to implement SCSs.<sup>64</sup>

## Medication-assisted treatment

Medication-assisted treatment (MAT) is the use of medications, often in combination with counseling and behavioral therapies, to treat substance use disorders and support a person's recovery.<sup>65</sup> MAT is considered the standard of care to treat opioid use disorders.<sup>66</sup> The U.S. Food and Drug Administration has approved three prescription medications to treat opioid use disorders: methadone, buprenorphine (the branded form of buprenorphine combined with naloxone is called Suboxone), and naltrexone (naltrexone comes in pill and injectable forms; the branded form of injectable, extended-release naltrexone is called Vivitrol).<sup>67</sup> These medications help treat opioid use disorders by reducing or eliminating withdrawal symptoms and cravings to use opioids, or by reducing or blocking the effects of opioid use.<sup>68</sup> People can safely take medications used in MAT for months, years, or even a lifetime.<sup>69</sup> Research studies have repeatedly shown that methadone and buprenorphine, in particular, can reduce overdose and HIV risk as well as HCV-related risk behavior, improve retention in treatment, and reduce criminal activity for people who use opioids.<sup>70</sup> Research on the effectiveness of extended-release naltrexone is less established.<sup>71</sup> The accepted standard of care among health professionals is to ensure that people are able to choose the MAT best suited to their clinical needs and life situation.<sup>72</sup>

Despite strong consensus among public health authorities that expanding access to MAT is critical for an effective response to the opioid overdose crisis, access has been limited by a host of barriers, including negative attitudes toward MAT among patients, providers, and the public; limited treatment capacity and infrastructure; a lack of Medicaid expansion; and regulatory policies and legislation that place strict restrictions on who can prescribe MAT and under what conditions.<sup>73</sup> Rural areas have



severe shortages of health providers who are certified to provide MAT, fewer treatment facilities, and long waiting lists for services.<sup>74</sup> Local and national studies have found that people accessing buprenorphine treatment, which can be prescribed at a doctor's office and in a variety of other settings by certified professionals, are more likely to be white and have higher levels of income or education compared to people accessing methadone treatment, which is dispensed through highly regulated treatment programs.<sup>75</sup> Access to MAT has also been particularly limited in criminal justice settings, which have demonstrated a strong preference for providing extended-release naltrexone only.<sup>76</sup> (See “Drug courts” on page 16 and “Jails and prisons” on page 17.)

## Heroin-assisted treatment

Heroin-assisted treatment (HAT; also known as heroin prescription, heroin maintenance, supervised injectable heroin treatment, and diamorphine prescription) provides people with free or low-cost pharmaceutical grade heroin—a safe supply—for consumption in a medical setting. This treatment option is most commonly made available to heroin-dependent people who have not responded to more traditional therapies such as MAT and aims to reduce the harms associated with using illicit opioids.<sup>77</sup> Research has shown that HAT contributes to reductions in criminal activity by decreasing people's reliance on the black market to obtain drugs, and improves people's social functioning by stabilizing drug use patterns and providing a pathway to additional services.<sup>78</sup> HAT is a viable treatment option in several European countries and Canada, but the legal landscape and public opinion toward HAT in the United States suggest significant barriers to implementation.<sup>79</sup>

## Drug content testing

Drug content testing gives people who use drugs information on the content—especially the toxicity—of their drug supply, helping them make informed decisions and potentially alter their behavior if an undesired substance is present.<sup>80</sup> Widespread adulteration of heroin, methamphetamine, cocaine, and counterfeit prescription pills with fentanyl has introduced a need for more accessible drug content testing services in order to curb unintentional overdose. Fentanyl testing strips can be used to test drug residue and solutions for the presence of fentanyl and its analogs.<sup>81</sup>

However, limitations to this method of content testing exist. Fentanyl analogs and derivatives are constantly evolving and may go undetected by fentanyl testing strips.<sup>82</sup> Additionally, fentanyl testing strips give a binary result indicating just the presence or absence of fentanyl, rather than how much of the drug is present.<sup>83</sup> Drug content testing using mass spectrometry and similar technologies can address the potential limitations of testing strips while also serving as a mechanism of surveillance.<sup>84</sup> Results from these tests, which are typically conducted by harm reduction organizations, can be used to alert relevant parties—such as people who use drugs, harm-reduction service providers, first responders, and emergency department personnel—when lethal concentrations have been detected in the local supply.<sup>85</sup>

## Responses across the justice system continuum

In addition to strengthening responses in community- and health system-based settings, there is an urgent need to transform how the criminal justice system responds to drug use. A public health approach to drug use suggests that justice-system contact should be dramatically reduced for people who use drugs whenever possible and that people who use drugs should also have access to evidence-based interventions for harm reduction, treatment, and recovery in all parts of the justice system. The following section describes a range of responses across the justice continuum, highlighting both good practices and areas of concern.

### Police

Police represent the front end of the justice system, and decades of enforcement-led approaches to drug use in the United States have driven mass incarceration and its collateral consequences, particularly in communities of color.<sup>86</sup> Wherever possible, police practices should be reconfigured to keep people who use drugs out of the justice system and facilitate access to public health, harm reduction, and treatment services, rather than relying on arrest and other forms of enforcement.

In some communities, police officers may be the first responders to the scene of an overdose and therefore are an important group to equip

with naloxone.<sup>87</sup> The number of law enforcement agencies that carry naloxone has increased dramatically in recent years; the North Carolina Harm Reduction Coalition (NCHRC) reported that as of November 2018, at least 2,482 law enforcement agencies in 42 states equipped their officers with naloxone, up from 1,214 agencies in 38 states in 2016.<sup>88</sup> Training law enforcement personnel to use naloxone can also help overcome stigma toward drug use and build understanding and support within law enforcement agencies for other harm reduction initiatives.<sup>89</sup>

In addition to carrying naloxone and providing assistance at the scene of an overdose, some law enforcement agencies have sought to facilitate access to treatment and harm reduction resources for people after incidents of nonfatal overdose.<sup>90</sup> Despite the good intentions of these initiatives, relying on police to conduct outreach after a person experiences an overdose raises concerns. NCHRC highlights the value of treatment, harm reduction, and/or peer-support staff leading follow-up visits and outreach rather than police, due to mistrust toward law enforcement among people who use drugs.<sup>91</sup> (See “Case study: Ross County, Ohio” on page 20, for more on post-overdose response teams led by police and public health collaborators in Ross County, Ohio.)

Police agencies are also expanding alternatives to making an arrest and/or booking people into jail for a variety of offenses, including drug-related offenses. These alternatives may be formal programs or informal practices in which police officers use their discretion to divert people to treatment and supportive services. Seattle’s Law Enforcement Assisted Diversion (LEAD) program, launched in 2011, is one of the most widely replicated models for police-assisted diversion. One key element of the LEAD model is that, following a harm reduction framework, people are not sanctioned for drug use or relapse once they are diverted to services.<sup>92</sup> A three-year evaluation of Seattle’s LEAD program demonstrated positive outcomes and cost savings; LEAD participants were more likely to obtain housing, employment, and legitimate income and were less likely to be arrested or charged with a felony.<sup>93</sup> According to the LEAD National Support Bureau, LEAD programs are now operating in almost 40 communities across 20 states, and exploration and development is underway in many other jurisdictions.<sup>94</sup> (See the Atlanta, Georgia, case study on page 32 for more about the Atlanta/Fulton County Pre-Arrest Diversion Initiative.)

Although many diversion programs are a promising intervention for the justice system, formalized programs are still limited in scope and scale, and some have narrow eligibility criteria that limit participation to those charged with low-level offenses or exclude people with prior criminal justice involvement.<sup>95</sup> And, because they rely on police discretion, the possibility of bias presents a critical threat to their efficacy and equity.<sup>96</sup>

## Drug courts

Drug courts (also known as drug treatment courts) are one of the primary criminal justice responses to drug use that continue to expand. These specialized courts offer court supervised treatment as an alternative to incarceration for drug charges for cases in which substance use disorder is deemed to be an underlying cause of the offense.<sup>97</sup> People enter into an agreement that their charges will be reduced or dismissed on successful program completion.<sup>98</sup> Drug courts have become widespread since the 1990s; as of mid-2018, there were more than 3,100 drug courts across the United States.<sup>99</sup> (See “Case study: Ross County, Ohio,” page 20, for more on local experiences with drug courts).

Reviews of the research evidence have concluded that, compared to traditional probation approaches, drug courts reduce both general and drug-related recidivism.<sup>100</sup> Yet the overall impact of drug courts on incarceration has been mixed: research has found that any benefits from fewer instances of incarceration resulting from the use of drug courts may be negated by longer sentences imposed on participants when they fail drug court programs.<sup>101</sup>

Drug court requirements may be particularly onerous for women, including pregnant women and women with childcare needs, and although research is limited, drug courts may exacerbate racial disparities, as people of color are less likely to be admitted to drug court, more likely to receive punitive sanctions, and less likely to graduate from drug court.<sup>102</sup> Drug courts have also been criticized for serving a limited number of people because eligibility and access are strongly influenced by prosecutorial decision-making.<sup>103</sup>

The effectiveness of drug courts as a setting for evidence-based, patient-centered treatment and recovery is also questionable. Many drug court programs expect participants to abstain from substance use and implement punitive sanctions, including incarceration, for people who relapse or fail a drug test.<sup>104</sup> As mentioned previously (See “Medication-assisted

treatment,” page 12), drug courts have not historically facilitated access to MAT, particularly to buprenorphine and methadone and particularly in rural areas, though there are signs that this has improved in recent years.<sup>105</sup>

## Prosecutors

Prosecutors wield tremendous power and discretion over both individual outcomes and broader changes within the criminal justice system, including responses to drug use. In some jurisdictions, prosecutors have pledged to reduce charges or not prosecute some drug possession cases (typically setting a threshold for small amounts and/or specifying certain types of drugs) and support diversion to treatment and support for people who use drugs.<sup>106</sup> Some prosecutors are also considering international models of decriminalization and legalization; in May of 2019, a group of more than 20 American prosecutors visited Portugal to learn about how the country decriminalized low-level possession and use of all drugs almost 20 years ago.<sup>107</sup>

Prosecutors must also acknowledge and address the ways that existing laws and policies are counteracting the goals of public health and harm reduction. Even as states have been expanding Good Samaritan laws, which decriminalize drug use and possession at the scene of an overdose to encourage witnesses to call 911 for emergency medical assistance, many states have enacted drug-induced homicide laws, which allow prosecutors to charge the person who provided the drugs in the event of an overdose death.<sup>108</sup> Drug-induced homicide laws may contribute to fears of arrest and prosecution among people who witness an overdose, dissuading them from calling 911.<sup>109</sup> District attorneys should issue formal policies instructing prosecutors not to bring manslaughter or homicide charges against people who are involved in minor drug transactions that precede an accidental death, and drug-induced homicide laws should be repealed in states where they exist.<sup>110</sup>

## Jails and prisons

Despite an expansion of programs aimed at diverting people who have substance use disorders from the justice system, large numbers of people who use drugs are still incarcerated in jails and prisons across the United States.<sup>111</sup> Additionally, many people who use drugs are incarcerated for nondrug-related charges, so they are not reached by attempts at diversion initiated by law enforcement or drug courts. The most up-to-date figures from the Bureau of

Justice Statistics show that 58 percent of people in prisons and 63 percent of sentenced people in jails meet the criteria for drug dependence or abuse.<sup>112</sup>

Given the high prevalence of people with substance use disorders and the increased risk of opioid-related overdose people face on release, it is the duty of correctional facilities to respond to the needs of those who are incarcerated by offering evidence-based treatment options that match the same standard of care as those available in the community.<sup>113</sup> However, barriers to effective jail- and prison-based responses make achieving this mission difficult. Due to perceived institutional limitations and a lack of uniform and enforced national health care standards for jails and prisons, correctional facilities across the country fail to meet some of the basic needs of their populations, and responding to an issue as complex as substance use presents many unique challenges.<sup>114</sup> Additionally, the prevailing culture of punishment in jails and prisons could lead to mismanaged care with a heavy emphasis on social control and abstinence.<sup>115</sup>

People should receive confidential screening for substance use disorder on intake into a correctional facility to ensure connection to treatment during incarceration and post-release.<sup>116</sup> Procedures for medical management of withdrawal, like those recommended by the American Correctional Association and other accredited bodies, should be in place, and methadone, buprenorphine, and naltrexone should all be available.<sup>117</sup> Rhode Island has led the way in providing MAT in correctional facilities by launching a comprehensive, statewide MAT program in 2016 that offers all three FDA-approved medications through a partnership with a community-based provider.<sup>118</sup> Correctional systems in a number of other states have followed suit in expanding access to MAT, but many correctional facilities still do not offer all forms of MAT (preferentially providing naltrexone only) and/or place restrictions on which groups of people are eligible for treatment.<sup>119</sup> Although expanding access to MAT in correctional facilities is crucial, MAT is not a viable solution for people with substance use disorders who do not use opioids; services such as counseling and peer education of appropriate intensity should also be available to ensure that all people have access to the support they need while incarcerated.<sup>120</sup>

## Reentry and community corrections

Due to periods of forced abstinence, during which tolerance to opioids decreases, compounded by a lack of supports on returning to the community,

people who are incarcerated (or in abstinence-oriented residential treatment) face dramatically increased risk of overdose death post-release.<sup>121</sup> To begin to address this increased risk, corrections-based overdose education and prevention programming should be widespread, and every person who leaves jail or prison, as well as the people who have visited them during their incarceration, should be offered naloxone and accompanying information on overdose prevention.<sup>122</sup>

Increased risk of fatal and nonfatal overdose after release can also be addressed by ensuring continuity of care on reentry into the community. Research has shown that few people pursue their MAT referrals after they are released from prison, so corrections staff should work in concert with community providers to ensure timely and sustained follow-up.<sup>123</sup> Access to health insurance is also crucial to minimizing disruptions in care. Health insurance disparities between people with and without criminal justice system involvement are well documented, but changes to Medicaid eligibility in 2014 mean that many justice-involved people now qualify for coverage.<sup>124</sup> Although some facilities already do so, all corrections facilities should screen for Medicaid eligibility and facilitate enrollment before each person's release.<sup>125</sup> States should also adopt policies that prevent termination of Medicaid coverage during periods of incarceration.<sup>126</sup>

People who are convicted of drug-related offenses are commonly placed on probation, and people who are released from prison prior to the end of their court-imposed sentence are placed on parole. In 2015, an estimated 4.65 million people were under community supervision—nearly twice the number of people incarcerated in jails and prisons.<sup>127</sup> Thirty-one percent of people on parole were placed there for a drug-related offense, as were 25 percent of people on probation.<sup>128</sup>

Community corrections agencies typically impose abstinence requirements on the people they monitor, which can have harmful consequences for people with substance use disorders.<sup>129</sup> Failed drug tests are one of the most common technical violations (failure to follow the conditions of probation or parole) resulting in incarceration among people on community supervision.<sup>130</sup> In general, the role of community corrections should be downsized, and particular attention should be given to the harms of mandating conditions that do not promote personal recovery goals, prohibit or fail to facilitate access to MAT or other evidence-based treatments, and routinely turn to technical violations for positive drug tests.<sup>131</sup>

# Local manifestations of and responses to the drug overdose crisis: Two case studies

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The justice system and community-based interventions described above exemplify the range of strategies needed for a comprehensive, health-centered response to drug use across the United States. Given that the current drug overdose crisis occurs in diverse communities across the country, Vera sought to better understand what is happening at the local level and how research and best practices are being implemented on the ground and in response to real world circumstances and constraints. The following section presents case studies from Ross County, Ohio, and Atlanta, Georgia.

As described earlier (see “Methodology,” page 3), these sites were chosen after considering the magnitude of the drug-related harms in the jurisdiction, the presence of clear programmatic or policy innovations, the geographic location and demographic composition of the population, and the research team’s ability to access a range of stakeholders. The case studies make clear the very local nature of the drug overdose crisis, as well as the need to balance providing communities with clear guidance about best practices and evidence for discrete interventions with recognizing that interventions must be flexible and adaptable to local communities.

## Case study: Ross County, Ohio

In some ways, Ross County (population 76,931) and Chillicothe, the county’s major city (population 21,698), fit the dominant narrative about the opioid overdose crisis in Ohio, which had the second highest rate of overdose deaths in the United States in 2016 and 2017, the two most recent years for which the CDC has available data.<sup>132</sup> According to the local stakeholders who spoke to Vera, as more people became addicted to opioid painkillers, fatal overdoses increased, particularly as fentanyl made



the drug supply more lethal. More young people now struggle with problematic drug use, and officials say that Ross County's jail population has swelled due to drug-related offenses, nearly doubling over the past decade to a daily average population of about 162 people (a rate of 314 people per 100,000 residents).<sup>133</sup>

But in the face of these challenges, Ross County has embraced an innovative response to the overdose crisis: a local, community-driven effort characterized by collaboration, creative problem-solving, and leadership by key people who have been instrumental in bringing the issue out in the open and persuading skeptics to embrace new ideas. "I think my standing in the community as a family physician and as coroner helped attract people to the table," said Dr. John Gabis, who first sounded the alarm about the rise in drug overdoses in Ross County. Fatal overdoses, according to records from the Office of the Coroner in Ross County, peaked at 44 deaths in 2016 and fell to 32 in 2018.<sup>134</sup>

Local leaders attribute some of this decline to an aggressive effort to distribute naloxone led by the Ross County Health District. Ross County has also begun to expand the number of treatment options available and operates three drug treatment courts—two providing an alternative to incarceration

### Ross County, Ohio: Methods and sources

In May 2019, a team of three Vera researchers visited Ross County to observe the local responses to the drug overdose crisis in a primarily white, rural county in the United States. Prior to arriving in Ross County, the research team connected with nearly 20 key stakeholders in the community to get a sense of the landscape and plan the site visit. The team then spent four days in Ross County interviewing a range of people and observing a variety of local interventions. The visit included:

- › interviews with health and criminal justice stakeholders, including representatives from the Ross County Hope Partnership Project, Ross County Sheriff's Office, Chillicothe Police Department, Ross County Court of Common Pleas, Ross County Health District, Adena Health System, BrightView Health, Recovery Council, OhioCAN, and Project 4-14;
- › interviews with drug court and recovery support group participants;
- › a ride-along and observations with the Hope Partnership Project and the Post Overdose Response Team;
- › observations of drug court proceedings; and
- › attendance of a recovery support group gathering.

for misdemeanor and low-level felony offenders, and one for parents with substance use disorder whose children have been removed from the home. A newer initiative involves training and hiring people in recovery to provide peer support services, including in the drug courts and the local jail.

Even so, Ross County residents recognize that many challenges remain. Funding for critical initiatives comes from a patchwork of short-term grants, jeopardizing the sustainability of these efforts. There is a dire need for safe, affordable housing for people at different stages of recovery, including those in outpatient treatment or returning to the community from jail or prison. Ross County Jail's high intake numbers—5,621 admissions in 2015—also indicate a need for more alternatives to incarceration, as well as help for people navigating the consequences of criminal justice involvement.<sup>135</sup> But one advantage of a smaller community is that personal connections make collaboration easier and give overdose statistics the urgency of recognizable faces and names. “My motivation is helping my friends, my neighbors, and my friends’ kids get better,” said one resident who works in the treatment field. “So many of us have been touched by it.”

## Fostering community collaboration

Recognizing the need for a coordinated strategy to address rising overdose rates, community leaders created the Heroin Partnership Project in 2015 with a \$100,000 grant from the Ohio Office of Criminal Justice Services.<sup>136</sup> In 2018, it was renamed the Hope Partnership Project to reflect the realities of polysubstance use and a desire to emphasize the potential for change.<sup>137</sup> The group works with local, state, and federal partners and includes representatives from law enforcement, corrections, the courts, and the health department in addition to treatment and mental health providers and community members impacted by drug use and overdose.

To guide their efforts, partnership members participated in a structured mapping and planning workshop in 2015.<sup>138</sup> By mapping how Ross County residents with substance use and co-occurring disorders move through the criminal justice system, the partnership identified its top priorities for change: 1) addressing housing needs; 2) educating families about substance use disorder and treatment options; 3) developing a protocol for emergency room patients who have overdosed; 4) creating opiate prescribing and detox guidelines; and 5) expanding medication-assisted treatment.<sup>139</sup>

Although the partnership has made progress on many of these goals, community members recognize the need to continue shifting toward a more holistic approach to substance use and mental health.<sup>140</sup> In addition to addressing justice system intercepts, the Hope Partnership Project also focuses on prevention and trauma-informed care for children, recovery supports, advocacy, and public relations, including initiatives to counter stigma. “I really think, through the work of the coalition and the efforts of the community partners, we’ve shed light on the problem and talked about it pretty openly,” said Melonie Oiler, overdose prevention program coordinator at the Ross County Health District. “Through that, we’ve been able to reduce stigma. . . . It’s not gone, but it has certainly changed.”

## Decreasing overdose deaths and harms associated with drug use

One of the partnership’s main goals is reducing overdose deaths through naloxone distribution. The Chillicothe Police Department started carrying naloxone in late 2015, and soon after, the Ross County Sheriff’s Department started carrying it too. “We’ve really seen a culture change with our law enforcement,” Oiler said, describing a shift from an attitude of “That’s not my job; I’m not an EMT,” to a few officers reviving someone and feeling gratified by that success. “It was like a domino effect, and the buy-in then completely changed.”

Although naloxone is available at 11 pharmacies in Ross County under a standing order, officials said that Ohio regulations, lack of pharmacist awareness, and cost and insurance barriers can limit the use of this channel.<sup>141</sup> Ohio regulations have also hampered naloxone distribution by community groups.<sup>142</sup> The result is that most naloxone for laypeople is administered through the Ross County Health District, which is one of Ohio’s Project DAWN (Deaths Avoided With Naloxone) sites.<sup>143</sup> Using the health department as the main avenue for naloxone distribution could inadvertently exclude people who are less likely to engage with formal services, but distribution through this pathway does allow for tracking of doses administered and facilitates easier follow-up with people who have experienced a nonfatal overdose.

Tracking is coordinated through weekly meetings of the county’s Post Overdose Response Team (PORT), which includes health district staff,

treatment providers, the Hope Partnership Project coordinator, and representatives from the police department and sheriff's office. Every Wednesday morning, the team reviews all of the overdoses during the past week, sharing the location, whether naloxone was used, how many doses were administered and by whom, and demographic information about the people involved, including previous overdoses if known.

After the meeting, a group of law enforcement officials and treatment providers take the list of addresses of the people who experienced a nonfatal overdose in the past week and conduct home visits to offer information about treatment options, as well as offer packs of naloxone and information on how to use it. Concerns about relying on police to conduct outreach after a person experiences an overdose are outlined earlier in this report; however, Hope Partnership and PORT team members feel that the involvement of law enforcement in these visits is valuable given resource constraints and the relationships and standing of the police department's community resource officer.<sup>144</sup> Team members said the response to their visits from people who have overdosed is mixed—some people do not think they have a problem—but team members often have success engaging family members, who may appreciate the chance to talk.<sup>145</sup> If no one answers the door, the team leaves a packet of information about treatment options.

The county also hopes to start distributing naloxone to people upon release from jail and has launched an initiative, called the Emergency Department Intercept and Navigation to Support (EDINS) project, at the local hospital's emergency department, to provide naloxone and case management to patients who have been treated for an overdose. The EDINS project was established with help from the Hope Partnership Project and is staffed by a social worker who, if on duty at the time of an arrival, meets with patients who have been treated for an overdose or presented to the emergency department with a health issue related to substance use—and conducts case management follow-up after people have been discharged. The EDINS project also provides fentanyl testing strips and bags for safe syringe disposal. This is particularly important in Ross County, where syringe exchange takes place largely through informal avenues and a formal program has not yet been established. The number of syringe service programs (SSPs) in Ohio has increased in recent years, largely due to changes in state law that allow for the formation of a SSP without declaring a public health emergency and for the use of federal Health and Human



Members of the Post Overdose Response Team (PORT) check in on a Ross County resident.  
Credit: Jess Grimm/USA Today Network

Services dollars for program operating costs.<sup>146</sup> Some Ross County community members feel that public opinion is not supportive of an SSP, but others are more optimistic, suggesting that it is mostly a matter of figuring out who will lead the program.

## Addressing concerns about drug courts

Ross County has three drug treatment courts: within the Municipal Court, the Juvenile and Family Court, and the Court of Common Pleas, which was the first to be certified in 2014.<sup>147</sup> The Ohio Supreme Court establishes standards that specialized dockets must follow, but judges can tailor court operations and participant requirements, and as a result, drug court practices and outcomes across the state depend heavily on the judge.<sup>148</sup> For example, although Ohio regulations allow for the use of all FDA-approved MAT medications for drug court participants, it is not required that courts provide all options.<sup>149</sup>

Judge Michael M. Ater oversees the Court of Common Pleas drug court docket, which is for people who have committed low-level felony offenses that are related to their problematic drug use. His team includes peer

recovery supporters, a probation officer (the drug court coordinator), representatives from the sheriff's office, and treatment providers. Participants apply to be in the program, which includes four phases of supervision and treatment and lasts at least 54 weeks. From 2014 through mid-2019, 132 people enrolled, 71 graduated, 28 were discharged as unsuccessful (and then sentenced), and the rest were still participating.<sup>150</sup> However, there have been a number of relapses and new criminal charges among the graduates, so the team recently added six more months of monitoring before graduates' charges are dismissed and sealed. The hope is that the extra monthly meetings and drug tests will offer a way to compel anyone who is struggling to return to treatment. The court supports MAT for participants, including methadone and buprenorphine, but there was frustration among the judge, team members, and participants about local MAT offerings, such as long waits at the methadone clinic and lack of counseling in conjunction with buprenorphine treatment.

Some community members shared concerns about drug courts, such as who is accepted into the program, how sanctions are imposed, and who graduates (based on factors like race, drug of choice, and the crime committed). People also shared concerns about population-level impacts of drug courts. Although Judge Ater's court expanded eligibility by accepting some people with drug trafficking charges if they were selling only small quantities of drugs to support their habit, drug courts are resource-intensive and typically serve a limited number of people.<sup>151</sup>

Ross County's family treatment court, part of the Juvenile and Family Court overseen by Judge Jeffrey Benson, aims to address the complex needs of parents with substance use disorder whose children have been removed from the home, and as such, the court wrestles with a range of challenges in the process.<sup>152</sup> In addition to debating when and how to extend visitation hours with a child, Judge Benson's team helps participants with public benefits and other practical matters, such as qualifying for Section 8 housing vouchers and dealing with fines to reinstate their driver's licenses. Participation in the program involves attending status review hearings, maintaining sobriety while completing alcohol and other drug treatment, abiding by court orders, and submitting to random home visits and drug and alcohol tests.<sup>153</sup> The program does allow MAT, and, of those using MAT (fewer than half of family treatment court participants at the time), most participants were taking naltrexone. As of mid-2019, 47



Members of Judge Ater's drug court treatment team discuss options for drug court participants. Credit: Robert McGraw/USA Today Network

people had enrolled in the family treatment court program. Twelve had graduated, 16 withdrew or were discharged for noncompliance, two had a neutral discharge, and the rest were still active participants. Rates of family reunification are high—out of 88 children served, 45 had been reunified with a parent— and family drug court participants appreciated the holistic approach and dedication of the treatment team.<sup>154</sup>

## Reducing incarceration and strengthening treatment in custody

Mirroring trends of rising incarceration in rural counties around the country, the annual intake at the Ross County Jail has increased—climbing from 3,869 admissions in 2000 to 5,621 admissions in 2015—and Sheriff George Lavender has proposed building a second jail to alleviate overcrowding.<sup>155</sup> Staff reports that the average daily population is now 200 people, 80 percent of whom are charged with felonies and 20 percent with misdemeanors, a shift from the opposite ratio a decade ago.

In 2016, the Hope Partnership Project created a new position for a jail case manager to identify and support people with problematic drug use and mental health problems, through screening, assessment, and reentry support. But with a two-week average stay and little space for programming, the services offered at the jail are limited.<sup>156</sup> Although jail staff said about 80 percent of people entering the jail have some type of substance use disorder, there is no detox protocol for people held in jail and many people go through withdrawal.<sup>157</sup> The jail case manager accompanies people who are incarcerated and interested in naltrexone to a local provider, but the logistics required to arrange for a corrections officer and transportation mean that this can take up to 30 days. Jail staff cited space limitations and the need for a dedicated wing as barriers to administering MAT in custody, but the jail can help people set up appointments to start those medications once they are released. The case manager also helps with Medicaid enrollment, a priority of the Ohio Department of Rehabilitation, and connects incarcerated people to residential or outpatient treatment after their release.<sup>158</sup> “If a person really wants to get into treatment, we can get them someplace,” the case manager said.

## Expanding community-based responses

Increasing affordable housing options was another top priority identified in the sequential mapping exercise Ross County completed.<sup>159</sup> This is also recognized as a priority at the state level, as Ohio has made a commitment to expanding Housing First, a model of housing assistance that focuses on connecting homeless or housing-insecure people to housing as quickly as possible and to additional supports once housing needs have been fulfilled.<sup>160</sup> Still, in Ross County few options exist for people returning to the community after residential treatment or incarceration, and many become homeless or live in residences that are not supportive environments for recovery.<sup>161</sup> Addressing this gap would make it possible to divert more people from jail and move upstream from justice system responses.

Ross County has one homeless shelter and limited recovery housing, including two faith-based residences for men, transitional housing for women, and a sober home for women operated by a local resident who lost her daughter to an overdose.<sup>162</sup> Most treatment in the county is outpatient, and local officials and community members expressed a need for more evidence-based inpatient and residential programs. Though community



members would like to open more recovery homes, many financial challenges, transportation barriers, and zoning restrictions present hurdles.<sup>163</sup> Two of the main treatment providers offer group therapy, individual counseling, case management, and peer support, and work with many drug court participants.<sup>164</sup> Medication-assisted treatment is available from several outpatient clinics as well as more than two dozen providers authorized to prescribe buprenorphine—all in Chillicothe, which is challenging for many residents to reach from other parts of the county.<sup>165</sup>

Although the public has become more accepting of MAT, community members expressed concerns about providers dispensing opioid medications without offering counseling and other services, particularly as polysubstance use becomes the norm.<sup>166</sup> Another challenge is finding treatment that a person's insurance plan will cover. Medicaid expansion has been critical to extending treatment access in Ohio, but people said that some programs do not accept Medicaid and that Medicaid could pose certain restrictions, such as limited coverage for inpatient care.<sup>167</sup> Another concern is about cash-only MAT providers that do not accept any insurance, especially in rural Ohio.<sup>168</sup>

## Uplifting peer support

Ross County has made significant investments in supporting and promoting Peer Recovery Supporters (PRSs)—people who have experienced a mental health and/or substance use disorder and have completed Ohio state-regulated training and certification. PRSs are being embedded in a variety of treatment settings, both in the community and across the criminal justice continuum.<sup>169</sup> Their role is to increase treatment readiness and retention while serving as a source of advice for local officials, service providers, and families. Although the criminal justice system has traditionally relied on referrals to 12-step meetings for this type of support, PRSs embrace a range of pathways to harm reduction and recovery, including MAT.

So far, several peer supporters have been hired in Ross County and there is momentum to increase their numbers and expand their duties.<sup>170</sup> The hope is that people struggling with problematic drug use will relate to someone who has been through a similar experience—like one person in jail who told a PRS, “You understand everything; I feel like I can trust you.”

Although many service providers recognize peer support as a best practice, there has been some resistance to embracing this role. “I thought it

would be awesome for them: Here I am, an example of all your hard work,” one PRS commented, but in some cases the response was, “I remember you. . . .What can you do for somebody when I was just arresting you?” The Hope Partnership Project has been trying to educate people about

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**One person in jail told a peer recovery supporter, “You understand everything; I feel like I can trust you.”**

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what PRSs do, and support from the local sheriff, judges, and other leaders has helped overcome some skepticism about the purpose of this role. In August 2019, the Hope Partnership Project was one of a number of local advocacy and support groups—including OhioCAN, Project 4-14, and the Peer Recovery Group—to support the opening of the Ross County Recovery Center, which serves as a supportive gathering place for PRSs and people seeking support and resources for substance use disorders, mental illness, and homelessness.<sup>171</sup> The center operates on a drop-in basis, offering peer recovery services, support groups, access to naloxone and other resources, as well as a place to do laundry, take a shower, and get a coffee and a hot meal.<sup>172</sup>

## Finding and maintaining funding

Although Ohio has received many federal grants to address the opioid epidemic, most of Ross County’s initiatives are supported by a patchwork of local, state, and federal grants that are often small, short-term, and limited in terms of how the money can be spent.<sup>173</sup> “They’ll fund the biggest health issue two years after you need the money, and then three years later, the funding goes away and there’s something else that’s the new priority of the day,” one official said. Officials also cited a need for help finding and writing grant applications, noting that without the time and expertise to navigate this process, it’s easy to miss out on funding opportunities.

Even though some grant requirements can strengthen local responses—such as mandating the formation of an overdose fatality review committee—other restrictions can decrease the community’s ability to innovate and shift course as the epidemic evolves. For example, many grants have focused on opioids alone and cannot be used to address broader problems associated with problematic drug use—a significant challenge for Ross County and other regions with rising methamphetamine use.<sup>174</sup>

Some residents expressed concern about whether investments in research—or potential settlements from opioid litigation—will ultimately benefit the people who need help.<sup>175</sup> Although building an evidence base and sharing data are vital, some community members expressed

## Ross County, Ohio: Summary of promising practices, current gaps, and recommendations

### Promising practices

- > Collaboration and information sharing among health providers, justice system agencies, and community members have fostered holistic responses to problematic drug use, including identifying priorities for the criminal justice system, health providers, and community-based prevention, treatment, and recovery supports.
- > Public education and open conversation about problematic drug use led by respected community leaders have reduced stigma and increased support for adoption of evidence-based practices.
- > Efforts to increase naloxone access have resulted in a decrease in drug-overdose death rates, and efforts to expand access to laypeople are promising.
- > Peer recovery supporters have been integrated into treatment roles in community and criminal justice settings, and people with personal and family experience with drug use, overdose, and recovery are leading community-based responses.

### Gaps and recommendations

- > Funders should promote flexibility by limiting restrictions that are tied to funding so that communities can tailor their responses to changes in drug use patterns and address local root causes and barriers.
- > The county devotes significant resources to drug courts and is considering construction of a new jail, which could take away resources from investments in community supports and increase rates of incarceration. The county should explore additional ways—such as alternatives to arrest—to divert people who use drugs from the justice system whenever possible.
- > State legislation in Ohio should be amended to create an environment that is more supportive of harm reduction. For example, the state should amend Good Samaritan laws to further protect people who seek medical assistance in the event of an overdose and lift restrictions on syringe distribution.
- > Community members expressed a need for more substance use treatment and recovery supports, including inpatient treatment, recovery homes, and MAT providers who accept Medicaid and other forms of insurance. All forms of MAT should be offered in criminal justice settings.

frustration about the lack of financial support for treatment and interventions that have already been proven effective, as well as public education about why they are important. For instance, a tax levy to support the Ross County Health District failed to pass several years ago, in part due to voter opposition to the district's activities distributing naloxone. That experience has contributed to hesitancy from the health department toward opening a syringe exchange, illustrating the range of issues local officials must navigate to implement and sustain initiatives, always mindful of financial, political, and public support.

Fortunately, a \$1 million grant awarded to Ross County by the U.S. Department of Health and Human Services in August 2019 could help alleviate some tensions caused by limited and restricted funds. This money will fund prevention, treatment, and recovery efforts, allowing the county to operate its services and develop less-established programs.<sup>176</sup> Still, additional flexible, long-term funds are crucial to create and maintain the infrastructure required to minimize the harms associated with drug use. Overall, Ross County residents Vera interviewed believe they are making progress, especially as compared to communities where the stigma of substance use has stymied an effective response. “That might be one of the reasons we are ahead of certain other areas in the state of Ohio,” one official said. “We’re willing to recognize and be open about the true issues that are here, and then we’re able to tackle them.”

## Case study: Atlanta, Georgia

As the birthplace of Martin Luther King, Jr. and an important organizing center of the civil rights movement, the city of Atlanta (population 498,044) has long been a political, economic, and cultural hub for the state of Georgia and the Deep South.<sup>177</sup> Atlanta is still one of the largest majority Black cities in the United States (52 percent of the population as of 2018) and also has one of the highest LGBT populations per capita; it is also one of the country's fastest gentrifying cities. Atlanta has high income inequality and has experienced large increases in its white population since the 2000s.<sup>178</sup>

Like many U.S. cities, Atlanta has experienced decades of police violence and mass incarceration as a result of “war on drugs” policies in the aftermath of slavery, Jim Crow, and racial segregation. But the city is also known for its resilience and resistance in the face of oppression. Indeed,

present-day Atlanta is notable for its bold strategic efforts—anchored in the leadership of community organizers, formerly incarcerated people, LGBTQ activists, and harm reduction advocates—to advance policies that divest from criminal justice responses to drug use. Local organizations are distributing new, sterile syringes and naloxone to people who use drugs; a

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“We’re willing to recognize and be open about the true issues that are here, and then we’re able to tackle them.”

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new diversion initiative is encouraging police to cut down on arrests and connect people to health and community services; and a landmark campaign to close down and repurpose a city jail is gaining traction. Although there are ongoing challenges facing community, health, and justice stakeholders, Atlanta appears to be charting a path to reorient its services, institutions, physical infrastructure, and systems to better support community health and wellness for its residents.

## Harm reduction in the heart of the city

For nearly 25 years, the Atlanta Harm Reduction Coalition (AHRC) has been providing syringe services, health education, HIV prevention, medical care, linkages to social services, and advocacy to people who use drugs and engage in sex work throughout the city. AHRC cofounder Mona Bennett explained that the coalition formed in response to the HIV epidemic of the mid-1990s by activists from the Atlanta chapters of the AIDS Coalition to Unleash Power (ACT-UP) and Prevention Point, along with collaborators from Emory University’s Rollins School of Public Health.

AHRC operates weekly syringe service programs (SSPs) that allow people to pick up sterile syringes, cookers, cotton, and other equipment, and return used syringes for disposal. For decades, it has been the only place in Atlanta, and all of Georgia, providing free syringes and injection equipment. In recent years, with funding from the state government and in collaboration with the

Georgia Overdose Project, AHRC has also had a relatively steady supply of naloxone to distribute at its SSPs and other service outlets in the community, providing a critical source of naloxone for people most likely to witness or experience an overdose. The organization reported distributing 12,828 doses of naloxone in 2018, resulting in at least 900 successful overdose reversals.<sup>179</sup> AHRC clients Vera interviewed said that most people they know carry naloxone, and many had administered the life-saving drug to multiple people or had been revived themselves. An older man who had been using heroin for the previous 13 years explained that people in his neighborhood “look out for one another.” But the fluctuating quality and potency of heroin and the changing mix of fentanyl and its analogs are contributing to spikes in overdose; drug-checking supplies are high on the wish list of AHRC staff and clients, though such funding has not been easy to secure.

## A complicated relationship with the police

Over the years, AHRC has had a complex relationship with police. Bennett explained that until Georgia’s laws were changed in 2019, distributing syringes was considered illegal “unless you were doing it for a legitimate medical purpose.”<sup>180</sup> Ever since they first started giving out syringes, Bennett said that AHRC “clung fiercely and tightly to those three

### Atlanta, Georgia: Methods and sources

In May 2019, a team of two Vera researchers spent four days in Atlanta to observe the local responses to overdose and drug-related harms in a large city with a majority Black population and a long history of civil rights activism. The team met with a range of stakeholders and observed a harm reduction program and a pre-arrest diversion initiative in action. This included the following:

- › Interviews with health and justice stakeholders from the Atlanta Harm Reduction Coalition (AHRC), Atlanta/Fulton County Pre-Arrest Diversion Initiative (PAD), the Georgia Public Defender Council, Atlanta Police Department (APD), Fulton County Department of Behavioral Health and Developmental Disabilities, Women on the Rise, and the Racial Justice Action Center
- › A ride-along with an APD community liaison to learn about pre-arrest diversion and the daily interactions among police officers and people who use drugs in downtown Atlanta
- › Visit to the AHRC syringe service program in the English Avenue neighborhood
- › Visit to the PAD initiative office in downtown Atlanta
- › Interviews with 16 AHRC and PAD clients

words”— legitimate medical purpose. Although courts have never ruled on AHRC’s interpretation of that phrase, she said that for the most part, police have looked the other way and allowed the SSP to operate. Bennett and her colleagues believe AHRC’s early alliance with the Rollins School of Public Health at Emory University helped prevent police interference when the SSP started. “We acted as if, especially with the presence of the [Emory] public health students, that we were doing public health [work]. And we also had the conviction of ‘f--- the law, we’re going to save some lives,’” she recalled. AHRC staff noted that educating police over time on the benefits of the SSPs for the health and safety of the neighborhood has also helped build tacit support for harm reduction.

Although police reportedly never arrested AHRC staff for distributing syringes, AHRC clients said that profiling, arrests, and incarceration are an ever-present fear.<sup>181</sup> One AHRC client explained that police routinely stop, interrogate, and search people for “basically breathing and being a live human in a high-intensity drug-trafficking area.” Mistrust of police and the criminal justice system is deeply rooted. Even though Georgia’s 911 Good Samaritan law covers people on probation or parole, AHRC clients said that some of their peers, particularly those who have criminal records or outstanding warrants, still prefer not to be at the scene of an overdose when police arrive.<sup>182</sup>

AHRC staff and clients have also emphasized how gentrification and demographic shifts have shaped police activity. Most of AHRC’s operations are anchored in the English Avenue neighborhood in Northwest Atlanta, an area that historically has been and remains one of the most underserved and over-policed parts of Atlanta. Longtime Black residents who lived through the crack cocaine era of the 1980s recounted experiencing harassment, brutality, and mass arrests at the hands of the Atlanta Police Department’s notorious Red Dog unit (known colloquially as “Running Every Drug Dealer Out of Georgia”).<sup>183</sup> The neighborhood’s nickname is “The Bluff,” which Chucky, a resident and AHRC outreach worker, explained is an acronym for “Better Leave, You F---ing Fool,” to convey that it may be an unsafe place for many people who visit. Several interviewees noted that nowadays, more young, white adults are coming in from Atlanta’s suburbs to buy heroin or pick up syringes and naloxone from AHRC, sometimes ending up “stuck” living in the Bluff. An older Black man said that police continue to target Black residents, and if a white person is walking down the street with a

Black person, police assume that the Black person is selling the white person drugs and will stop and question them: “When the cops see a lot of white kids coming into the neighborhood, they really start cracking down. They crack down hard.” At the same time, a young white woman explained that police assume that all white women in the neighborhood are sex workers and drug users: “Police stop me all the time, search, run my name,” she said, adding that it is easier to cooperate than to challenge the officers. A young Black man living in the Bluff said he understands that the city wants to address drug sales and use in the neighborhood, but he fears that police will double-down on their old tactics of arresting, incarcerating, and displacing people. If it were up to him, he would want the city to think about what neighborhood residents need, increase economic opportunities, and expand access to treatment and recovery services.

## Expanding access to treatment

Many AHRC clients that Vera researchers spoke with have experienced barriers to accessing substance use treatment, including MAT. One primary issue is lack of health insurance; Georgia has one of the highest uninsured rates in the United States (nearly 14 percent of residents, according to 2018 U.S. Census data), and the state did not expand Medicaid eligibility under the Affordable Care Act.<sup>184</sup> According to several AHRC client interviewees, MAT is also difficult to access in Atlanta because most providers operate on a cash-based system. One client said that he has faced waiting lists for residential treatment that are “so long that you are back out there using again” and that many health care providers do not understand that relapse is a normal part of a substance use disorder.

AHRC clients Vera interviewed also described how their interactions with the criminal justice system caused them significant harm and hampered their prospects for recovery. Atlanta has long had drug courts, but several AHRC clients described how drug court programs set them up to fail: a young woman said, “It is too hard to keep a job and go on with your life,” and a middle-aged man explained, “Everybody is still craving and trying to sneak around the system, and if they get caught, they get kicked out.” Many AHRC clients also described negative experiences in Atlanta jails, such as going through the extremely painful process of withdrawal without any withdrawal management supports. Although the Fulton County Jail recently started providing buprenorphine to alleviate withdrawal symptoms, AHRC



client interviewees indicated that people were not provided a supply of the medication or connections to providers in the community when they were released.<sup>185</sup> What's more, people are not receiving naloxone when they are released, a critical missed opportunity to reduce overdose mortality during this high-risk transition. When asked what the criminal justice system could do to better respond to drug use, one AHRC client who has been coming to the SSP since he got out of prison in 2002 put it simply: "Stop locking people up. That's the main thing."

## Moving from criminalization to health and wellness

A few neighborhoods over, in downtown and midtown Atlanta, police have been adopting a new approach to keep people out of jail who are struggling with issues related to substance use, mental illness, homelessness, and poverty. Instead of arresting people for criminalized behaviors such as trespassing and panhandling, officers have been making diversion referrals to the Atlanta/Fulton County Pre-Arrest Diversion Initiative (PAD). PAD is a local adaptation of LEAD that launched in October 2017 on four police beats, and has since expanded to a 28-beat area.<sup>186</sup> In its first two years, 150 people were diverted from arrest and referred to the initiative.<sup>187</sup> PAD has a team of care navigators who provide intensive case management guided by Housing First, harm reduction, and trauma-informed approaches and engage with people immediately to address their needs for housing, medical care, mental health and substance use treatment, job training, and more. In Atlanta's pre-arrest diversion model, no charges related to the diversion are filed, and there are no conditions or requirements for people to engage in services or penalties for relapsing. As one of PAD's care navigators explained, "There's nothing hanging over their head" that could lead to re-arrest for the original offense.

Moki Macías, PAD's executive director, explained that the program was born from many years of community organizing by groups directly impacted by policing and incarceration. Back in 2013, a coalition of community activist groups, including Women on the Rise, Trans(forming), LaGender, and the Racial Justice Action Center launched the campaign "Solutions Not Punishment" and later, a coalition to fight back against the criminalization, policing, and marginalization of Black trans and

gender-nonconforming people engaging in sex work in Midtown Atlanta.<sup>188</sup> The coalition presented pre-arrest diversion as a potential alternative and was closely involved in designing PAD with a group of government, criminal justice, social service, and community stakeholders.

Building support for PAD in the police department has been an ongoing process, yet many Atlanta police officers have told PAD staff that they have come to understand that repeatedly arresting and incarcerating people is not working and are excited to have the initiative as an alternative option.

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“We’re really trying to do that reframing . . . bringing the harm reduction framework into every conversation we are having with all these partners.”

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“We’re not trying to arrest and put everyone in jail,” said Officer Crawford, the department’s PAD liaison officer. Still, diversion relies on police discretion, and increasing the use of diversion instead of arrest has required PAD to work closely with the police department to train officers, keep them engaged with the initiative, and pay close attention to equity issues. Even though PAD staff tell officers that they can make a diversion for any charge (the only exclusion is if someone has a prior open case for one of seven violent crimes), they still tend to think of people charged with quality-of-life offenses as the primary candidates for diversion.<sup>189</sup> As Macías explained, “there’s a lot of pressure on the police department to basically handle every social issue that is visible on the street,” and in many cases, there is pressure from business owners, residents, or other community members who expect arrests to be made.<sup>190</sup>

Another challenge is that so far only a small number of transgender and gender-nonconforming people have been diverted from arrest to PAD. In a recent encounter described by one of PAD’s partners illustrating how police discretion plays out for this population, an officer who decided to arrest a



Members of the “Close the Jail ATL: Communities Over Cages” campaign gather at Atlanta City Hall to discuss plans to repurpose the Atlanta City Detention Center. Credit: Lovette Thompson

transgender woman outside of a Walgreens store instead of making a diversion referral said, “I just didn’t think she deserved to be diverted to PAD.” The staff of PAD hopes that devoting additional resources for outreach to the transgender community, as well as dedicating spots on its caseload for trans and gender-nonconforming people, can help reduce the frequency of negative encounters with the police and criminal justice system.

Importantly, PAD continues to work at the systems level to help the city of Atlanta move away from arrest and criminalization and strengthen its capacity for health-centered and community-based responses. Every month, PAD convenes a working group of its criminal justice partners to review recent referrals, identify resolutions for open cases or re-arrests, and discuss broader system reforms. At a recent meeting, for example, PAD asked prosecutors to put together a list of all the types of charges that recur and pile up, charges they would prefer not to have to prosecute. “We’re really trying to do that reframing . . . bringing the harm reduction framework into every conversation we are having with all these partners,” explained PAD program

manager Mary Naoum. This is something PAD staff learned from Seattle and the LEAD model: acting as the convening body is one of the critical components for successful diversion programs, not just for the program itself on the ground, but also in fostering shifts among criminal justice partners as they consider alternatives to policing and punishment. Arrest numbers suggest that the city is moving in the right direction. In late 2019, Atlanta police were on pace to make roughly 28,000 arrests, including about 4,300 for narcotics and more than 5,000 for quality-of-life violations.<sup>191</sup> This represents a big change from a decade ago when, in 2009, 46,432 arrests were made citywide, with 7,215 narcotics arrests and 14,415 quality-of-life arrests.<sup>192</sup> “If the point [of diversion] isn’t ultimately decriminalization, what are you doing?” Macías asked. And recognizing that the initiative relies on having health and social services to divert people to, one of PAD’s overarching goals and ongoing priorities is to continue to advocate for reallocating criminal justice funding to mental health crisis services, supportive housing, and other community-based services.

## Communities over cages

Building on the life-saving services and support of AHRC and PAD, a larger movement is gaining momentum in Atlanta to divest from the criminal justice system and shift funding and resources to community services and supports instead.

The same organizing forces that paved the path for PAD—Women on the Rise, the Racial Justice Action Center, the Solutions Not Punishment Coalition, and a coalition of more than 40 other community organizations committed to a range of criminal justice, racial justice, and gender justice issues—came together again in 2018 to campaign to close the Atlanta City Detention Center (ACDC) and transform the facility into a wellness and freedom center.<sup>193</sup> Marilyn Winn of Women on the Rise explained that they have been building up to the campaign “Close the Jail ATL: Communities Over Cages” through sustained organizing and advocacy efforts to reduce the number of people being held in ACDC—a strategy she refers to as “starving the beast.” In 2017, the city reduced the penalty for marijuana possession from \$1,000 to \$75 and eliminated jail time.<sup>194</sup> With pressure and support from community groups, Mayor Keisha Lance Bottoms (who took office in January 2018) has passed bail reform legislation and signed an executive order to remove U.S. Immigration and



Bridgette Simpson, lead organizer from Women on the Rise, addresses the crowd at Atlanta City Hall during a rally and press conference for the “Close the Jail ATL: Communities Over Cages” campaign. Credit: Jerome Bryant

Customs Enforcement detainees from the detention center.<sup>195</sup> The coalition of community groups is campaigning to close the jail and reallocate the millions of dollars spent annually on its operation to programs, services, and physical spaces that will support community safety, civic engagement, health, and wellness. In May 2019, the campaign won a key victory when the city council passed a resolution to close ACDC and create a task force to develop the plan.<sup>196</sup> When the mayor and city council got behind the proposal, Winn said, “It was like divine order. Like a spirit or a power greater than us that was bringing things to us.”

The task force began meeting in July 2019 and has been asked to report back to Mayor Lance Bottoms with its recommendations by February 2020.<sup>197</sup> Xochitl Bervera of the Racial Justice Action Center wants the task force to tackle the physical repurposing of the facility, consider the range of programs and services that could be funded when ACDC shuts down, and advocate for policy changes to support further decarceration. Winn explained her vision for transforming the facility from a space of punishment and oppression into one for health, healing, and liberation; she wants Atlantans to have a “one-stop shop” where they can access a whole range

of services, including health care, substance use treatment, food, childcare, temporary housing, employment services, and literacy and educational services. “The jail has been a drain on the human and financial capital of Atlanta,” Winn said, but there is an opportunity for transformative investment to address the history of structural racism and oppression in this city. There are challenges ahead and the stakes are high—Bervera is firm that the outcome of Close the Jail ATL “won’t be a gentrification project.” Looking beyond ACDC, the Fulton County Jail in northwest Atlanta has been severely overcrowded in recent months.<sup>198</sup> But Atlanta is a place where people who use drugs and those directly impacted by the criminal justice system are leading the transformation of the systems, institutions, and policies that cause harm.

## Atlanta, Georgia: Summary of promising practices, current gaps, and recommendations

### Promising practices

- › SSPs and other harm reduction services can thrive and meet their goals when state laws permit their operation and expansion—and local police understand their benefits for community health and do not interfere with service delivery.
- › Community-based overdose education and naloxone distribution (OEND) programs that focus on distributing naloxone directly to people who use drugs are an effective way to prevent overdose deaths.
- › Efforts to reduce reliance on the criminal justice system and strengthen community-based services have been driven by community groups directly impacted by the justice system and focused on issues of racial and gender justice.
- › Diversion initiatives can also catalyze criminal justice reform by engaging justice system stakeholders

and building support for alternatives to arrest and criminalization and strengthening the infrastructure for health and social services.

### Gaps and recommendations

- › State lawmakers and health care agencies should expand access to evidence-based substance use disorder treatment, including MAT, and expand Medicaid to address high rates of people who are uninsured.
- › Corrections agencies should ensure access to MAT in correctional facilities and provide naloxone to people on release from jail or prison.
- › State and philanthropic funders should create and sustain reliable sources of funding for naloxone, syringes, drug testing kits, and other harm reduction supplies for local service providers.

# Changing course: Lessons from the field

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The previous sections of this report provided a brief overview of the context of the current drug overdose crisis, the ways in which criminal justice responses have affected people and communities, and the spectrum of community-based and justice system-based interventions that are applied in response to drug use. The two case studies in Ross County, Ohio, and Atlanta highlighted a range of successes and ongoing challenges for local health and justice systems responding to overdose and drug-related harms in two different contexts.

Drawing on the insights from interviews with national experts (see Appendix, page 56), as well as the local experiences of health and justice stakeholders in Ross County and Atlanta, this final section outlines five key strategies and recommendations for minimizing the harms associated with punitive responses to drug use while advancing health-centered and community-based approaches. These strategies include advancing harm reduction in criminal justice settings, diverting people from that system and strengthening upstream responses, supporting diverse definitions of recovery, elevating the experience and leadership of people directly impacted by drug use and the criminal justice system, and centering racial equity and justice in all policies and initiatives.

## Adopt harm reduction across the justice continuum

Key elements of advancing a public health approach to drug use rather than a criminal justice approach include minimizing justice-system contact for people who use drugs and shrinking the role of police, courts, and correctional agencies in responding to drug use. But the reality is that people who use drugs continue to be arrested, incarcerated, and entangled in the criminal justice system. Therefore, it is critical that people who use drugs have access to evidence-based supports for harm reduction, treatment, and

recovery in criminal justice settings. Leo Beletsky, professor of law and health sciences at Northeastern University, underscored the necessity of this strategy.<sup>199</sup>

“In the same way that we want to meet people where they’re at, we need to also meet systems where they’re at. And right now the systems are configured in a way that makes it much more likely that a person with substance use disorder comes into contact with the criminal justice system—and right now those encounters are a source of major harm. So I think it is an imperative to reconfigure those encounters to be less of a source of harm and more of a source of benefit.”

Lindsay LaSalle, managing director of public health law and policy at the Drug Policy Alliance, framed the issue similarly, emphasizing that harm reduction and treatment services should be available in any place where lives can be saved and positive change is possible, including carceral settings:

“As long as we’re operating within a prohibitionist system, we have to embrace incremental reform, which includes things like providing buprenorphine and methadone in jails and prisons . . . and trying to ensure that drug courts and probation and parole agencies do not penalize people for being on these medications.”

As the quotes from Beletsky and LaSalle imply—and as described by many of the experts Vera interviewed—expanding access to harm reduction interventions throughout the justice-system continuum and continuing to push for all forms of MAT in all settings are key priorities for improving justice system responses to drug use. In Ross County, Ohio, and in Atlanta, Vera saw examples of law enforcement stakeholders supporting syringe service programs and naloxone distribution—and despite concerns about access to treatment in the community, there were supporters and advocates for MAT within Ross County’s drug court programs. But both jurisdictions are struggling to provide comprehensive harm reduction and treatment services in jails and prisons, as well as after release.



## Recommendations:

- › Police officers should carry naloxone to prevent overdose deaths and support community-based harm reduction interventions, including OEND, SSPs, and SCSs.
- › OEND and MAT should be available in all criminal justice settings, including drug courts, jails, prisons, and through community corrections.

## Move responses upstream

In addition to acknowledging the urgency needed in implementing evidence-based public health, harm reduction, and treatment services in criminal justice settings, experts interviewed by Vera discussed the need to move responses to drug use upstream by diverting people who use drugs from the criminal justice system and ensuring that there are robust, accessible health and social services in the community.

**Divert people from the justice system and disentangle health care delivery.** National experts were concerned with how the criminal justice system has become entangled with health care delivery, such that police, judges, corrections personnel, and probation officers frequently act as gatekeepers to health care, treatment, and other services. Referring to the proliferation of drug courts, Lindsay LaSalle highlighted, “There’s no business of a judge adjudicating a treatment plan for someone when it really should be [managed] by a doctor in the community.” Devin Reaves, executive director of the Pennsylvania Harm Reduction Coalition, said he would prefer communities that are expanding drug courts to consider LEAD programs instead. Other experts noted the limitations of LEAD and advocated for a future in which access to services does not hinge on the threat of arrest or interactions with police. “Any program that retains the control of what happens to a person in the hands of law enforcement officers is inherently a broken program,” said Louise Vincent, executive director of the Urban Survivors Union. Moki Macías explained the longer-term vision for Atlanta’s pre-arrest diversion initiative: “For us, the long game is that officers are not the gatekeeper[s], and there’s another place to bring people. There has to be another place to bring people, and

we can get police officers out of the business of responding to these kinds of things.”

To shift resources and capacity for responding to drug use upstream from the domain of criminal justice agencies into the hands of health systems and community-based harm reduction advocates and service providers, experts discussed the importance of reforming laws and policies to support the adoption and expansion of harm reduction services and evidence-based treatment for substance use disorders. The proliferation of

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“There has to be another place to bring people, and we can get police officers out of the business of responding to these kinds of things.”

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911 Good Samaritan and naloxone access laws, increased legalization of SSPs, regulations that increase the types of providers eligible to prescribe buprenorphine, and the recent federal court decision on SCS were cited as examples of positive legal reforms.

**Strengthen infrastructure for a robust public health response.** When considering the path forward to move away from criminal justice-focused responses to drug use, many of the experts Vera interviewed highlighted the need to address deficits in health systems and strengthen the capacity of health and social services to meet the needs of people who use drugs. This was a key priority for the Atlanta Harm Reduction Coalition and the Atlanta/Fulton County Pre-Arrest Diversion Initiative, as well as the community-led campaign to reallocate funding and repurpose the physical facility of Atlanta’s city jail.

National experts, including Leo Beletsky, underscored that across wide swaths of the United States that are experiencing overdose surges, there are “treatment deserts . . . where there’s just no [medication-assisted, methadone

and buprenorphine] treatment available still, and that's just shocking given that we know it works, and have had data on this for a long time." Dr. Daniel Ciccarone of the University of California, San Francisco School of Medicine, added, "There are still plenty of places in the country that don't have the basics. They do not have syringe exchange. There isn't enough naloxone to handle this current overdose crisis. This is basic stuff that still needs to happen that we need political muscle and money for." When the resources and infrastructure to deliver these services to communities are not in place, localities will keep leaning on the criminal justice system to fill the void and struggle to scale up public-health community-based responses. Dr. Daliah Heller, the director of drug use initiatives at the global public health organization Vital Strategies, articulated this point: "The public health side is broken. So while you're working on convincing criminal justice people to reform how they approach drug use, nothing looks appealing on the [public health] side, since we've been lacking resources and internal coordination for building out a true health response."

Building a more robust health-centered response to the overdose crisis is also inevitably related to the availability and distribution of funding. Expanding Medicaid to ensure that people have coverage for a full array of substance use treatments is essential in parts of the country where people still lack health insurance. Medicaid is also a vital funding stream for expanding the capacity of MAT, as well as residential and outpatient services for people seeking abstinence. The decision not to expand Medicaid in Georgia continues to frustrate stakeholders in Atlanta, and people in Atlanta and Ross County noted that many MAT providers still do not accept insurance. In addition to improving access to treatment, jurisdictions also need to invest in community-based groups that are providing harm reduction services. Experts noted that drug user unions and harm reduction organizations in particular are too frequently hampered by a lack of financial support for supplies, staffing, and services.<sup>200</sup> Public and private funding mechanisms often fail to adequately support advocacy efforts and frontline service delivery by grassroots community groups led by people who use or have used drugs.

**Decriminalize drug use.** Experts also discussed the value of decriminalizing drug use and lessons learned from other countries. Scott Burris, the director of Temple University's Center for Public Health Law Research,

described the basic building blocks for a legal framework to replace criminalization: “We should have a system of legal regulation for access and control as the first piece to get rid of the criminal justice system. The second piece would be to create a vigorous public health-based, harm-reducing regulatory approach whose goal is to nudge people as much as possible toward less dangerous drugs and less dangerous formulations of those drugs to suppress consumption, as much as we reasonably can without causing black markets.”

Robert Childs, technical expert lead at JBS International and former executive director of the North Carolina Harm Reduction Coalition, described Portugal’s approach: “If you have an encounter with a law enforcement officer and have no more than a 10-day supply of a substance, instead of being incarcerated, you get interviewed by [a committee made up of a social worker, a psychiatrist, and an attorney]. They look at the underlying problems that a person has and then say, ‘Oh, you’re a recreational user who is managing their use without issue,’ and thus that person may be given just community service or a small fine to [a] charity of their choice or the government. Or they say, ‘There’s some items we may need to help you out with here. Let’s offer you mental health services and assist you with housing. Let’s get you access to methadone or Suboxone and access to a harm reduction program. Let’s support you in your recovery.’ So they actually work with people on getting them access to harm reduction, treatment, recovery, housing and/or mental health care services instead of incarceration.”<sup>201</sup> Lindsay LaSalle said that although Portugal is the most famous example, there is also much to learn from the Netherlands about pairing decriminalization with large-scale investments in a full array of harm reduction services. She noted that each country has its strengths and limitations, but that each offers valuable lessons for the United States: “In terms of harm reduction, the Netherlands, they’ve got it all. They’ve got lots of safe consumption sites. They have heroin-assisted treatment and wide access to syringe access.” Dr. Joanne Csete, an associate professor at Columbia University’s Mailman School of Public Health and an expert in international drug policy, said that Swiss police have supported harm reduction services such as HAT “enormously because they know that otherwise they’re going to be encountering these people on the street.”

**Address root causes.** Many experts emphasized that policymakers must consider the root causes of why people use drugs and prioritize policies

and programs that address the social determinants of health and drug use.<sup>202</sup> Historian Dr. Samuel K. Roberts of Columbia University pointed out that “drugs showed up in cities in the first place because by 1965, and certainly by 1984 a lot of these areas were severely economically depressed. Unemployment was high, housing availability was getting low, the social services and support net was fraying, and the education system no longer promised upward mobility. Getting involved in the low-level drug trade offered some sort of employment, and using drugs offered some reprieve from the stress of it all. Although these considerations did not factor into how the ‘war on drugs’ unfolded, this is no different from our understanding of the opioid epidemic in Appalachia today.” Mona Bennett of the Atlanta Harm Reduction Coalition agreed and said that policymakers need to listen to people who use drugs to figure out the root causes and longer-term solutions: “Let’s talk about why people use drugs in society. Let’s really talk about that and listen to those answers and act upon them, immediately and fearlessly. Opioids for example. Effective painkiller. Where’s this pain coming from? What kind of pain are people in that they have to take a substance to deal with it?”

Although a full discussion of the social, economic, and political changes necessary to address root causes of drug use is beyond the scope of this report, experts highlighted several ways that policies and practices in the justice system can undermine access to resources and support for someone with a substance use disorder. For instance, having stable employment is vital to economic security, increasing a person’s prospects for recovery and diminishing their future involvement in the justice system. Yet having an arrest or felony conviction record is a substantial barrier to gaining employment.<sup>203</sup> Legislation and regulatory policies to expunge and seal criminal records for drug crimes are examples of policy changes that can help address this.<sup>204</sup> Other examples include ensuring that state laws do not restrict access to food, housing, and other social benefits on the grounds of drug use or a criminal record.<sup>205</sup>

### **Recommendations:**

- › Reform laws and policies to expand access to evidence-based harm reduction and treatment services, including OEND, SSP, and MAT.
- › Increase resources and infrastructure for public health,

community-based responses including expanding Medicaid, improving the capacity of substance use treatment providers, and supporting peer and community-led harm reduction activities.

- › Enact regulatory frameworks to decriminalize drug use and minimize drug-related harms.
- › Reform laws and policies that limit and prohibit people with criminal histories from accessing employment, housing, and other social benefits.

## Diversify definitions of recovery

Stigmatization of people who use drugs and resistance toward harm reduction, MAT, and patient-centered decision-making continue to persist among criminal justice stakeholders, health providers, and policymakers. Too often, approaches to substance use disorders in community and justice-system settings rely on coercive abstinence-based treatment paradigms that punish people who continue to use drugs or relapse rather than offering them resources and support to work toward their own form of recovery. Recognizing that abstinence is the goal for some but not all people who use drugs is an important principle of harm reduction that should inform all responses to drug use.<sup>206</sup>

Mona Bennett of the Atlanta Harm Reduction Coalition reported that when speaking to skeptics of harm reduction, she likes to highlight that “harm reduction and treatment and recovery are not mutually exclusive.” Bennet believes that “harm reduction is a bridge to treatment. . . . You can even call it treatment readiness if you want to.” To Bennett’s point, a variety of harm reduction, treatment, and abstinence-based interventions should be widely available to all people with a substance use disorder, to determine what works best for them.<sup>207</sup> Dr. Daniel Ciccarone emphasized that medical standards recognize that relapse is a common part of substance use disorder and said that community and correctional health systems need to adopt “open-door policies for treatment that allow people to constantly be invited back, because you don’t know whether it’s going to be the first time, the third time, or the 13<sup>th</sup> time that the treatment sticks.” Without such policies, “People disappear. They fall through the cracks. They try to hide. Hiding does not help public health. Exposure helps public health.”

## Recommendations:

- › Ensure the availability of a variety of harm reduction, treatment, and abstinence-based recovery interventions for substance use disorder.
- › Make sure that programs and interventions for substance use disorder in community and criminal justice settings do not enforce abstinence, punish relapse, or stigmatize MAT.

## Empower people who use drugs

People who use drugs have long played critical roles in developing community-led responses to preventing overdose, promoting wellness and safety for themselves and their peers, and advocating for policy and system changes. People who use drugs and have firsthand interactions with the health and criminal justice systems have unique knowledge and experience to guide policymakers,—and they also play a key role in implementing new strategies.<sup>208</sup> Before being officially legislated and implemented by formal health systems, unsanctioned grassroots initiatives that save lives, support recovery, and prevent disease transmission are frequently spearheaded by people who use drugs, along with other harm reduction advocates.<sup>209</sup> In Ross County, Ohio, for example, responses to the opioid overdose crisis have been driven by community members directly impacted by drug use—including people who have lost family members and loved ones to overdose—and peer recovery supporters are contributing to treatment and support in a variety of settings. In Atlanta, grassroots efforts to provide harm reduction services and develop alternatives to arrest and incarceration have been led by people who use drugs and other community members who have been directly affected by the criminal justice system. Louise Vincent of the Urban Survivors Union pointed to the importance of listening to people who use drugs and supporting the efforts they are fighting for:

“While this is a time when we have all of this pain and all of this horrible stuff happening, it is also when you see the beauty of community resilience. If people will look, then they will see that there are drug users who are fighting to change things and fighting to make things better.”

Unfortunately, the efforts of people who use drugs who have firsthand experience with the health and criminal justice systems have not always been recognized or welcomed in institutional settings and policy-making, and there is not sufficient financial support for their involvement in frontline service delivery or advocacy and policymaking. Interventions developed without user input may be inaccessible and ineffective. Vincent

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**“There is a way to meaningfully engage people that use drugs and it is done all around the world; we just don’t do it well here in the United States.”**

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expressed frustration about how often people who use drugs are not seen as experts: “I’m often alarmed at how often we have police at the table before we’ve established trust with the community. How are we gonna bring the police to the table and have them at the table before we bring the people who we’re trying to help to the table?”

There was widespread consensus among the drug policy experts Vera interviewed that it is essential to elevate the leadership of people who use drugs to develop effective responses to the overdose crisis. Corey Davis of the Network for Public Health Law put it bluntly when saying that the time is past due for policymakers to be “taking the beliefs, values, goals, and desires of people who use drugs seriously.” Vincent emphasized that people who use drugs should be meaningfully involved in the development of U.S. drug policy. As she put it, “I’ve been sitting at the United Nations while drug users were being consulted at community consultation about everything from HIV, hepatitis C, to criminal justice responses. There is a way to meaningfully engage people that use drugs and it is done all around the world; we just don’t do it well here in the United States.”



## Recommendations:

- › Include people who use drugs and community members who have been directly impacted by drug use and the health and criminal justice systems in developing policies and programmatic responses.
- › Support the leadership of local and national groups representing the perspectives of people who use drugs.
- › Expand opportunities for peer recovery supporters and other roles in health, harm reduction, and recovery services.

## Center racial equity and justice

Drug policy has never been race-neutral. For more than a century, drug policy in the United States has criminalized people and communities of color and contributed to police violence and mass incarceration while failing to acknowledge or address social and economic inequities.<sup>210</sup>

A transformative response to drug use requires centering racial equity and justice in all policies and practices. Dr. Daliah Heller called for government agencies to “apply a racial equity lens” to all current and future policies, including open, transparent data collection and reporting to allow for assessment of the impacts of these policies.<sup>211</sup> Heller emphasized that this is particularly important because of how responses to the current opioid overdose crisis have centered the experience of white communities: “The issue is how are you creating responses for the status quo? . . . If the mainstream structures are built and powered by or emblematic of white supremacy, then that’s how they’re going to function. They’re not going to serve the people they’re already not serving unless they do something different.”

Several experts Vera interviewed highlighted the need to move beyond discrete interventions for prevention and risk reduction to address structural inequities, particularly for communities of color. Devin Reaves of the Pennsylvania Harm Reduction Coalition noted that efforts to implement syringe service programs and supervised consumption sites without a focus on addressing systemic oppression in educational, economic, health, and criminal justice systems, for example, can seem inadequate: “There’s a lot of arguments that Black people make, like. . . ‘Why aren’t you fixing the problems that led us to being jacked up instead of putting a Band-aid on it in a supervised injection site?’ That’s hard to argue with. We should get that.”

Others echoed the sentiment that addressing systemic issues should be a focus for drug policy moving forward. A number of the experts Vera interviewed discussed the context of the intergenerational harms of the “war on drugs” on Black and Latinx communities and highlighted the importance of reparative justice as a framework for advancing racial equity and justice in drug policy.<sup>212</sup> The Drug Policy Alliance’s campaign and conference on race and reparative justice called for acknowledgment of and atonement for the harm done to communities of color by criminalization and punitive drug policies, as well as action to advance reforms that are nonpunitive and health-oriented.<sup>213</sup> Monique Tula of the Harm Reduction Coalition highlighted how the organization’s recent North Star statement makes an explicit call to broaden its vision of harm reduction to focus on “reparative strategies to address trauma, social divisions, injustices and inequities, and health” to heal the harms of racialized drug policies.<sup>214</sup> A few experts discussed the importance of reparative justice and racial equity in current efforts to legalize marijuana.<sup>215</sup> And echoing the calls to consider the root causes of drug use and move beyond discrete interventions, Columbia University’s Dr. Samuel K. Roberts discussed the importance of anchoring reparations for the “war on drugs” along with broader movements for racial justice and reparations: “What I’m saying is that all this ties into justice across the board. If our schedule of reparations is only about helping people who were ‘directly’ affected by the drug war, then that’s really shortsighted because then the logic is everything else that we’re doing was A-OK. A federal government (and many state governments) which spent more time and resources in coordinating drug law enforcement than in coordinating education, the economy, and labor for the basic survival of millions of its citizens must account for that.”

### **Recommendations:**

- › Apply a racial equity lens to all policies and programs to analyze, monitor, and taken action to eliminate racial disparities.
- › Collaborate across criminal justice and drug policy reform and broader health, racial, and social justice movements to address structural inequities and root causes of drug-related harms.

# Conclusion

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**D**rug overdose is the leading cause of accidental death in the United States, and communities across the country are struggling to respond. Although it is widely recognized that the “war on drugs” has driven mass incarceration, exacerbated racial disparities within the criminal justice system, and devastated communities of color, U.S. policies, practices, and systems continue to criminalize and punish people who use drugs within and beyond the criminal justice system. It is clear that a punitive approach is ill-equipped to address one of the most pressing public health emergencies of the 21<sup>st</sup> century. The United States needs a new paradigm that prioritizes community health, harm reduction, and recovery.

In this report, Vera offers practical guidance to practitioners, policy-makers, and funders to transform the criminal justice system’s response to drug use. A new path forward requires not only bold leadership at the local level, where true transformation can occur, but also sustained investment in community organizations led by people who are affected directly. This guidance is grounded in the experience and expertise of national experts and local stakeholders and emphasizes the critical need to continue to move responses upstream by increasing access to community-based harm reduction, treatment, and recovery services, while minimizing justice-system contact for people who use drugs whenever possible and ensuring access to evidence-based care for those who are entangled in the justice system. And regardless of where services are provided, the recommendations of this report also call for elevating the leadership and funding the efforts of people who have been most directly impacted by punitive drug policies, as well as centering racial equity and justice in all practices and policies.

**Interviews**

<b>Interview #</b>	<b>Name</b>	<b>Organization and role</b>
1	Robert Childs	JBS International, technical expert lead, and North Carolina Harm Reduction Coalition, former executive director
2	Daliah Heller	Vital Strategies, director of drug use initiatives
3	Lindsay LaSalle	Drug Policy Alliance, managing director of public health law and policy
4	Corey Davis	The Network for Public Health Law, director, Harm Reduction Legal Project, and deputy director, Southeastern Region
5	Scott Burris	Temple University, director of the Center for Public Health Law Research, and professor of law and public health
6	Devin Reaves	Pennsylvania Harm Reduction Coalition, executive director
7	Daniel Ciccarone	University of California, San Francisco, professor of family community medicine
8	Moki Macías	Atlanta/Fulton County Pre-Arrest Diversion, executive director
	Mary Naoum	Atlanta/Fulton County Pre-Arrest Diversion, program manager
9	Leo Beletsky	Northeastern University School of Law, professor of law and health sciences and director of Health in Justice Action Lab
10	Monique Tula	Harm Reduction Coalition, executive director
11	Brandon del Pozo	Burlington, Vermont, former chief of police
12	Joanne Csete	Columbia University, associate professor of population and family health, and director of the Health and Human Rights Program
13	Jennifer Clarke	Rhode Island Department of Corrections, medical programs director
14	Erica Poellot	Harm Reduction Coalition, director of faith and community partnerships, and Judson Memorial Church, senior community minister of healing justice
	Blyth Barnow	Faith in Public Life Ohio, harm reduction coordinator, and Feminary, founder
	Charles King	Housing Works, chief executive officer
15	Louise Vincent	Urban Survivors Union, executive director
16	Samuel Kelton Roberts	Columbia University, associate professor of history and sociomedical sciences

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## Endnotes

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- 57 At legally sanctioned supervised consumption sites (SCSs), clients bring their own drugs to use; staff do not directly assist in consumption or handle any drugs that clients bring. Importantly, legally sanctioned SCSs are “exempt from prosecution for having illicit drugs on the premises.” See University of Southern California, “Supervised Injection Sites are Coming to the United States,” 2019.
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- 59 Potier et al., “Supervised Injection Services,” 2014, 63; Mary Clare Kennedy, Mohammad Karamouzian, and Thomas Kerr, “Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: A Systematic Review,” *Current HIV/AIDS Reports* 14, no. 5 [2017], 161-183; and European Monitoring Centre for Drugs and Drug Addiction, “Drug Consumption Rooms: An Overview of Provision and Evidence,” July 6, 2018, <https://perma.cc/M938-QMR6>.
- 60 Potier et al., “Supervised Injection Services,” 2014, 63; and Kennedy et al., “Public Health and Public Order,” 2017, 177.
- 61 Harm Reduction International’s (HRI’s) publication *The Global State of Harm Reduction 2018* reported that 117 legally sanctioned SCSs were operating in Canada, Australia, and Western Europe, in a total of 11 countries. HRI also reported that unsanctioned SCSs were said to be operating in Latin America and North Africa. HRI’s November 2019 update noted that two more countries, Portugal and Ukraine, have implemented legal SCSs, bringing the global total to 13 countries. See Katie Stone and Sam Shirley-Beavan, *Drug Consumption Rooms, Global State of Harm Reduction 2018* (London: HRI, December 11, 2018), <https://perma.cc/H6M8-7UWH>; and HRI, “Global State of Harm Reduction: 2019 Updates,” 2019, <https://perma.cc/72JN-3WWY>. Also see Vendula Belackova, Allison M. Salmon, Carolyn A. Day, et al., “Drug Consumption Rooms: A Systematic Review of Evaluation Methodologies,” *Drug and Alcohol Review* 38, no. 4: [2019], 406-422; Alene Kennedy-Hendricks, Jenna Bluestein, Alex H. Kral, et al., “Establishing Sanctioned Safe Consumption Sites in the United States: Five Jurisdictions Moving the Policy Agenda Forward,” *Psychiatric Services* 70, no. 4 [2019], 294-301, <https://perma.cc/68AY-ZBKW>; and Alex H. Kral and Peter J. Davidson, “Addressing the Nation’s Opioid Epidemic: Lessons from an Unsanctioned Supervised Injection Site in the US,” *American Journal of Preventive Medicine* 53, no. 6 [2017], 919-922, [www.ajpmonline.org/article/S0749-3797\(17\)30316-1/pdf](http://www.ajpmonline.org/article/S0749-3797(17)30316-1/pdf).
- 62 Ayden Scheim and Dan Werb, “Integrating Supervised Consumption into a Continuum of Care for People Who Use Drugs,” *CMAJ* 190, no. 31 [2018]: E921-22, <https://perma.cc/TNP5-ATAE>.
- 63 The opening of supervised consumption sites is being discussed on the city and state level. This discourse includes researching SCSs, holding public conversations about them, and introducing bills to authorize their use. City-led efforts are taking place in Boston; Burlington; Denver; Ithaca, New York; Madison, Wisconsin; New York City; Philadelphia; Portland, Maine; San Francisco; and Washington, DC. State-led efforts are occurring in California, Colorado, Delaware, Maine, Maryland, Massachusetts, Missouri, Rhode Island, and Vermont. Azeen Ghorayshi, “The Feds Say Safe Injection Sites Are Illegal, Here Are All the Place



Considering Them Anyway,” BuzzFeed, September 6, 2018, <https://perma.cc/TWQ9-9F4J>. See also Kennedy-Hendricks et al., “Establishing Sanctioned Safe Consumption Sites,” 2019.

A research study of 360 residents and 79 business owners and staff in the Philadelphia neighborhood where Safehouse plans to open the SCS found that 90 percent of residents and 63 percent of business owners and staff are in favor of opening a site. Support was higher among Asian/Pacific Islander, Hispanic/Latinx, and Black respondents as compared to white respondents; among people who currently use opioids than those who do not; and among people who are unstably housed as compared to those who have stable housing. See Alexis M. Roth, Alex H. Kral, Allison Mitchell, et al., “Overdose Prevention Site Acceptability Among Residents and Businesses Surrounding a Proposed Site in Philadelphia, USA,” *Journal of Urban Health* 96, no. 3 (June 1, 2019), 341-352, <https://perma.cc/Y9R5-BUNL>. The attorneys general of seven states and the District of Columbia have also declared support for the proposed SCS. See Aubrey Whelan and Jeremy Roebuck, “Philadelphia Supervised Injection Site Plan Gets Backing from Attorneys General in 7 States,” *The Philadelphia Inquirer*, July 11, 2019, <http://www.inquirer.com/health/safehouse-supervised-injection-site-state-right-20190711.html>.

At least one unsanctioned SCS has been operating in the United States for the past several years, by an unnamed agency at an undisclosed location. Researchers working with the unsanctioned SCS reported that, since opening in September 2014, the SCS has supervised 9,000 injections for more than 500 people. Carlyn Zwarenstein, “Data Show the First Supervised Injection Site in the U.S., Although Illegal, Prevented Overdose Deaths,” *The Globe and Mail*, April 29, 2019, [www.theglobeandmail.com/world/article-data-show-the-first-supervised-injection-site-in-the-us-although](http://www.theglobeandmail.com/world/article-data-show-the-first-supervised-injection-site-in-the-us-although); Kral and Davidson, “Addressing the Nation’s Opioid Epidemic,” 2017; and Peter J. Davidson, Andrea M. Lopez, and Alex H. Kral, “Using Drugs in Un/Safe Spaces: Impact of Perceived Illegality on an Underground Supervised Injecting Facility in the United States,” *International Journal of Drug Policy* 53 (2018), 37-44.

Some syringe service programs have recognized that clients may be using and injecting drugs in the on-site bathrooms and have taken steps to prevent overdoses, such as having staff members check on clients in the bathrooms at regular intervals. See Sanjay Gupta, “Opioid Addiction and the Most Controversial Bathroom in New York,” CNN, Oct 26, 2017, <https://perma.cc/H6XF-ZU57>. The New York State Department of Health updated its policies and procedures for syringe exchange programs in 2016 to include guidelines on bathroom and washroom procedures to reduce the incidence of overdose. See New York State Department of Health, “Syringe Access and Disposal,” <https://perma.cc/R2HL-NGLB>; and Melissa Vallejo, “Safer Bathrooms in Syringe Exchange Programs: Injecting Progress into The Harm Reduction Movement.” *Columbia Law Review* 118, no. 4 (2018), 1185-1224, <https://perma.cc/L6E2-SE2J>.

- 64 *United States of America v. Safehouse and Jose Benitez*, Case 2:19-cv-00519-GAM, Judge J. McHugh, memorandum filed October 2, 2019, <https://perma.cc/X5GJ-SP6D>; and “United States v. Safehouse,” <https://perma.cc/F8XM-DTGX>.
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- 66 A 2018 press release from the Surgeon General’s office notes that MAT, when combined with community-based recovery support and psychosocial therapy, is the gold standard of care. HHS, “Surgeon General Releases Spotlight on Opioids,” press release (Washington, DC: HHS, September 30, 2018), <https://perma.cc/G7Z8-7BV5>. For more information about evidence of the benefits of MAT, see Hilary Smith Conner, “Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions,” *Harvard Review of Psychiatry* 23, no. 2 (2015), 63-75, <https://perma.cc/K3HH-REH8>.
- 67 HHS, Food and Drug Administration (FDA), “Information about Medication-Assisted Treatment (MAT),” February 14, 2019, [www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat](http://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat).
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- 69 SAMHSA, “Medication and Counseling Treatment,” May 7, 2019, <https://perma.cc/M4RC-XNP2>.
- 70 For a review of methadone-assisted treatment, see Catherine Anne Fullerton, Meelee Kim, Cindy Parks Thomas, et al., “Medication-Assisted Treatment With Methadone: Assessing the Evidence,” *Psychiatric Services* 65, no. 2 (2014), 146-157, <https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201300235>. For a review of buprenorphine-assisted treatment, see Cindy

Parks Thomas, Catherine Anne Fullerton, Meelee Kim, et al., "Medication-Assisted Treatment With Buprenorphine: Assessing the Evidence," *Psychiatric Services* 65, no. 2 (2014), 158-170, <https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201300256>. See also Nora D. Volkow, Thomas R. Frieden, Pamela S. Hyde, et al., "Medication-Assisted Therapies—Tackling the Opioid-Overdose Epidemic," *New England Journal of Medicine* 370, no. 22 (2014), 2063-2066, [www.nejm.org/doi/full/10.1056/nejmp1402780](http://www.nejm.org/doi/full/10.1056/nejmp1402780).

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- 73 Among privately funded substance treatment programs in the United States, less than half offer MAT—and only 34.4 percent of patients with opioid use disorder at those programs received it. Hannah K. Knudsen, Amanda J. Abraham, and Paul M. Roman, "Adoption and Implementation of Medications in Addiction Treatment Programs." *Journal of Addiction Medicine* 5, no. 1 (2011), 21-27, <https://perma.cc/3BAP-Y4AZ>.

Given that nearly 40 percent of Americans who have an opioid use disorder rely on Medicaid, the expansion of Medicaid programs under the Affordable Care Act in recent years has been important in facilitating access to treatment, including MAT. As of August 2019, 37 states and the District of Columbia had adopted Medicaid expansion. Kendal Orgera and Jennifer Tolbert, *The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment* (San Francisco: Kaiser Family Foundation, 2019), <https://perma.cc/NV9M-LVGK>; and Larissa Antonisse, Rachel Garfield, Robin Rudowitz, and Madeline Guth, *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review* (San Francisco: Kaiser Family Foundation, 2019), <https://perma.cc/ZRD2-AS3B>. See also Matt Boaddus, Peggy Bailer, and Aviva Around-Dine, *Medicaid Expansion Dramatically Increased Coverage for People with Opioid-Use Disorders, Latest Data Show* (Washington, DC: Center on Budget and Policy Priorities, 2018), <https://perma.cc/4UJ5-7H7H>; and Prescription Drug Abuse Policy

System, "Medicaid Coverage of Medication Assisted Treatment," August 1, 2019, <https://perma.cc/ZP7S-ZG6V>.

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- 102 See Harlan Matusow, Samuel L. Dickman, Josiah D. Rich, et al., "Medication Assisted Treatment in US Drug Courts: Results from a Nationwide Survey of Availability, Barriers and Attitudes," *Journal of Substance Abuse Treatment* 44, no. 5 (2013), 473-480, <https://perma.cc/ZLT3-B4ZJ>; Nyaradzo Longinaker and Mishka Terplan, "Effect of Criminal Justice Mandate on Drug Treatment Completion in Women," *American Journal of Drug & Alcohol Abuse* 40, no. 3 (2014), 192-199; and Drug Policy Alliance, "Moving Away from Drug Courts: Toward a Health-Centered Approach to Drug Use," *Drug Policy Alliance*, 2014, <https://perma.cc/YD3Y-CUHK>. In recent years, the National Association of Drug Court Professionals has developed a set of Adult Drug Court Best Practice Standards and a toolkit that focuses on equity and inclusion for participants: National Association of Drug Court Professionals, "Adult Drug Court Best Practice Standards," <https://perma.cc/CP9K-8YAJ>;

and National Association of Drug Court Professionals, “Equity & Inclusion Toolkit: Equivalent Access Assessment and Toolkit,” 2019, <https://perma.cc/EBE4-KTDR>.

103 Nicholas Freudenberg and Daliah Heller, “A Review of Opportunities to Improve the Health of People Involved in the Criminal Justice System in the United States,” *Annual Review of Public Health* 37, no. 1 (2016), 313-333, <https://doi.org/10.1146/annurev-publhealth-032315-021420>.

104 Ryan King and Jill Pasquarella, *Drug Courts: A Review of the Evidence* (Washington, DC: The Sentencing Project, 2009), 4. <https://perma.cc/UJX9-VWHG>.

105 Matusow and colleagues’ national survey of drug courts in 2010 found that only 56 percent of these specialty courts offered MAT, even though virtually all programs (98 percent) acknowledged that at least some of their participants had opioid use disorders. In addition to cost and lack of local providers (particularly for drug courts in rural areas), the survey found that one of the most frequently cited reasons for not providing access to buprenorphine or methadone was court policy. See Matusow et al., “Medication Assisted Treatment,” 2013, at 6 and 7.

In 2015, the Substance Abuse and Mental Health Services Administration stipulated that federal grant support will not be available to drug courts that deny MAT to participants. However, because many drug courts receive local and state funding, the impact of this change is unclear. Joanne Csete, “Criminal Justice Barriers to Treatment of Opioid Use Disorders in the United States: The Need for Public Health Advocacy,” *American Journal of Public Health* 109, no. 3, (2019), 419-422.

The NDCI now offers training on implementing MAT. See NDCI, “Medication-Assisted Treatment,” <https://perma.cc/69TX-GHVE>. Christopher Deutsch from the National Association of Drug Court Professionals commented in 2017 that “the treatment court community has really embraced the use of MAT,” while acknowledging that there has been no national research on the availability of MAT since 2012, so it is difficult to know how much expansion has occurred. See Francie Diep, “The FDA Just Approved a New Injection for Treating Opioid Addiction. Will Drug Courts Actually Let Defendants Take It?” *Pacific Standard*, December 7, 2017, <https://perma.cc/R87J-CLGD>.

106 Fair and Just Prosecution, “Harm Reduction Responses to Drug Use,” 2019, <https://perma.cc/9EK8-PXYK>. For examples of efforts in Philadelphia and Seattle, see Julie Shaw, “Report: DA Krasner ‘Very Close’ to Rolling Out Policy Decriminalizing Drug Possession,” *The Philadelphia Inquirer*, May 8, 2019, [www.inquirer.com/news/philadelphia-district-attorney-larry-krasner-drug-possession-20190508.html](http://www.inquirer.com/news/philadelphia-district-attorney-larry-krasner-drug-possession-20190508.html); Justin Jouvenal, “No Charges for Personal Drug Possession: Seattle’s Bold Gamble to Bring ‘Peace’ After the War on Drugs,” *Washington Post*, June 11, 2019, [www.washingtonpost.com/local/public-safety/no-charges-for-personal-drug-possession-seattles-bold-gamble-to-bring-peace-after-the-war-on-drugs/2019/06/11/69a7bb46-7285-11e9-9f06-5fc2ee80027-a\\_story.html](http://www.washingtonpost.com/local/public-safety/no-charges-for-personal-drug-possession-seattles-bold-gamble-to-bring-peace-after-the-war-on-drugs/2019/06/11/69a7bb46-7285-11e9-9f06-5fc2ee80027-a_story.html); and Nicholas Kristof, “Seattle Has Figured Out How to End the War on Drugs,” *New York Times*, [www.nytimes.com/2019/08/23/opinion/sunday/opioid-crisis-drug-seattle.html](http://www.nytimes.com/2019/08/23/opinion/sunday/opioid-crisis-drug-seattle.html). In June 2018, the State’s Attorney’s Office in Chittenden County, Vermont, announced that it would no longer prosecute any citations or arrests for possession of buprenorphine and related compounds for MAT. See Mike Riggs, “This Vermont Prosecutor Is Pushing Back Against the DOJ’s Drug Warriors.” *Reason*, June 15, 2018, <https://perma.cc/M67L-2SW8>.

107 Fair and Just Prosecution (FJP), “Prosecutors to Visit Innovating Criminal Justice Models in Germany and Portugal,” press release (Los Angeles: FJP, May 6, 2019), <https://perma.cc/F448-HLXC>; and Nina Feldman, “Can Portugal Offer Philadelphia Lessons in How to Rethink Drug Charges?” *WHYY*, May 15, 2019, <https://perma.cc/P7LN-LG8J>.

108 Health in Justice Action Lab and Legal Science, “Drug Induced Homicide Laws,” January 1, 2019, <https://perma.cc/RG5F-JTCQ>; Brandon D.L. Marshall and Abdullah Shihpar, “The Latest Failure in the War on Drugs,” *New York Times*, November 19, 2019, [www.nytimes.com/2019/11/19/opinion/drug-induced-homicide-overdose.html](http://www.nytimes.com/2019/11/19/opinion/drug-induced-homicide-overdose.html); and Leo Beletsky, “America’s Favorite Antidote: Drug-Induced Homicide in the Age of the Overdose Crisis.” *Utah Law Review* 2019, no. 4 (2019), <https://doi.org/10.2139/ssrn.3185180>. Additionally, some states do not have specific laws on drug-induced homicide, but still charge people with manslaughter and homicide-related charges if they were involved in the sale or administration of a dose of drugs that resulted in a fatal overdose. Drug Policy Alliance, *An Overdose Death Is Not Murder: Why Drug-Induced Homicide Laws Are Counterproductive and Inhumane* (New York: Drug Policy Alliance, 2017), 2, 40, <https://perma.cc/2ZZJ-FEFK>.

109 Stephen Koester, Shane R. Mueller, Lisa Raville, et al., “Why Are Some People Who Have Received Overdose Education and Naloxone Reticent to Call Emergency Medical Services in the Event of Overdose?” *International Journal of Drug Policy* 48 (2017), 115-124.

110 For example, the Massachusetts Supreme Judicial Court recently issued an important decision to vacate the involuntary manslaughter conviction of a man who provided drugs in a fatal overdose. WBUR News, “SJC Tosses Involuntary Manslaughter Conviction of Man Who Provided Heroin in Fatal Overdose,” October 3, 2019, <https://perma.cc/VVL4-B7YG>.

The Urban Survivors Union, a national drug users union, has been leading a national campaign against drug-induced homicide laws called “Reframe the Blame,” through which thousands of people who use drugs have signed on to a Do Not Prosecute Directive stating that, in the event that they experience fatal overdose, they do not want their deaths to be used in the prosecution of anyone else. Louise Vincent, “The Rage of Overdose Grief Makes It All Too Easy to

- Misdirect Blame,” *Filter*, December 5, 2018, <https://perma.cc/G2TS-Y9MR>; and Urban Survivors Union, “Drug Induced Homicide Laws and #REFRAMETHEBLAME,” <https://perma.cc/7BYM-JKTT>.
- 111 In addition to the growth of diversion programs outlined earlier in this report, research from the Center for Health and Justice at TASC shows the landscape of diversion programs and initiatives. See Center for Health and Justice at TASC, *No Entry: A National Survey of Criminal Justice Diversion Programs and Initiatives* (Chicago: Center for Health and Justice at TASC, 2013), <https://perma.cc/G3CA-TBSR>. For more details about the number of people with substance use issues who pass through jails and prisons, see Lauren Brinkley-Rubinstein, Nickolas Zaller, Sarah Martino, et al., “Criminal Justice Continuum for Opioid Users at Risk of Overdose,” *Addictive Behaviors* 86 (2018), [www.researchgate.net/profile/Nickolas\\_Zaller/publication/323387127\\_Criminal\\_justice\\_continuum\\_for\\_opioid\\_users\\_at\\_risk\\_of\\_overdose/links/5ab967a50f7e9b68ef532f92/Criminal-justice-continuum-for-opioid-users-at-risk-of-overdose.pdf](http://www.researchgate.net/profile/Nickolas_Zaller/publication/323387127_Criminal_justice_continuum_for_opioid_users_at_risk_of_overdose/links/5ab967a50f7e9b68ef532f92/Criminal-justice-continuum-for-opioid-users-at-risk-of-overdose.pdf).
- 112 Jennifer Bronson, Jessica Stroop, Stephanie Zimmer, et al., *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009*, special report, NCJ 250546 (Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2017). <https://perma.cc/FK9S-F2B2>.
- 113 Anthony-North et al., *Corrections-Based Responses*, 2018, 4.
- 114 Karen Cropsey, Ingrid Binswanger, C. Brendan Clark, et al. “The Unmet Medical Needs of Correctional Populations in the United States,” *Journal of National Medical Association* 104, no. 11-12 (2012), 487-492, <https://perma.cc/P4VZ-SGRU>.
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- 116 Roger H. Peters, Elizabeth Rojas, and Marla G. Bartoi, *Screening and Assessment of Co-Occurring Disorders in the Justice System* (Rockville, MD: SAMHSA, 2015), <https://perma.cc/3EBC-RT2U>.
- 117 The American Correctional Association (ACA), the National Commission on Correctional Health Care, and the Federal Bureau of Prisons (BOP) have all released guidance on the proper medical management of withdrawal. ACA and American Society of Addiction Medicine (ASAM), “American Correctional Association and American Society of Addiction Medicine Release Joint Policy Statement on Opioid Use Disorder Treatment in the Justice System,” press release (Alexandria, VA, and Chevy Chase, MD: ACA and ASAM, March 20, 2018), <https://perma.cc/H8AZ-N4LL>; National Commission on Correctional Healthcare, “Opioid Detoxification Guideline,” <https://perma.cc/QTP2-MEPE>; Federal Bureau of Prisons, *Clinical Guidance: Detoxification of Chemically Dependent Inmates*, (Washington, DC: U.S. Department of Justice, BOP, 2014, reformatted 2018), <https://perma.cc/9W56-CTJL>; and Kevin Fiscella, Andrew Moore, Judith Engerman, et al., “Management of Opiate Detoxification in Jails,” *Journal of Addictive Diseases* 24, no. 1 (2005), 61-71. For additional practice guidelines that outline the importance of providing all FDA-approved forms of MAT to people, see Kyle Kampman and Margaret Jarvis, “American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use,” *Addiction Medicine* 9, no. 5 (2015), 4, <https://perma.cc/4NG9-AMBE>. Research has shown that when receipt of MAT is interrupted by a period of incarceration, people are less likely to continue treatment post-release, which is another reason that it is vital to allow people to continue MAT while they are incarcerated. Jeronimo Maradiaga, Shadi Nahvi, Chinazo Cunningham, et al., “‘I Kicked the Hard Way. I Got Incarcerated.’ Withdrawal from Methadone During Incarceration and Subsequent Aversion to Medication Assisted Treatments,” *Journal of Substance Abuse Treatment* 62 (2016), 49-54, <https://perma.cc/WYP4-QTD8>.
- 118 In 2016, screening and treatment with all three FDA-approved forms of MAT launched at the Rhode Island Department of Corrections in collaboration with a community provider. A retrospective cohort analysis in Rhode Island found that overdose deaths post-release decreased by 60.5 percent, contributing to a 12 percent reduction in overall overdose deaths for the state. See Traci C. Green, Jennifer Clarke, Lauren Brinkley-Rubenstein, et al., “Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System,” *JAMA Psychiatry* 75, no. 4 (2018), 405-407, <https://doi.org/10.1001/jamapsychiatry.2017.4614>.
- 119 Correctional systems in five states [Connecticut, Massachusetts, New Jersey, Pennsylvania, and Vermont] have established MAT programs that offer all three FDA-approved forms of MAT. See JB Nicholas, “Drug Treatment Is Reaching More Prisons and Jails,” *The Appeal*, July 31, 2019, <https://perma.cc/4U5A-MS89>. The most recent survey of prisons conducted in 2008 found that only 55 percent of facilities offered methadone (of these facilities, most provided methadone only to pregnant women or for chronic pain management of acute withdrawal); only 14 percent offered buprenorphine, and fewer than half referred people to MAT programs on release. Amy Nunn, Nickolas Zaller, Samuel Dickman, et al., “Methadone and Buprenorphine Prescribing and Referral Practices in US Prison Systems: Results from a Nationwide Survey,” *Drug and Alcohol Dependence* 105, nos. 1-2 (2009), 83-88, <https://perma.cc/MQU7-CAB3>.
- 120 Wayne N. Welsh and Patrick McGrain, “Predictors of Therapeutic Engagement in Prison-Based Drug Treatment,” *Drug and Alcohol Dependence* 96 (2008), 274-280. [www.researchgate.net/publication/5364917\\_Predictors\\_of\\_therapeutic\\_engagement\\_in\\_prison-based\\_drug\\_treatment](http://www.researchgate.net/publication/5364917_Predictors_of_therapeutic_engagement_in_prison-based_drug_treatment).

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- 121 Anthony-North et al., *Corrections-Based Responses*, 2018.
- 122 Brinkley-Rubinstein et al., “Criminal Justice Continuum,” 2018; and Anthony-North et al., *Corrections-Based Responses*, 2018. Jails and prisons should consider making naloxone available for use on-site. Though national data is limited, California reported a 113 percent increase in overdose incidents in prisons from 2015 to 2018. See Megan Cassidy, “Overdoses in California Prisons Up 113% in Three Years – Nearly 1,000 Incidents in 2018,” *San Francisco Chronicle*, May 5, 2019, [www.sfchronicle.com/crime/article/Overdoses-in-California-prisons-up-113-in-three-13819811.php](http://www.sfchronicle.com/crime/article/Overdoses-in-California-prisons-up-113-in-three-13819811.php).
- 123 Brinkley-Rubinstein et al., “Criminal Justice Continuum,” 2018.
- 124 Johns Hopkins Bloomberg School of Public Health, “Inmates Getting Access to Medicaid upon Release from Jail or Prison,” *ScienceDaily*, December 7, 2015, <https://perma.cc/6875-9UFJ>.
- 125 Legal Action Center, “Health Coverage Enrollment of Justice-Involved Individuals,” <https://perma.cc/P6WB-DCPB>.
- 126 As of 2018, 19 states terminated Medicaid benefits during periods of incarceration, 14 suspended Medicaid benefits with a time limit, and 17 states and the District of Columbia suspended Medicaid benefits. Terminating Medicaid during periods of incarceration makes it more difficult to reactivate coverage and reenroll upon release. See Medicaid and CHIP Payment and Access Commission, (MACPAC), *Medicaid and the Criminal Justice System*, (Washington, DC: MACPAC, 2018), <https://perma.cc/8PMF-5RET>.
- 127 Alexi Jones, *Correctional Control 2018: Incarceration and Supervision by State* (Northampton, MA: Prison Policy Initiative, 2018), <https://perma.cc/3R57-559H>; and Danielle Kaeble and Thomas O. Bonczar, *Probation and Parole in the United States*, 2015 (Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2016, revised 2017, NCJ 250230), <https://perma.cc/9G6Z-TRYR>.
- 128 Kaeble and Bonczar, *Probation and Parole*, 2016.
- 129 Drug testing people who are on probation and parole imposes expectations of abstinence. SAMHSA has put forth guidance reflecting the need for a more nuanced approach to handling relapse in the context of community corrections. See Brinkley-Rubinstein et al., “Criminal Justice Continuum,” 2018, 108.
- 130 The Council of State Governments Justice Center, *Confined and Costly: How Supervision Violations Are Filling Prisons and Burdening Budgets*, (New York: Council of State Governments Justice Center, 2019), <https://perma.cc/V8UL-9FT4>; and The Pew Charitable Trusts, *To Safely Cut Incarceration, States Rethink Responses to Supervision Violations: Evidence-based Policies Lead to Higher Rates of Parole and Probation Success* (Washington, DC: Pew Charitable Trusts, Public Safety Performance Project, 2019), <https://perma.cc/2EXD-BAG9>.
- 131 CSG, *Confined and Costly*, 2019, 2; and Pew Charitable Trusts, *To Safely Cut Incarceration*, 2019, 13.
- 132 The estimated population of Ross County was 76,931 as of July 1, 2018. See United States Census Bureau, “QuickFacts Ross County, Ohio,” <https://perma.cc/RUA9-SLB3>. The estimated population of Chillicothe was 21,698 as of July 1, 2018. See United States Census Bureau, “QuickFacts Chillicothe city, Ohio,” [www.census.gov/quickfacts/fact/table/chillicothe-city-ohio/IPE120218?](http://www.census.gov/quickfacts/fact/table/chillicothe-city-ohio/IPE120218?). The most recent data collection from the CDC showed that Ohio had the second-highest age-adjusted drug overdose death rate in 2016 and 2017. See CDC, “Drug Overdose Deaths,” <https://perma.cc/WP4L-UJHS>.
- 133 Vera Institute of Justice, “Incarceration Trends – Ross County, Ohio, Incarceration Trends,” 2019, <http://trends.vera.org/rates/ross-county-oh>.
- 134 This data comes from an unpublished chart entitled “Drug Overdose Death Comparison Chart” collected by the Office of the Coroner in Ross County, Ohio.
- 135 Vera Institute of Justice, “Incarceration Trends – Ross County,” 2019.
- 136 Heroin Partnership Project (HPP) and Ohio Office of Criminal Justice Services (OCJS), “National Criminal Justice Association Award,” press release [Chillicothe, OH: HPP/OCJS, June 7, 2018], <https://perma.cc/HFE8-7L6B>.
- 137 Hope Partnership Project, “Home,” [www.hopepartnershipproject.com](http://www.hopepartnershipproject.com); and Michaela Sumner, “Ross County’s Heroin Partnership Project Gets a New Name, Seeks to Rebuild with Hope,” *Chillicothe Gazette*, October 5, 2018, [www.chillicothe-gazette.com/story/news/2018/10/05/ross-county-heroin-hope-partnership-project-rebrand-expands-include-all-substance-abuse/1457759002](http://www.chillicothe-gazette.com/story/news/2018/10/05/ross-county-heroin-hope-partnership-project-rebrand-expands-include-all-substance-abuse/1457759002).
- 138 Ross County Heroin Partnership Project, *Sequential Intercept Mapping and Action Planning Final Report*, (Rootstown, OH: Ohio Criminal Justice Coordinating Center of Excellence, Northeast Ohio Medical University, 2015), <https://perma.cc/G6K9-V34R>.
- 139 *Ibid.*, 20.
- 140 *Ibid.*, 21.
- 141 State of Ohio Board of Pharmacy, “Ohio Board of Pharmacy List of Pharmacies that Dispense Naloxone Without a Prescription,” <https://perma.cc/B2NR-J7MX>; and “Naloxone Resources,” <https://perma.cc/3D3A-BPWZ>.
- 142 Erin Winstanley, Angela Clark, Judith Feinberg, et al., “Barriers to Implementation of Overdose Prevention Programs in Ohio,” *Substance Abuse* 37, no. 1 (2016), 42-46, <https://perma.cc/P9HM-B6G6>. Although Ohio has passed legislation naloxone access and

911 Good Samaritan laws, the specific provisions are less supportive of overdose prevention efforts than in most other states. See The Network for Public Health Law, “Naloxone Access and Overdose Good Samaritan Law in Ohio” (Edina, MN: The Network for Public Health Law, 2018), <https://perma.cc/Q3H4-UWL2>. There is promising momentum for naloxone distribution by community groups in Ohio: “We were approved this afternoon for a Terminal Distributor of Dangerous Drugs (TDDD) License by the Ohio Board of Pharmacy to distribute naloxone (Narcan) in Ohio. We are the first non-profit organization outside the medical field to obtain a ‘T-Triple D’ License to legally distribute naloxone in this state of 11.6 million people. With this license, HRO will create a statewide network of laypersons trained to furnish naloxone. Our effort will provide naloxone DIRECTLY to people who use drugs and are at significant risk of fatal overdose. HRO’s naloxone network will work to get naloxone to ALL Ohioans who need the opioid overdose-reversing naloxone. We will emphasize underserved demographic, geographic and drug-using (i.e., cocaine, meth) groups. . . .” See Harm Reduction Ohio, “Harm Reduction Ohio is celebrating today!” Facebook, June 21, 2019, <https://perma.cc/X49C-5XUK>. For more on community-based distribution efforts in Ross County, see Harm Reduction Ohio, “Harm Reduction Hero Tracey Kemper-Herman Named HRO’s Ross County Director,” September 4, 2018, <https://perma.cc/VNH7-HXSV>.

emergency related to blood-borne pathogens in order to create a syringe service program (SSP). Ohio Revised Code 3707.57 made it so that local boards of health in Ohio could establish a blood-borne infectious disease prevention program without declaring a public health emergency. To establish a program, local boards of health are required to consult “local law enforcement agencies and prosecutors; community addiction services providers; persons in recovery; hepatitis C and HIV advocacy organizations; the local alcohol, drug addiction and mental health services board; representatives of the city, village, or township where the program is to be established; and local residents.” See Tara Britton, *Syringe Exchange Programs in Ohio* (Cleveland and Columbus, OH: The Center for Community Solutions, 2016), 3, <https://perma.cc/743J-93ZJ>. Harm Reduction Ohio provides an overview of the current status of SSPs in the state. See Harm Reduction Ohio, “Ohio Syringe Programs: New, Updated List with All Locations and Hours,” updated July 31, 2019, <https://perma.cc/ZF99-Z5KH>. In addition, a Determination of Need for SSPs filed with the CDC by the Ohio Department of Health went into effect in July 2018, allowing for the use of federal Health and Human Services money for program operating costs. See Department of Health and Human Services, letter to Lance Himes, Director of Health, Ohio Department of Health, July 24, 2018, <https://perma.cc/432R-CJL7>.

- 143 The number of participating sites fluctuates, so the full scope of naloxone distribution is not necessarily reflected in this list. Also, ODH implemented a new system for Project DAWN program registration, a system that might change the number of sites. See Ohio Department of Health, “Project DAWN [Deaths Avoided with Naloxone],” June 26, 2019, <https://perma.cc/4VJQ-6P7X>.
- 144 Chillicothe’s version of an overdose response team was modeled after a program in Cincinnati, and other overdose response programs are in Ohio, including those in Franklin and Fairfield counties. See Franklin County Sheriff’s Office, “H.O.P.E. Task Force,” <https://perma.cc/2MHK-CYQZ>; and Trista Thurston, “Project FORT: Progress in Opiate Response Group,” *Lancaster Eagle Gazette*, July 3, 2017, [www.lancastereaglegazette.com/story/news/local/2017/07/03/project-fort-progress-opiate-response-group/444089001](http://www.lancastereaglegazette.com/story/news/local/2017/07/03/project-fort-progress-opiate-response-group/444089001). A similar initiative in Huntington, WV, is led by a social worker. See Sharyn Alfonsi, “Cops Bring Addiction Counselor on Drug Raids to Fight Opioid Crisis,” *CBS News, 60 Minutes*, June 16, 2019, <https://perma.cc/8SL6-9L3Y>. Internationally, programs like those operating in Vancouver are led by outreach and social workers. See Vancouver Coastal Health, “Vancouver Coastal Health’s Overdose Outreach Team Expands,” August 31, 2018, <https://perma.cc/FD6X-4L68>.
- 145 Michaela Sumner, “PORT Reflects, Stays on Task to Help Addicts,” *Chillicothe Gazette*, March 16, 2018, [www.chillicothe Gazette.com/story/news/crime/high-in-ohio/2018/03/16/after-two-years-post-overdose-response-team-reflects-stays-task/403702002](http://www.chillicothe Gazette.com/story/news/crime/high-in-ohio/2018/03/16/after-two-years-post-overdose-response-team-reflects-stays-task/403702002).
- 146 Until 2015, a city health district could declare a public health

- 147 The Ross County Common Pleas Court’s drug court received initial certification in 2014. See Jona Ison, “Ross County Drug Court Given Green Light to Begin,” *Coloradoan*, April 2, 2014, [www.coloradoan.com/story/news/2014/04/02/local-drug-court-given-green-light/7231215](http://www.coloradoan.com/story/news/2014/04/02/local-drug-court-given-green-light/7231215). Ohio has more than 125 drug and treatment courts throughout the state, with plans to add many more. See The Supreme Court of Ohio and the Ohio Judicial System, “Specialized Dockets Section,” <https://perma.cc/4F8Q-4JRS>. For a regularly updated document with the certification status of all Ohio Specialized dockets, see “Ohio Specialized Dockets Certifications Status Sheet,” updated October 30, 2019, <https://perma.cc/D9J6-TFVQ>.
- 148 The Supreme Court of Ohio, “Rules of Superintendence for the Courts of Ohio,” Appendix I, <https://perma.cc/JYX7-ZKR3>.
- 149 The Supreme Court of Ohio, “Principles for the Use of Medication Assisted Treatment (MAT) in Drug Courts,” November 2016, <https://perma.cc/4CN5-5D6J>.
- 150 For more information on what is required of drug court participants, visit the Ross County Common Pleas Court website, “Ross County Drug Court Program,” <https://perma.cc/2K3Y-XAXL>.
- 151 Freudenberg and Heller, “A Review of Opportunities,” 2016, 317.
- 152 For more information on the family drug court, see Christine B. Hannon and Steven E. Drotleff, “Ross County Court of Common Pleas, Juvenile Division Local Rules of Procedure,” modified January 25, 2017, 32, <https://perma.cc/5ZRK-DALJ>.



- 153 According to the National Drug Court Resource Center (NDCRC), 319 family treatment drug court programs were operating in the United States as of late 2018. See NDCRC, “National Drug Court Database & Map,” <https://ndcrc.org/database>. The National Center on Substance Abuse and Child Welfare has a collection of resources on family treatment drug courts as well as local and state examples. See National Center on Substance Abuse and Child Welfare, “Family Treatment Drug Courts,” <https://perma.cc/SUJ6-CNNB>.
- 154 A family drug court administrator shared an analysis of data from the past 30 months with Vera. As of mid-2019, the court had served 74 participants: 17 participants remain active in the program, 12 graduated from the program, 16 were unsuccessful (participants withdrew or their cases were discharged for noncompliance), and two left the program on neutral discharge (both parties, due to various circumstances, determined that the program was not appropriate). A total of 88 children had been served: 45 children were reunified, 14 went into legal custody, six went into permanent custody, and 23 remain in the custody of agency or temporary custody of a relative pending program completion.
- 155 Jacob Kang-Brown, Oliver Hinds, Jasmine Heiss, and Olive Lu, *The New Dynamics of Mass Incarceration* (New York: Vera Institute of Justice, 2018), 22, <https://perma.cc/2KNH-FXRY>; Vera Institute of Justice, “Incarceration Trends – Ross County, 2019”; and Jona Ison, “Ross County Sheriff Eyes Building Second Jail Facility,” *Chillicothe Gazette*, June 10, 2019, [www.chillicothe gazette.com/story/news/2019/06/10/ross-county-sheriff-eyes-building-second-jail-facility/1408374001](http://www.chillicothe gazette.com/story/news/2019/06/10/ross-county-sheriff-eyes-building-second-jail-facility/1408374001).
- 156 The Ross County Jail has implemented a day reporting program for people charged with first-time nonviolent felony and misdemeanor offenses; it involves taking classes on topics like underage consumption, anger management, and the cognitive behavior change program Thinking For a Change.
- 157 Jennifer Bronson, Jessica Stoop, Stephanie Zimmer, and Marcus Berzofsky, *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009*, NCJ 250546 (Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, 2017), <https://perma.cc/5PMS-B62U>; and Eric Westervelt, “County Jails Struggle with a New Role as America’s Prime Centers for Opioid Detox,” National Public Radio, April 24, 2019, <https://perma.cc/JK2K-V2PG>.
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- 162 Among these resources is Seeds of Hope, a faith-based homeless shelter that opened in late 2017 for women, children, and men with families and can serve 16 people at a time; for more information, go to [www.seedsofhopeohio.com](http://www.seedsofhopeohio.com). Another Chance Ministries, an outreach ministry associated with Zion Church, operates two residential recovery environments for men who experience addiction or have been released from prison; read more at [www.zion-baptist.org/another-chance-ministry](http://www.zion-baptist.org/another-chance-ministry). The Recovery Housing Program serves women who have achieved sobriety and wish to maintain drug-free lives; for more information, go to [www.therecoverycouncil.org/transitional-program.html](http://www.therecoverycouncil.org/transitional-program.html). Bugg’s House is a recovery house that opened in 2018, which the Vera team visited. See Jona Ison, “Turning Grief into Hope: Chillicothe Mom Opens Sober Living Home,” *Chillicothe Gazette*, December 22, 2018, [www.chillicothe gazette.com/story/news/2018/12/23/turning-grief-into-hope-chillicothe-mom-opens-sober-living-home/2337293002](http://www.chillicothe gazette.com/story/news/2018/12/23/turning-grief-into-hope-chillicothe-mom-opens-sober-living-home/2337293002).
- 163 Operators of recovery homes need to find a landlord willing to rent to them, or they must raise the capital to buy a house. In Chillicothe, a maximum of five unrelated people are allowed to live together in a single home without state authorization for a “group residential facility,” but opening sober housing in outlying parts of the county creates transit challenges for those who do not drive. See City of Chillicothe Planning and Zoning Code, September 2010, 8, 12, <https://perma.cc/4H87-YXMS>.
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- 165 MAT providers in Ross County include BrightView (<https://brightviewhealth.com>), part of a chain that opened a location in Chillicothe in 2018 and offers buprenorphine and naltrexone as well as; Chillicothe Treatment Services (<https://pinnacle-treatment.com/location/ohio/chillicothe/chillicothe-treatment-services>), a methadone clinic owned by Pinnacle Treatment Centers that opened in 2018 and also offers buprenorphine; and Hopewell Health ([www.hopewellhealth.org](http://www.hopewellhealth.org)), which the Ross County Jail works with to provide people incarcerated there access to Vivitrol. According to the federal government’s buprenorphine

practitioner locator, more than two dozen providers are authorized to prescribe buprenorphine in Ross County, all in Chillicothe. (See the Substance Abuse and Mental Health Services Administration's Buprenorphine Practitioner Locator at [www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator](http://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator).) Of these providers, more than half of the centers that provide access to methadone are located in urban cores, and this leaves most people in rural areas of Ohio essentially without access to this treatment. See Mark Rembert, Michael Betz, Bo Feng, et al., *Taking Measure of Ohio's Opioid Crisis* (Columbus, OH: Ohio State University, C. William Swank Program in Rural-Urban Policy, 2015), 15, <https://perma.cc/KY5T-2MA3>.

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- 172 Reutter-Mathews, “Community Combats Addiction, 2019. Naloxone is distributed by Project 4-14, a local group that provides community-based overdose education and naloxone distribution. Also see Harm Reduction Ohio, “Harm Reduction Hero,” 2018.
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## Acknowledgments

Support for this report was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

The authors appreciate the support of senior program officer Mona Shah throughout the duration of this project. The authors would like to thank our generous site contacts in Ross County, Ohio, and Atlanta, Georgia, for welcoming us into their communities and partnering with us on this project. In particular, we are grateful to the participants of Ross County's drug court programs and recovery support groups and the clients of the Atlanta Harm Reduction Coalition and the Atlanta/Fulton County Pre-Arrest Diversion Initiative. We are also thankful to the experts interviewed for sharing their insights with Vera researchers and for reviewing a draft of the report. Susan Stellan participated in the Ohio site visit and led the team that wrote this section of the report. We appreciate the Vera staff members who supported this project as thought partners and reviewers and thank Elle Teshima and Léon Digard for their thoughtful editing of the report; Dan Redding for design and layout; and Cindy Reed, Tim Merrill, and Jules Verdone for editorial support.

David Cloud is a member of the board of directors for the Atlanta Harm Reduction Coalition.

## About citations

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## Suggested citation

Jason Tan de Bibiana, Charlotte Miller, Leah Pope, Susan Stellan, Jim Parsons, and David Cloud. *Changing Course in the Overdose Crisis: Moving from Punishment to Harm Reduction and Health*. New York: Vera Institute of Justice, 2020.

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