Submission to the Special Rapporteur to help inform preparation of the next thematic report to the Human Rights Council, to be held in June 2024, on the theme of "Drug policies and responses: a right to health framework on harm reduction" pursuant to Human Rights Council Resolution 51/21.

15 November 2023

DRUG POLICY ALLIANCE

The Drug Policy Alliance (DPA) is the leading organization in the U.S. promoting alternatives to the war on drugs. We envision a just society in which the use and regulation of drugs are grounded in science, compassion, health, and human rights; in which people are no longer punished for what they put into their own bodies; and in which the fears, prejudices, and punitive prohibitions of today are no more.

Since 2000, we led the way on creating cutting-edge policies that have fundamentally transformed the direction of drug policy in the U.S. and beyond. Our recent initiative Uprooting the Drug War[1] exposed how the impact of the war on drugs extends far beyond arrest and incarceration and has contaminated nearly every aspect of people's lives, including education, healthcare, housing, immigration, and employment.

DPA is pleased to offer this submission to help inform the report from the Special Rapporteur. For additional information, please contact:

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[1] https://uprootingthedrugwar.org

Key Questions

1. **While the concept of harm reduction has traditionally been applied to drug use, the Special Rapporteur is taking a broadened approach to harm reduction. What types of harm reduction policies, programmes, and practices are in place in your community, and what is their purpose or aim? How successful have they been at achieving that aim? Please provide data, as possible.**

"Social determinants of health are estimated to contribute as much as 80-90% to a person's health outcomes, while traditional health care accounts for just 10-20." [1] As such, health equity and a broad approach to harm reduction requires addressing the impacts of the drug war on underlying determinants of health, which include stable housing, employment, food security, education, and health care.

In the United States, legislative and policy-based harm reduction advocacy efforts have centered on reducing the impact of the drug war on civil systems including: fighting against bans on food assistance for people with a drug charge, removing barriers to public housing and employment opportunities based on a drug conviction, and lifting the federal ban on student financial aid for people behind bars and those with drug convictions.

Recent reforms such as cannabis legalization efforts in key states have included provisions to protect people from punishment within civil systems. In California, New Jersey, New Mexico, and New York, legalization efforts included expungement for past marijuana convictions, shielding people from being denied access to employment opportunities or housing based on a prior record.

For decades, federal student financial aid was banned for people with drug convictions, impeding opportunities in higher education. In 2020, the U.S. Congress restored student financial aid for people with drug convictions following years of advocacy. Providing access to financial assistance for post-secondary education provides people an opportunity to move out of poverty, achieve economic mobility and improve health outcomes.

Reforms at the state level such as New York's 2021 cannabis legalization law also included protections in the family regulation system.[2] The law provided crucial protections to keep families together, prohibiting loss of parental rights, custody or visitation based solely on lawful cannabis-related conduct.

While these efforts and other policy shifts have made an impact, much more work remains to be done in terms of reducing and limiting the harms of the drug war in the lives of people residing in the United States.

2. **How do legal frameworks affect the harm reduction policies, programmes, and practices (whether related to drug use or otherwise) that are available in your community, country, or region? Are there laws or policies that either facilitate or serve as a barrier to adopting or implementing certain harm reduction policies, programmes, and practices? Aside from legal and regulatory barriers, are there other obstacles in place? Please provide specific examples.**

Punitive drug policies have seeped into many areas of our lives beyond the criminal legal system – in healthcare, child welfare, employment, public benefits, housing, drug treatment, immigration, and more. Surveillance, nonconsensual drug testing, and mandatory reporting have led to families being separated, people made homeless,

denied employment and social benefits, intergenerational poverty, and more. Each of these areas – housing, family ties, employment, public benefits – have implications for health outcomes, including overdose risk. Research shows that removing a child from their parent can be a major driver of fatal overdose.[3]

The family regulation system (FRS), also called the child welfare system, often treats any real or perceived drug use as a predictor of child abuse or neglect, even though research shows that poverty is one of the largest predictors of adverse infant and child health outcomes.[4]

The Child Abuse Prevention and Treatment Act (CAPTA) of 1973 set the framework for the current punitive child welfare system and closely tracks the ramping up of the war on drugs in the 1980s.[5] Between 1986 and 1996, the number of children removed from their parents' care more than doubled at the same time the number of people in jails and prisons due to drug offenses exploded.[6] From 1982 to 2003, federal funding to support removal of children skyrocketed over 20,000 percent, with no increases to funding for support services for families.[7]

In many U.S. states, parental drug use, even without any showing of harm to a child, is often grounds to terminate parental rights and is the second most common reason to remove a child from a home.[8] Nearly 80,000 children, more than one-third of all removals, were placed in foster homes due to parental drug use in 2019, and an estimated 80 percent of all foster system cases involve parental drug use allegations at some point in the case.[9]

These policies have discriminatory impacts on low-income African Americans and Indigenous people, who are subjected to drug testing and reported to the authorities at higher rates[10] due to their frequent interaction with public systems with mandated reporting requirements.[11]

3. How does the jurisdiction in place in your region/country/state approach the criminalisation (or decriminalisation) of drug use? Please provide disaggregated data, including but not limited to gender, age, race/ethnicity, status of poverty, sexual orientation and the number of persons deprived of liberty for drug possession or consumption.

Laws in forty-nine states in the U.S. as well as at the federal level criminalize possession of drugs for personal use.[12] Oregon is the only state that passed a law in 2020 that decriminalized possession of small amounts of drugs for personal use.[13]

Drug offenses are the leading cause of arrest in the United States. In 2020, there were over 1.1 million drug-related arrests, the majority of which were for personal possession alone.[14] "Black people – who are 13% of the U.S. population – made up 24% of all drug arrests in 2020, despite the fact that people of all races use and sell drugs at similar rates."[15] The penalties and rates of imprisonment for drug offenses vary based on the specific jurisdiction.

There are 1.9 million people incarcerated in the United States, of which 1 in 5 are behind bars for a drug offense.[16] Close to 75% of those in federal prison and almost 55% in state prison for drug offenses are people of African or Latin American descent.[17] Women are one of the fastest growing segments of the U.S. prison population. Nearly 45% of women in federal prison and around 25% of people in jail and state prisons are

incarcerated for drug offenses.[18] Most women behind bars are mothers, many of them sole caregivers.

Criminal penalties and longer sentences for drug use do not result in improved health outcomes. In a study published in 2018, Pew Trusts found that "higher rates of drug imprisonment did not translate into lower rates of drug use, arrests, or overdose deaths."[19] In fact, estimates suggest that between 1999-2020 "one million people died of a drug-involved overdose, with over 100,000 deaths occurring in a calendar year for the first time in 2021."[20] The increase in overdose deaths disproportionately impacted "Black and American Indian/Alaska Native persons – increasing 44% and 39% respectively between 2019 and 2020."[21]

Criminalization of drug use prioritizes punishment over health and does not address the drivers of substance use disorder. Spending on punishment comes at the expense of funding effective health and recovery services, including drug treatment, mental health services, and other vital support and care that would better help those most in need and address some of the root causes of problematic drug use.

4. Beyond reducing the adverse health, social, and legal consequences of drug use, what other areas can benefit from harm reduction policies, programmes, and practices in furtherance of the right to health and related human rights? Examples may include, but are not limited to, the decriminalisation of sex work, the decriminalization of abortion, and safe sex programmes.

Drug war logic in civil systems in the United States exacerbates food and economic insecurity.[22, 23, 24] Harm reduction efforts include ending the ways the drug war intrudes into everyday life:

- Private workplaces and government agencies must remove prior criminal records, including drug offenses, as a basis to deny employment or the issuance of occupational licenses to millions of people.[25, 26] Employers must remove the widespread use of drug testing in employment decisions, which has documented racial disparities, as there is no evidence to support a causal connection between drug testing and improved workplace safety nor productivity.[27, 28, 29]

- Government housing agencies and landlords must remove punitive policies that make it difficult for people to stay in or access housing. For many people, stabilizing their housing situation is associated with decreases in drug use[30] and decreased use of emergency psychiatric services.[31] Yet various federal laws extended the reach of the drug war into housing policies, allowing for eviction of tenants for *suspected* drug related activity on or near public housing facilities by tenants *or guests*, without requiring an arrest or proof that the tenant or guest were engaged in drug use or sales.[32]

- Public benefit agencies must remove the bar for people with prior drug involvement. Over half of U.S. states limit welfare and food assistance eligibility for people with a felony drug record.[33] In addition to outright bans, many programs require drug testing of anyone with a prior drug conviction or suspected of drug use.[34, 35] Some programs expect the individual to cover the cost of testing, posing an enormous barrier to people who are struggling to earn a living. A positive drug test can disqualify someone from receiving cash assistance, resulting in severe health outcomes and instability.[36]

5. **What type of harm reduction policies, programmes, and practices, as well as mental health and other support (e.g., housing, legal, social, educational, and economic), are available for people who use drugs in the community, institutions, or detention facilities? Please share examples of the impact of criminalisation, discrimination, stereotypes and stigma on the different groups of the population e.g., persons in situation of homelessness, migration, or poverty, sex workers, women, children, LGBTIQ+ persons, persons who are detained or incarcerated, persons with disabilities, Indigenous Peoples, Black persons, persons affected by HIV or hepatitis, and persons living in rural areas, etc.).**

The impact of criminalizing drug use is compounded for pregnant people with substance use disorder. A report by the White House Office of National Drug Control Policy "outlines how overdose-related deaths in pregnant and postpartum women can be prevented with evidence-based treatment for opioid use disorder (OUD) like buprenorphine and methadone."[37] Unfortunately, there are systemic and cultural barriers to accessing care. The report found:

> In states like Ohio and Tennessee, overdose is the leading cause of pregnancy-related death in the year following delivery of a baby. These deaths are preventable with treatment, especially when treatment is inclusive of medications for opioid use disorder (OUD), like buprenorphine and methadone. Medications for OUD reduce risk of relapse and death for pregnant and postpartum women, and improve pregnancy outcomes – making it more likely that babies will be born at term, rather than prematurely. Still, pregnant and postpartum women with SUD face substantial systemic and cultural barriers in accessing this care.
>
> In a recent randomized field experiment, individuals posing as pregnant women with SUD were 17% less likely to be accepted for OUD treatment appointments by outpatient buprenorphine providers compared to identical non-pregnant women. Access to treatment is even more challenging for pregnant women with SUD of certain races and geographies. For example, studies suggest that individual characteristics, such as being a person of color, living in a rural community, and not speaking English are independently associated with a lower likelihood of receiving medications for OUD in pregnancy. (internal citations omitted).

Additionally, medical providers in many states are mandated to report pregnant patients suspected of drug use to child welfare authorities.[38] Despite the lack of evidence linking drug use during pregnancy and harm to the fetus or impacts on child development, drug use is presumed to be evidence of maltreatment.[39, 40] This can lead to removal of children born to parents who used drugs during pregnancy, even without signs of harm.

At least half of reports to child protective services about newborns exposed to drugs in utero come from medical professionals,[41] leaving pregnant people hesitant to access prenatal care for fear of being reported to the authorities.[42]

6. **Are there alternative measures to institutionalisation or detention? For example, are there outpatient or inpatient facilities available in your country for people using drugs? Please provide additional details (are they compulsory,**

voluntary; number available in urban and rural areas; entity in charge; type of support provided and type of staff working in these facilities/centres)?

In 2018, more than 20 million United States residents were estimated to have a substance use disorder (SUD), but only about 3.7 million accessed treatment (less than 20 percent of those in need).[43] Only a small fraction of those who access treatment receive interventions backed by scientific research.[44] This helps explain why less than half of people who access treatment actually complete it, as implementing evidence-based care is known to increase treatment engagement.[45]

The criminal legal system in the U.S. plays a substantial role in substance use treatment by requiring participation in and completion of treatment as part of participating in drug court, part of a sentence, or as a condition of release from incarceration. "A quarter or more of all admissions to substance use disorder treatment in the U.S. comes from criminal legal system referrals."[46]

Additionally, in the family regulation system, as a condition to keep a child at home or reunify with a child, most parents agree to complete "service plans" required by the child welfare agency, at times without judicial oversight. Even if drug use is not the reason a report to child protective services was made on a parent, they are often subjected to drug testing and mandated drug treatment as a requirement of their "service plan." Substance use disorder (SUD) treatment is notoriously unavailable, prohibitively expensive, challenging to access, and varies in quality. However, when parents struggle to access these scarce services and come up short, they are often labeled as "non-compliant." This "non-compliance" then becomes a basis for a finding of parental unfitness and is used to justify termination of parental rights.[47] Parents with a history of substance use reported to Human Rights Watch that they were subjected to random drug tests more frequently than parents without such history, causing unplanned disruptions that made it difficult for them to maintain employment, as those who were selected to drug test were often notified the same day and required to travel to designated testing sites within a few hours.[48, 49]

Outside of institutionalization or detention, contingency management is being used by some government entities with positive results.[50] Both the Substance Abuse and Mental Health Services Administration (SAMHSA)[51] and National Institute on Drug Abuse (NIDA)[52] recognize contingency management as an established evidence-based intervention. The Department of Veterans Affairs has incorporated it into their health services throughout the United States[53] and encourages this method for reducing stimulant use among people who access its SUD services.[54] However, contingency management remains the least implemented evidence-based SUD treatment in the U.S.[55]

7. **Please provide examples of harm reduction policies, programmes, and practices adopted or implemented with international cooperation or through foreign assistance in your country, as well as their impact on different groups within the population. What types of challenges can arise from reliance on foreign assistance? Please also provide examples focusing on the need for, and impact of, harm reduction policies, programmes, and practices on different groups of the population (e.g., persons in situation of homelessness, migration, or poverty, sex workers, women, children, LGBTIQ+ persons, persons who are detained or incarcerated, persons with disabilities, Indigenous Peoples, Black persons, persons affected by HIV or hepatitis, and persons living in rural areas, etc.).**

n/a

8. **Are there programmes of research and innovation related to harm reduction from a right to health perspective (e.g., needle and syringe programmes, supervised injection and drug use facilities, opioid substitution therapy, and others beyond the area of drug use), including outreach and education programmes, in your community, country, or region? Please provide good practices and examples.**

There are a minimal number of promising programs working to support the health and safety of newborns that may be affected by withdrawal symptoms while also following evidence-based best practices and keeping families together and avoiding contact with the family policing system.

Research in this area over the past ten years points to the importance of evidence-based practices that support and encourage the infant-birthing parent dyad – e.g. rooming-in, breastfeeding – as the most effective form of treatment for infants experiencing neonatal abstinence symptoms, neonatal opioid withdrawal, or otherwise experiencing symptoms of withdrawal. These evidence-based practices, such as the "Eat, Sleep, Console Approach," have shown to not only reduce the length of stay in the hospital but also reduce the need for treatment with additional pharmalogical agents, while also resulting in better outcomes – both for the newborn and also for the birthing parent.[56]

In addition to being more effective in terms of infant health and family relationship, studies have shown that practices like rooming in and breastfeeding provide savings over traditional pharmacologic-driven interventions for newborns with symptoms of withdrawal and can reduce length of stay in a clinical setting.[57]

One such program is an infant recovery center called Lily's Place in Huntington, West Virginia, which was created in 2012 in response to overcrowding in the newborn intensive care unit. At Lily's Place, infants born with in utero drug exposure were treated by the same doctor and team of nurses who treated drug exposed babies in the hospital, plus a social worker and administrative staff. Parents were able to visit their newborns throughout the day and stay overnight before taking them home. The cost of caring for an infant experiencing neonatal abstinence syndrome (NAS), neonatal opioid withdrawal syndrome (NOWS), or symptoms of withdrawal due to in-utero drug exposure in a hospital is nearly 20 times the cost of hospital care for an infant not experiencing NAS, NOWS, or other symptoms of withdrawal, whereas the cost of caring for newborns at Lily's Place is one-fifth the daily rate of a hospital intensive care unit.

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