Preventing Overdose and Reducing Drug-Related Harm

A Policy Guide for State and Local Change

ChangeLab Solutions

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Executive summary

Background[i]

According to the National Center for Health Statistics (NCHS) at the Centers for Disease Control and Prevention (CDC), drug overdose deaths are occurring at an unprecedented scale in the United States, with fatalities increasing over 450 percent since 2001.[1] Provisional data predict that more than 107,500 people in the United States died from a drug overdose in the 12-month period ending in December 2023.[2] Nonfatal overdoses and other drug-related harms (including blood-borne infections and other health problems) have also been on the rise.[3]

While drug overdoses affect every community in the United States, overdose deaths are increasingly characterized by inequities across race, income, and geography. These inequities reflect the impact of structural racism, economic inequality, and the legacy of laws and policies that criminalize people who use drugs (PWUD) rather than provide care.

Even in the face of this growing crisis, many drug overdoses are preventable. State and local decision makers can take action to save lives, mitigate risk, and advance health equity in their communities.

Purpose

This guide is intended to support state and local decision makers, government agencies, public health practitioners, and community members as they consider policies to prevent overdose and reduce other drug-related harms in their communities. It presents 11 policy strategies that are supported by peer-reviewed evidence and backed by experts in the field. These strategies were selected for their potential to save lives, advance health equity, and be feasibly implemented at state, local, and institutional levels (e.g., by schools or health care systems). This document accompanies **Implementing State and Local Overdose Prevention Policies: A Resource for Navigating the Policy Process**, which offers complementary information on the policy process, including guidance on implementing overdose prevention policies so that they achieve their intended goals. **Key terms** are defined at the end of this guide.

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Focus sectors

This guide focuses on policies implemented in four key sectors: health care, criminal legal, school (K–12), and community. These sectors were selected for their ability to reach people who use drugs, capacity to deliver needed programs and services, and intersection with populations facing the greatest risk of overdose. Many of the policy strategies featured in this guide can be implemented in more than one sector and may require collaboration across these and other relevant sectors.

Methods

The policy strategies highlighted in this guide were identified through the following methods:

- **Policy scan:** A review of drug overdose prevention policies in peer-reviewed and gray literature across four sectors: health care, criminal legal, school, and community
- **Key informant interviews:** Interviews with 22 overdose prevention experts representing each of the four sectors, to gather informants' perspectives, experiences, and recommendations. See **Appendix A** for details about our interviewees.
- **Policy assessment:** An assessment of policies identified in the scan and recommended by key informants across a range of feasibility and impact criteria (e.g., strength of evidence and ability to advance equity). See **Appendix B** for detailed information about the assessment.

Centering equity

Deepening racial inequities in overdose deaths reflect the impact of structural racism broadly,[4,5,6,7] as well as racism in the specific legal and policy interventions enacted to control drugs and people who use them. These racial inequities include past law and policy decisions cumulatively referred to as the War on Drugs, which have fueled the over-policing, arrest, and mass incarceration of Black Americans and other people of color.[8,9,10] Present-day policies, like those that increase penalties for offenses involving specific drugs like fentanyl, extend this harmful legacy of prioritizing criminal punishment of PWUD rather than investing in treatment.[11]

Structural racism often intersects with gender and class biases as well as other forms of discrimination, which can increase risk of overdose through heightened stigma and greater barriers to care, especially for people with the following risk factors:

- Current or previous incarceration
- Lack of stable housing
- Pregnancy

Considerations for tailoring policies to reach these priority groups as well as Black, Indigenous, and other people of color (BIPOC) are presented with each option in this guide. Given that community needs vary from jurisdiction to jurisdiction, engagement with community members with lived and living experience — especially PWUD who are BIPOC — is also necessary to identify the options that will best respond to people's needs on the ground.

Policy strategies

In this guide, policy strategies are organized into two sections — those that are well-established and those that are new and emerging — according to the existing evidence base. Each option is worthy of consideration, and jurisdictions likely need to pursue several complementary strategies to effectively address the multi-faceted nature of the overdose crisis.

Well-established policies to prevent overdose deaths

Policies in this section have a strong evidence base, as defined by the authors' assessment criteria, and have been implemented in multiple state and/or local jurisdictions across the United States.

Expand access to medications for opioid use disorder (MOUD). Medications for opioid use disorder are considered the gold standard of treatment for opioid use disorder (OUD). While MOUD are proven to reduce illicit drug use and prevent overdose,[12,13] they remain out of reach for many PWUD. Policies can reduce legal or financial barriers to MOUD and can be tailored to increase access for groups with elevated risk, including pregnant, postpartum, and/or incarcerated PWUD.

Increase access to naloxone. Naloxone — a medication used to quickly reverse the effects of an opioid overdose — is lifesaving, but it is not always readily available when and where it is needed.[14] While all states have passed some version of a naloxone access law, state and local jurisdictions can take additional action to ensure that PWUD, their friends and family, and any community member who may witness an overdose can access naloxone when they need it. Policies that increase access to naloxone can include implementing or expanding tailored distribution programs to reach those most at risk of overdose and/or likely to witness an overdose, mandating naloxone access in schools, and reducing the cost of the medication.

Strengthen overdose Good Samaritan laws. Overdose Good Samaritan laws (GSLs) provide legal protection for people who seek emergency care in the event of a drug overdose by providing immunity from arrest, charge, and/or prosecution for certain drug-related offenses. Under such laws, people who witness an overdose can call for help without fear that it will lead to their own arrest or prosecution for those offenses. However, current GSLs leave people at risk of being arrested and charged for other crimes; such laws could be strengthened to encourage more PWUD to call for help if an overdose occurs.[15]

Authorize and expand access to syringe services. Syringe services programs (SSPs) provide access to sterile syringes and other equipment (e.g., naloxone, fentanyl test strips, safer smoking supplies, and first aid supplies) for safer drug use. SSPs are a proven strategy to reduce the spread of infectious disease, connect PWUD with treatment and other health services, and improve other health outcomes.[16,17] States and local jurisdictions can promote access to syringe services by eliminating laws that prohibit or limit SSPs' operation or funding as well as access to syringes from other sources, such as pharmacies.

Examine policies related to Medicaid and enrollment assistance. Access to health insurance can help connect PWUD with vital health services and may help mitigate underlying conditions that can contribute to drug use and overdose risk in the first place. In states that have not yet adopted Medicaid expansion, doing so could help connect low-income PWUD with treatment for substance use disorder (SUD) and care for other

drug-related harms. In addition to Medicaid expansion, policies can include providing enrollment assistance for those most at risk of overdose, especially those preparing to exit prisons and jails; extending Medicaid postpartum coverage beyond 60 days; and eliminating prior authorization requirements and other barriers to MOUD.

Strengthen behavioral health supports for youth. Young people across the United States are facing a rising tide of mental and behavioral health challenges, including increased overdose mortality. Young people need tailored support to address their unique needs.[18] Policies that strengthen care for young people include adequately staffing all schools with counselors, psychologists, and social workers; designating trained personnel to respond to students in crisis; and implementing Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs, which identify students at risk of SUD and connect them with support.

New and emerging policies to prevent overdose deaths

Policy strategies in this section show significant promise as strategies to prevent overdose and other drug-related harm but have a more limited evidence base — in many cases, due to the recency of their adoption or implementation. While all of these policy strategies have been implemented in the United States, they are less widespread than those in the previous section.

Remove policy barriers to fentanyl test strips (FTS) and other drug-checking equipment. States and localities can expand the use of FTS and other drug-checking equipment by removing criminal penalties associated with personal possession, use, and distribution of FTS, xylazine test strips, and all other drug-checking technologies that may be considered drug paraphernalia. Such equipment can test substances for fentanyl and other deadly adulterants in the drug supply, and policies that allow use of drug-checking equipment may reduce risk of overdose and other harms.[19]

Examine the impact of overdose prevention centers (OPCs). Overdose prevention centers are facilities that provide a monitored setting in which people can consume substances that they have obtained elsewhere. OPCs provide trained staff who can intervene immediately in the event of an overdose. While OPCs are not legal under federal law — primarily under the Controlled Substances Act (CSA) — some state and local jurisdictions have moved forward with policies such as adopting authorizing legislation and creating agreements with community-based nonprofits to establish or expand OPCs.

Examine policies that criminalize PWUD. Removing criminal penalties for possession and/or distribution of all illicit drugs may reduce arrest and incarceration of PWUD and strengthen linkages to and retention in care and treatment. Policies can be enacted by removing criminal penalties through state-level legislation or voter referenda and can involve diverting savings from reduced criminal enforcement to treatment and harm reduction services.

Support Housing First. Housing First connects people who are unhoused with housing first and provides supportive services second. Housing First does not require sobriety or abstinence from drug use in order to access housing. Drug overdose is a leading cause of death among people who are unhoused, and housing stability may help mitigate that risk.[20] State and local decision makers can consider laws requiring that housing providers

prioritize permanent supportive housing programs (e.g., Housing First); enact policies that incentivize a specific percentage of housing units in new affordable housing developments to be set aside for unhoused people and families; and identify sustainable funding for housing initiatives.

Improve and expand income support. Income support programs provide financial assistance to help individuals and families living on low income meet their basic needs. While not specific to PWUD, income support programs can be a strategy to reduce poverty-related stress,[21] which can exacerbate overall health risks, including for overdose and SUD.[22] Policy strategies to increase access to income support among PWUD include eliminating bans on people with prior felony drug convictions and ending drug-screening requirements in public benefit programs like Temporary Assistance for Needy Families (TANF); implementing state-level tax credits like earned income tax credits and child tax credits; and creating and evaluating innovative strategies like guaranteed basic income programs.

A note on stigmatizing language

Language can contribute to stigma about substance use, addiction, and overdose.[23] It can also evolve rapidly over time. This guide aims to use non-stigmatizing, person-first language whenever possible, but may include some language that could be interpreted as stigmatizing. These instances may be embedded in direct quotes from interviewees or other sources in which exact language is critical to understanding the substance of what the interviewee or author meant.

Introduction and background

In recent years, drug overdoses have claimed more lives across the United States than at any other point in our nation's history. According to the National Center for Health Statistics (NCHS) at the Centers for Disease Control and Prevention (CDC), drug overdose deaths are occurring at an unprecedented scale in the United States, with fatalities increasing over 450 percent since 2001.[24] Provisional data predict that more than 107,500 people in the United States died from a drug overdose in the 12-month period ending in December 2023.[25]

Nonfatal overdoses have also been on the rise.[26] These carry their own emotional, social, and economic costs and can have lasting health consequences, including brain injury and elevated risk of experiencing a fatal overdose in the future.[27,28,29]

Opioids, often in combination with other substances, are largely responsible for the increase in overdose and other drug-related harms.[30] Powerful synthetic opioids, especially illicitly manufactured fentanyl, are driving a growing share of overdose deaths.[31] More recently, an emerging wave of overdoses involving stimulants like methamphetamine and cocaine (often in combination with opioids) has further complicated the crisis.[32]

In the face of this profound loss of life, people who use drugs (PWUD), their friends and families, and a multitude of public health agencies and organizations are working to keep one another and their communities safe. Many overdose deaths are preventable through harm reduction strategies that mitigate risk or even reverse the effects of overdose (i.e., naloxone administration) and upstream solutions that prevent overdose before it occurs. States, localities, and institutions like schools and health care systems have begun implementing a variety of policies to support communities, advance evidence-based interventions, and shift toward a response to substance use rooted in care rather than punishment.

The role of fundamental drivers of health inequity

While overdose deaths have increased in nearly every segment of the population and in all parts of the country, they are characterized by deepening inequities across race, income, and geography. As with other health outcomes, disparities in overdose mortality are rooted in the fundamental drivers of health inequity:[33] (1) structural racism and other intersecting forms of discrimination, (2) income inequality and poverty, (3) disparities in opportunity (e.g., in education or employment), (4) disparities in political power, and (5) governance that limits meaningful participation.[34] These drivers shape the social, economic, and environmental conditions in which people are born, live, work, and age (i.e., the social determinants of health)[35] and in turn influence physical, mental, and behavioral health outcomes.

When people struggle to meet their basic needs — for example, when they experience income, food, or housing insecurity or face discrimination or exclusion from full participation in education, the job market, and other parts of life — they are more likely to experience the kinds of stress that can degrade health overall and contribute to substance use and overdose risk.[36,37,38,39,40] For example, experiences of childhood trauma (including abuse, poverty, and homelessness) are associated with a younger age of initiation of illicit opioid use, injection drug use, and overdose.[41] At the community level, regions facing greater income inequality, rising unemployment, and widespread experiences of despair are associated with fatal overdose.[42,43,44]

Inequities are deepening, especially across race

Policies and systems that uphold the fundamental drivers of health inequity — including laws enacted to control the manufacture, distribution, and consumption of illicit drugs themselves (i.e., the War on Drugs) — have made some BIPOC communities more vulnerable to health harms and undermined their access to treatment, harm reduction, and other resources that reduce overdose risk and promote health.[45]

As a result, Black people, Native American and Alaska Native people, and people with low income are experiencing some of the most acute and fastest-growing impacts of overdose. From 2019 to 2021, there was a 78 percent increase in drug overdose death rates among Black people and an 85 percent increase among Native Americans and Alaska Natives, compared with a 40 percent increase among white people.[46] While overdose deaths among Latine, Asian, and Pacific Islander populations remain lower than among other racial and ethnic groups, fatalities have begun to rise precipitously among Latine people as well.[47] Overdose deaths are highest in counties with the greatest levels of income inequality, reflecting the impact of economic disparity and experiences of poverty on increased risk of drug-related harms.[48] Over time, overdose rates have also shifted increasingly from rural communities to cities, with overall fatality rates now highest in urban areas.[49]

State and local policies can advance effective interventions

PWUD, community-based organizations, and public health practitioners have responded to the crisis by building harm reduction infrastructures that have enabled them to implement grassroots overdose prevention education, establish syringe services programs (SSPs), and distribute naloxone kits, among other strategies. PWUD have long been innovators of harm reduction solutions in their communities; their efforts can be bolstered by well-informed state and local policies and public investment.

State and local decision makers can adopt and implement laws and policies that are rooted in health equity, supported by evidence, and aligned with the needs and experiences of PWUD facing the greatest risk of overdose. This guide presents a set of policy strategies for state and local jurisdictions to consider in their work to prevent overdose, reduce other drug-related harms, and ultimately save lives. No single policy option will end the epidemic on its own. Jurisdictions need to consider complementary strategies that both respond to the immediate needs of people experiencing acute risk of overdose and move upstream to prevent overdose risk before it occurs. While not exhaustive, the strategies we outline in this guide can work together to form a comprehensive response.

How to use this guide

This guide is intended to support state and local decision makers, government agencies, public health practitioners, and community members as they consider policies to prevent overdose and reduce other drug-related harms in their communities. It presents 11 policy strategies that are supported by peer-reviewed evidence and backed by experts in the field. These strategies were selected for their potential to save lives, advance health equity, and be feasibly implemented at the state, local, and institutional levels (e.g., by schools or health care systems).

This document accompanies ***Implementing State and Local Overdose Prevention Policies: A Resource for Navigating the Policy Process***, which offers complementary guidance on how to put these strategies into practice on the ground. **Key terms** are defined at the end of this guide.

Focus sectors

This guide is focused on policies implemented in four key sectors that are actively engaged in overdose prevention policy across the country. They have been selected because of their ability to reach PWUD, capacity to deliver needed programs and services, and intersection with populations facing the greatest risk of overdose. Many of the policies can be implemented in more than one sector and may require collaboration across sectors to be implemented effectively. The four sectors are as follows:

- **Health care:** Hospitals, health systems, emergency medical services, pharmacies and pharmaceutical companies, and insurance providers
- **Criminal legal:** Law enforcement, courts, prisons, jails, and other carceral settings that relate to criminal penalties for drug-related offenses
- **School:** Schools and school districts, with a focus on K–12 settings
- **Community:** Outside the health care, criminal legal, and school sectors (e.g., housing, social services), including settings that address a broad range of social determinants of health

How policy strategies are organized

The policy strategies included in this guide are organized into two sections, which are informed by the results of the authors' policy assessment (described in **Methods** and **Appendix B**). The two sections are as follows:

- **Well-established policies to prevent overdose and other drug-related harms:** These policies possess a strong evidence base (as defined by the assessment criteria described below)[i] and have been implemented in multiple state and/or local jurisdictions across the United States. While many jurisdictions are already leveraging these strategies, significant gaps in uptake and effective implementation remain.
- **New or emerging policies to prevent overdose and other drug-related harms:** These policies have a more limited evidence base, largely due to the recency of their adoption or implementation. However, existing research suggests that they may be effective at reducing overdose and other drug-related harm. While all policy strategies included in this section have been implemented within the United States, they are less widespread than those included in the previous section. In some cases, they have only been implemented in a single jurisdiction.

Each section includes policies that increase support for people experiencing acute risk of fatal overdose as well as policies situated further upstream which aim to address social determinants of health with a documented relationship to substance use, SUDs, and overdose risk.

For each policy, the guide provides a brief description and then answers the following questions:

- **What are the policy details?** Describes the policy type; jurisdictional level at which it may be adopted, implemented, and enforced; ways in which the policy may be strengthened in jurisdictions where it has already been implemented; and any potential legal barriers
- **What are the policy's benefits?** Briefly reviews evidence of positive health outcomes and other benefits documented in the literature or identified by experts in the field
- **How can the policy be designed to advance equity?** Explains how the policy might be tailored to reach communities most affected by overdose
- **What does the policy look like in practice?** Offers examples from state or local jurisdictions
- **Additional resources** provides relevant links for further reading and information

i While each of the policy strategies included in this category are supported by evidence rated as "strong" in the authors' policy assessment, there are some cases in which we include a specific approach whose evidence was rated "moderate" or "weak." Although the evidence base is not as robust as for the primary or overarching strategy, these approaches are supported by some evidence that they may reduce overdose or drug-related harm and were included to provide information on the range of related policy strategies that communities can consider. Policy assessment results can be found in Appendix B.

Methods

The policy options presented in this guide were identified based on information gathered through the following methods:

Policy scan

In the first phase of analysis, ChangeLab Solutions conducted a scan of drug overdose prevention policy strategies implemented within one or more of the focus sectors described above (criminal legal, health care, community, and K–12 schools). The scan was conducted by searching peer-reviewed and gray literature across several search engines and electronic databases (e.g., Google, Google Scholar, PubMed, and ProQuest), using various combinations of search terms, including "overdose prevention," "substance use disorder," "drug use," "policy," "law," "criminal justice," "healthcare," "community-based," "social services," "schools," and "education." The objective was to build an understanding of the current policy landscape, including the range of policies being implemented across the four focus sectors, the approach those policies take (i.e., supply side, demand side, or harm reduction), and the level of government at which they are situated. The scan also identified gaps, including policy interventions that had not been implemented or were implemented less frequently, and informed direction for future information gathering.

Key informant interviews

Following the policy scan, ChangeLab Solutions conducted 22 key informant interviews with overdose prevention experts representing each of the four sectors. Interviewees included policy experts, policymakers, researchers, persons with lived experience, and practitioners. They reflected a range of organizational backgrounds, geographic locations, and perspectives across levels of government (national, regional, state, local, and tribal). Interviewees were identified by opportunistic selection with recommendations from CDC, the Network for Public Health Law, and key informant referrals. In-depth, qualitative interviews were conducted using a semi-structured interview guide and explored interviewees' perspectives, experiences, and recommendations related to legal and policy strategies to reduce overdose and other drug-related harm and advance health equity. (For detailed information on key informants, see **Appendix A. Key informant interviewees**.)

All interviews were recorded with interviewee consent, transcribed, and analyzed. A codebook was developed by a team of policy analysts and attorneys. The team that developed the codebook also coded the interviews to ensure inter-rater reliability, which allowed consistent identification of common themes and patterns, permitting deductive and inductive coding throughout the analysis of transcripts.

Policy assessment

In the final phase of analysis, ChangeLab Solutions assessed a group of overdose prevention policies across a range of feasibility and impact criteria to understand which strategies have the greatest potential to reduce overdose and other drug-related harms and can be implemented at state or local levels. Policy strategies were included in the

assessment if they were (1) identified in the initial policy scan or (2) identified by key informants as promising approaches to reduce overdose. The initial assessment included 101 policies.

A team of policy analysts and attorneys reviewed peer-reviewed and gray literature, data from key informant interviews, and state and local statutes and regulations to conduct the assessment. Each policy was screened across eight feasibility and impact criteria (described below), which were developed based on input from key informant interviews and refined with CDC feedback. The assessment used information that was publicly available at the time (spring 2023).

After conducting an initial assessment, the team excluded a portion of the original number of policies because they did not reflect a feasible, well-defined policy strategy; were situated at the federal level; performed poorly on equity and people-centered criteria; or were programs rather than policies[i] (e.g., peer support and recovery programs). We also consolidated policy strategies that had significant overlap.

Following the initial assessment round, the ChangeLab team completed an internal review of the remaining 48 policies to conduct additional research to resolve questions, as needed, and ensure consistency across criteria ratings. The Network for Public Health Law also provided expert review of the legal restrictions criterion to ensure that we identified relevant issues regarding the interplay among federal, state, and local law; litigation; preemption; negative rulings; and other legal barriers that may affect policies included in the assessment.

The policy strategies included in this guide performed strongly across at least half of the feasibility and impact criteria, meaning they received the highest or most positive rating in at least four of the eight criteria included in the assessment. The assessment criteria are presented in full in **Appendix B**.

The policy assessment was designed to identify a broad menu of promising policy options and examine their relative strengths and weaknesses. Assessment results for the policies included in this guide are intended to be a resource and a conversation starter. The probable outcome listed for each criterion is not meant to serve as a complete review of every local or state policy or practice.

i While the ChangeLab team removed programs from the assessment, we retained those that are codified by law and policy (i.e., those for which a statute, regulation, ordinance, or other policy is in place to authorize or support the program) or otherwise have significant policy implications. For example, syringe services programs (SSPs) remained in the final assessment (and appear in this guide) because they may require changes to state drug paraphernalia laws or authorization by state or local governments.

Key considerations for tailoring solutions to those at greatest risk

Racial inequities in drug-related harms are deepening, with Black, Native American, and Alaska Native people experiencing disproportionate and fast-growing rates of overdose death. These inequities reflect the impact of structural racism broadly, but also how it is embedded in specific legal and policy interventions enacted to control drugs and people who use them. Throughout our nation's history, drug policy has been deeply influenced by race and racism, and has historically been tied to criminal penalties and prosecution over treatment.[50,51,52]

Structural racism and the War on Drugs

Current drug policy in jurisdictions across the United States is rooted in a set of aggressive laws and policies meant to curtail the production, distribution, and sale of illicit drugs, cumulatively termed the "War on Drugs." These laws and policies increased criminal penalties for drug infractions and heavily invested in criminal enforcement, fueling overpolicing, arrest, and mass incarceration in many Black and other communities of color.[53,54] The War on Drugs was catalyzed, in part, by racialized moral panic about drug use among Black communities in urban areas and led to widening racial inequities across the criminal legal system.[55,56]

One of the best-known examples of racial discrimination embedded in the War on Drugs is the 100-to-1 sentencing ratio for crack cocaine versus powder cocaine, which was established by the Anti-Drug Abuse Act of 1986. Under this legislation, the distribution of five grams of crack cocaine carried a minimum five-year federal sentence, while the same sentence for the distribution of powder cocaine required a 500-grams amount. While the guidelines have since been updated, this disparity in sentencing inequitably criminalized Black individuals more likely to be convicted of crack-related crimes.[i]

The criminalization-oriented framework of the War on Drugs failed to reduce drug use and ultimately worsened health harms by exacerbating stigma and focusing resources on arresting and incarcerating PWUD rather than providing treatment. Its emphasis on criminalization continues in the present day through, for example, the recent uptick in enforcement and enactment of so-called drug-induced homicide laws, which are intended to place legal responsibility for an overdose death on the person who provided the drugs involved.[57] Such laws have frequently punished friends and family members of the decedent and other PWUD.[58] Many jurisdictions have also enacted other legislation to increase criminal penalties for specific drugs like fentanyl, rather than investing in treatment and prevention.[59]

i The crack cocaine versus powder cocaine sentencing guidelines were updated under the 2010 Fair Sentencing Act, which lowered the sentencing disparity to an 18:1 ratio. In December 2022, the **US attorney general instructed federal prosecutors** to end disparities in the way offenses involving crack versus powder cocaine are charged.

Intersecting forms of discrimination increase overdose risk among certain groups

Structural racism intersects with other forms of discrimination based on income and socioeconomic status, gender, sexuality, disability, immigration status, and other aspects of identity. These intersections may increase risk of overdose through heightened stigma and greater barriers to care,[60,61] especially for the following populations:

- **People who are incarcerated or were previously incarcerated:** Due to a history of inequitable policing practices, sentencing, and mass incarceration, Black Americans and other people of color are disproportionately likely to be involved in the criminal legal system.[62,63,64] Research shows that people with a history of incarceration are more vulnerable to overdose. Following a period of incarceration, PWUD may have diminished opioid tolerance and are likely to confront a changed drug supply upon reentry.[65] In the two weeks immediately following release, evidence indicates that the risk of death from drug overdose may be nearly 13 times higher among recently released persons than it is among the general population — and even higher among women who have been recently released.[66]
- **People who are unhoused:** Black, Native American, Alaska Native, and Latine people are overrepresented among people who are unhoused in the United States, reflecting economic inequality, discrimination in the housing market, and a historical legacy of segregationist and exclusionary housing policies.[67,68] Drug overdoses are a leading cause of death among all people who are unhoused,[69] with one study indicating overdose mortality rates 12 times higher than the general population.[70] Lack of access to stable housing can increase stress and undermine access to health services and is associated with a range of worsened health outcomes, including onset of SUDs.[71]
- **People who are pregnant and postpartum:** PWUD who are pregnant and postpartum face intense scrutiny, heightened barriers to treatment, and potential criminal punishment or noncriminal consequences (including child welfare involvement and loss of custody), which can lead them to delay prenatal care, drug treatment, or engagement with other resources.[72] This is particularly true for Black, Native American, and other pregnant and postpartum people of color who are disproportionately targeted by the criminal legal and child welfare systems.[73,74] Stigma related to substance use during pregnancy can have deadly consequences, as forgoing or delaying care can lead to poor infant and parental health outcomes and increase overdose risk during pregnancy and the postpartum period. Research shows that overdose deaths among pregnant or postpartum people rose sharply between 2018 and 2021, especially for those aged 35–44, whose overdose mortality ratio tripled during that time.[75] Research also suggests that risk of overdose is greatest in the postpartum period, with most drug-related deaths occurring in the year following delivery.[76]

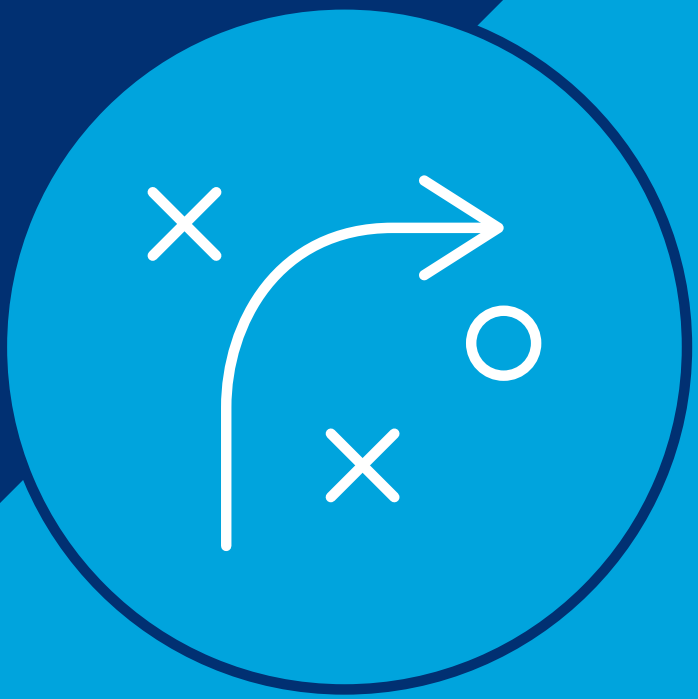
Considerations for tailoring policy to reach these populations and advance health equity are presented with each option in this guide. Several policy strategies included here are specifically designed to meet the pressing survival needs of these priority populations (e.g., Housing First) and reduce overdose by increasing access to resources that may serve as protective factors against overdose risk.

Including those with relevant lived experience in every step of the policy process

Based on the evidence base and key informant interviews, many of the policies uplifted in this guide reflect the needs and experiences of PWUD, their friends and families, and the community-based organizations that serve them. At the same time, the policies presented here should be considered only a starting point. Policy decision makers will need to engage PWUD and other community members in their jurisdictions to determine which options will best meet their particular needs.

To advance overdose prevention in a manner that centers health equity, it is critical that PWUD be involved in all aspects of the policy process, including selection, design, implementation, and evaluation. Across every policy examined in this guide, meaningfully engaging people with lived and living experience, especially those who are actively using drugs, not just those in recovery, and BIPOC communities, is necessary to design interventions that adequately respond to the specific needs and experiences of those facing the greatest risk of drug-related harm. More information on community engagement can be found in the companion resource ***Implementing State and Local Overdose Prevention Policies: A Resource for Navigating the Policy Process***.

Policy strategies



Well-established policies to prevent overdose deaths

Policies considered well established are widely used across the nation and supported by robust evidence (as documented in scientific reviews synthesizing evidence from peer-reviewed studies and other sources). The policies presented in this section have demonstrated effectiveness at reducing overdose and/or other drug-related harms (such as HIV, other blood-borne infections, and drug-related arrest and incarceration). Additionally, these policies are feasible to implement in many jurisdictions with little or no change to existing laws. While many states and localities have already implemented these policies to some degree, many communities continue to experience gaps in uptake and effective implementation. In addition to presenting options for enacting new policy, this section also highlights how existing laws and policies may be strengthened to improve critical protections for people at risk of overdose (e.g., Good Samaritan laws).

Expand access to medications for opioid use disorder (MOUD)

SECTORS: CRIMINAL LEGAL, COMMUNITY, HEALTH CARE

Medications for opioid use disorder (MOUD) are an evidence-based approach to treating opioid use disorder (OUD) that assists in reducing illicit drug use and preventing overdose.[77] MOUD are widely considered the gold standard in addiction medicine, and the US Food and Drug Administration (FDA) has approved three forms of these medications: methadone, buprenorphine, and naltrexone.[78] These medications operate to normalize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and normalize body functions without the negative effects of the substance used.[79] MOUD are safe to use for months, years, or even a lifetime. However, despite their clinical effectiveness, they remain out of reach for many due to limited availability, cost, and the stigma associated with treatment that is often wrongfully perceived as "substituting one drug for another."[80,81]

Policies expanding MOUD access can be tailored to address barriers for specific populations facing heightened risk of drug-related harm, such as people who are pregnant or postpartum, those who are incarcerated, and those with low incomes. We describe approaches to tailoring policies to these priority populations below.

What are the policy details?

Expand MOUD access for pregnant or parenting PWUD

Policies for improving MOUD access can be tailored to meet the needs of pregnant and parenting PWUD. Not only are methadone and buprenorphine approved to treat OUD during pregnancy;[82] their use is supported by the White House Office of National Drug Control Policy (ONDCP), which has published a report outlining how overdose-related deaths in pregnant and postpartum individuals can be prevented with MOUD.[83]

- Jurisdictions can create and fund drug treatment programs specifically tailored to people who are pregnant (e.g., West Virginia's Drug Free Moms and Babies Project, which provides treatment and wraparound services to pregnant and postpartum people with SUDs).[84] They can also provide pregnant people with priority access to state-funded

drug treatment programs.[85] These programs can include treatment with MOUD, other medical care in inpatient, outpatient, and residential settings; counseling; education; and community support services.[86,87] However, it is important to note that even in states that have implemented tailored programs or established priority access, significant gaps in access remain.

- States may also seek federal funding to support expanding MOUD access among pregnant and postpartum PWUD. Federal initiatives have supported state programs serving this population, including the Substance Abuse and Mental Health Services Administration (SAMHSA) Pilot Program for Treatment for Pregnant and Postpartum Women.[88] This program provides grant money to states to fund the delivery of evidence-based treatment services, including the use of MOUD to treat pregnant and postpartum PWUD.[89]
- Four in ten births are supported by the Medicaid program,[90] and states have been able to reduce access barriers to MOUD for postpartum PWUD by extending postpartum Medicaid coverage either by using state funds or through a Section 1115 waiver (which allow states flexibility to pilot improvements to better serve Medicaid recipients).[91] As of September 2023, 38 states and the District of Columbia had implemented a 12-month postpartum extension.[92,i] Research shows that this extension is associated with increased insurance coverage and improved continuity of coverage for new parents.[93] (For more information on the postpartum extension, see the **Examine policies related to Medicaid and enrollment assistance** section.)

Expand MOUD access for people who are incarcerated

Policies to expand access to MOUD can also be designed to reach incarcerated PWUD. Research has shown that medication-assisted treatment provided during incarceration increased community-based substance use treatment engagement, and in the case of methadone, decreased illicit opioid use and injection drug use post-release.[94] However, in one survey of more than 500 prisons in states with the highest rates of overdose deaths, 61 percent did not offer any type of MOUD.[95]

- Policies expanding access to MOUD in prisons and jails have been enacted through state-level legislation, executive order, and agency policy. At least 28 states have executive orders or agency policies in place governing access to MOUD in carceral settings, and almost all states have at least one jail or prison that offers some form of MOUD.[96]
- These policies vary based on which forms of MOUD are made available, whether intake includes a screening for OUD, and whether MOUD are offered to all people entering the jail or prison with OUD or if access is limited to a specific subpopulation.[97] While some jurisdictions allow any patient who needs MOUD during incarceration to start or continue treatment, others limit MOUD treatment options to people who are pregnant, those who were receiving MOUD prior to incarceration, or those with upcoming release dates.[98] Some policies also limit the types of MOUD offered to people who are incarcerated, with at least 10 states permitting treatment only with naltrexone as of June 2022.[99] Jurisdictions can remove such restrictions to expand access to the spectrum of FDA-approved MOUD for all incarcerated people who need it.

i In addition to tailored approaches for pregnant and postpartum people, Section 1115 waivers can also be used to enhance access to MOUD for Medicaid beneficiaries broadly. For more on expanding Medicaid coverage during the postpartum period and improving SUD care for all Medicaid enrollees, see the **Examine policies related to Medicaid and enrollment assistance** section.

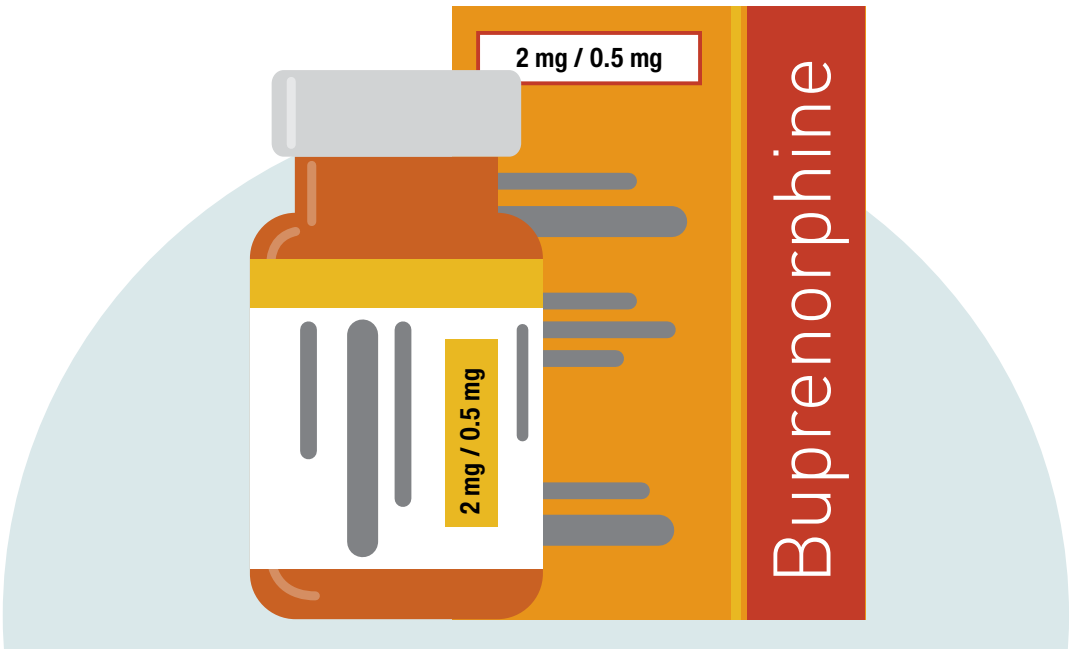
Expand MOUD access through Medicaid

States can also increase access to MOUD among people with low income by expanding Medicaid and by using Medicaid flexibilities to reduce barriers to MOUD access. (For more information, see the **Examine policies related to Medicaid and enrollment assistance** section.)

What are the policy's benefits?

A robust evidence base supports expanding access to methadone and buprenorphine as effective treatment for PWUD.[100] Randomized clinical trials have found methadone, buprenorphine, and extended-release injectable naltrexone to each be more effective in reducing illicit opioid use than no medication.[101] Methadone, the oldest of FDA-approved MOUD, is supported by the largest evidence base of these medications, which finds that it's associated with reduced risk of overdose death, reduced illicit opioid use, reduced risk of HIV and other infectious diseases, reduced rates of HIV risk behavior, and reduced criminal behaviors.[102] Buprenorphine is also supported by substantial and long-term evidence, which finds that it is associated with reduced risk of overdose death, reduced illicit opioid use, reduced HIV risk behaviors, and retention in treatment.[103] The evidence on naltrexone is more mixed, with some studies finding it as effective as buprenorphine,[104] and others finding it less effective or not protective against overdose.[105,106] Naltrexone may be less effective than other forms of MOUD because it requires that patients stop using opioids for a period of time prior to treatment, making initiation more difficult.[107]

For pregnant PWUD, treatment with methadone and buprenorphine during pregnancy have been shown to improve birth outcomes,[108] including decreased "preterm delivery, intrauterine growth restriction, and intrauterine fetal demise," as well as "longer gestation and higher infant birth weight."[109] Methadone and buprenorphine treatment during pregnancy have also been associated with decreased rates of overdose, with the odds of overdose declining by two percent for each additional week of use.[110] A scoping review of drug treatment programs for pregnant women with OUD in the United States found that



certain program elements — including co-locating treatment services with other kinds of care (e.g., obstetric/gynecologic care and pediatric care); collaboration between health care providers, social workers, and other professionals; and providing services in groups — can improve access, coordination, and quality of care.[111] An evaluation of West Virginia's Drug Free Moms and Babies Project specifically found that the program reached high-risk, medically underserved women, and was associated with reducing drug use among those who completed the program.[112] Research on the impact of state laws that grant pregnant people priority access to drug treatment finds that they may continue to face substantial barriers to implementation.[113] This suggests that such laws may need to be paired with other steps like allocating additional resources to treatment programs and amending punitive state prenatal drug use laws, such as those that impose legal consequences for substance use during pregnancy or require health professionals to test for or report substance use to authorities,[114] to increase access.[115]

The evidence supporting MOUD access for incarcerated populations is strong. When methadone is provided during incarceration, it has been shown to increase post-release treatment engagement.[116,117,118] However, most carceral facilities do not provide MOUD and have not developed linkage to MOUD care strategies for those being release.[119] The findings from an economic evaluation study that modeled the association of MOUD access during incarceration and at release with population-level overdose mortality and OUD-related treatment costs in Massachusetts suggests that offering MOUD during incarceration could prevent opioid overdose deaths. The analysis demonstrated that providing only naltrexone at release, a commonly used strategy, is a relatively poor use of limited resources, due to both retention challenges and its high cost. A strategy that includes all three forms of MOUD (i.e., naltrexone, buprenorphine, and methadone) was both impactful and cost effective.[120] One study analyzing the effects of Rhode Island's MOUD program, which offers all three forms of MOUD to all persons entering jail or prison after screening for OUD at intake, found that overdose deaths fell by two-thirds among people who were recently incarcerated in the first year after the program went into effect.[121]

Researchers note, however, that critical longitudinal data on treatment-related outcomes in carceral settings are needed to guide clinical recommendations.[122]

How can the policy be designed to advance equity?

Policies expanding MOUD access can be tailored to communities that experience disproportionate risk of overdose and drug-related harms, including to pregnant and parenting PWUD and PWUD who are incarcerated. Experts emphasize, however, the role that stigma and existing laws can play for pregnant and parenting PWUD considering treatment. For example, the threat of prosecution under the Child Abuse Prevention and Treatment Act[i] and related state laws, as well as the threat of child welfare involvement (including removal of children from their homes or loss of custody)[123,124] could create barriers, especially for BIPOC pregnant and parenting people. One health care sector expert explained that a pregnant person diagnosed with OUD who is receiving treatment may be reported for child abuse at the time of their delivery, even though medication is the safest and best treatment for their disease. This has a chilling effect and is a disincentive to engage in effective treatment:

i Among other provisions, the Child Abuse Prevention and Treatment Act requires health care providers to notify child protective services when caring for an infant "identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder" (CAPTA § 106b2Bii).

> *"I'll never forget a case of a woman who was pregnant and didn't want to try medication treatment because she knew that it would lead to a child welfare filing at delivery.... She overdosed in June, and she and the baby both died."*

States may mitigate these barriers by eliminating or amending laws that deem prenatal drug use to be child maltreatment, require that prenatal drug use be reported to child protective services, or criminalize prenatal drug use.[125]

Furthermore, an equitable MOUD policy considers who has access to which types of medications and works to reduce disparities across racial, socioeconomic, and geographic lines. For example, areas that have greater concentrations of Black and Latine individuals, areas that have higher rates of poverty, and rural areas generally are less likely to have access to MOUD.[126] Among those who are treated with MOUD, Black, Latine, and low-income individuals[127] are more likely to receive methadone, while their white counterparts — especially those with private insurance or who self-pay — are far more likely to receive buprenorphine.[128] Buprenorphine is typically more convenient and flexible for patients to use because it can be taken at home, whereas methadone treatment requires daily in-person visits to a special clinic. Jurisdictions can consider policy changes to increase access to this lower-barrier form of MOUD.

What does the policy look like in practice?

Maine Department of Corrections Medications for Substance Use Disorder (MSUD) Program

The Maine Department of Corrections (MDOC) provides universal access to MOUD for all residents of a state correctional facility who meet medical eligibility criteria through its Medications for Substance Use Disorder (MSUD) program.[129] The program, established through an executive order from the state's governor in 2019, began on a pilot basis and provided buprenorphine or naltrexone to patients who were within 180 days of their release date. In 2021, the program was expanded to offer universal access to the full range of MOUD so that any medically eligible patient, regardless of release date, can access buprenorphine, naltrexone, or methadone as needed.

MSUD prioritizes normalized delivery of MOUD, so that the medications are administered alongside other routine prescriptions rather than in a separate medication line with additional security protocols. The MDOC has also established partnerships with the Maine Department of Health and Human Services as well as community-based SUD treatment providers in order to improve continuity of care. These partnerships help link patients with MaineCare, the state's Medicaid program, and with treatment so that patients can continue their care without disruption or lag time when they are released.[130]

Additional resources

A National Snapshot: Access to Medications for Opioid Use Disorder in U.S. Jails and Prisons (O'Neill Institute for National and Global Health Law at Georgetown Law Center): This report summarizes current laws, policies, and court actions related to access to MOUD in carceral facilities in the United States as of April 2021.

Substance Use During Pregnancy (Guttmacher Institute): This fact sheet summarizes state laws and policies regarding substance use and drug treatment for pregnant individuals.

Increase access to naloxone

SECTORS: CRIMINAL LEGAL, SCHOOLS, COMMUNITY, HEALTH CARE

Naloxone[i] is a medication used to quickly reverse the effects of an opioid overdose. Naloxone is available as an intranasal spray and an intramuscular injection, among other forms, and can be easily administered by emergency responders as well as laypeople without formal medical training.[131]

Naloxone is safe and effective, carries no risk of abuse potential, has no significant effects on people without opioids already in their system, and poses negligible risk of harm if misused.[132] At the federal level, the FDA approved Narcan 4 mg naloxone hydrochloride nasal spray for over-the-counter (OTC) use in March 2023, and RiVive 3 mg naloxone hydrochloride nasal spray for OTC use in August 2023. Approving all formulations of the medication for OTC use, including injectable forms, could expand access even further.

All states have adopted some version of a naloxone access law (NAL). While the specifics vary, most state NALs permit naloxone to be distributed by standing order or through another mechanism that allows individuals to access the medication without first obtaining a prescription from a health care provider.[133] While these policy changes are designed to promote wider access to naloxone, additional efforts are likely needed to ensure that the medication is available to every person, in every place an overdose may occur. Lack of insurance coverage of OTC naloxone and its $45 out-of-pocket cost, for example, may leave the medication out of reach for many PWUD who need it most.[134]

State and local decision makers can consider several additional strategies to further reduce access barriers and ensure that naloxone is readily available to all who may need it:

- Implementing or expanding tailored distribution programs for people most at risk of overdose, especially those who are incarcerated or were recently released from incarceration
- Mandating naloxone access in schools
- Implementing strategies to reduce the cost of the medication

What are the policy details?

Expand naloxone distribution, especially in prisons and jails, and on release from incarceration

Naloxone distribution programs equip individuals who are most likely to witness or experience an overdose (especially PWUD, their friends and family, first responders, and community-based organizations that work with PWUD) with naloxone and provide training in its use. These programs have often been referred to as overdose education and naloxone distribution (OEND) programs, although specific education is generally not required to administer naloxone in an emergency.

- The federal government, states, and local jurisdictions can consider ways to support access to free supplies of naloxone to community-based harm reduction groups, first responders, SUD treatment programs and other health care facilities, and others who work with PWUD. Often state or local public health departments administer the funding

i Naloxone is often referred to by the brand name Narcan, but that name refers to only a singular pharmaceutical company's product, and many other formulations and brands exist. Other overdose reversal medications, including nalmefene (known as the brand name Opvee), have also been approved by the FDA.

and provide training and technical assistance to recipients. Some states work to keep the cost of naloxone down for distribution programs by adopting a policy that allows for bulk purchasing or special contracts with pharmaceutical companies.[i] Another strategy to reduce costs is buying and distributing the intramuscular injection version of the medication, which is significantly cheaper than nasal sprays and easy to use.[135]

- States can also consider legislative strategies to increase naloxone distribution in certain settings, including state prisons. In 2017, for example, New Mexico adopted House Bill 370, which requires that incarcerated people with OUD receive overdose education, two doses of naloxone, and a prescription for naloxone when they are discharged from a correctional facility as funding permits.[136,ii] State prison and county jail systems can consider adopting an institutional-level policy to mandate naloxone distribution within their facilities and at discharge, so that PWUD can access naloxone during the reentry period when risk of overdose is especially elevated.[137] Distributing free naloxone via vending machine (in prisons, jails, and other settings) may further reduce barriers by increasing anonymity and eliminating the need to ask for the medication.[138,139]
- While states have already enacted NALs to support naloxone distribution, programs in some jurisdictions may continue to face legal barriers. Policies that support distribution without civil and criminal liabilities or other restrictions can address some of these challenges.[140]

Increase school access to naloxone

Overdose deaths among adolescents and teens have risen sharply due in large part to the presence of fentanyl and fentanyl analogs in counterfeit pills.[141] Schools represent both an increasingly likely site of overdose and a critical venue for naloxone access and education on harm reduction. One key informant noted:

> *"I just saw a news story about a 17-year-old in Connecticut who had used one Percocet pill, and it turned out that it was a fentanyl pill, and he just collapsed immediately and ultimately died.… There are some kids who are going to experiment, and we need to make sure that those folks are not going to accidentally get fentanyl and die."*

States, local jurisdictions, and school boards can consider implementing policies to address this growing danger:

- Seven states and a number of local jurisdictions and school boards mandate that schools store naloxone on their premises in school first aid kits and ensure that school nurses and other personnel are trained to administer the medication.[142] These mandates can be achieved by adopting a state statute, local ordinance, or school board policy. Typically, the policies require that a certain number of doses of naloxone be stocked on school grounds at all times and that schools develop a protocol for overdose response.[iii]
- Twenty-three other states allow schools to possess and administer naloxone.[143] As with tailored naloxone distribution programs, states can consider policy strategies that support administration of naloxone on school grounds without incurring civil or criminal liability.

i See, for example, **Colorado's Naloxone Bulk Purchase Fund**.
ii New Mexico House Bill 370 also mandates that all federally qualified opioid treatment programs provide overdose education, two doses of naloxone, and a prescription for naloxone to every patient and that all law enforcement officers in the state carry two doses of naloxone.
iii It should be noted that in many states, training in naloxone administration is not required, making for fewer restrictions on who may administer it.

Reduce cost

Many states have enacted laws that make it easier to prescribe and distribute naloxone. But naloxone's out-of-pocket costs remain a barrier, especially among uninsured patients.[144] The following strategies could help address cost issues:

- Federal or state legislation could consider means to incentivize health insurance providers to cover all formulations of naloxone or other FDA-approved overdose reversal medications, including OTC products.[145]
- States could consider ways to alleviate financial barriers through programs that help reduce copayments, provide free naloxone (including by mail) to individuals who are uninsured, and fund naloxone distribution programs — for example:
  - States can create copayment assistance programs to cover the out-of-pocket cost of naloxone. Pennsylvania and New York have implemented programs that cover copayments up to, respectively, $75 and $40, for individuals using their insurance to obtain naloxone.[146,147]
  - Some states, local jurisdictions, and community-based organizations partner to provide free naloxone by mail to people who are uninsured or face barriers to accessing in-person services. States can invest public funds to support or expand services like NEXT Distro, an online harm reduction platform that distributes naloxone by mail.[148,i]

What are the policy's benefits?

Naloxone distribution programs, particularly community-based programs that provide free naloxone to PWUD and others likely to witness an overdose, are supported by evidence that they effectively train bystanders on the use of naloxone, improve long-term knowledge regarding opioid overdose, and are associated with reduced opioid-related mortality.[149,150]

While there is relatively less research on tailored naloxone distribution in prisons, jails, and upon release from incarceration, several studies indicate that increasing access to naloxone during this period can prevent deaths. A study of Scotland's National Naloxone Programme, which provides brief training and standardized naloxone supply to individuals at risk of opioid overdose, found the policy's implementation was associated with a 36 percent reduction in opioid-related deaths in the first four weeks after release.[151] Many key informants highlighted the urgent need for greater naloxone access generally:

> *"I think our current policies [around greater naloxone access and distribution] have been positive, but we just need naloxone in more places."*

Stocking naloxone on school premises may provide needed access for youth, among whom overdoses are also on the rise. School access could reduce fatalities among students and remain available during the range of community activities that schools frequently host (e.g., sporting events, driver's education). While there is little research on the effectiveness of stocking naloxone in schools, the US National Association of School Nurses recommends naloxone be incorporated into school emergency preparedness and response plans.[152] Studies suggest that the practice is relatively inexpensive[153] and demonstrate that in schools where naloxone is available, school nurses and other personnel have used the

i **Analyses conducted by the Network for Public Health Law's Harm Reduction Legal Project** provide information on potential legal barriers to mailing naloxone. Please consult an attorney to determine the legality of mailing naloxone in your jurisdiction.

medication to reverse an opioid overdose.[154] Key informants also endorsed this approach, indicating that naloxone is an integral component of first aid and that schools can consider incorporating training on its use into health curricula:

> *"We need naloxone in first aid kits. In health class where you learn CPR, you should learn how to recognize the signs of an overdose."*

Reducing or eliminating the cost of naloxone for individuals is likely to increase access to the medication, particularly among people with low incomes and people who are uninsured. In 2018, the average out-of-pocket cost per naloxone prescription among insured people was $18 — and $250 for those who were uninsured.[155] Research finds that while naloxone distribution has increased significantly following the adoption of NALs, that distribution has been largely concentrated among people who are insured.[156] For some uninsured people, the price of OTC naloxone may put it out of their reach.[157] Policies that address price may help reduce this disparity.

How can the policy be designed to advance equity?

Policymakers can advance equitable access to naloxone by tailoring distribution strategies to reach BIPOC populations facing growing risk of overdose. This may be achieved by implementing distribution programs in settings where BIPOC individuals are disproportionately represented[158,159,160] and in BIPOC community spaces like cultural centers, neighborhood gathering spaces, businesses, churches and other religious institutions. It may also be achieved by ensuring that the entities responsible for distributing the medication are trusted community partners with whom PWUD feel safe to ask for support. Key informants suggested that PWUD who are BIPOC may be especially hesitant to engage with law enforcement or emergency medical services to access naloxone because of fears of criminal consequences, bias, or police violence:

> *"There are way too many communities in this country where calling 911 for a medical emergency is synonymous with calling the cops.... And oftentimes, law enforcement being the first responder — or the idea that if EMS isn't in the vicinity and a cop could show up before the ambulance comes — is enough of a deterrent that in the moment of an emergency, people will not call 911. And that often contributes to death."*

Because of such concerns, community-based harm reduction organizations may be better positioned to provide meaningful access, as long as they are equipped with an adequate, sustained, and free or reduced-cost supply of naloxone.

What does the policy look like in practice?

Installing naloxone vending machines in Los Angeles County jails

Research has found that the expansion of naloxone availability to incarcerated persons and carceral facility staff is an effective method to ensure timely naloxone administration and successful overdose reversal in prisons and jails.[161] Since 2019, the Los Angeles County Jail has operated free, self-serve vending machines that make naloxone available to every person who is released.[162] English and Spanish language video training on overdose response and prevention is located next to the vending machines. This strategy provides ultra-low-barrier access to the medication by eliminating the need for any personal interaction or for individuals to identify themselves as PWUD, which may deter them from requesting the medication.

During the first nine months of 2020, more than 20,000 doses of naloxone were distributed via vending machine.[163] In 2021, in response to rising overdose deaths *inside* county jails, Los Angeles County began a program to place naloxone inside the common areas of its jails as well.[164] The medication is attached to the walls of dormitories so that it is immediately accessible in the event of an overdose.[165]

Mandating naloxone access in Maryland public schools

In 2017, Maryland passed the Heroin and Opioid Education and Community Action Act, also known as the Start Talking Maryland Act, which requires all public schools to obtain and store naloxone or other opioid overdose reversal medication on their premises.[166] The state does not provide the naloxone; school districts must obtain the medication on their own by partnering with local health departments, participating in pharmaceutical company programs that offer naloxone to schools, or becoming authorized to provide overdose response training and dispense naloxone under the state's Overdose Response Program.[167] The law also requires that each county board establish a policy that authorizes school nurses, school health personnel, or other school staff to administer naloxone to anyone on school property believed to be experiencing an overdose. School nurses provide training to nonmedical school staff on how to administer the medication.[i]

Additional resources

Naloxone Access: Summary of State Laws (Legislative Analysis and Public Policy Association): This compendium compiles naloxone access laws, including information on who is legally permitted to distribute naloxone and who has immunity when dispensing or administering naloxone, in all states, territories, and the District of Columbia.

Fentanyl and Opioids: Preventing Overdoses and Related Emergencies at K-12 and Higher Education Campuses (Readiness and Emergency Management for Schools Technical Assistance Center): This fact sheet provides information on opioid overdoses in schools and guidance on developing and implementing a plan to address them.

Naloxone Education for School Nurses Toolkit (National Association of School Nurses): Created in collaboration with the National Institute on Drug Abuse and the National Institutes of Health, this toolkit offers resources to assist school nurses and other school leaders in evaluating and responding to drug overdose.

Corrections-Based Responses to the Opioid Epidemic (Vera Institute): This report details the efforts of New York State to implement an overdose education and naloxone distribution (OEND) program for people who have been recently released from incarceration in state prison, assesses the results of the program, and offers insights for other carceral systems seeking to implement OEND programs.

i For more information, see Maryland State Department of Education and Department of Health's **School Naloxone Administration Policy Development: Frequently Asked Questions**.

Strengthen overdose Good Samaritan laws

SECTORS: CRIMINAL LEGAL, COMMUNITY, SCHOOLS

Overdose Good Samaritan laws (GSLs) refer to legislation adopted at the state level that provides legal protection for individuals who seek emergency care (e.g., by calling 911) in the event of a drug overdose. These laws generally provide immunity from arrest, charge, and prosecution for certain controlled substance possession, paraphernalia possession, or other drug-related offenses for the person witnessing or experiencing an overdose.[168] Because emergency medical services are frequently accompanied by law enforcement officers, people witnessing an overdose are often afraid that they, the person experiencing the overdose, or others at the scene may face criminal penalties for drug-related crimes. Good Samaritan laws help address this barrier by allowing bystanders to summon the emergency medical care needed to reverse overdose without putting themselves at risk.[169]

The strength of overdose GSLs varies across states and, in many cases, the laws may be strengthened to provide more comprehensive protection to people likely to witness or experience an overdose.

What are the policy details?

Forty-eight states and the District of Columbia have enacted overdose Good Samaritan legislation as of May 2023.[170] Research and expert opinion suggest that GSLs may be strengthened by including additional protections for people witnessing or experiencing an overdose.[171] States can consider supporting policies such as the following:

- Include protection from arrest, not just charge or prosecution. Even in states with existing GSLs, police officers still routinely make arrests at drug overdose scenes.[172] Research suggests that GSLs that provide protection from arrest are more effective than those that provide protection from charge or prosecution alone.[173]
- Provide immunity from being considered in violation of parole, probation, pretrial conditions, or a restraining or protective order, as well as protection from arrest on outstanding minor warrants at a drug overdose scene.[174,175] Some states with more expansive laws provide immunity from other drug-related crimes (such as those related to substance use, sale, or distribution) or protection from civil forfeiture, or they provide that reporting an overdose can be a "mitigating factor" in the prosecution of crimes for which immunity is not available (which may lessen the severity of a sentence).[176,177]
- Ensure that GSLs are fully accessible to PWUD, their friends, family, and community members by considering the following provisions:[178,179,180,181]
  - No limit on the number of times immunity may be used
  - Immunity for people on probation or parole
  - Allowing callers to maintain privacy with regard to providing names and sharing information with law enforcement
  - Allowing optional rather than mandatory participation in drug treatment as a condition of immunity

  Ensuring access to GSL protections can help mitigate concerns among PWUD facing high risk of overdose, including individuals who have overdosed in the past or were recently incarcerated,[182,183,184] who may otherwise be deterred from seeking lifesaving assistance due to fear of criminal sanctions.

- Strengthen education and training, so that state and local law enforcement appropriately implement the law and community members understand its provisions. Research indicates that public awareness of GSLs may affect individuals' willingness to call 911 and that law enforcement officers' knowledge of the law may affect how the law is enforced.[185] Key informants described issues related to law enforcement wrongfully arresting people for possession of paraphernalia or confiscating naloxone, even when a jurisdiction's existing GSL should protect against such actions. One emphasized:

  "There could be much more, and much more effective, ongoing training, education, and accountability with law enforcement to respect Good Samaritan laws.... Having [passed a] Good Samaritan law doesn't do any good if people who use drugs don't feel like they can take advantage of it."

What are the policy's benefits?

A Government Accountability Office (GAO) review of 17 studies found a pattern of lower rates of opioid-related overdose deaths among states that have enacted overdose Good Samaritan laws.[186] The research indicates, however, that effects are not immediate; reductions in overdose mortality take time to appear following the adoption and implementation of these laws. There is also some evidence suggesting that GSLs increase calls to emergency medical services at the scene of an overdose.[187]

Other factors that may limit the effectiveness of Good Samaritan laws include lack of knowledge that GSLs exist (among both PWUD and law enforcement), mistrust of police, and persistent fear of criminal or civil consequences.[188] Studies note that even in jurisdictions where GSLs are in effect, many PWUD fear maltreatment by paramedics or police, are skeptical that police will follow the law, or don't believe that the law will protect them from being arrested or charged.[189,190,191] In addition to drug-related charges, PWUD also fear they could face other criminal or civil consequences if they call 911, such as loss of housing or custody of children.[192] At least one study suggests that GSLs that include protections from arrest (not just charge and prosecution) as well as the presence of a naloxone access law in the jurisdiction may make them more effective.[193] Key informants underscored this finding, describing that barriers to calling 911 persist even when a bystander cannot be charged:

"People who call 911 can't be charged. However, they still can be arrested, their information can still be taken, and that is a barrier to some people calling for help."

The research and key informants' comments suggest that GSLs may be more effective when they provide more expansive protections from criminal and civil consequences and when their implementation includes robust outreach and education to increase awareness of the law.

How can the policy be designed to advance equity?

BIPOC individuals may experience heightened barriers to calling 911 in the event of an overdose out of the well-grounded fear of a racially biased, potentially violent law enforcement response.[194,195,196] Good Samaritan laws may have the greatest potential to advance equity when BIPOC community members are meaningfully included in their implementation and when sustained efforts are made to increase awareness of the law and build trust among these communities. Robust education and training for law enforcement and accountability mechanisms for improper enforcement of laws provide opportunities to build trust. Some communities (e.g., in Vancouver, Canada) have implemented police nonattendance policies wherein police officers either do not attend or limit their presence when emergency medical services are called to respond to an overdose.[197] These efforts may reduce fear, address mistrust of law enforcement, and encourage bystanders to call for help.[198]

Overdose GSLs that contain exclusions or limits or do not extend immunity to charges related to the violation of parole or probation may pose heightened barriers to people — disproportionately Black and Latine — with prior or existing involvement in the criminal legal system.[199] Laws that provide expansive protections from a range of offenses, not just drug-related charges, may be best positioned to promote equity and reduce overdose.

What does the policy look like in practice?

Maine's Good Samaritan Law

Enacted in 2022, Maine's overdose Good Samaritan law makes immunity the default, not the exception. Under the Maine law, a protected person — someone "who in good faith calls for assistance for another person experiencing a suspected drug-related overdose, any person rendering aid at the location of the suspected drug-related overdose, and any person who is experiencing a suspected drug-related overdose"[200] — is immune from arrest and prosecution for all but certain enumerated crimes. Although the list of excluded crimes encompasses 21 separate statutes, in practice, few generally apply in the context of a call for help in the event of an overdose. None of the excluded crimes are crimes of poverty or other low-level crimes (e.g., trespassing, loitering, vagrancy, and public intoxication violations) that may be of concern to PWUD, especially those who are unhoused.[201] This comprehensive approach to immunity may help ensure that individuals know that the state views the provision of emergency care as more important than arresting and incarcerating someone who experiences an overdose and those who seek help on their behalf.

Additional resources

Legal Interventions to Reduce Overdose Mortality: Overdose Good Samaritan Laws (The Network for Public Health Law): This compendium describes GSLs in all states and the District of Columbia, including whether a jurisdiction has implemented a GSL and the type of protections it offers.

Equitable Enforcement to Achieve Health Equity (ChangeLab Solutions): This guide explores the equity implications of traditional public health enforcement tools and highlights strategies to avoid unintended negative consequences when addressing violations of the law. It discusses best practices that can be applied to the design of many policies, including overdose Good Samaritan laws, to help avoid inequitable impacts and promote community health.

POLICY PRACTICE TIP FOR COLLEGES AND UNIVERSITIES

While overdose Good Samaritan laws are typically adopted, implemented, and enforced at the state level, they can also be adopted at the institutional level. Some colleges and universities have implemented these policies to eliminate disciplinary consequences for students who seek help in the event of an overdose or other drug- or alcohol-related emergency.[i]

Authorize and expand access to syringe services

SECTORS: COMMUNITY, HEALTH CARE

Increasing access to sterile syringes can significantly reduce the health risks associated with injecting drugs. Syringe services programs (SSPs) are a proven strategy for increasing access to sterile syringes, other equipment for safer drug use (including sterile smoking equipment, drug-checking equipment like fentanyl test strips, naloxone, and basic first aid supplies), and overdose prevention education.[202] SSPs are generally operated by community-based harm reduction organizations, local health departments, or medical clinics. Although increased access to safer supplies is the primary goal, SSPs also represent a critical opportunity to provide a broader array of health services and supports. SSPs can connect PWUD with other health services, such as MOUD for people seeking treatment, testing for HIV and hepatitis C, vaccination, and mental health services. They also regularly offer referrals to other resources to help meet basic needs, such as housing, food assistance, and income support. In some cases, SSPs are co-located with treatment and other supportive services, facilitating low-barrier referrals and ease of access. Among other potential models for increasing access to sterile syringes are peer-delivered syringe services that tap into social networks to reach people who may not be able to access traditional SSPs.[203]

State and local laws, including drug paraphernalia laws, play a central role in the diffusion of syringe services.[204] Drug paraphernalia laws — largely modeled and adopted after a DEA model paraphernalia law created in 1979 — typically prohibit the possession or distribution of certain objects for use in the preparation, packaging, or consumption of illicit drugs, including syringes.[205] While these laws do not explicitly prohibit SSPs and were not enacted with the intent of regulating legitimate health services, they can jeopardize the legality of SSPs and other sources of syringe access such as pharmacies by making employees, volunteers, and participants susceptible to arrest and prosecution.[206] Some states have supported syringe services by enacting laws to explicitly authorize SSP operations, while others have passed policies that condition SSPs on local approval or require SSPs to

i See, for example, the University of Buffalo's Good Samaritan policy: **www.buffalo.edu/studentlife/life-on-campus/community/safety/good-samaritan-policy.html**.

meet certain requirements (e.g., they must use a one-for-one exchange model, wherein participants may receive one syringe for each used syringe they turn in).[207] Some local governments have passed policies to prohibit SSPs entirely.[208]

Despite SSPs' proven effectiveness at preventing overdose, reducing the spread of infectious disease, and improving other health outcomes,[209,210] only a minority of US counties have an SSP.[211] State and local decision makers can consider policies to support SSP operation and allocate funding to increase the reach of these critical programs.

What are the policy details?

Jurisdictions interested in authorizing and/or expanding access to syringe services can consider the following policy strategies:

- States can consider repealing or amending drug paraphernalia laws that create penalties for paraphernalia-related offenses, including possession of syringes. This could increase access to vital harm reduction supplies and reduce PWUD's involvement in the criminal legal system. (For more on drug paraphernalia laws, see the **Remove policy barriers to fentanyl test strips (FTS) and other drug-checking equipment** section.)
- Without decriminalizing drug paraphernalia or repealing drug paraphernalia laws altogether, some states have facilitated access to syringe services by enacting laws to: (1) explicitly authorize SSP operation, (2) strike the word "syringe" and references to injecting from state drug paraphernalia laws, or (3) make an exemption in the law for people who participate in SSPs or for syringes obtained at approved SSPs.[212,213,214] Some states have also enacted laws exempting drug residue on returned syringes from drug possession laws, creating more protection for participants. As of April 2022, the use and possession of needles and syringes was legal for at least some individuals (e.g., harm reduction service providers) in at least 39 states and the District of Columbia.[215]
- SSPs face significant financial challenges in providing services and supplies.[216] While federal funds can be used to support SSP operations if certain requirements are met, federal dollars cannot be used to purchase syringes.[217] Many states also prohibit taxpayer funds from being used for that purpose. States can review existing policies and funding streams to determine what means are available to support SSPs services and increase access to supplies.

What are the policy's benefits?

SSPs are a proven and effective overdose prevention strategy that can provide a range of benefits, including access to and disposal of sterile syringes and injection equipment, vaccination, testing, and linkages to infectious disease care and SUD treatment. A robust and longstanding evidence base demonstrates the ability of SSPs to reduce drug-related harm and positively influence a range of related health outcomes, including these:[218,219,220,221,222,223]

- Decreased HIV, hepatitis C, and other blood-borne infections
- Increased linkage to and engagement with SUD treatment
- Decreased needle stick injuries and improper syringe disposal
- Increased cost savings associated with HIV treatment

SSPs that provide naloxone also reduce overdose mortality.[224] The evidence also shows that authorizing SSPs does not increase illegal drug use or crime.[225,226,227] Laws that authorize SSPs may also improve health by reducing arrest and incarceration related to syringe possession, potentially diverting PWUD away from the criminal legal system.[228]

Key informants underscored the importance of increasing syringe access and specifically addressing laws that criminalize the possession of syringes to advance equity — for example:

> *"In Vermont, New York, and Rhode Island, syringes are nothing; they're not a crime. You can carry them. You can have 50 in your pocket.... But in another setting, possessing the exact same things is a felony. So, here's what I'm getting at: Injection is more of a route of administration in Black communities,... so reform surrounding syringe possession and bolstering SSPs is important, I believe, for equity."*

How can the policy be designed to advance equity?

Rather than eliminating criminal penalties for possession and distribution of syringes, many states provide limited carve-outs to exempt SSP operators and/or participants.[229] One study suggests that this halfway approach can potentially make PWUD who access SSPs more visible to police and thus more subject to arrest for paraphernalia.[230] Instead, broadly removing prohibitions on personal possession of drug paraphernalia has the potential to remove many obstacles to harm reduction resources and reduce arrest, incarceration, or other involvement with the criminal legal system.[231]

Policies that support SSPs and related harm reduction strategies may increase access to critically needed prevention and treatment services among populations that may otherwise be less likely to seek regular medical care.[232] SSP services can be tailored to account for the unique challenges of BIPOC and other communities most affected by health inequities related to injection drug use by leveraging design strategies that increase access (such as location, hours of operation, and protecting confidentiality), minimize stigma, and ensure that policies and programs are designed to eliminate or reduce the exposure of PWUD to the criminal legal system.

Other best practices for advancing health equity include removing limits on the number of supplies an SSP can distribute (e.g., one-for-one needle exchange, which has been implicated in HIV outbreaks), ensuring that the supplies SSPs distribute are inclusive of the full range of substances that PWUD use (e.g., offering safer-smoking supplies in addition to sterile syringes), and offering nonjudgmental, culturally congruent, trauma-informed, and fully voluntary services.[233,234,235]

What does the policy look like in practice?

North Carolina Harm Reduction Coalition

The North Carolina Harm Reduction Coalition (NCHRC) is a peer-led, nonprofit organization that operates SSPs and related services in many counties across the state.[236] It offers syringe services at fixed sites and by mobile delivery to increase access for community members who have limited transportation or may be uncomfortable visiting an office to request support.[237] The organization provides sterile syringes and other injection equipment, naloxone, and other first aid supplies; HIV and hepatitis C testing; and overdose prevention education. The organization also provides referrals to SUD treatment if desired and other supportive services for clients who express interest and need.

NCHRC's SSPs are supported by a state law enacted in 2016.[238] According to the law, no employee, volunteer, or participant in a syringe services program can be charged with possession of syringes or other injection equipment, including those with residual amounts of illicit drugs in them, obtained from or returned to a SSP.[239] This law limits this protection to those who obtain paraphernalia from SSPs.[240]

Additional resources

Guide to Developing and Managing Syringe Access Programs (National Harm Reduction Coalition): This guide outlines the process for developing and starting a syringe access program or SSP.

Federal Restrictions on Funding for Syringe Services Programs (Network for Public Health Law): This resource presents information about federal funding restrictions related to syringe purchase and other SSP operations.

Syringe Services Programs Strategy Brief (National Association of Counties): This brief outlines background information and provides a summary of laws and policies that present barriers to SSP services.

Syringe Services Programs: Summary of State Laws (Legislative Analysis and Public Policy Association): This includes information on state drug paraphernalia laws and other laws related to SSPs across all states and the District of Columbia.

Examine policies related to Medicaid and enrollment assistance

SECTORS: HEALTH CARE, CRIMINAL LEGAL, COMMUNITY

Under a provision of the Affordable Care Act (ACA), 40 states and the District of Columbia adopted Medicaid Expansion as of May 2023,[241] extending health insurance coverage to adults under age 65 with incomes up to 138 percent of the federal poverty level.[242] The federal government covered the full cost of expansion from 2014 to 2016 and has phased down gradually since then, now paying 90 percent of the cost for the expansion population and leaving states to cover the remainder.[243]

States that have expanded Medicaid have reduced the uninsured rate, increased access to care, and improved health outcomes for people living on low incomes.[244,245] Research suggests that PWUD are disproportionately uninsured, with approximately 26 percent of people with SUDs uninsured compared to 20 percent of the general population.[246] States that have expanded Medicaid may be able to better connect PWUD with vital health services, including MOUD treatment and care for other drug-related harms like HIV, hepatitis C, and other blood-borne infections. Access to health insurance, a key social determinant of health,[247] may also help mitigate the underlying conditions that can contribute to the onset of SUDs and increase overdose risk.

Policymakers can also consider other strategies to improve access to health coverage and continuity of care, including conducting outreach and enrollment assistance for people at risk of overdose; reducing barriers to MOUD and covering all evidence-based SUD care; and extending postpartum coverage beyond 60 days.

MITIGATING COVERAGE LOSSES DURING THE UNWINDING OF THE MEDICAID CONTINUOUS ENROLLMENT PROVISION

Medicaid enrollment increased during the pandemic, primarily due to the Medicaid continuous coverage requirement established as part of the federal government's response to COVID-19, which required states to maintain coverage for most enrollees.[248,249] That requirement ended on March 31, 2023.[250] Since states have resumed Medicaid eligibility reviews, enrollees who no longer qualify or who are unable to complete the renewal process are having their coverage terminated. The result is that millions of people, especially children and people of color, may lose health coverage.[251] This loss of coverage may increase overdose risk among PWUD by, for example, disrupting access to MOUD or other SUD-related care. States that expand Medicaid may have an easier time maintaining health coverage during the unwinding period and can consider other strategies to mitigate widespread losses of coverage.[252] For more information on the steps that states can take to preserve coverage, see the Center on Budget and Policy Priorities resources on the **End of Pandemic-Era Medicaid Continuous Coverage Requirement**.

What are the policy details?

Provide Medicaid outreach and enrollment assistance to those at risk of overdose, especially people preparing to exit prisons and jails

- Medicaid enrollment assistance is individualized support to help people understand Medicaid benefits, verify their eligibility, and navigate the application and enrollment processes.[253] States already partner with community-based organizations and employ state Medicaid agency staff to provide enrollment assistance, so they can leverage their existing networks to increase support for people at risk of overdose, including those who have recently exited incarceration.[254]
- States and localities can implement or expand tailored outreach and enrollment efforts in carceral facilities by establishing enrollment as part of the discharge process. In jurisdictions that have implemented this approach, corrections or Medicaid agency staff provide application support as part of routine reentry planning before an individual is released from custody.[255]
- States can also establish automated electronic processes to facilitate enrollment and release coordination and may seek federal approval and funding through Medicaid Section 1115 demonstration waivers to support the data and technology investments needed for such processes.[256]

Reduce barriers to MOUD and cover the continuum of evidence-based SUD services

- All Medicaid programs are required to cover medication-assisted treatment (MAT), including all MOUD drugs approved by the FDA; however, several barriers remain in place in many states.[257] State Medicaid programs can reduce barriers to MOUD by eliminating: (1) the prior authorization requirement that necessitates advance approval of a prescription by the patient's health plan or insurer; (2) step therapy requirements stipulating that patients must first try a more cost-effective medication before they can receive a more expensive alternative; and (3) quantity limits, which establish a maximum quantity of medication covered for one prescription or copayment.[258]

- States can also seek Medicaid Section 1115 demonstration waivers to expand their Medicaid programs' coverage of services that support treatment and recovery and address health-related social needs. Examples of such services include supportive housing, supported employment, and peer recovery coaching and support.[259,260,261] Arkansas, for example, has obtained a Section 1115 waiver that makes housing assistance, nutrition support, and case management available to certain Medicaid enrollees with a SUD diagnosis.[262,263]
- States can also seek waivers to extend Medicaid coverage to residential behavioral health treatment so that Medicaid funds can be used to reimburse for residential care for SUDs or other mental health conditions.[264] As of September 2023, 35 states have obtained a waiver to cover residential SUD treatment in their Medicaid programs.[265]

Extend postpartum coverage beyond 60 days

- States can work to reduce overdose risk for pregnant and postpartum people by ensuring that individuals do not lose access to Medicaid in the year following delivery, when risk of drug-related death is elevated[266] and new parents are still recovering from delivery and navigating a major transition in their family life.[267]
- Federal law currently requires states to provide Medicaid coverage from pregnancy through 60 days postpartum for people with incomes below 138 percent of the federal poverty level, and states have the option to extend that coverage to 12 months by submitting a plan amendment (as provided by the American Rescue Plan Act) or a Medicaid Section 1115 demonstration waiver.[268] As of September 2023, 38 states had implemented a 12-month extension of Medicaid coverage for postpartum patients.[269]

What are the policy's benefits?

Robust evidence links Medicaid expansion with increased health insurance coverage, service use, quality of care, and improved health outcomes.[270,271,272] A systematic review of peer-reviewed studies found that ACA-related Medicaid expansion was associated with increases in the use of primary care, preventive care, and mental health visits, as well as decreased hospital lengths of stay among enrollees.[273] Studies included in the review also found that expansion was associated with improvements in care, including better rates of cancer screenings and glucose monitoring and improvements in enrollees' self-reported mental and overall health.[274] At least one study suggests that Medicaid expansion can reduce premature death, finding that expansion saved the lives of at least 19,200 adults aged 55 to 64 between 2014 and 2017.[275] The evidence related to Medicaid expansion's impact on overdose and other drug-related harms is more mixed, with one study indicating that the increase in opioid overdose deaths during the first year of the COVID-19 pandemic was similar in states with and without Medicaid expansion.[276] Several other studies suggest that expansion is associated with increased insurance coverage among low-income adults with SUDs, increased access to MOUD, increased rates of naloxone dispensing, and decreased overdose mortality.[277,278,279]

Research also indicates that expanding Medicaid coverage for 12 months postpartum is associated with increased insurance coverage and improved continuity of coverage for new parents with low income.[280] Similarly, states that have implemented prerelease Medicaid enrollment services have seen evidence that such services are associated with increased Medicaid enrollment and increased use of health care services among people recently released from incarceration.[281,282] Key informants noted the importance of Medicaid expansion to ensure continuity of SUD treatment services. They explained that eliminating the gap in care that previously occurred in the period following release is critical to supporting recovery and preventing overdose:

> *"I think that the most fundamental policy shift that I've witnessed having the biggest impact is the expansion of Medicaid services to our criminal justice populations, specifically at the time of release.... When Medicaid expansion [was implemented], it opened up a level of access to [SUD treatment] services in the community, and at the same time, it allowed us as a Department of Corrections to align our processes so that the day an individual walked out of our facilities, they had those services in place.... [Now,] we [can] schedule them an appointment the same day or... within 72 hours."*

How can the policy be designed to advance equity?

Medicaid expansion can address underlying health equity issues. Adults with incomes too low to qualify for subsidies in the ACA marketplace but too high to meet Medicaid financial eligibility thresholds in states that have not adopted expansion are caught in a so-called coverage gap.[283] Medicaid expansion can reduce racial inequities in health insurance by providing needed coverage to those caught in this gap, who are disproportionately BIPOC.[284,285]

What does the policy look like in practice?

Washington Apple Health for justice-involved populations

Federal rules prohibit Medicaid from paying for medical services and prescriptions for people who are incarcerated, except when inpatient or other institutional services are provided in a community-based setting.[286] Given this prohibition, some state Medicaid programs terminate coverage when an individual is incarcerated.[287] Washington State adopted legislation in 2017 that directs the state Health Care Authority to suspend, rather than terminate, Apple Health (state Medicaid) coverage for individuals in correctional facilities.[288] Under the statute, people who are incarcerated can maintain their Apple Health eligibility, but the scope of their coverage is limited to inpatient hospitalization only. Full coverage is automatically restored when they are released.[289,290]

The state's Department of Corrections and some local jails provide enrollment assistance for individuals who did not have Apple Health coverage prior to incarceration, support made possible by a memorandum of understanding between the state Medicaid agency and the corrections facility. The state has also enacted a statute requiring the agency to expedite Apple Health eligibility determination and provide timely access to medical assistance for individuals with certain mental health challenges who are being released from confinement, including prison, jail, and psychiatric hospitals.[291] Together, these policies support increased access to health coverage during the reentry period.

It should also be noted that California has received a Section 1115 waiver that, for the first time, partially waives the federal rules that prohibit Medicaid from paying for medical services for people who are incarcerated. The US Department of Health and Human Services **has released guidance encouraging other states to apply for waivers** that similarly support access to health care for people in the reentry period. (For more on California's Reentry Demonstration Initiative, see the Kaiser Family Foundation's **Section 1115 Waiver Watch**.)

Additional resources

Connecting Recently Released Prisoners to Health Care — How to Leverage Medicaid (National Council of State Legislatures): This report details a variety of Medicaid policy levers and **financing strategies** to connect people recently released from incarceration to Medicaid benefits and leverage federal matching funds.

Eliminating Barriers to Medication-Assisted Treatment in Medicaid (National Health Law Program): This brief provides an overview of the federal requirements for state Medicaid programs to cover MOUD, identifies persistent barriers to treatment, and offers recommendations to improve access to MOUD for beneficiaries.

The Kaiser Family Foundation maintains a variety of resources tracking state Medicaid policy, including **Section 1115 demonstration waivers**, **postpartum coverage extension**, and information related to the opportunities states have to use Medicaid to **address health-related social needs** (e.g., housing instability, homelessness, food insecurity).

Strengthen behavioral health supports for youth

SECTORS: SCHOOLS, HEALTH CARE

Across the United States, children and adolescents are experiencing a growing mental health crisis characterized by widespread symptoms of anxiety and depression, rising deaths by suicide, and a twofold increase in fatal drug overdoses among 12–17 year olds in recent years.[292] While youth behavioral health challenges — including overdose — pre-date COVID-19, the pandemic and other factors like the increase in gun violence are linked with worsening outcomes for many young people.[293] In early 2023, recognizing the mental health crisis among youth, the US Department of Education announced $188 million from bipartisan federal legislation[294] to support school-based mental health services.[295] In addition to producing positive social, emotional, and academic outcomes and improving access to care for students overall,[296,297] investments in school behavioral health infrastructure can provide tailored support for those at risk of developing SUDs or experiencing overdose.[298] Given the impact of childhood environments on drug-related harms later in life, early interventions that expand access to care and improve school connectedness may also protect against the onset of risky substance use in the first place.[299,300]

Many schools, however, lack the staffing and infrastructure to provide needed behavioral health care to students. For example, although the American School Counselor Association recommends a 250-to-1 ratio of students to school counselors, the national average was 385-to-1 for the 2022–2023 school year.[301] Just eight percent of school districts met the National Association of School Psychologists' recommended 500-to-1 ratio of students to school psychologists.[302] Only a third of schools provide outreach services, including evidence-based universal behavioral health screenings (like Screening, Brief Intervention, and Referral to Treatment [SBIRT]) that can identify students with the greatest needs.[303]

States, localities, school districts, and individual schools can consider implementing policy or prioritizing funding to strengthen school-based behavioral health services and establish universal screenings to support students experiencing heightened risk of overdose.

What are the policy details?

Expand school-based mental and behavioral health services

- Schools are an ideal environment in which to provide mental health services given the amount of time that young people spend at school and the school environment's impact on social development.[304] School-based mental health services include "any program, intervention, or strategy applied in a school setting that was specifically designed to influence students' emotional, behavioral, and/or social functioning."[305] The format or delivery of these services may vary widely.[306] These services may mitigate barriers to health care access, such as provider shortages and lack of insurance.[307]
- Having adequate funding and other resources may be an important factor in successful implementation of school-based mental health services.[308,309] States, localities, and school districts can consider ways to increase investment to ensure that all schools are adequately staffed with counselors, psychologists, and social workers. Such personnel are equipped to respond to students at risk of overdose and help connect them with treatment, harm reduction, and other supportive services.

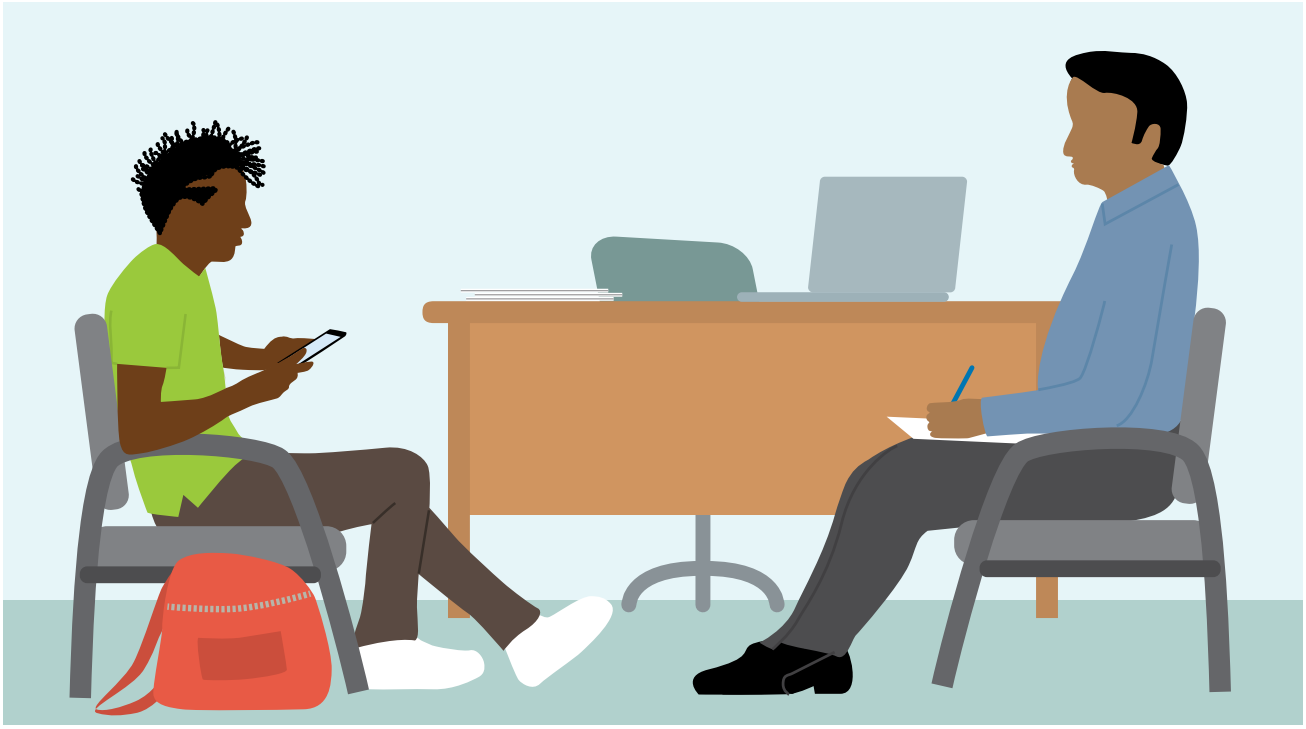
Implement Screening, Brief Intervention, and Referral to Treatment (SBIRT)

- Designed to identify and address emerging or ongoing substance use and prevent the onset of addiction or other consequences, SBIRT involves the use of a validated instrument to screen for substance use that exceeds recommended guidelines, brief intervention to provide education and increase an individual's motivation toward behavioral change, and referral to treatment, harm reduction services, and other appropriate behavioral health care for those who need more intensive support. SBIRT can be implemented across a variety of settings but has been most commonly adopted in medical settings and school-based health centers.[310,311]
- State and local governments can consider policies to require schools to implement SBIRT or other evidence-based universal screening and allocate funding to train school staff to conduct screenings. School districts and individual schools can also design initiatives and consider prioritizing funding to implement SBIRT within their institutions to help identify and support students experiencing elevated risk of drug-related harms.

What are the policy's benefits?

Evidence demonstrates that school-based behavioral health services may improve a range of student social, emotional, behavioral, and academic outcomes and decrease mental health problems.[312,313] Research indicates that school-based universal interventions improve students' attitudes about themselves, others, and school; increase prosocial behavior; and reduce conduct and internalizing problems.[314] Studies also find that school-based mental health services reduce barriers (like transportation and parent work schedules) and increase access to care.[315]

While studies on the specific impact of these services on student substance use, SUDs, and overdose are more limited, available research is promising. Studies suggest that schools may be an ideal environment for screening, intervention, and treatment of SUDs, especially



because school-based screening and treatment may be positioned to support youth who do not view substance use as a problem and may be unlikely to seek treatment in a clinic setting.[316] School-based mental health services can also promote ongoing connectedness with the school community, which may be protective against substance use.[317] Data from the 2021 Youth Risk Behavior Survey indicate that students who report feeling connected to others at school had lower prevalence of risk behaviors, including decreased prescription opioid misuse.[318]

A study examining risk of non-medical prescription opioid use among Canadian high school students with mental health impairment found that risk was lower among students from schools with greater school-based mental health services.[319] Other research suggests that an absence of services is associated with increased risk of students with disabilities engaging in health risk behaviors, such as substance use, self-harm, and delinquency.[320]

Some studies also find that SBIRT implemented in medical settings is associated with meaningful reductions in alcohol and drug use.[321,322] While there is less research on the effectiveness of school-based SBIRT specifically, existing evidence suggests that its implementation is associated with reduced substance use among students who receive brief intervention.[323]

SBIRT is also supported by experts in the field. One key informant shared,

> *"I'm a big fan of SBIRT because it's probably among the most cost-effective and feasible things you can do. It's been implemented in the adult population really successfully — for example, in emergency room settings — studied, and found to be highly effective. I would love for SBIRT to be funded in such a way that we could do it meaningfully for our seniors before they leave us.*
>
> *"In order to do that, you need to have enough supports in place, because you're going to have a lot more students screening in, but I also feel like we fail our students who drop out, our students who don't go to college, and even our students who do go to college. We know that during freshman year of college, drug overdose rates and suicide rates are very, very high right now. Something is not happening for young adults in America."*

How can the policy be designed to advance equity?

Investments in behavioral health can advance equity by prioritizing any expansion of services in schools with the greatest populations of young people most affected by overdose and drug-related harms, such as BIPOC students.[324] Schools can also work to implement culturally and linguistically responsive behavioral health care, offering support that affirms and responds to students' diverse racial, ethnic, and cultural backgrounds to mitigate disparities in access to quality care among BIPOC youth.[325] School-based behavioral health interventions can also advance equity for LGBTQ+ students (who experience disproportionate behavioral health challenges and frequently lack safety in school environments) by fostering an institutional culture that affirms LGBTQ+ identities through staff training, inclusive curricula, and policies that explicitly provide protections based on sexuality and gender identity.[326]

Experts also identified how, in designing policies, school decision makers can consult with students about the specific services that are needed:

> *"Schools can have a huge role, right? They can decide not to let the cops in. They can decide to hire social workers. They can decide to have more afterschool programs.… They can also decide what they want in their first aid kit. Naloxone is not a psychoactive substance. You can put it in your first aid kit, you know. They can decide what they want health teachers to cover in the class.…*
>
> *"Because very few programs actually use any sort of evidence-based manualized system…a lot of teachers have a lot of autonomy over what they cover in the classroom. I think that those kinds of things can be incorporated, and I think student government can be encouraged to be part of these conversations…as well as youth groups, and asking, 'What it is that you think you need?'"*

Decision makers can also underscore that mental health providers are needed and best positioned to address students' growing behavioral health needs. Schools can use their discretion to ensure that behavioral health screening policies do not increase harmful interaction with law enforcement or result in increased exclusionary disciplinary actions, but rather increase access to treatment and supportive services for students struggling with substance use.

What does the policy look like in practice?

SBIRT in Massachusetts schools

Massachusetts passed a law in 2016 requiring schools to administer a verbal substance use screening tool.[327] To aid schools in meeting this requirement, the Massachusetts Department of Public Health trains school staff in SBIRT.[328] The screening tool promotes behavior change through empathic interviews and guided discussions.[329] It is also primed to target students who are most at risk due to personal substance use or environmental factors, such as family members with SUDs.[330]

During the 2017–2018 school year, the vast majority (87 percent) of screenings were administered by school nurses and counselors, and some were administered by social workers and psychologists. Some potential limitations of this screening model are that students may opt out of the screenings, may not disclose substance use, or may refuse treatment even if they receive a referral. Overall, 1.3 percent of students screened were referred for further assessment or counseling, with the majority of referrals being referred to in-school counseling.[331]

Additional resources

Preventing and Reducing Youth and Young Adult Substance Misuse: Schools, Students, Families (US Department of Education): This web page lists resources for schools, students, and families about how to create supportive school environments to prevent and reduce youth and young adult substance misuse.

School and Campus Health Resources (SAMHSA): This web page connects to Substance Abuse and Mental Health Services Administration's School and Campus Health Program, which supports school-based efforts to promote mental health and prevent substance use.

POLICY PRACTICE TIP: SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT) IN HEALTH CARE SETTINGS

While this guide has focused on SBIRT as a school-based strategy to increase support for youth experiencing increased risk of overdose, it can also be implemented across a range of health care settings serving people of all ages.[332] Primary care settings, federally qualified health centers, and hospital emergency rooms, among other settings, can all implement SBIRT as part of patient care. Health care institutions implementing SBIRT use a range of clinicians and clinic staff to conduct the screening, provide intervention and referrals for patients experiencing risk of overdose, and prevent harm. States, tribal governments, territories, and health care systems have obtained federal funding through SAMHSA to implement SBIRT in primary care and community health settings.[333]

New and emerging policies to prevent overdose deaths

Policies considered new and emerging have shown significant promise in preventing and reducing overdose deaths and other drug-related harms, but evidence is still emerging.[334,335] Experts in the field strongly endorsed the policies that follow for their potential to advance equity and their alignment with the needs and experiences of PWUD, their friends and families, and the community-based organizations that serve them. Some of the policies included in this section have not been widely implemented in the United States and/or are still early in their implementation, and thus there is limited research on their effectiveness. In some cases, strategies may be supported by more robust scientific literature based on their longstanding implementation in other countries. We include findings from such literature where relevant.

New and emerging policies may require significant changes to existing legal frameworks to successfully implement at the state and local levels and may face stigma-related challenges to political feasibility. Still, they are worthy of serious consideration by decision makers; given the growing overdose crisis, innovative policy strategies and transformative changes are likely necessary to save lives.

Remove policy barriers to fentanyl test strips (FTS) and other drug-checking equipment

SECTOR: CRIMINAL LEGAL

Drug-checking equipment such as fentanyl test strips (FTS) can help prevent drug overdose by detecting the presence of fentanyl and fentanyl analogs in cocaine, methamphetamine, heroin, and many other drugs, in most of the forms they come in (including pills, powders, or injectables).[336] Beyond FTS, other drug-checking methods include xylazine test strips, which detect the presence of xylazine (a nonopioid tranquilizer not approved for human use) that has been involved in an increasing number of overdose deaths.[337] Both types of testing strips are disposable, single use, and can be used by PWUD anywhere they are consuming drugs.[338] They are also relatively inexpensive, and federal guidance permits the use of HHS dollars to purchase FTS. Other methods of drug checking (like the use of

infrared spectrometry) can check substances for a broad range of adulterants and must be performed on-site at facilities like SSPs or overdose prevention centers with technicians who are trained to analyze the results.[339]

As mentioned in the section titled **Authorize and expand access to syringe services**, possessing or distributing certain items deemed "drug paraphernalia" is illegal in almost all states.[340] Drug paraphernalia laws commonly impose criminal penalties on the possession of all manner of objects used to ingest or distribute illegal drugs, including equipment like FTS that is used to test the purity or potency of illicit drugs.[341] This can restrict effective harm reduction strategies for preventing overdose.[342]

Jurisdictions can consider supporting access to FTS and other drug-checking equipment by removing penalties from the personal possession, use, and distribution of FTS; xylazine test strips; and all other drug-checking technologies considered drug paraphernalia.

What are the policy details?

Although there is a federal drug paraphernalia law, it is rarely used and explicitly exempts individuals authorized by local, state, or federal law to possess or distribute paraphernalia.[343] States and localities, therefore, have considerable flexibility to enact policies that reduce criminal penalties related to FTS and other drug-checking equipment. Specifically:

- The broadest approach to removing policy barriers to FTS and other drug-checking equipment includes repealing drug paraphernalia laws or otherwise eliminating penalties for all items considered paraphernalia in statute. (This would not only remove legal barriers to possessing and distributing drug-checking equipment, but also mitigate legal barriers to other harm reduction approaches, including SSPs.) At least 11 states do not prohibit the possession or use of *any* type of drug paraphernalia, and Alaska does not have a drug paraphernalia law.[344,345] States could also consider changes to their drug paraphernalia laws that apply retroactively, including processes to invalidate or expunge arrests or convictions that occurred under the previous law.[346]
- States may consider removing certain items from the statutory definition of "drug paraphernalia," including FTS, xylazine test strips, and other drug-checking equipment as well as other harm reduction supplies (like syringes). As of August 2023, it is legal to possess all drug-checking equipment in 26 states and the District of Columbia.[347] In 14 other states, it is legal to possess fentanyl test strips, but other drug-checking equipment likely remains criminalized.[348]
- States that decriminalize drug-checking equipment can also expand access by purchasing FTS or facilitating distribution to people at risk of overdose. Some states (e.g., New York, Wisconsin, and Maryland) purchase FTS and distribute them to entities that work with PWUD (e.g., health clinics, health departments, and community-based harm reduction organizations) or directly to individuals who request them via the mail.[349,350,351] These states often leverage existing channels for naloxone distribution to distribute FTS as well.

What are the policy's benefits?

An emerging body of research examining the efficacy of FTS suggests that their usage is associated with behavioral changes that promote safer drug use and increased feelings of safety among PWUD.[352] In one US study, respondents who used FTS and received a positive result (indicating that their drugs contained fentanyl) reported that they had modified their drug use based on that result, including by engaging in harm reduction practices like using a smaller dose, having naloxone nearby, or performing a tester shot (i.e., using a small amount of a drug to test the strength of the supply).[353] Other research (also conducted in the United States) has also shown that receiving a positive FTS result is associated with adopting overdose risk reduction behaviors.[354,355] One study of a fentanyl drug-checking program at a Canadian overdose prevention center found that a positive test result was associated with intended dose reduction, which was in turn associated with lower odds of overdose.[356]

There is less research on xylazine test strips, but existing studies suggest that the strips are effective at detecting the presence of xylazine in real-world drug residue samples with a concentration ≥2.5 μg/m[357] and that their performance is acceptable for drug-checking purposes.[358] Other studies indicate that PWUD in the United States express need for and interest in using xylazine test strips.[359,360]

Experts in the field widely cited drug paraphernalia laws as a barrier to overdose prevention, highlighting their capacity to harm public health by encouraging PWUD to engage in risky behaviors such as needle sharing, prevent an understanding of the contents and relative dangers of the drugs they use, and pose obstacles to the formation of harm reduction infrastructure. Said one key informant:

> *"As a surgeon, I've treated a lot of complications from drug prohibition. For example, because of prohibition and drug paraphernalia laws, people use contaminated needles, and they get soft tissue infections which I have to treat…problems that arise from the use of drugs that are obtained on the black market.…Or I have people who happen to have a substance use disorder but come in with something like appendicitis or another surgical problem."*

Imposing criminal penalties on the possession of FTS and other drug-checking equipment or including them in the definition of illegal drug paraphernalia can lead to PWUD being less likely to use these tools or be aware that they exist.[361] Decriminalizing drug paraphernalia may also reduce harmful contact with the criminal legal system by eliminating one possible cause for questioning or arrest by police.

How can the policy be designed to advance equity?

Policies that eliminate criminal penalties for drug-checking equipment can help redress past harm and prevent future harm by including a process for expunging convictions for offenses that are now legal or decriminalized. Such processes may help ensure that BIPOC individuals who are disproportionately punished for drug-related offenses do not face lasting barriers to housing, employment, and other resources based on a criminal record. States can look to examples from laws legalizing cannabis, many of which provide expungement pathways.[362] If a wholesale approach to drug paraphernalia decriminalization is not feasible, the state may consider consulting with PWUD, harm reduction service providers, and public defenders to identify specific paraphernalia items to prioritize for decriminalization.

What does the policy look like in practice?

Decriminalizing drug-checking equipment in Pennsylvania

In 2023, Pennsylvania implemented Act 111 to decriminalize drug-testing products, including fentanyl test strips. The law removes FTS and other drug-checking technologies from the definition of drug paraphernalia in the state's Controlled Substance, Drug, Device and Cosmetic Act.[363] Under the new law, people in Pennsylvania who buy or carry drug-checking equipment, like FTS and xylazine test strips, no longer face criminal charges for possession of drug paraphernalia. This change increases legal access to drug-checking equipment for PWUD and also empowers community-based organizations, local health departments, and other entities to strengthen existing harm reduction services through the broad distribution of drug-checking equipment to anyone at risk of overdose.

Additional resources

Drug Paraphernalia: Summary of State Laws (Legislative Analysis and Public Policy Association): This report summarizes drug paraphernalia laws in every state and the District of Columbia.

Enhancing Harm Reduction Services in Health Departments: Fentanyl Test Strips and Other Drug-Checking Equipment (National Council for Mental Wellbeing): This brief summarizes the findings from a literature review and key informant interviews that identify commonly used drug-checking equipment and strategies to expand access to FTS and drug-checking services.

Examine the impact of overdose prevention centers (OPCs)

SECTORS: HEALTH CARE, COMMUNITY, CRIMINAL LEGAL

Overdose prevention centers (OPCs) are health care or community-based facilities in which people can consume drugs that they have obtained elsewhere in a monitored setting, where trained staff can intervene immediately in the event of an overdose. Like SSPs, OPCs typically offer additional services, including sterile equipment, overdose prevention education, naloxone distribution and training, FTS or on-site drug checking to test substances for the presence of dangerous adulterants, and referrals to MOUD treatment and other supportive services to help PWUD meet basic needs. More than 100 OPCs now operate in at least 10 countries worldwide.[364]

While OPCs were identified as a promising policy option by the experts interviewed for this guide and are supported by evidence of effectiveness at reducing overdose and other drug-related harms, they are not *federally* allowable due to the legal barriers described below. Still, many state and local jurisdictions are considering pathways to establish this novel harm reduction approach to respond to the needs of PWUD in their communities.

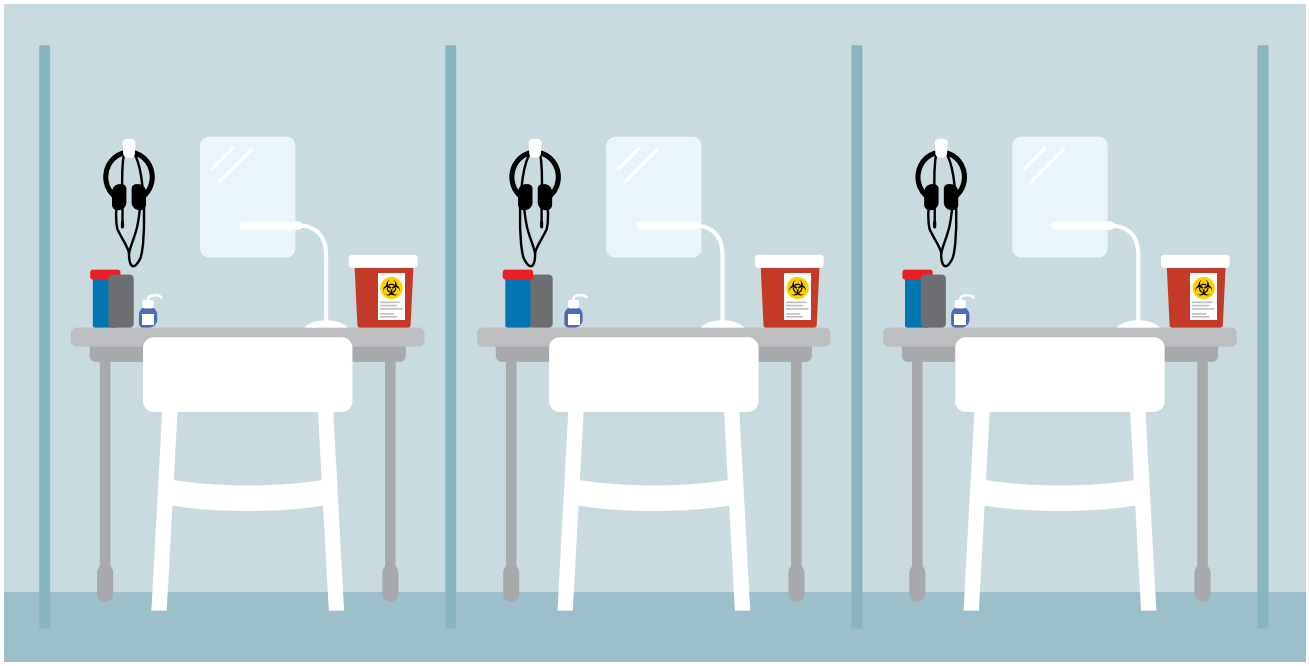
What are the policy details?

The state of Rhode Island and New York City have recently taken steps to implement OPCs in their jurisdictions — Rhode Island by adopting state legislation to authorize OPC operations and New York City by implementing OPCs led by a community-based nonprofit organization. New York City's OPC facilities were opened following endorsement by the mayor and engagement with local law enforcement, district attorneys, and other local government partners.[365]

While OPCs have been operating in other countries for many decades, a federal statute has prevented their expansion and operation in the United States:

- Under 21 U.S.C. 856 of the Controlled Substances Act (CSA), it is a felony to knowingly open, lease, rent, use, or maintain any place for the purpose of using any controlled substance.[366] Recent legal proceedings have explored whether this law applies to overdose prevention efforts.
- There has been federal litigation over whether OPCs are legal under this statute, and the Third Circuit ruled against the establishment of an OPC in Philadelphia in *United States v. Safehouse*.[367] However, this interpretation applies only to states in the federal Third Circuit, Delaware, New Jersey, and Pennsylvania.
- In addition to federal statute, local land use and zoning actions may need to be addressed prior to siting an OPC if the proposed land use is not allowable by local laws.

Some state and local jurisdictions have moved forward with authorizing OPCs in the interest of advancing public health goals, including prevention of drug overdose deaths and transmission of infectious diseases.[368] A feasibility study published in 2017 that explored legal pathways for OPCs in New York City noted that "although state legislation would not safeguard [overdose prevention sites] against the federal CSA, the state legislative pathway provides the greatest legal security with respect to state and local law."[369] While Rhode Island is the only state that has enacted a law to authorize OPCs, eight other state legislatures have considered similar legislation in recent years.[370]



What are the policy's benefits?

The evidence base establishing the impact of OPCs on overdose within the United States is limited, given that the first sanctioned US site opened in 2021. However, evidence from research conducted in other countries is strong,[371,372] and early evaluations from within the United States indicate that OPCs may show promise in preventing overdose deaths.[373,374] OPCs have been operating in other countries, including Australia, Canada, and several nations throughout Europe, since the 1980s.[375]

A range of studies has demonstrated the effectiveness of OPCs:

- A systematic review published in 2014 that included research from North America as well as Australia and Spain, among other countries, found that OPCs were effective in reducing the frequency of overdose. The review also found that OPCs' additional benefits include their capacity to specifically attract people who inject drugs and experience higher risk of overdose; promote safer injection practices; and improve access to primary health care. Authors also found that OPCs are not associated with an increase in crime in surrounding areas.[376]
- A 2021 review that focused on 22 OPCs in Vancouver, Canada reported similarly promising results, including significant reductions in opioid overdose morbidity and mortality, improvements in injection behaviors and harm reduction, significant improvements in access to addiction treatment programs, and no increases in crime.[377]
- An early evaluation conducted after the first two months of New York City's OPC operations found that the sites were heavily used and early data suggested that supervised consumption in the centers was associated with decreased overdose risk.[378] As of July 2023, the OPCs reported that staff have intervened in over 1,000 overdoses since their launch in November 2021.[379]
- Another study of an unsanctioned OPC in the United States reported 10,514 injections and 33 opioid-involved overdoses over a five-year period, all of which were reversed by trained staff, with no deaths were reported.[380]
- Some other research indicates that OPCs may also generate long-term cost savings. The 2017 feasibility study cited above suggested that opening four OPCs in New York City would save up to 130 lives and $7 million in direct health care costs per year.[381]

Key informants underscored the importance and potential impact of authorizing and expanding OPCs. One key informant commented on the effectiveness and safety of OPCs, as well as their global reach:

> *"Allowing supervised consumption or overdose prevention sites to operate freely…the evidence is very strong that they are effective. No one has ever died in such a facility and there are dozens operating in many countries across the globe. It's not a panacea, but it's one tool in the toolbox of effective interventions. And you'd want to have adequate facilities for people to use them wherever they are. But it would be a huge step and a really important part of our interventions."*

Another spoke of the role OPCs play in reducing harm, including overdose, while also not inflicting harm on the communities in which they are situated:

> *"We know from other countries that have overdose prevention centers in place that they seem to be effective in terms of reducing unsafe modes of drug use…reducing harms associated with drug use and reducing overdose rates without any consequent harm to the surrounding community. So, especially with the increasingly lethal drug supply*

that we're seeing in the United States, offering a place for people to be able to consume drugs under supervision so that overdoses can be intervened on early and where potentially their drug supply can be checked — policies that authorize the function and opening of overdose prevention centers — are critical."

How can the policy be designed to advance equity?

OPCs may be especially effective in reducing overdose risk for people who are unhoused, as public drug use is associated with greater risk of interactions with the police, harassment, robbery, and stigmatization, all of which can lead to rushed and unsafe levels of drug use.[382] OPCs can provide a hygienic, indoor space where people who are unhoused can build relationships with OPC staff who can encourage the adoption of harm reduction practices and provide other support to help meet basic needs.[383] As with SSPs, OPCs can be inclusive of the range of substances PWUD use by, for example, including safer smoking rooms in addition to spaces for injection drug use and offering nonjudgmental, culturally congruent, trauma-informed, and fully voluntary services.

What does the policy look like in practice?

OnPoint NYC's first-in-the-nation authorized OPCs

In December 2021, the non-profit harm reduction organization OnPoint NYC opened the nation's first sanctioned OPCs. The OPCs, in East Harlem and Washington Heights, were opened within the organization's SSPs as an expansion of their existing services. The centers do not receive city, state, or federal funds, instead relying on private donations to support their operation. They opened following endorsement by former Mayor de Blasio, who had obtained commitments from local law enforcement and district attorneys that criminal actions would not be brought against OnPoint NYC or program participants.[384] The NYC Department of Health and Mental Hygiene also developed guidelines for entities providing OPC services within the city to help promote safety and quality.[385]

The OPCs provide smoking rooms outfitted with ventilation systems and booths where people can smoke, inject, or otherwise consume drugs. The facility is staffed by trained personnel who provide nonjudgmental supervision and intervene to mitigate overdose risk as needed, providing oxygen or administering naloxone to individuals using opioids, and providing hydration, cooling, or de-escalation for individuals with stimulant-related symptoms.[386] The NYC Department of Health and Mental Hygiene is also piloting a drug-checking program at OnPoint using a spectroscopy machine, which tests drugs for the presence of fentanyl, other potent synthetic opioids, and other adulterants like xylazine.[387] In light of the increasingly toxic drug supply, integrating drug checking is a critical strategy to reduce harm and save lives. (For more on this, see the section **Remove policy barriers to fentanyl test strips (FTS) and other drug-checking equipment**.)

Rhode Island's enabling legislation

In July 2021, Rhode Island Governor Daniel McKee signed legislation to allow an OPC pilot program in the state.[388] The law authorized the Rhode Island Department of Health to create regulations detailing the services that OPCs (called "harm reduction centers" in the legislation) must offer and promulgating a procedure for licensure. Organizations interested in opening OPCs can submit applications subject to the review of the Department of Health and must demonstrate compliance with defined regulations, including requirements that

they offer syringe access, naloxone, and other harm reduction supplies, as well as referrals for medical treatment and other supportive services.[389] Rhode Island's law also requires that OPCs receive local approval, such that a municipality's governing body must sign off in order for an OPC to open within its jurisdiction. In February 2024, the Providence City Council approved the establishment of the state's first center.[390]

Additional resources

The Nation's First Publicly Recognized Overdose Prevention Centers: Lessons Learned in New York City (Giglio et al.): This case study outlines the events that led to the opening of OnPoint NYC's OPCs, describing the role of the health department, mayor, and other key partners.

Prevent Overdose Rhode Island: This website contains both resources and data related to overdose and overdose prevention. A **dedicated portion** of the site contains information, including videos, that points to the evidence in connection with overdose prevention centers along with explanation of how they function.

Examine policies that criminalize PWUD

SECTOR: CRIMINAL LEGAL

Removing criminal penalties for possession of currently illicit drugs — often referred to as *decriminalization* — generally means that people will no longer be arrested and incarcerated for possession of drugs for personal use. Although cannabis is still listed as a Schedule I drug under federal law, most states have modified state law to create a regulated system in which it may be legally distributed and possessed in some circumstances;[391] a similar mechanism could be expanded to include other drugs. However, at the time that this guide was written, no state had adopted a broader drug decriminalization policy.

While removing criminal penalties for drug possession was identified as a promising policy option by the experts interviewed for this guide, as in the case of cannabis decriminalization, doing so would conflict with existing federal drug laws in many cases.

What are the policy details?

Removing criminal penalties for drug possession could be enacted at the state level vis-à-vis state-level legislation or voter approval of a referendum. Such a policy could also be structured in different ways. For example, decriminalization could broadly apply to all possession or use of illicit drugs (e.g., heroin, methamphetamine, cocaine) or apply only to the possession of small amounts of illicit drugs — as was the case under Oregon's former law. Through Measure 110, the Drug Addiction Treatment and Recovery Act, Oregon made small amounts of possession punishable by a civil citation and up to a $100 fine, and it was possible to have the fine waived by seeking a health screening from a recovery hot line.[392] The law also required savings accrued from ending criminal enforcement for these possession offenses to be invested in treatment and harm reduction services.[393] Oregon has since rolled back Measure 110 and reintroduced some criminal penalties for possession of illicit drugs.[394]

Abroad, the Australian Capital Territory recently adopted a similar decriminalization measure with administrative penalties and mandatory diversion programs in late 2023.[395] Elsewhere, another sub-national jurisdiction, Canada's British Columbia, has also decriminalized small amounts of drugs in a three-year pilot program that started in February of 2023.[396]

State jurisdictions have also taken steps to reduce, rather than remove, criminal penalties for the possession or distribution of drugs. For example, Washington state passed a law making drug possession a gross misdemeanor rather than a felony, and law enforcement is encouraged to refer individuals to alternative, diversion, or recovery navigator programs in lieu of prosecution.[397]

Finally, many states and localities have used prosecutorial discretion to decline to enforce state drug laws, which has proven to be an important option to implement some aspects of decriminalization without fully committing to a legislative change.[398] Prosecutorial discretion refers to the authority that prosecutors have to make decisions about whether to pursue criminal charges, the types of charges to bring, and how to handle cases within the criminal justice system. This can include choosing to not bring charges, diverting low-level offenders to recovery programs, and dismissing charges outright.[399] Prosecutorial discretion has been used purposefully to reduce or nullify the inequitable effects of laws such as sentencing minimums.[400]

What are the policy's benefits?

Arrest and incarceration worsen health outcomes for PWUD, with overdose being the leading cause of death of people recently released from incarceration.[401,402,403,404] Decriminalizing drugs may divert PWUD away from the criminal legal system, strengthen harm reduction and behavioral health infrastructures that may mitigate overdose harm and treat SUD, and, as one key informant described, remove barriers to treatment:

> *"Another [set of policy strategies] would be thinking about the ways that we criminalize people who use drugs, as that is a disincentive for them to be able to get treatment, and it ensnares them in the criminal legal system, which just makes it harder for them to get well and more likely for them to die from overdose."*

While the evidence linking drug decriminalization to overdose prevention is still emerging, available research shows promise. In the year following the implementation of decriminalization, legal changes in Oregon and Washington to remove or decrease criminal penalties for drug possession were not associated with fatal drug overdose.[405] One study, however, suggests a correlation between the implementation of Oregon's Measure 110 and a later increase in overdose deaths, which the author suggests occurred when state investment in public health programs was delayed.[406]

Other analysis on the impact of Oregon's decriminalization law credits its passage with reduced felony and misdemeanor arrests for personal drug possession in the state,[407] with no increase in arrests for violent crime.[408] Moreover, arrests for drug possession decreased at a higher rate for Black individuals versus white individuals, though the racial disparity in the arrest rate overall still persisted.[409]

Some Oregon addiction experts believe that Measure 110 was ended too soon, pointing to a nearly 300 percent increase in people seeking screenings for substance use disorders in the first full year of reporting after it went into effect.[410] Another noted that the measure's

$100 million in annual funding did not reach those it was intended to support for the first 18 months, "so we weren't able to get the investments that were so critical to meeting folks where they're at."[411]

Abroad, researchers have also examined the impact of Portugal's decriminalization policy, in which personal possession of all drugs has been decriminalized and instead is treated as an administrative offense. Decriminalizing is one part of a larger, comprehensive public health–based approach to drug policy in the country.[412] One study found that decriminalization contributed to a "decrease in the number of heroin and cocaine seizures, a decrease in the number of offenses and drug-related deaths, and a decrease in the number of clients entering treatment."[413] It is worth noting that in the last two years of the study — 2005 to 2007 — the number of clients entering treatment began increasing.

Elsewhere in Europe, Czech drug policy includes the decriminalization of all drugs in personal use amounts, along with an emphasis on harm reduction and recovery.[414] Czechia has a drug-induced mortality rate substantially below the average rate in the European Union (8 deaths per million versus 18.3 per million in 2021), and relatively low rates of HIV and hepatitis transmission among people who inject drugs.[415] In the Netherlands, while "hard" drugs such as opioids are technically still illegal, possession in small amounts is de facto decriminalized.[416] The Netherlands has low rates of overdose deaths compared to the rest of the world, and one of the lowest rates of injection drug use in Europe.[417]

Experts in the field, including some working in law enforcement, also endorse decriminalization as a promising approach. One key informant encouraged states to decriminalize not just possession of small amounts of drugs but also low-level drug crimes more generally, as well as to shift resources away from criminal enforcement to addressing the inequitable conditions that exacerbate risk of SUD and overdose in the first place. They also identified opportunities to fund mental health services, job training, education, and other services:

> *"Essentially, I think part of the issue is people see drug decriminalization and safe supply as giving away drugs… but it's using the funds that were used to arrest people again and keep them in jail for $50,000 a year or more to fund treatment, recovery, and harm reduction services. And what those services are can really depend on what the community needs or what the community is looking for."*

Another key informant shared that removing criminal penalties may reduce stigma and help increase care for PWUD:

> *"Of course, the ultimate thing that can be done, which will really do the best work, is to end drug prohibition, because almost all of these things that we're seeing are due to the fact that there is prohibition. Now, I'm not saying that… if all these drugs were legalized, there wouldn't be some people developing substance use disorders. Alcohol is legal. We have people with alcohol use disorder. Gambling is legal. Some people get gambling addiction.… So, I'm not saying you're not going to have problems, but so many of the problems are due to the fact that people are having to access these things on the black market where you don't know the purity, you don't know the dosage, or if it is what it says it is.… And if it was legal, then we could deal with people who have substance use disorder the same way we deal with people who have alcohol use disorder — without stigmatizing, and looking at it as a health problem and having compassion and offering help to people."*

How can the policy be designed to advance equity?

Policies can call for investing cost savings from reduced arrests, prosecutions, and incarceration into services for PWUD who are at greatest risk of overdose-related harms. Oregon's model directed some cannabis tax revenue into prevention, treatment, and harm reduction.[418] This reinvestment in services appears to be crucial to reducing overdose.

Policies can also be designed to create oversight councils, like the one previously included in Oregon's law.[419] Oregon's Oversight and Accountability Council reserved at least two spots on the council for people with lived experience of drug use. These councils acted as accountability mechanisms for the state that could make recommendations about how to maximize the health equity impact of Measure 110.

Additional resources

Oregon's Measure 110: Principles and Metrics for Effective Evaluation (Drug Policy Alliance): This resource provides a set of crafted evaluation principles and suggested metrics to support equitable policy evaluation of Measure 110.

Decriminalization: Options and Evidence (Canadian Centre on Substance Use and Addiction): This issue brief describes key concepts, summarizes outcomes and lessons from jurisdictions with decriminalization policies, identifies considerations for evaluation of new policies, and proposes policy options.

A Quiet Revolution: Drug Decriminalisation Across the Globe (Release): This resource provides an overview of many decriminalization policies across the world, including how they are implemented and their effects.

More Imprisonment Does Not Reduce State Drug Problems (The Pew Charitable Trusts): This issue brief explores the research in the United States on criminal penalties and their effect on drug use, distribution, and other drug-law violations.

Support Housing First

SECTOR: COMMUNITY

Lack of access to safe, stable, and affordable housing affects all aspects of health, including the risk of overdose. For example, a cohort study conducted in Boston found that between 2004 and 2018, the overdose mortality rate among people who are unhoused was 12 times higher than the general adult population of the state, and the number of overdose deaths increased rapidly over the study period.[420] Similarly, in Philadelphia, drug overdose has been reported as the leading cause of death among people who are unhoused since at least 2011.[421]

One specific policy approach that acknowledges the interconnection between housing and risk of drug-related harm is known as Housing First,[422] which connects people who are unhoused with housing first and provides services second. Unlike some other forms of supportive housing, Housing First programs do not require sobriety or abstinence from drugs and alcohol as a precondition for participation. Instead, the programs allow people who are actively using drugs to access resources.[423] While Housing First models take different forms, they typically include the provision of housing assistance plus voluntary wraparound support services (e.g., MOUD treatment, mental health care, job training) to meet the needs of people experiencing steep barriers to housing.[424] Two common models

include permanent supportive housing, which provides long-term rental assistance tailored to people who have experienced chronic or long-term homelessness, and rapid re-housing, which provides a shorter period of rental assistance and is focused on supporting people in obtaining housing quickly.[425]

An important feature of Housing First is that people are not required to receive services they do not want in order to retain housing, and the model does not prescribe a one-size-fits-all path from housing insecurity to residential stability. Participants are supported in accessing whatever resources or supportive services they believe that they need.[426]

What are the policy details?

Housing First can be supported by a broad spectrum of local and state housing policies, specifically:

- State and local governments can enact policies requiring all housing programs that receive state or local funding to adopt the Housing First model. California, for example, enacted legislation in 2016 that mandates all housing programs that receive state funds adhere to a defined set of Housing First principles (including acceptance of applicants regardless of sobriety).[427]
- Jurisdictions can also implement new Housing First programs leveraging state and local funding, federal dollars, and/or private donations. Some cities (like Houston, Texas) have prioritized Housing First in their homelessness response strategies, with municipal agencies partnering with community-based housing programs and other partners in the local Continuum of Care to improve coordination and more rapidly move people who are unhoused into permanent housing.[428]
- As a more general strategy to increase housing availability for people who are unhoused, state and local jurisdictions can introduce or amend policy to require or incentivize a specific percentage of units be set aside for unhoused individuals and families within new affordable housing developments. In some jurisdictions, however, preemption laws (in which a higher level of government may limit or eliminate the power of a lower level of government to regulate specific issues) may limit the extent to which laws can impose income restrictions on housing units or other tenant protections.[429]

What are the policy's benefits?

Housing First is supported by a robust evidence base demonstrating its effectiveness at improving housing outcomes, including randomized controlled trials (conducted in the United States and Canada) whose results indicate that the model leads to a quicker exit from homelessness and greater housing stability over time than treatment as usual.[430] Other studies suggest that Housing First may lead to reduced use of emergency department services, fewer hospitalizations, and shorter hospital stays among participants.[431] While evidence on overdose and drug-related harms is more mixed, one study found that consistently implemented Housing First principles were associated with improved housing and substance use outcomes among people with a history of substance use and chronic homelessness.[432] Another study examining mortality among Housing First participants found that drugs or alcohol accounted for a smaller percentage of deaths among Housing First participants compared with those who remained unhoused at the time of their death.[433]

Key informants also identified Housing First as a key harm reduction strategy, explained by one of them this way:

> *"It's interesting to think about the Housing First model, where people with substance use problems and housing instability are offered housing, and they're not kicked out of housing because they continue to use. The program connects people to services that seem to be effective in terms of ensuring that they're retained in treatment and receive other services.... [And] at a broader level, some studies have shown that opportunities to place people in affordable and safe housing have broader, longer-term consequences for their health and their mental health. I would imagine that could also have an impact on the risk of substance use and overdoses."*

How can the policy be designed to advance equity?

Due to structural racism, BIPOC communities in the United States are overrepresented among people who are unhoused[434] and therefore may stand to disproportionately benefit from efforts like Housing First. The Housing First model may also help mitigate racial bias by eliminating application processes in which housing providers exercise discretion around who is "deserving" of support.[435] The core features of Housing First (including rapidly making housing available, tailoring units to the most vulnerable, and providing optional and robust social services) may also be aligned with anti-racist practices (e.g., focusing on client empowerment and choice) in order to promote better outcomes among BIPOC individuals.[436] State and local decision makers and developers of affordable housing can also partner with BIPOC-led community-based organizations to site Housing First projects and deliver culturally responsive services.

What does the policy look like in practice?

Housing First in the Denver Supportive Housing Social Impact Bond Initiative

Launched by the City and County of Denver, Colorado in 2016, the **Denver Supportive Housing Social Impact Bond (SIB) Initiative** provided a housing subsidy and supportive services to people who experienced long-term homelessness, were frequently involved in the criminal legal system, and frequently used emergency health systems. The program leveraged a Housing First approach, aiming to quickly move people into housing, without requiring participants to meet any preconditions. It was funded through a social impact bond (a financing mechanism wherein the city agreed to repay private investors with a return if the program yielded successful outcomes) as well as Medicaid and housing assistance funding streams.[437]

Evaluation by the Urban Institute and The Evaluation Center at the University of Colorado Denver found that the program improved housing outcomes and reduced criminal legal involvement among participants. While researchers did not measure substance use and overdose-related outcomes, program participants had fewer arrests for drug violations and used city-funded detoxification services less frequently than their counterparts not in supportive housing. Instead, those in the Housing First program accessed more preventive, community-based care, and less emergency care.[438]

There are many other examples of Housing First programs that have been implemented across the United States:

- Philadelphia currently provides housing to 600 people through its Housing First program, **Pathways to Housing PA**, which has wraparound services and provides applicants with scattered-site housing opportunities.
- In Los Angeles County, the **Permanent Supportive Housing program** matches people experiencing homelessness with housing and intensive case management services that can offer referrals to services, including mental and physical health care. The program seeks to support housing retention and offers a variety of additional services, including connection to disability benefits and vocational and educational opportunities.
- Massachusetts has implemented a **statewide Housing First program** that has housed over 2,100 people since 2006.

Additional resources

HUD Implementation Resources for Housing First (US Department of Housing and Urban Development [HUD]): HUD maintains a library of resources that provide guidance to communities and entities seeking to implement a Housing First approach in their projects and programs.

Social Determinants of Health: Permanent Supportive Housing with Housing First (Community Preventative Services Task Force): This resource includes a 2018 systemic review of evidence associated with Housing First initiatives, considerations for implementation, and links to additional resources.

Local Housing Solutions' Racial Equity Resources (an initiative led by New York University's Furman Center): This resource provides guidance, best practices, and case studies on how to promote racial equity through housing policy broadly.

Improve and expand income support

SECTOR: COMMUNITY

Income support programs provide financial assistance to help individuals and families living on low incomes meet their basic needs. While these programs are not tailored to PWUD, income support is a proven strategy to improve health.[439,440] Income support programs are designed to reduce poverty and promote economic stability — a key social determinant of health.[441] Financial assistance can improve recipients' access to stable housing, child care, and reliable transportation, the lack of which may make it harder for PWUD to engage with treatment and other supportive services.[442,443] Income support can also reduce stressors related to economic hardship (e.g., having to make difficult financial trade-offs, such as whether to pay rent or the utility bill) that may exacerbate overdose risk and influence the development of SUDs in the first place.[444]

Several distinct policies and programs that fall under the umbrella of income support across the federal, state, and local levels offer different types of assistance to specific populations who meet income criteria and other eligibility requirements. The requirements are often related to household type and citizenship status, among others. Major programs include **Temporary Assistance for Needy Families (TANF)**, which provides financial assistance and supportive services (e.g., vocational training) to families with children; **Supplemental Security Income (SSI)**, which dispenses monthly payments to people with disabilities; and the **Earned Income Tax Credit (EITC)**, a refundable tax credit for working people who have low and moderate incomes.

While many income support programs are funded primarily by the federal government and governed by federal rules, tribal and state governments sometimes have flexibility to set policies that reduce barriers and increase access to assistance. For example, states have discretion to include people with prior felony drug convictions in their TANF and **Supplemental Nutrition Assistance Program (SNAP)** programs and make assistance available to more people who have struggled with substance use.[445] State, local, and tribal governments can also create and fund their own programs that augment existing benefits. Thirty states; Washington, DC; and Puerto Rico, for example, have adopted their own EITCs to supplement the federal credit.[446] To increase access to income support among people at risk for overdose, states and local governments can consider policies to include PWUD in existing programs and implementing low-barrier forms of assistance.

What are the policy details?

Eliminate bans on people with prior felony drug convictions and end drug-screening requirements

- While TANF and SNAP are subject to a provision of federal law that bars states from providing assistance to people convicted of a drug-related felony, states have a choice in whether they implement this provision.[447] Several states have passed legislation to fully lift the ban.[448]
- Some states have enacted drug-testing requirements for TANF applicants and recipients they suspect may be using illicit drugs. (While universal drug testing has been ruled unconstitutional, states can screen all applicants, but test only those found to have "reasonable suspicion" of drug use.)[449] Although the USDA for the most part does not allow states to use drug testing in determining eligibility for SNAP, some states have

also passed laws to make people with past felony drug convictions submit to a drug test to be eligible for SNAP benefits.[450] SNAP participants may also be disqualified from SNAP based on noncompliance with a drug-testing requirement in other programs (like TANF) in states that implement such a requirement.[451] In both cases, states can consider adopting statutes to remove requirements for drug screening and drug testing in TANF, SNAP, and any other benefit programs.

Create low-barrier forms of assistance

- States and local jurisdictions can expand available income support for all people with low incomes by implementing their own programs. One approach to low-barrier assistance is state-level tax credits like EITCs and child tax credits for families with children.[452] States can adopt statutes to enact such credits, and they can be structured to provide meaningful assistance and reach the widest range of taxpayers possible by, for example, making credits refundable and removing exclusions based on age, household type, or citizenship status.[453,454]
- Another approach is to implement new programs like guaranteed basic income (GBI), which provides regular, unconditional cash payments to individuals and families with low income.[455] GBI is intended to set an income floor below which no one can fall. Many local governments have adopted ordinances or issued executive orders to implement pilot GBI demonstrations for a range of participants, including pregnant people, single parents, and young adults aging out of foster care.[456] The **Stanford Basic Income Lab and Center for Guaranteed Income Research** are tracking data from more than 30 guaranteed income pilot programs across the United States (in Newark, NJ; Louisville, KY; Tacoma, WA; Shreveport, LA; and more).[457] The programs differ in monthly payment amounts, program duration, and participant populations.

What are the policy's benefits?

A substantial body of research documents the health benefits of income support programs broadly. For example, the EITC is associated with improved maternal and infant health in areas ranging from reduced maternal smoking, decreased stress, and improved self-reported mental health to reduced incidence of low birthweight and preterm birth.[458,459] Some research also suggests that the EITC may reduce alcohol misuse, with one study finding that more generous state EITC policies were associated with a lower prevalence of binge drinking among pregnant parents.[460] SNAP has also been shown to reduce the incidence of low birthweight and improve long-term health among those who receive benefits in early childhood.[461]

While there is relatively less evidence related to TANF, some research suggests that more generous policies are associated with improved health outcomes.[462] Additionally, although there is not substantial research on the impact of eliminating bans on people with prior felony drug convictions or drug- screening or drug-testing requirements, some evidence finds that such requirements are costly, ineffective at identifying SUDs, and may produce unreliable results.[463,464,465]

Evidence related to more innovative models of income support, like GBI, is still emerging. Early outcomes from pilot programs suggest that unconditional cash transfers can improve health, financial stability, and employment outcomes.[466,467,468] While studies have not measured outcomes related to overdose or SUD, evidence on cash transfer programs in

other national contexts suggests that such programs may decrease household expenditures on goods like alcohol, tobacco, and illicit drugs.[469] Experts in the field also expressed support for GBI and other antipoverty measures as critical to addressing the underlying causes of the overdose crisis. In describing the need for a guaranteed basic income, one key informant said:

> *"So many of the things that we're dealing with are the results of or exacerbated by wealth inequality.... Navigating the harm that poverty has on the people we're trying to serve and keep safe is impossible. If there is a way of doing a better job of being more loving and caring, then that's what we should be doing. And I feel like access to health care and alleviating poverty, creating community — these are all the pieces that need to come together to support people in their lives."*

How can the policy be designed to advance equity?

States and localities can advance equity by considering less restrictive eligibility and participation requirements in existing programs, to the extent allowable under federal law. In TANF, research shows that Black people are more likely to face penalties that remove them from the program or reduce their benefit amount, in part due to caseworkers' discretion in applying sanctions related to work requirements.[470,471] States can support policies with more flexible work requirements that are responsive to the barriers that families with low incomes face when attempting to obtain employment, like lack of child care, transportation, and physical and mental health challenges. States and localities can also design their own programs to reach communities that are excluded from federal benefits based on eligibility criteria like citizenship status. For example, some state EITCs are available to individuals who are not eligible for the federal credit, like many immigrant workers who file taxes with an Individual Taxpayer Identification Number.[472]

What does the policy look like in practice?

Piloting guaranteed income in Alachua County, Florida

Just Income GNV is a guaranteed income pilot program serving residents of Alachua County, Florida, who have been recently released from a state or federal prison or from a county jail with a felony conviction, or who began felony probation within six months of the program's application deadline. The initial cohort of participants included 115 people who received unrestricted cash assistance for a 12-month period, receiving $1,000 in the first month and $600 per month for the remainder of the program period. Just Income GNV is operated in partnership with the City of Gainesville mayor, but it does not receive any public funds. The program, funded through private donations, is operated by a nonprofit organization and was designed by formerly incarcerated people. In 2021, the City of Gainesville also adopted a **resolution** urging the Biden administration to develop a federal guaranteed income program that would establish an income floor for everyone in the United States. While the resolution expresses support for guaranteed income, it does not invest in Just Income GNV or institutionalize a city-level program.

Additional resources

No More Double Punishments: Lifting the Ban on TANF and SNAP for People with Prior Felony Drug Convictions (Center for Law and Social Policy): This brief tracks state policies that remove or modify the exclusion of people with prior drug felony convictions from certain safety net programs and outlines recommendations for the full removal of this barrier.

States Can Enact or Expand Child Tax Credits and Earned Income Tax Credits to Build Equitable, Inclusive Communities and Economies (Center on Budget and Policy Priorities): This report outlines recommendations for state implementation and expansion of state-level EITCs and CTCs.

Mayors for a Guaranteed Income: This network of mayors advocates for the adoption of guaranteed income to ensure that all people in the United States have an income floor. Their website houses information about cities that have implemented a guaranteed income demonstration or pilot program and relevant research. **Guaranteed Income Pilots Dashboard** visualizes data and houses stories from evaluations of guaranteed income pilots across the United States.

Just Income GNV. This Gainesville, Florida–based project of the nonprofit organization Community Spring focused on dismantling poverty and spurring economic mobility. They operate a guaranteed income pilot program supporting people in reentry.

Limitations and conclusion

In the face of unprecedented increases in overdose deaths across the United States, state and local decision makers can take powerful actions to save lives in their communities. Indeed, many drug overdoses can be prevented by ensuring that PWUD have access to vital harm reduction tools; effective treatment; and resources — like stable housing, income, and access to health care — that can mitigate underlying conditions that exacerbate risk of drug-related harm.

The strategies outlined in this guide offer a roadmap of policy options that are grounded in evidence, backed by experts in the field, and positioned to advance equity in response to growing racial disparities in overdose deaths. These strategies focus on promoting public health and prioritizing care rather than criminal punishment for people at risk of overdose.

This guide can be a starting place for state and local decision makers, staff in government agencies, and public health practitioners who are working to prevent overdose in their communities. In addition to evidence-based policy options, meaningful community engagement is necessary to understand which strategies may best respond to the needs and experiences of PWUD and others affected by drug-related harm in a specific community.

Several limitations must also be acknowledged. First, the authors did not conduct a systematic review of the literature for each policy strategy that is included. Although extensive, the policy assessment, which included a scan of existing research, was not exhaustive, and some evidence may have been left out. Assessment outcomes are not meant to serve as a review of every local or state policy or practice. Additionally, the assessment relied on information that was publicly available at the time (spring 2023) to rate policies across impact and feasibility criteria. Trends in substance use and in the drug supply can change rapidly, making it necessary to keep pace with emerging threats and evolving needs as well as additional approaches to addressing the steady increase of stimulant-involved overdoses and reducing drug-related harm.

For more information on the process of enacting and implementing the policies outlined in this guide, please see ***Implementing State and Local Overdose Prevention Policies: A Resource for Navigating the Policy Process***. We hope that these resources will support our readers in their efforts to pursue policy interventions that respond at scale to the pressing needs of people affected by overdose and other drug-related harms in their communities.

Key terms & appendices

Key terms

Community engagement: A set of activities that government institutions such as local public health departments or other local or state agencies, for example, use to engage communities in public discussions or to inform public policy or planning decisions. Common examples include holding public hearings or community workshops, conducting surveys or interviews, and posting notices or flyers in newspapers or other media sources or in public spaces like libraries or post offices to request community participation.[473] This set of traditional community engagement activities is not always sufficient to engage communities most affected by health inequities, including those at risk of overdose. Decision makers can pursue more innovative strategies, such as conducting outreach in partnership with community-based harm reduction organizations, to better reach people who use drugs.

Decision makers: Individuals and governmental bodies comprising government staff, officials, elected representatives, and appointed members who can exercise governmental powers and decision-making authority within a jurisdiction.[474] In state and local overdose prevention, these individuals and governmental bodies often include governors, mayors, city or town councils, state legislators, state and local public health officials, law enforcement officials, and more.

Health equity: "State in which everyone has the opportunity to attain their full health potential and no one is disadvantaged in achieving this potential because of social or economic position, or any other socially defined circumstance."[475]

Law: Includes ordinances, statutes, and regulations that codify and institutionalize a government policy. Note that all laws are policies, but not all policies are laws.

Medications for opioid use disorder (MOUD): Evidence-based treatment for individuals with OUD that involves the use of one of three types of medication: methadone, buprenorphine, and naltrexone. These medications operate to normalize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and normalize body functions. MOUD are effective at treating opioid use disorder and sustaining recovery and can be safely used for months, years, or even a lifetime.[476]

Opioid use disorder (OUD): Recurrent use of opioids that causes clinically significant impairment including health problems, disability, and failure to meet major responsibilities at work, school, or home. Opioids are a class of drugs that includes prescription pain medications available legally (e.g., oxycodone), the illegal drug heroin, and synthetic opioids like fentanyl.[477]

Overdose: Injury to the body (poisoning) that happens when a drug is taken in excessive amounts. An overdose can be fatal or nonfatal.[478]

Overdose prevention centers (OPCs), also called *safe* or *supervised consumption sites*: Facilities in which people can consume drugs that they obtained elsewhere in a monitored setting where trained staff can intervene immediately in the event of an overdose. Like SSPs, OPCs may offer a range of additional services such as overdose prevention education, sterile supplies, naloxone, drug checking, and linkages to care for people seeking substance use disorder treatment or assistance with other health care needs.

People who use drugs (PWUD): Refers to individuals who use drugs for recreational or other nonmedicinal purposes. This person-first term is generally preferred over more stigmatizing terms (e.g., drug user, addict). It intends to affirm the dignity and humanity of people who use drugs by focusing on the individual first rather than defining them by their drug use.

Policy: Laws, regulations, procedures, administrative actions, incentives, and voluntary practices of governments and other institutions.

Structural racism: "System in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing, ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with 'whiteness' and disadvantages associated with 'color' to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead, it has been a feature of the social, economic and political systems in which we all exist."[479]

Substance use disorder (SUD): Recurrent use of drugs, alcohol, or both that causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.[480]

Syringe services programs (SSPs): Programs that provide a range of services to people who inject drugs and other people who use drugs, that may include access to and disposal of sterile syringes, injection equipment, safer smoking supplies, naloxone, wound care and other basic first aid supplies; testing for infectious diseases; and linkages to care for those seeking substance use disorder treatment and other health care needs.[481]

Appendix A. Key informant interviewees

Name	Title	Organization	Role
Community			
Bayla Ostrach, PhD, MA, CIP	Member-Director & Appointed Faculty	Fruit of Labor Action Research & Technical Assistance, LLC & Boston University, School of Medicine	Researcher
Christine Marsh	State Senator	State of Arizona	Policymaker
Keegan Wicks	National Advocacy and Outreach Manager	Faces and Voices of Recovery	Policy advocate
Lori Nesbitt	Opioid Program Manager	Yurok Tribe	Practitioner
Magdalena Cerda, DrPH	Professor	New York University, School of Medicine	Researcher
Soma Snakeoil	Co-founder	Sidewalk Project Los Angeles	Practitioner
Criminal Legal			
Brandon del Pozo, PhD, MA, MPA	Assistant Professor *Former Police Chief, Burlington, VT and former Police Officer, New York City Police Department*	Brown University	Practitioner, researcher
José Garza, JD	District Attorney	Travis County District Attorney's Office	Practitioner
Roseanne Scotti, JD	Senior Technical Advisor, Syringe Access Services	Vital Strategies	Policy advocate
Ryan Thornell, PhD	Director *Former Deputy Commissioner of Corrections, Maine Department of Corrections*	Arizona Department of Corrections	Practitioner
Shoshanna Scholar	Director of Harm Reduction and Community Based Diversion	Office of Diversion and Reentry, Los Angeles County Department of Health Services	Practitioner
Tracie Gardner	Senior Vice President of Policy Advocacy	Legal Action Center, Black Harm Reduction Network	Policy advocate
Health Care			
Jeffrey Singer, MD	Senior Fellow	Cato Institute	Researcher
K. Catalyst Twomey, RN	Nurse, Volunteer	Sidewalk Project	Practitioner
Lucas Hill, PharmD, BCACP, FCCP	Director	Pharmacy Addictions Research & Medicine Program, University of Texas at Austin, College of Pharmacy	Practitioner, researcher
Sarah Wakeman, MD	Senior Medical Director for Substance Use Disorder	Mass General Brigham	Practitioner, researcher

Name	Title	Organization	Role
Schools			
Jess Geisthardt, RN	School Nurse	Waupun Area School District	Practitioner
Jordan Goto, MPH	Health and Wellness Coordinator	Boulder Valley School District	Practitioner
Karen Robitaille, MBA, MSN, RN, NCSN	Director, School Health Services	Massachusetts Department of Public Health	Practitioner
Rhana Hashemi	PhD student; Founder & Executive Director	Know Drugs	Practitioner
Robert Hofmann	*Former Policy & Advocacy Director, Students for Sensible Drug Policy*		Policy advocate
Sheila Vakharia, PhD, MSW	Deputy Director, Research & Academic Engagement	Drug Policy Alliance	Researcher, policy advocate

Appendix B. Policy assessment table

Communities can use this table to think through possible policy strategies to prevent overdose and other drug-related harms and consider their relative potential impacts and feasibility. The assessment results included here are intended to be a resource and a conversation starter; the probable outcome listed for each criterion is not meant to serve as a complete review of every local or state policy or practice.

Assessment criteria

Evidence base

How strong is the evidence that supports this policy?

Strong: The policy is well supported by reviews synthesizing evidence from multiple studies and sources.

Moderate: The policy is supported by small-scale studies; there may be conflicting evidence in the literature.

Weak: There is little or no evidence supporting the policy, or the evidence is speculative. (Note: Some policies included in this ranking may have emerging evidence of efficacy, but the body of research may be limited due to the relative recency of the policy.)

Outcomes described in the research

Outcomes measured, observed, or otherwise described in the evidence (e.g., reduced rates of overdose, increased access to SUD treatment, increased access to naloxone) are listed.

Existing implementation

Has this policy been implemented at a US state or local level?

Implemented in multiple jurisdictions: The policy has been implemented in more than one state and/or local jurisdiction.

Implemented in one jurisdiction: The policy has been implemented in one state or local jurisdiction.

Not implemented: The policy has not been implemented in any state or local jurisdiction.

Resource requirements

Does this policy require significant funding or other resources (including staff capacity, training, expertise, or infrastructure) for state or local governments to implement?

High: The policy may require a high level of financial investment to implement. It may also require new or additional personnel or infrastructure resources to implement.

Moderate: The policy may require a moderate level of financial investment and/or some new or additional personnel or infrastructure resources to implement.

Low: The policy may require little to no financial investment and can be largely implemented with existing personnel and infrastructure.

Legal restrictions

Aside from the lack of a law authorizing the policy or the presence of a prohibitive/restrictive law, the repeal/amendment of which is inherent to the policy itself, how likely is it that the policy faces legal restrictions, barriers, or challenges (e.g., preemption, negative court treatment, negative AG opinions)?

Likely: The policy is likely preempted by or illegal under federal law (for policies to be implemented at the state or local level), OR substantially similar policies have faced negative treatment by at least one federal court, and that decision was not overturned.

Somewhat likely: The policy is not likely preempted by or illegal under federal law, but there is likely state preemption in at least one state, OR substantially similar policies have faced negative treatment by at least one state appellate court, and that decision was not reversed, OR there are likely laws at the enacting level of government that restrict or bar the policy's enactment, apart from those that are inherently changed by the policy itself.

Unlikely: The policy is not likely preempted by or illegal under federal law, and there have been no obviously negative federal court rulings or state appellate court rulings against the policy or substantially similar policies. There have been either no known legal challenges to substantially similar policies, or there have been few, and they have been unsuccessful. The only extant legal restrictions are inherently changed through the passage of the policy.

Equity

Does this policy advance equity by addressing the disproportionate impact of overdose and other drug-related harms on Black, Indigenous, and other people of color; people who are currently or were previously incarcerated; people who are unhoused; and/or pregnant or birthing people?

Yes: The policy addresses the disproportionate impact of overdose and other drug-related harms on Black, Indigenous, and other people of color; people who are currently or were previously incarcerated; people who are unhoused; and/or pregnant or birthing people by

effecting change across one or more domains of structural racism or other intersecting forms of structural discrimination. The policy might address inequities in arrest, charge, prosecution, and incarceration for drug-related offenses; child removal and loss of parental rights; school punishment; access to treatment, recovery, and related health care services; or access to housing.

Unclear/sometimes: Some parts of the policy may address the disproportionate impact of overdose and other drug-related harms on certain groups, but the policy does not/it's unclear whether the policy combats structural racism or other intersecting forms of discrimination. The policy's ability to advance equity may depend on the details of its implementation.

No: The policy does not address the disproportionate impact of overdose on certain groups or reinforces inequities in power, opportunity, wealth, or health.

Addresses needs related to social determinants of health

Does this policy address one or more social determinants of health that influence risk of substance use disorder and overdose?

Yes: The policy improves the conditions in which PWUD are born, grow, work, live, and age by addressing at least one social determinant of health, such as income and social protection; education; unemployment and job insecurity; working life conditions; food insecurity; housing, basic amenities, and the environment; early childhood development; social inclusion and non-discrimination; structural conflict; and access to affordable health services of decent quality.

No: The policy does not address social determinants of health.

People-centered

Is the policy in alignment with the needs and expressed demands of people who use drugs?

Strong alignment: The policy is responsive to the needs of people who use drugs as expressed by PWUDs and/or community-based organizations that serve PWUDs.

Moderate alignment: Some parts of the policy are responsive to needs of PWUDs as expressed by PWUDs and/or community-based organizations that serve PWUDs, but alignment may depend on the details of the policy's implementation.

Weak alignment: The policy is not responsive or is only tangentially responsive to the needs of PWUDs as expressed by PWUDs and/or community-based organizations that serve PWUDs.

Reduces harmful contact with the criminal legal system

Does the policy reduce harmful contact between PWUD and the criminal legal system, such as arrests or incarceration?

Reduces harmful contact: The policy reduces harmful contact with the criminal legal system — for example, by reducing criminal penalties related to substance use and overdose and diverting PWUD from incarceration.

Does not increase harmful contact: The policy does not reduce harmful contact with the criminal legal system, but it does not increase arrests, incarceration, and other harmful criminal legal system involvement among PWUD. In some cases, the policy may have the downstream effect of contributing to a reduction in harmful contact in the long term.

Increases harmful contact: The policy increases harmful contact with the criminal legal system — for example, by increasing the likelihood and/or severity of arrest, incarceration, and other harmful criminal legal system involvement among PWUD.

Unclear: The policy's impact on harmful contact between PWUD and the criminal legal system depends on the details of its implementation.

Policy Name	Policy Description	Policy Example *Note: Examples are not exhaustive, but reflect at least one jurisdiciton where the policy has been implemented.*	Source	Sector(s)	Jurisdiction Level(s)	Evidence Base	Outcomes Described in the Research	Existing Implementation	Resource Requirements	Legal Restrictions	Equity	Addresses Needs Related to Social Determinants of Health	People-Centered	Reduces Harmful Contact with the Criminal Legal System
Expand access to medications for opioid use disorder (MOUD)														
Provide MOUD treatment to people who are incarcerated	Provide access to the full range of MOUD for people who are incarcerated and facilitate the transition to a community-based treatment provider upon their release. Make MOUD available (on a voluntary basis) to any patient who needs it and remove any restrictions based on pregnancy status, release date, or other criteria. Note: Distribution of burprenorphine in correctional settings should also be normalized, so that it is dispensed like other prescription medications.	The Maine Department of Corrections' Medications for Substance Use Disorder (MSUD) program includes universal access to MOUD for any prison resident in need of treatment.	https://www.maine.gov/corrections/sites/maine.gov.corrections/files/inline-files/MDOC%20MSUD%20Year%20Three%20Report-2022.pdf	Criminal Legal, Community, Health Care	State, Local	Strong	Decreased overdose mortality; increased retention in treatment; reduced illicit drug use	Implemented in multiple jurisdictions	High	Unlikely	Yes	Yes	Strong alignment	Does not increase harmful contact
Expand MOUD access for pregnant and postpartum PWUD	Expand access to MOUD treatment for pregnant and postpartum people who use drugs and infants who have been exposed to substances. Strategies may include tailoring programs to provide buprenorphine and methadone as part of prenatal and postpartum care (including for Medicaid patients who lose coverage at 60 days postpartum); investing in supportive services for MOUD patients (including child care, legal aid to navigate child welfare involvement, etc.); and training health care providers to help reduce stigma.	Colorado Special Connections program provides comprehensive SUD treatment for Medicaid-eligible people who are pregnant and up to 12 months postpartum. The program is supported by an approved state Medicaid plan amendment and 1915(b) waiver. Four cohorts of states have received funding to expand care under SAMHSA's State Pilot Program for Treatment for Pregnant and Postpartum Women (2021 cohort included AL, KS, MI, and WV).	Colorado Special Connections & 1915(b) waiver: https://hcpf.colorado.gov/special-connections; https://hcpf.colorado.gov/sites/hcpf/files/Regulatory%20Resource%20Center%20Section%201915%28b%29%20waiver%20renwal.pdf SAMHSA State Pilot Program for Treatment for Pregnant and Postpartum Women: https://www.samhsa.gov/grants/grant-announcements/ti-23-003	Health Care, Community	State, Local	Strong	Decreased overdose mortality; improved maternal/parental and infant health outcomes	Implemented in multiple jurisdictions	High	Unlikely	Yes	Yes	Strong alignment	Reduces harmful contact
Increase access to naloxone														
Tailored naloxone distribution	Equip individuals who are most likely to witness or experience an overdose (including PWUD, their friends and family, first responders, and community-based organizations that work with PWUD) with naloxone and provide training on its use. Strategies include community-based naloxone distribution; equipping first responders with naloxone (to administer in emergency response and leave behind with patients who are at risk of overdose); and take-home naloxone distribution for patients at risk of overdose who interact with health systems like emergency rooms, OUD treatment programs, or the Veterans Health Administsration. Jurisdictions can support distribution by providing free or subsidized naloxone to eligible entities.	Community-based distribution: California Civil Code Section 1714.22 First responder distribution: Howard County, Maryland ER-based distribution: Washington Rev. Code § 70.41.0001(1) Health systems-based distribution: California Civil Code § 1714.22 OTP-based distribution: New Mexico HB 370	Community-based distribution: https://www.dhcs.ca.gov/individuals/Documents/Naloxone-Distribution-Project-FAQs-December-2020.pdf First responder distribution: https://www.opioid-resource-connector.org/program-model/howard-county-naloxone-leave-behind-program ER-based distribution: https://www.networkforphl.org/wp-content/uploads/2021/10/50-State-Survey-SUD-Related-Emergency-Department-Mandates.pdf Health systems-based distribution: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=CIV&sectionNum=1714.22.&highlight=true&keyword=naloxone OTP-based distribution: https://www.nmlegis.gov/Sessions/17%20Regular/bills/house/HB0370HCS.PDF	Community, Health Care, Criminal Legal	State, Local	Strong	Decreased opioid overdose mortality; increased access to naloxone	Implemented in multiple jurisdictions	Moderate	Unlikely	Yes	Yes	Strong alignment	Does not increase harmful contact
Naloxone distribution in prisons and jails and upon release from incarceration	Make naloxone available in prisons, jails, and other carceral settings and to all people exiting incarceration. Distribution strategies may include vending machines.	Los Angeles County jails have set up vending machines to distribute naloxone to people leaving incarceration and have installed containers that dispense naloxone within the jail facilities. The programs are supported by a partnership between the LA County Sherriff's Department and the Department of Health Services' Office of Diversion and Reentry.	https://www.latimes.com/california/story/2021-06-07/opioid-overdoses-sheriff-narcan-jails	Criminal Legal, Health Care, Community	State, Local	Strong	Decreased opioid overdose mortality; increased access to naloxone	Implemented in multiple jurisdictions	Moderate	Unlikely	Yes	Yes	Strong alignment	Does not increase harmful contact
Access to naloxone in schools	Make naloxone available in schools (including school first aid kits) and ensure that teachers and other school personnel are trained to administer the medication.	The Start Talking Maryland Act (Educ. §7-426.5) requires all public schools to obtain and store naloxone or other opioid overdose reversal medication.	https://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SHS/NaloxonePolicyFAQ.pdf	Schools	State, Local	Weak	Evidence base has been assessed as weak because evidence related to school access to naloxone is just emerging; however, research on other policy changes that make naloxone easier to access are supported by strong evidence of decreased overdose mortality.	Implemented in multiple jurisdictions	Moderate	Unlikely	Unclear/ sometimes	Yes	Strong alignment	Does not increase harmful contact
Free or reduced-cost naloxone	Make naloxone available at no cost, including for individuals with low income and those who are uninsured or under-insured, including by providing copayment assistance, issuing coupons/vouchers targeting the uninsured, or distributing free naloxone to any resident who requests it through a public agency or CBO partner. Note: These strategies overlap with programs in "Tailored naloxone distribution" that distribute naloxone for free. The approaches described in this row include co-payment assistance and providing naloxone by mail upon request.	Copayment assistance: New York Department of Health's Naloxone Copayment Assistance Program (N-CAP) covers up to $40 in prescription copayments for those getting naloxone from a participating pharmacy. Free naloxone upon request: Delaware's Division of Public Health partners with NEXT Distro to provide free naloxone by mail to residents who may not otherwise access the medication. Residents request the medication online and must watch a training video.	New York: https://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/docs/n-cap_faqs.pdf Delaware: https://nextdistro.org/dechoice	Community, Health Care, Criminal Legal	National, State	Strong	Decreased opioid overdose mortality; increased access to naloxone	Implemented in multiple jurisdictions	High	Unlikely	Yes	Yes	Strong alignment	Does not increase harmful contact

Policy Name	Policy Description	Policy Example *Note: Examples are not exhaustive, but reflect at least one jurisdiciton where the policy has been implemented.*	Source	Sector(s)	Jurisdiction Level(s)	Evidence Base	Outcomes Described in the Research	Existing Implementation	Resource Requirements	Legal Restrictions	Equity	Addresses Needs Related to Social Determinants of Health	People-Centered	Reduces Harmful Contact with the Criminal Legal System
Strengthen overdose Good Samaritan laws														
Strengthen Good Samaritan laws	Ensure that overdose Good Samaritan laws provide broad protections against arrest, charge, and prosecution when a person who is witnessing and/or experiencing an overdose contacts 911 or seeks medical attention. Eliminate limits/exclusions that exist in certain jurisdictions (e.g., immunity can only be used twice, people on probation or parole are not eligible) and strengthen implementation so that state and local law enforcement, community members, and other stakeholders understand and appropriately implement the law.	Maine's overdose Good Samaritan law (Me. Stat. tit. 17-A § 1111-B) was expanded in 2022 and now makes immunity the default rather than the exception.	https://mainelegislature.org/legis/bills/getPDF.asp?item=7&paper=SP0661&snum=130	Criminal Legal	State	Strong	Decreased opioid overdose mortality	Implemented in multiple jurisdictions	Moderate	Unlikely	Yes	Yes	Strong alignment	Reduces harmful contact
Authorize and expand access to syringe services														
Authorize and expand syringe services programs (SSPs)	Establish syringe services programs (SSPs) to provide sterile syringes, injection equipment, smoking supplies, and safe disposal to PWUD. SSPs can also offer other harm reduction supports like naloxone, fentanyl test strips, overdose prevention education, and referrals to SUD treatment and other services. Note: In some jurisdictions, law and policy changes, including amending drug paraphernalia laws, may be required to authorize or enable expanded implementation of SSPs. For more information, see "Remove policy barriers to fentanyl test strips (FTS) and other drug-checking equipment" later in this table.	SSPs in California are supported by state law explicitly authorizing their operation and excluding syringes from the definition of drug paraphernalia.	https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/CA_Law_SSPs_Factsheet_ADA%20FINAL%20(April%202021).pdf	Community, Health Care, Criminal Legal	State, Local	Strong	Decreased HIV, HCV, and other blood-borne infections; increased engagement with SUD treatment; decreased needle stick injuries and improper syringe disposal; does not increase illicit or injecting drug use	Implemented in multiple jurisdictions	High	Somewhat likely Note: Because the policy option described here is the establishment of a syringe services program, it was flagged as "somewhat likely" rather than "unlikely" to face legal barriers, as many states may need to change multiple laws, primarily their drug paraphernalia laws, in order for a syringe services program to be established. See CA example policy, which encompasses exemption of syringes from the drug paraphernalia law in addition to a law explicitly authorizing the SSP.	Yes	Yes	Strong alignment	Reduces harmful contact
Examine policies related to Medicaid and enrollment assistance														
Medicaid expansion	Expand Medicaid in those states that have not yet adopted expansion, to extend health care coverage to people with income of less than 138% of the federal poverty level.	40 states (including Washington DC) have adopted Medicaid expansion; 11 states have not yet done so.	Status of state Medicaid expansion map: https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map	Health Care	State	Strong	Evidence has been assessed as strong because robust research finds that Medicaid expansion increases insurance coverage, service use, quality of care, and access to naloxone; some studies suggest increased access to SUD treatment and decreased overdose mortality, but evidence on these outcomes is more mixed.	Implemented in multiple jurisdictions	Low	Unlikely	Yes	Yes	Strong alignment	Does not increase harmful contact
Medicaid enrollment assistance for incarcerated people	Provide pre-release Medicaid enrollment assistance to all people in carceral facilities, to support increased access to health care (including SUD treatment) during the reentry period. Some states provide expedited enrollment to individuals being discharged from state prisons, jails, and psychiatric hospitals.	Washington Apple Health (Medicaid) for People Released from Prison	https://nohla.org/wordpress/img/pdf/FAQIncInd.pdf	Criminal Legal, Health Care, Community	National, State	Moderate	Increased access to and use of health carre services, including treatment; reduced financial stress; reduced self-reported risk of recidivism	Implemented in multiple jurisdictions	Moderate	Unlikely	Yes	Yes	Strong alignment	Does not increase harmful contact
Strengthen behavioral health supports for youth														
Strengthen mental and behavioral health services for students	Invest in mental and behavioral health infrastructure in schools to increase and improve support for students and provide tailored care for those at risk of developing SUD or experiencing overdose. Such investments can include ensuring that all schools are adequately staffed with counselors, psychologists, and/or social workers and designating trained personnel to respond to students in crisis; connect them with treatment, harm reduction, and other supportive services; and help divert them from the criminal legal system.	Oklahoma State Department of Education's School Counselor Corps is an investment in approximately 300 new counselors and school-based mental health professionals to help address OK students' academic and social-emotional needs. The corps was created in response to COVID-19 and designed to address heightened mental health needs related to the pandemic.	https://readytogether.sde.ok.gov/sites/default/files/2021-05/School%20Counselor%20Corps%20Initiative_0.pdf	Schools, Health Care, Community	State, Local	Strong	Evidence has been assessed as strong because robust research finds that school-based mental health services improve social, emotional, and mental health outcomes and increase access to care; some studies suggest reduced risk of engaging in health risk behaviors, including substance use, but evidence on these outcomes is more limited.	Implemented in multiple jurisdictions	High	Unlikely	Yes	Yes	Strong alignment	Does not increase harmful contact
Screening, Brief Intervention, and Referral to Treatment (SBIRT) or other universal screening in schools	Implement SBIRT or other evidence-based universal screening models in schools to identify students who are at risk of SUD and overdose and connect them with harm reduction providers and treatment options.	The Wisconsin School SBIRT Implementation Project provides a stipend, training, and other resources to support participating WI schools in implementing SBIRT. Massachusetts state law mandates annual verbal substance use screening in all public and charter schools statewide, and the Department of Public Health and Department of Elementary and Secondary Education selected SBIRT as the state's approach to conduct screenings.	Wisconsin: https://www.wishschools.org/SBIRT/School%20SBIRT%20Report_Final%202021-2022.pdf Massachusetts: https://malegislature.gov/Laws/SessionLaws/Acts/2016/Chapter52	Schools, Health Care, Community	State, Local	Moderate	Reduced alcohol and drug use	Implemented in multiple jurisdictions	High	Unlikely	Unclear/ sometimes	Yes	Moderate alignment	Unclear

Policy Name	Policy Description	Policy Example *Note: Examples are not exhaustive, but reflect at least one jurisdiciton where the policy has been implemented.*	Source	Sector(s)	Jurisdiction Level(s)	Evidence Base	Outcomes Described in the Research	Existing Implementation	Resource Requirements	Legal Restrictions	Equity	Addresses Needs Related to Social Determinants of Health	People-Centered	Reduces Harmful Contact with the Criminal Legal System
Remove policy barriers to fentanyl test strips (FTS) and other drug-checking equipment														
Amend or repeal drug paraphernalia laws to remove criminal penalties for fentanyl test strips (FTS), drug-checking equipment, and other paraphernalia	Repeal or amend state drug paraphernalia laws to remove criminal penalties for the possession or use of fentanyl test strips (FTS), other drug-checking technologies, and other items considered paraphernalia, including syringes and other supplies used for injecting drugs.	Removing criminal penalties for FTS and other drug-checking technologies: Pennsylvania Act 111 excludes drug-testing products, including fentanyl test strips, from the definition of drug paraphernalia. Removing criminal penalties for syringes: New York SB S2523 removes hypodermic needles and other items used for injection drug use from the definition of drug paraphernalia and decriminalizes possession of hypodermic needles with a residual amount of drugs. Removing criminal penalties for all paraphernalia: Alaska has no laws restricting drug paraphernalia.	Pennsylvania: https://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2022&sessInd=0&act=111 New York: https://www.nysenate.gov/legislation/bills/2021/S2523#:~:text=S2523%20(ACTIVE)%20%2D%20Summary,of%20hypodermic%20needles%20and%20syringes Alaska: http://legislativeanalysis.org/wp-content/uploads/2022/09/Drug-Paraphernalia-Summary-of-State-Laws-FINAL.pdf	Criminal Legal	State	Strong	Decreased HIV, HCV, and other blood-borne infections; increased engagement with SUD treatment; decreased needle stick injuries and improper syringe disposal; modified drug use behavior and increased engagement in harm reduction practices Note: The evidence cited in support of this policy is drawn from research on FTS usage as well as on SSPs, which generally require syringe decriminalization or explicit authorization in state law to legally operate. At least one study suggests that legalizing SSPs without removing criminal penalties for syringe possession may result in higher arrests and poor health outcomes among PWUD. The authors did not find research related to laws that remove criminal penalties for all paraphernalia.	Implemented in multiple jurisdictions	Low	Unlikely	Yes	Yes	Strong alignment	Reduces harmful contact
Community drug checking	Monitor the illicit drug supply to check for the presence of fentanyl, other potent synthetic opioids, and other emerging adulterants like xylazine. Strategies include point-of-care drug checking at locations that offer other harm reduction services, collection and testing of remnant drug packaging and paraphernalia with residue, and distribution of and training on FTS and other drug-checking technologies for PWUD.	Massachusetts Drug Supply Data Stream (MADDS) collects remnant drug packaging and paraphernalia with residue from PWUD and noncriminal samples from partnering police departments. Point-of-care drug checking is being piloted by the New York City Department of Health and Mental Hygiene at the city's overdose prevention centers.	Massachusetts: https://heller.brandeis.edu/opioid-policy/community-resources/madds/index.html New York: https://www.nyc.gov/office-of-the-mayor/news/575-22/mayor-eric-adams-takes-action-curb-opioid-overdoses-expanding-access-tools-test-for	Community, Health Care	State, Local	Moderate	Modified drug use behavior and increased engagement in harm reduction practices; decreased opioid overdose mortality	Implemented in multiple jurisdictions	High	Somewhat likely	Yes	Yes	Strong alignment	Does not increase harmful contact
Examine the impact of overdose prevention centers (OPCs)														
Overdose prevention centers (OPCs)/safe consumption sites	Authorize overdose prevention centers for people to consume drugs safely in the presence of trained personnel who can intervene in the event of an overdose. Like SSPs, OPCs can offer a range of harm reduction services, overdose prevention education, and referrals to SUD treatment and other supportive services. Efforts to create OPCs may require the repeal of 21 U.S.C. 856.	New York City has two OPCs that are operated by the nonprofit OnPoint NYC. The OPCs opened pursuant to an agreement among the city, local law enforcement, and prosecutors that allow the sites to operate freely; they do not receive city, state, or federal funds.	https://www.nyc.gov/office-of-the-mayor/news/793-21/mayor-de-blasio-nation-s-first-overdose-prevention-center-services-open-new-york	Community, Health Care	State, Local	Strong	Decreased opioid overdose mortality; increased access to healthcare services; decreased public drug injections and improper syringe disposal; modified drug use behavior and increased engagement in harm reduction practices Note: Much of the evidence in support of this policy is drawn from research conducted in international contexts, given that the first sanctioned US OPC opened in 2021.	Implemented in multiple jurisdictions	High	Likely	Yes	Yes	Strong alignment	Reduces harmful contact
Examine policies that criminalize PWUD														
Remove criminal penalties for drug possession	Remove criminal penalties for possession and/or distribution of illicit drugs.	Oregon Measure 110 removed criminal penalties for personal possession of illicit drugs. The measure also directed that savings accrued from ending criminal enforcement, arrest, and incarceration be invested in treatment and harm reduction services.	https://www.oregon.gov/oha/hsd/amh/pages/measure110.aspx	Criminal Legal	National, State	Weak	Evidence has been assessed as weak because research on decriminalization policies is still emerging, given the relative recency of adoption. Research conducted in other national contexts (e.g., Portugal) suggests that decriminalization contributes to decreased overdose mortality. Note: While there is limited evidence related to decriminalization, there is strong evidence that arrest and incarceration worsen health outcomes, including SUD and overdose.	Implemented in one jurisdiction	Low	Unlikely	Yes	Yes	Strong alignment	Reduces harmful contact
Support Housing First														
Housing First	Enact policies to connect unhoused people with housing first, and services second. Under Housing First, programs do not require sobriety/abstinence, but instead allow people who are actively using drugs to access resources. Models that fall under this umbrella can include permanent supportive housing, an approach that combines the provision of long-term housing assistance with voluntary support services to meet the needs of people experiencing steep barriers to housing (e.g., SUD, chronic homelessness).	Housing First: California Welfare & Institutions Code § 8255 Permanent Supportive Housing: LA County Department of Health Services Permanent Supportive Housing	Housing First: https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=8.&title=&part=&chapter=6.5.&article Permanent Supportive Housing: https://dhs.lacounty.gov/housing-for-health/our-services/housing-for-health/programs/#1607639443766-0b3c0b4d-b0bb	Community, Health Care	State, Local	Moderate	Evidence has been assessed as moderate because evidence on drug-related outcomes is mixed; some studies suggest reduced rates of substance use and lower rates of drug-involved death than among the unhoused population. However, Housing First has a strong evidence base demonstrating that the model increases housing stability.	Implemented in multiple jurisdictions	High	Unlikely	Yes	Yes	Strong alignment	Reduces harmful contact

Policy Name	Policy Description	Policy Example *Note: Examples are not exhaustive, but reflect at least one jurisdiciton where the policy has been implemented.*	Source	Sector(s)	Jurisdiction Level(s)	Evidence Base	Outcomes Described in the Research	Existing Implementation	Resource Requirements	Legal Restrictions	Equity	Addresses Needs Related to Social Determinants of Health	People-Centered	Reduces Harmful Contact with the Criminal Legal System
Improve and expand income support														
Guaranteed basic income (GBI)	Provide regular, unconditional cash payments to individuals and families with low income. GBI is intended to set an income floor below which no one can fall.	Stockton Economic Empowerment Demonstration (SEED) was a mayor-led initiative that gave 125 randomly selected city residents $500/month for 24 months. Other demonstrations are ongoing, but SEED was the first of its kind.	https://www.stocktondemonstration.org	Community	State, Local	Weak	Evidence on GBI and other unconditional cash transfer policies and programs is still emerging, given the relative recency of their adoption; however, existing research suggests improved health, financial stability, and employment outcomes.	Implemented in multiple jurisdictions	High	Somewhat likely	Yes	Yes	Strong alignment	Does not increase harmful contact
Eliminate policies that ban people with previous drug felony convictions and/or drug screening requirements in public assistance programs	Eliminate drug screening requirements in public assistance programs like Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP), and eliminate policies that ban people with previous drug felony convictions from receiving benefits. Note: The federal law that established TANF – the Personal Responsibility and Work Opportunity Reconciliation Act – included a lifetime ban on benefits for people with drug felony convictions, but states can partially or fully lift the ban by passing legislation. Some states (e.g., Georgia) have enacted legislation to make drug screening part of the application process for certain benefits. Universal drug testing of TANF applicants has been ruled unconstitutional; states with screening requirements generally screen all applicants, but test only those found to have "reasonable suspicion" of drug misuse.	Fully lifted drug felon ban: Washington DC	Drug testing in TANF & SNAP: https://sgp.fas.org/crs/misc/R42394.pdf Drug felon ban in TANF & SNAP: https://www.clasp.org/publications/report/brief/no-more-double-punishments	Community	National, State	Moderate	Drug-testing requirements are costly and ineffective at identifying SUD, and results may be unreliable. Note: The evidence cited in support of this policy is drawn from research on the effects of drug-screening and drug-testing requirements, not on the effects of eliminating such requirements.	Implemented in multiple jurisdictions	Low	Somewhat likely	Yes	Yes	Strong alignment	Reduces harmful contact

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