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Ending the War on Drugs

By Betsy Pearl and Maritza Perez June 27, 2018

Nationwide, communities face an unprecedented rise in substance misuse fatalities. A record 63,600 overdose deaths were recorded in 2016, two-thirds of which involved opioids.[1] To stem the tide of this crisis, some communities are doubling down on the war on drugs, despite clear evidence that increasing arrests and incarceration does not lower drug use. But an increasing number of cities are bucking the trend and adopting models that treat substance misuse as a disease, not a crime. Instead of criminalizing substance use disorders, communities are focusing on saving lives and reducing the harmful effects of drug use.

The idea of "harm reduction" may seem like common sense today, but it signifies a radical departure from traditional U.S. responses to drug use, which relied heavily on the criminal justice system. More and more cities are expanding access to clean syringes, launching safe-injection facilities, and decriminalizing possession of controlled substances. Public acceptance of these approaches was unthinkable just a few years ago. Today, however, they are filtering into the mainstream. In fact, support for harm reduction spans the ideological spectrum. These strategies are underway in red and blue states alike, representing promising steps toward dismantling the country's failed drug policy agenda.

The war on drugs

The rise of public support for harm reduction strategies cannot be separated from the fact that white Americans have been hardest hit by the opioid epidemic, though black communities are increasingly experiencing its effects.[2] The modern war on drugs, launched by former President Richard Nixon in 1971, did not provide harm reduction alternatives for black Americans dealing with substance misuse issues.[3] Instead, drug use was criminalized, and black Americans were locked up en masse. Four decades later, the number of Americans behind bars has grown by 350 percent. By 2017, more than 2.2 million Americans were in prison or jail, and nearly 60 percent were black or Latino.[4] Today, 1 in 9 black children has an incarcerated parent, as does 1 in 28 Latino children.[5]

The disproportionate impact on communities of color is no coincidence. President Nixon waged the war on drugs in response to public demonstrations led by civil rights activists and Vietnam War opponents, pushing a narrative that linked black communi-

ties and protesters with drug use.[6] John Ehrlichman, a prominent official in the Nixon White House, owned up to this agenda years later. "We knew we couldn't make it illegal to be either against the war or black," Ehrlichman said in an interview in 1994, "but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities."[7]

Nixon's policy agenda took hold across all levels of government, leading to exponential growth in incarceration without any discernible health or safety benefits. Since then, increased incarceration has had essentially no effect on violent crime rates; at best, it has yielded marginal decreases in property crime.[8] Criminalizing substance misuse has also failed to improve health outcomes. A state-by-state comparison found that increasing incarceration for drug offenses did not yield any reductions in substance misuse, overdose fatalities, or drug arrests.[9]

Liberalizing marijuana policies

States are increasingly decriminalizing marijuana. To date, 30 states and the District of Columbia have liberalized their marijuana laws to some degree, and a majority of states have recognized marijuana's medicinal benefits and legalized marijuana for medical reasons.[10] A recent poll by the Center for American Progress showed that 68 percent of Americans support the legalization of marijuana.[11]

Marijuana is often treated as separate from other controlled substances based on a growing body of research that supports its use in medical settings and suggests that it is not susceptible to abuse.[12] In order to fully understand the public health consequences of marijuana use, however, more research needs to be done on the drug. So far, research has been limited by federal prohibitions on marijuana, which impede funding for research in this area. Thus, advocates and legislators are calling for marijuana legalization at the federal level, a strategy that has the added benefit of keeping people from becoming entrapped in the criminal justice system. In 2016, more than half a million people were arrested for marijuana violations.[13] Black Americans are nearly four times more likely to be arrested for marijuana possession than their white counterparts, despite comparable usage rates across groups.[14] States that have liberalized their marijuana laws have done so to close these racial disparities, as well as to save on associated criminal justice costs. Legalizing substance use is one consideration to begin treating drug misuse as a public health issue rather than a criminal justice one.

Harm reduction

Today, more and more Americans are acknowledging the failure of the war on drugs. As early as the late 1980s, justice system professionals began searching for a more effective approach.[15] In 1989, Miami-Dade County launched the country's first drug court, a specialized program to divert defendants with substance use disorders away from incarceration.[16] More than 3,100 jurisdictions have established drug courts, which pair intensive recovery services and case management with rigorous accountability mechanisms for participants.[17] Mayor Karen Freeman-Wilson of Gary, Indiana, an early champion of the drug courts movement, touts the model as a more effective and cost-efficient alternative to the "revolving door" of recidivism.[18] "[U]nless you address the underlying issue of addiction, which is what drug courts do, then you're likely to offend," Freeman-Wilson explained in a 2014 interview.[19]

Drug courts were an important first step away from the status quo. As the name implies, however, they are still part of the criminal justice system, and participants who do not successfully complete the program could face lengthy sentences of incarceration.[20] There is robust debate about how to reduce the punitive aspects of drug courts, but today, policymakers and the public alike are increasingly adopting approaches that treat substance misuse as a health issue rather than a criminal justice one.

Unlike the justice system, which tends to place more emphasis on punishment than on treatment, harm reduction approaches focus on improving the well-being of all individuals and aim to reduce the risks associated with substance misuse. Harm reduction is based on the understanding that abstinence is not a realistic option for everyone. Instead of giving up on such individuals, harm reduction strategies meet people where they are. These interventions focus on preventing fatalities, disease, and other harms by promoting safer substance use behaviors. Three promising strategies—syringe access programs, safe-injection facilities, and Law Enforcement Assisted Diversion—are working in conjunction with local justice systems to reduce the harmful impact of substance misuse in a smart, fair, and effective manner.

Syringe access programs

Syringe access programs are one example of harm reduction programming that has gained traction in recent years. Sometimes referred to as needle exchanges, syringe access services provide people with sterile injection equipment to reduce the incidence of syringe sharing—a risky practice linked to transmission of bloodborne infections. By ensuring that people have access to clean injection equipment, these programs can significantly reduce the incidence of new HIV and hepatitis C diagnoses. In Washington, D.C., for example, a syringe access program reduced new HIV cases by 70 percent over two years, saving the city an estimated $44.3 million in averted health care costs.[21]

Syringe access sites have demonstrated success as a path to treatment and supportive services. Dayton, Ohio, Mayor Nan Whaley explains that syringe access is "an opportunity for us to open the door so we have a relationship [with clients] … That way, when they're ready for treatment, we can get them into treatment very quickly."[22] Dayton's syringe access program, CarePoint, connected more than one-fifth of clients to substance misuse treatment in its first year of operation, and referred another 10 percent of clients to medical and mental health services.[23]

Twenty years ago, syringe access was so controversial that the U.S. Congress banned the use of federal funds to support these programs, pending an evaluation of their efficacy.[24] Today, syringe access programs currently operate in 40 states,[25] more than half of which have Republican governors.[26] The rapid adoption of the syringe access model is a testament to its success at improving health outcomes.

Safe-injection facilities

A number of U.S. cities are now planning to take harm reduction one step further by adopting a strategy known as supervised injection facilities (SIFs). Sometimes called "safe-injection sites" or "supervised consumption facilities," these sites are staffed by medical professionals who are trained to recognize and respond to fatal dosages, mitigating the risks associated with substance misuse. Like syringe access services, SIFs offer sterile injection equipment and safe disposal options for used needles. Critically, SIFs also provide clients with a hygienic place to inject preobtained drugs under medical supervision. Furthermore, SIFs are an avenue to treatment as people build vital connections with health care providers who are on hand to provide immediate referrals to social services and treatment options.

On all measures, the model has yielded promising results. With staff available to administer naloxone at the first sign of overdose, SIFs have been shown to reduce fatalities associated with substance misuse. In Vancouver, British Columbia, the arrival of a SIF reduced overdose deaths by 35 percent in the surrounding area. A similar facility in Sydney, Australia, averts an estimated 25 overdose fatalities every year.[27] SIFs also improve health outcomes by promoting safer injection behaviors. SIF users in Vancouver were 70 percent less likely to share syringes, a practice linked to transmission of bloodborne diseases.[28] On average, estimates suggest that Vancouver's SIF prevents 35 new HIV diagnoses each year.[29]

Concerns that SIFs will increase drug-related crime have been shown to be unfounded. In Vancouver, neighborhood crime rates remained stable following the launch of the SIF.[30] In fact, vehicle theft and vehicle break-ins actually declined in the vicinity of the SIF.[31] SIFs have also been shown to improve public order by keeping used needles off the streets and reducing incidence of public drug use.[32] Most notably,

SIFs have proven effective as a tool for engaging a traditionally hard-to-reach population. By providing connections to vital resources, SIFs reduce the barriers to entry into treatment. In Vancouver, the SIF model has increased the number of people entering treatment by 30 percent, and roughly half of participants successfully complete the program.[33]

More than 100 SIFs are currently operating in cities across Europe, Canada, and Australia. But as recently as 2016, the SIF model was considered radical in the United States. That year, *The New York Times* called SIFs an "unorthodox idea" and "unheard-of in the United States."[34] Two years later, *The New York Times* Editorial Board penned an op-ed urging state and local leaders to implement SIFs in their communities.[35] Although no legally sanctioned SIFs exist in the United States, many American cities are moving forward with plans to launch SIFs based on the model's success internationally.

- New York City, for example, plans to pilot a SIF program to reduce the rise of opioid-related fatalities in the city, which accounted for more deaths in 2017 than car crashes, suicides, and homicides combined.[36] New York's SIFs would have the potential to save up to 130 lives each year, as well as $7 million in health care costs.[37]

- Philadelphia officials are encouraging private organizations to launch SIFs, which studies show could prevent up to 76 overdose fatalities and avert up to 18 new HIV infections and 213 new cases of hepatitis C every year.[38] Conservative estimates suggest that community user engagement sites (CUES) would save at minimum $14.6 million annually in health care costs and averted deaths.[39] Philadelphia Mayor Jim Kenney is a proponent of the plan, which is just one piece of a broader effort to reshape the way the city responds to substance misuse. The war on drugs, Kenney says, was a mistake that Philadelphia will not make twice.[40] "We're not going down that road again. We're not going to try to lock our way out of this problem," he insisted in a speech in 2018. "It's an addiction, it's an illness, and it needs to be treated medically."[41]

- Seattle Mayor Jenny Durkan, who is leading an effort to establish SIFs in her city, shares Kenney's views. In the past decades, the country's response to substance misuse "missed the mark," Durkan said in a 2017 mayoral debate.[42] Instead, she's allotted $1.3 million in the city budget to stand up SIFs,[43] which she views as "one way we treat this as a public health issue and not a criminal justice issue."[44]

The road to SIFs in the United States is not without obstacles. In particular, the laws around safe-injection sites remain murky. States have clear authority to authorize SIFs, though localities would not necessarily need explicit state authorization to implement SIFs.[45] American SIFs, however, would be vulnerable to challenges from federal law enforcement officials. In response to a safe-injection proposal in Vermont, the Trump-appointed U.S. attorney threatened criminal prosecution for both SIF clients and staff.

"It is a crime, not only to use illicit narcotics, but to manage and maintain sites on which such drugs are used and distributed,"[46] the U.S. attorney's office concluded, referring to a provision of the federal Controlled Substances Act that prohibits property owners from knowingly allowing the use or distribution of illegal substances onsite.[47] But as the federal government continues to resurrect the war on drugs, cities are following the evidence and pressing forward with promising harm reduction strategies.

Law Enforcement Assisted Diversion

Notably, harm reduction strategies have found support among law enforcement officers through programs such as Law Enforcement Assisted Diversion (LEAD). Through LEAD, law enforcement officers are empowered to redirect individuals with substance use disorders to social services, rather than making low-level arrests. The program is founded on the understanding that incarceration can lead to unnecessary harm—or even death—for people with substance use disorders. Overdoses are the leading cause of death among individuals recently released from prison, who are 129 percent more likely to die from an overdose during that period than is the general public.[48]

Instead, LEAD directs participants to a continuum of community-based care options, which can include treatment—but is not mandated to do so. Importantly, LEAD serves even those clients who are not yet ready for recovery. Through LEAD, officers make immediate referrals to case managers, who meet the client in the field to discuss their needs and preferred next steps. Case managers focus on addressing clients' self-identified needs and building their capacity from the point of entry, regardless of their readiness to enter treatment.[49]

The program, pioneered in Seattle, has proven successful at improving individual and community-level outcomes. On average, individuals diverted through LEAD were 58 percent less likely than nonparticipants to be rearrested and spent 39 fewer days in jail per year.[50] Participants also showed significant improvements in housing and economic stability after referral to the program.[51] Based on the successes in Seattle, LEAD has been replicated in 16 jurisdictions nationwide, with dozens more working to launch LEAD in their communities.[52]

Other effective strategies

Naloxone

Naloxone is a lifesaving drug that reverses the symptoms of opioid overdose. By expanding access to naloxone, communities nationwide are preventing unnecessary overdose fatalities. In Baton Rouge, Louisiana, for example, emergency services personnel saved more than 600 lives with naloxone in 2017 alone.[53] Distributing naloxone to laypeople—particularly the families and friends of individuals at high risk of overdose—has also proven effective at preventing fatalities.[54] A pilot program sponsored by the University of Alabama at Birmingham provided training and naloxone to roughly 100 individuals with close ties to substance misusers, saving nine lives in less than a year.[55] Other jurisdictions are providing naloxone directly to individuals at high risk of overdose, another distribution strategy shown to reduce fatalities. In Los Angeles County jails, for example, incarcerated people at high risk of opioid misuse are trained to recognize and respond to the signs of an overdose and are given naloxone kits prior to release.[56] Additionally, many syringe access sites offer free naloxone kits and overdose education programming for clients and their loved ones.[57]

Medication-assisted treatment

Medication-assisted treatment (MAT) treats opioid use disorder through behavioral health therapy and medications, such as buprenorphine, that alleviate the symptoms of withdrawal and block opiate cravings.[58] MAT's dual program of counseling and medication has proven more effective than either intervention on its own, increasing the likelihood that patients adhere to treatment and abstain from opioid misuse.[59] Hospitals can serve as an important link to MAT for individuals with opioid use disorder, who tend to be frequent utilizers of emergency departments or urgent care centers.[60] In a randomized clinical trial, an emergency room treated eligible patients with buprenorphine and sent them home with enough doses to last until a follow-up appointment, when they would begin a 10-week MAT program. After 30 days, nearly 80 percent of MAT patients were engaged in treatment, compared with only 37 percent of patients who were discharged with a referral to recovery services.[61] In Boston, Massachusetts General Hospital has recently implemented a similar MAT initiative in its emergency department. The Boston program is one of only a handful nationwide that offers MAT services 24/7, ensuring that a MAT-certified doctor is always present in the emergency room.[62]

Conclusion

In a departure from the failed policies of the war on drugs, local leaders are now rallying around strategies that reduce the harm of substance misuse. Gripped by the devastation of the opioid crisis, cities are bringing once-fringe policy solutions into the mainstream, citing their successful track records at saving lives and preventing disease. The strategies detailed in this issue brief represent promising progress toward ending a decades-old policy agenda of criminalizing substance misuse. But importantly, approaches that are limited to addressing opioid misuse—a primarily white phenomenon—risk perpetuating racial disparities in the justice system. Cities must develop inclusive approaches that treat all substance use disorders—not just opioid misuse—as a disease, not a crime.

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