Open Society Foundations
224 West 57th Street
New York, NY 10019, USA

p. +1 212-548-0600
f. +1 212-548-4600

November 14, 2023

Submission to the UN Special Rapporteur on the highest attainable standard of physical and mental health in response to call for submissions on "Drug policies and responses: a right to health framework on harm reduction."

Introduction

Open Society Foundations (OSF) make this submission in response to the Special Rapporteur's recent call for contributions to her forthcoming report on a right to health framework on harm reduction. This submission focuses on responses to overdose in the United States – now the leading cause of death for people under 50[1] and a driver of overall reductions in life expectancy.[2] **In this submission we suggest that, given the gravity of the overdose problem in the US and the failure to adequately scale up harm reduction efforts since they were first introduced in the US more than three decades ago, attention to this topic should be part of the Special Rapporteur's report**.

This submission is structured as follows: First we provide background on OSF's involvement with harm reduction and drug policy. Second, we summarize the toll of overdose in the United States. Third, we answer the questions posed by the Special Rapporteur that are most relevant to the topic of overdose in the US. Finally, we offer some recommendations for the Special Rapporteur's report.

OSF's Vantage Point

The Open Society Foundations, founded by George Soros, are the world's largest private funder of independent groups working for justice, democratic governance, and human rights. The foundations provide thousands of grants every year through a network of national and regional foundations and offices, funding a vast array of projects. This submission is based on experiences accumulated over 30 years of supporting organizations worldwide that document the harms of drug prohibition, develop and implement activities to mitigate these harms, and advocate for new approaches to drugs that put

---

[1] Katz, J. (2017, June 5). Drug deaths in America are rising faster than ever. *The New York Times*. https://www.nytimes.com/interactive/2017/06/05/upshot/opioid-epidemic-drug-overdose-deaths-are-rising-faster-than-ever.html

[2] Centers for Disease Control and Prevention. (2022, December 20). *New report confirms U.S. life expectancy has declined to lowest level since 1996*. [Press release].
https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/20221222.htm

human rights, public health, and social support at their center. With more than US$300 million invested, OSF is far and away the largest private donor to fund efforts to understand and address the harms of drug prohibition.

OSF began funding organizations working on drug policy issues in the 1990s because it recognized that drug prohibition was fundamentally at odds with key open society principles such as justice, democratic governance, human rights, transparency, accountability, and participation. An open society approach to tackling a public health and social challenge like use of potentially harmful substances would rely on evidence-based health and social interventions, engagement and empowerment of affected communities, de-stigmatization of these communities, and respect for human rights. By contrast, prohibition seeks to solve this challenge through criminalization of affected populations, heavy-handed law enforcement interventions, and stigmatization.

Through decades of work in this field, we have seen over and over again how drug prohibition tends to go hand-in-hand with authoritarian tendencies, to disproportionately affect or target minority populations, and to involve the unaccountable expenditure of huge amounts of public funds on mostly ineffective drug control measures. OSF's initial funding in this field roughly coincided with the height of the AIDS epidemic which, of course, starkly highlighted prohibition's harms as the HIV virus spread like wildfire among people who injected drugs and who had had little or no access to health and social services because they were criminalized and had been driven underground.

Over the last three decades, we have funded hundreds of organizations worldwide that research and document the harms of prohibition, implement program to mitigate these harms, and advocate for drug policy changes. Over the last several years, we have invested in a portfolio of work to address overdose in the United States. This includes efforts to advance drug decriminalization, work to establish publicly operating overdose prevention centers, initiatives to broaden the availability of the overdose reversal agent naloxone, efforts to promote access to evidence-based drug treatment, and advocacy to ensure that funds are invested in systems of care rather than punitive approaches.

Overview of Overdose in the United States

In 2022 approximately 110,000 people died from drug overdoses in the United States. More than 80,000 of those deaths involved opioids.[3] The United States is currently in what is often termed the "fourth wave" of overdose deaths. The first coincided with broad prescribing of prescription painkillers. Following crackdowns on prescribing, many people who were by then dependent on opioids transitioned to using street heroin, ushering in the second wave. Heroin interdiction efforts created conditions for the emergence of more potent and less bulky products such as fentanyl and its analogs, which have

[3] Ahmad, F., Cisewski, J., Rossen, L., & Sutton, P. (2023). *Provisional drug overdose death counts*. National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

overtaken most heroin markets throughout the US, leading to spikes in overdoses.[4] The fourth wave involves polysubstance overdoses, with people who use stimulants increasingly experiencing overdose.[5] Between 2013 and 2019, the stimulant-involved death rate increased 317%.[6] One third of overdose deaths now involve both fentanyl and stimulants, while about 18% of deaths involve stimulants alone.[7] **Black, Indigenous, and People of Color (BIPOC) groups face an outsized impact of stimulant-related overdose mortality,[8] and Black and Indigenous populations now have the highest overall rates of overdose in the US**.[9] New and dangerous adulterants continue to infiltrate the unregulated US drug supply, complicating efforts to address drug-related harms. Though the current US administration has been supportive of harm reduction, making it a key part of national strategy documents,[10] there has been a pushback from more conservative legislators.[11]

The Special Rapporteur's Questions

Below we respond to the Special Rapporteur's questions that we believe are most relevant to the issue of overdose 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.*

---

[4] Dasgupta, N., Beletsky, L., & Ciccarone, D. (2018). Opioid crisis: No easy fix to its social and economic determinants. *American Journal of Public Health*, *108*(2), 182–186. https://doi.org/10.2105/AJPH.2017.304187

[5] Ciccarone, D. (2021). The rise of illicit fentanyls, stimulants and the fourth wave of the opioid overdose crisis. *Current Opinion in Psychiatry*, *34*(4), 344. https://doi.org/10.1097/YCO.0000000000000717

[6] Centers for Disease Control and Prevention. (2023, February 24). *Stimulant guide*. https://www.cdc.gov/drugoverdose/featured-topics/stimulant-guide.html

[7] Friedman, J., & Shover, C. L. (2023). Charting the fourth wave: Geographic, temporal, race/ethnicity and demographic trends in polysubstance fentanyl overdose deaths in the United States, 2010–2021. *Addiction*, *118*(12), 2477–2485. https://doi.org/10.1111/add.16318

[8] Townsend, T., Kline, D., Rivera-Aguirre, A., Bunting, A.M., Mauro, P.M., Marshall, B.D.L., Martins, S., Cerdá, M. (2022). Racial/ethnic and geographic trends in combined stimulant/opioid overdoses, 2007-2019. *American Journal of Epidemiology. 191*(4), 599-612. https://doi.org/10.1093/aje/kwab290

[9] National Center for Health Statistics. (n.d.) *Age-adjusted rate of drug overdose deaths, by race and Hispanic origin: United States, 2020 and 2021.* National Vital Statistics System, Mortality File. https://www.cdc.gov/nchs/images/databriefs/451-500/db457-fig3.png

[10] Office of National Drug Control Policy. (n.d.) *National drug control strategy, 2022*. The White House. https://www.whitehouse.gov/ondcp/the-administrations-strategy/national-drug-control-strategy/

[11] Mann, B. (2023, May 4). As fentanyl deaths surge, some state lawmakers push back against "harm reduction." *NPR*. https://www.npr.org/2023/05/04/1173288227/fentanyl-overdose-penalty-crime-harm-reduction

Drug prohibition and the regime of criminalization broadly impacts harm reduction efforts to curb overdose. While decriminalizing drugs would address many barriers, here we outline some key issues that could be addressed in the meantime or in tandem with decriminalization:

- **Safer use supplies:** Currently 38 states, Washington, DC and Puerto Rico authorize the operation of syringe service programs (SSPs).[12] However, SSP laws vary considerably in their requirements.[13] Even where SSPs are authorized, most states have drug paraphernalia laws that criminalize distribution and possession of syringes.[14] While many states include exceptions for SSPs, in practice, paraphernalia laws still provide a pretext for law enforcement to confiscate supplies and arrest people who use drugs. In many states, carveouts to support SSPs do not protect safer smoking supplies.

- **Drug checking**: Drug checking can reduce risks by giving people information about the contents of their drugs. At least a dozen states criminalize the distribution of free drug checking equipment. Some states allow only modalities that test for particular drugs. Some have laws that allow test strips to be distributed to SSP participants, but do not allow programs to house more advanced drug checking machines.[15]

- **Naloxone**: Most formulations of naloxone are only available by prescription in the US, which introduces a host of legal barriers.[16] Barriers include lack of legal protections for prescribers or laypeople administering the drug; absence of enabling laws allowing nonprofits to stock and dispense the medication without a provider present, and prohibitions on possession without an individual prescription. Not all states allow naloxone to be prescribed to "third parties" who could respond to a loved one in need.

- **Overdose Prevention Centers (OPCs):** Though 120 centers operate in about a dozen other countries, their legality is contested in the

[12] LAPPA. (2023, August). *Syringe services: Summary of state laws.* Legislative Analysis and Public Policy Association. https://legislativeanalysis.org/wp-content/uploads/2023/09/Syringe-Services-Programs-Summary-of-State-Laws.pdf
[13] For example, some states require participants to register with the SSP, some prohibit operation without the approval of local governing bodies, and some mandate the programs operate using a 1-for-1 model, which is associated with increased syringe sharing and risk of infections. See https://legislativeanalysis.org/wp-content/uploads/2023/09/Syringe-Services-Programs-Summary-of-State-Laws.pdf
[14] Ibid.
[15] Harm Reduction Legal Project. (2023, August). *Legality of drug checking equipment in the United States.* Network for Public Health Law. https://www.networkforphl.org/wp-content/uploads/2023/11/50-State-DCE-Fact-Sheet-2023.pdf
[16] Harm Reduction Legal Project. (2023, August 1). *Legal interventions to reduce overdose mortality: Naloxone access laws.* Network for Public Health Law. https://www.networkforphl.org/wp-content/uploads/2023/11/Naloxone-Access-Laws-50-State-Survey-2023.pdf

United States.[17] Rhode Island[18] and Minnesota[19] enacted legislation to authorize OPCs, but centers have not yet opened. Philadelphia has preemptively banned sites in most of the city.[20] New York City has two publicly operating centers; they exist with support from the mayor and police chief. However, the US Attorney for the Southern District of NY has claimed the centers operate illegally and threatened to shut them down.[21] A case about the legality of OPCs is making its way through federal courts.[22]

- **Drug-Induced Homicide Laws**: These laws enable harsh sentences for selling or sharing drugs involved in another person's death. The majority of prosecutions are brought against people who are low-level dealers or friends/family of the decedent. These laws deter people from calling for emergency help during an overdose. Research shows that median sentences for BIPOC defendants are much longer than for white defendants charged with the same crimes.[23]

- **Good Samaritan Laws:** Though 48 states and Washington, DC have now adopted some form of Good Samaritan law (intended to promote calling for help in an overdose emergency), most offer limited protections that do not extend to more serious drug-related crimes and do not protect against laws criminalizing poverty, like trespassing or vagrancy. Most also do not protect against outstanding warrants or drug-induced homicide charges.[24]

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,*

---

[17] Beletsky, L., Davis, C. S., Anderson, E., & Burris, S. (2008). The law (and politics) of safe injection facilities in the United States. *American Journal of Public Health*, *98*(2), 231–237. https://doi.org/10.2105/AJPH.2006.103747

[18] H5245 Substitute A, January Session 2021. (RI 2017). http://webserver.rilin.state.ri.us/BillText/BillText21/Proposed21/H5245A.pdf

[19] SF 2934 4th Engrossment—93rd Legislature (MN 2023—2024). https://www.revisor.mn.gov/bills/text.php?number=SF2934&version=latest&session=ls93&session_year=2023&session_number=0

[20] Orso, A. (2023, September 28). *Philadelphia bans supervised injection sites in most of the city after City Council rejects Mayor Jim Kenney's veto*. https://www.inquirer.com/politics/philadelphia/supervised-injection-site-philadelphia-city-council-ban-20230928.html

[21] Otterman, S. (2023, August 8). Federal officials may shut down overdose prevention centers in Manhattan. *The New York Times*. https://www.nytimes.com/2023/08/08/nyregion/drug-overdoses-supervised-consumption-nyc.html

[22] Leonard, N. (2023, July 30). DOJ seeks to dismiss Safehouse supervised injection site suit as settlement talks fail. *WHYY*. https://whyy.org/articles/safehouse-supervised-injection-suit-department-justice-dismiss/

[23] The Action Lab. (n.d.). *Drug-induced homicide*. https://www.healthinjustice.org/drug-induced-homicide

[24] Harm Reduction Legal Project. (2023, May 1). Legal interventions to reduce overdose mortality: Overdose Good Samaritan laws. Network for Public Health Law. https://www.networkforphl.org/wp-content/uploads/2023/07/Legal-Interventions-to-Reduce-Overdose-Mortality-Overdose-Good-Samaritan-Laws-2.pdf

race/ethnicity, status of poverty, sexual orientation and the number of persons deprived of liberty for drug possession or consumption.

Drug criminalization has resulted in the United States having the largest prison population in the world. One in five incarcerated people in the United States is locked up for a drug offense – that's 353,000 people on any given day.[25] There are more than 1 million drug possession arrests each year – more than for any other crime.[26] Although the overall number of arrests in the US decreased by nearly 25% from 2009 to 2019, arrests for drug possession remained stable (despite the fact that a growing number of states legalized cannabis during this time period).[27]

Black adults account for 27% of drug arrests, while constituting only 12% of the population. Black youth are also arrested disproportionately, accounting for 22% of drug arrests and just 14% of the population.[28] This is despite similar levels of drug use compared to white people. **Women are more likely to be incarcerated for drug offenses: 25% of women in state prison have been convicted for a drug offense, compared to 12% of men**.[29] LGBTQ+ people are also disproportionately impacted: According to research that the Prison Policy Initiative did using the National Survey on Drug Use and Health, **in 2019, gay, lesbian and bisexual individuals were 2.25 times as likely as straight people to be arrested in the past 12 months**. This disparity is driven by lesbian and bisexual women, who are 4 times as likely as straight women to be arrested.[30]

Harm reduction is virtually nonexistent in prisons. Despite the fact that 85% of the prison population has a substance use disorder or was incarcerated for a crime involving drugs,[31] only about 1 in 13 people with drug dependency receive treatment while in jail or prison.[32] Recent lawsuits that have forced some jails to provide treatment.[33] While some closed settings offer naloxone to incarcerated people upon release, it is not provided during incarceration. Similarly, sterile drug use equipment is not provided to incarcerated people in US prisons or jails.

---

[25]Sawyer, W. & Wagner, P. (2023). *1 in 5 incarcerated people is locked up for a drug offense*. Prison Policy Initative. https://www.prisonpolicy.org/graphs/pie2023_drugs.html

[26] Pew Charitable Trusts. (2022, February 15). *Drug arrests stayed high even as imprisonment fell from 2009 to 2019* [Issue brief]. https://pew.org/3GzjeVl

[27] Ibid.

[28] Ibid.

[29] Monazzam, N. & Budd, K.M. (2023, April 3). *Incarcerated women and girls* [Fact sheet]. The Sentencing Project. https://www.sentencingproject.org/fact-sheet/incarcerated-women-and-girls/

[30] Jones, A. (2021, March 2). *Visualizing the unequal treatment of LGBTQ people in the criminal justice system*. https://www.prisonpolicy.org/blog/2021/03/02/lgbtq/

[31] National Institute on Drug Abuse. (2020, June). Criminal Justice DrugFacts. National Institutes of Health, US Department of Health and Human Services. https://nida.nih.gov/publications/drugfacts/criminal-justice

[32] Pew Charitable Trusts, Op. Cit.

[33] Legal Action Center. (2023, October 16). *Cases involving discrimination based on treatment with medication for opioid use disorder (MOUD).* https://www.lac.org/assets/files/Cases-involving-denial-of-access-to-MOUD.pdf

Disruptions in tolerance, the lack of treatment, and the trauma related to incarceration puts people at great risk. Research in Washington state found that people incarcerated there were 129 times more likely to die from overdose in the two weeks following release from prison, compared to the general public.[34] **A more recent study in North Carolina found that formerly incarcerated people were 40 times more likely to die of an opioid overdose in the two weeks after release.[35] Overdose is also the third leading cause of death in custody in US jails**.[36]

Only one state in the United States – Oregon – has decriminalized drug use broadly. Washington state also decriminalized small amounts of drugs and largely decriminalized the possession of drug paraphernalia. A study looking at decriminalization in Oregon and Washington showed that it resulted in dramatic reductions in arrests for drug possession without increasing arrests for violent crimes.[37]

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.).*

At least 534 syringe service programs now operate in 45 states, Washington, DC and Puerto Rico,[38] though there are still major gaps in coverage. Programs that exist are often unable to provide services as expansively as they would like, due to limited funding.[39] People living in rural areas face challenges – for example, one study found that 98% of young people living

---

[34] Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison—A high risk of death for former inmates. *The New England Journal of Medicine*, *356*(2), 157–165. https://doi.org/10.1056/NEJMsa064115

[35] Ranapurwala, S. I., Shanahan, M. E., Alexandridis, A. A., Proescholdbell, S. K., Naumann, R. B., Edwards, D., & Marshall, S. W. (2018). Opioid overdose mortality among former North Carolina inmates: 2000–2015. *American Journal of Public Health*, *108*(9), 1207–1213. https://doi.org/10.2105/AJPH.2018.304514

[36] Fiscella, K., Noonan, M., Leonard, S. H., Farah, S., Sanders, M., Wakeman, S. E., & Savolainen, J. (2020). Drug- and alcohol-associated deaths in U.S. jails. *Journal of Correctional Health Care*, *26*(2), 183–193. https://doi.org/10.1177/1078345820917356

[37] Davis, C. S., Joshi, S., Rivera, B. D., & Cerdá, M. (2023). Changes in arrests following decriminalization of low-level drug possession in Oregon and Washington. *International Journal of Drug Policy*, *119*, 104155. https://doi.org/10.1016/j.drugpo.2023.104155

[38] LAPPA, Op. Cit.

[39] Wenger, L. D., Kral, A. H., Bluthenthal, R. N., Morris, T., Ongais, L., & Lambdin, B. H. (2021). Ingenuity and resiliency of syringe service programs on the front lines of the opioid overdose and COVID-19 crises. *Translational Research*, *234*, 159–173. https://doi.org/10.1016/j.trsl.2021.03.011

with hepatitis C virus lived more than 10 miles from the nearest SSP, compared to 47% of those in urban areas.[40] There are also stark racial disparities in access to care. While in 2015, SSP use was fairly even amongst Black, white and Hispanic people who inject drugs (at around 50%), by 2018, the proportion of Black people who inject drugs receiving syringes from an SSP had dropped to 40%, while it had increased to 63% for both white and Hispanic people.[41] Furthermore, while rates of cocaine use amongst Black and white people are about the same, rates of cocaine-involved overdose deaths were more than twice as high amongst Black people compared to white people in 2019. Rates of psychostimulant (e.g., methamphetamine) overdose were generally higher amongst indigenous people compared to other groups.[42] The fact that most harm reduction programs don't offer safer smoking and snorting supplies, either because of legal prohibitions or lack of funding, may limit opportunities to reach BIPOC stimulant users with harm reduction services.

The US has a contaminated drug supply, due to the unregulated drug market that is a consequence of drug criminalization. Drug checking programs (with more advanced machines)[43] are still few and far between in the United States, with perhaps 50 programs getting set up or currently operating across the country.[44] Lack of funding and enabling legislation limits these potentially lifesaving programs in many states.

People who use drugs often report stigma and discrimination in hospital and mainstream healthcare settings, deterring them from seeking care.[45] OSF harm reduction grantees have reported that their participants are strip-searched upon admission to the hospital and not allowed most personal possessions or visitors – not even caseworkers or clergy. People often report denial of medications to control pain or alleviate withdrawal, because they are assumed to be "drug seeking." More work needs to be done to train healthcare

---

[40] Canary, L., Hariri, S., Campbell, C., Young, R., Whitcomb, J., Kaufman, H., Vellozzi, C. (2017). Geographic disparities in access to syringe services programs among young persons with hepatitis C virus infection in the United States. *Clinical Infectious Diseases, 65*(3), 514-517. https://doi.org/10.1093/cid/cix333

[41] Handanagic, S. (2021). HIV infection and HIV-associated behaviors among persons who inject drugs—23 metropolitan statistical areas, United States, 2018. *MMWR. Morbidity and Mortality Weekly Report*, *70*. https://doi.org/10.15585/mmwr.mm7042a1

[42] CDC. (2021, October 19). *Cocaine and psychostimulant-involved overdose deaths disproportionately affect racial and ethnic minority groups*. Centers for Disease Control and Prevention. https://go.usa.gov/xek9f

[43] Carroll, J. J., Mackin, S., Schmidt, C., McKenzie, M., & Green, T. C. (2022). The Bronze Age of drug checking: Barriers and facilitators to implementing advanced drug checking amidst police violence and COVID-19. *Harm Reduction Journal*, *19*(1), 9. https://doi.org/10.1186/s12954-022-00590-z

[44] Personal communication with the Remedy Alliance Drug Checking Guild. (2023, November 9).

[45] Biancarelli, D. L., Biello, K. B., Childs, E., Drainoni, M., Salhaney, P., Edeza, A., Mimiaga, M. J., Saitz, R., & Bazzi, A. R. (2019). Strategies used by people who inject drugs to avoid stigma in healthcare settings. *Drug and Alcohol Dependence*, *198*, 80–86. https://doi.org/10.1016/j.drugalcdep.2019.01.037

workers on stigma[46] and to reform hospital policies dealing with substance use.[47]

Many housing programs in the US require people to be abstinent from drugs or exclude people who have drug-related convictions. This can happen either because landlords run criminal background checks and then discriminate against people with convictions, or because many supportive housing programs require sobriety.[48] Some housing also excluding people using medications for addiction treatment, though this may constitute a violation of the Americans with Disabilities Act and at least one legal challenge resulted in a favorable settlement.[49] **Research has found that people who are houseless are nine times more likely to die from an opioid overdose than people who are stably housed.[50] The lowest-income renters (disproportionately BIPOC Americans) have the fewest options for affordable housing**.[51]

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)?*

While calls for a public health approach have achieved significant changes in some places, like Oregon, elsewhere they have led to coercive models. Drug courts have proliferated, offering a chance at treatment rather than incarceration, with many drawbacks.[52] Quality treatment is inaccessible in many areas, as discussed below. Furthermore, many drug courts prohibit medications for addiction treatment – the gold standard of care for opioid use

---

[46] Aronowitz, S., & Meisel, Z. F. (2022). Addressing stigma to provide quality care to people who use drugs. *JAMA Network Open*, *5*(2), e2146980. https://doi.org/10.1001/jamanetworkopen.2021.46980

[47] Martin, M., Snyder, H. R., Otway, G., Holpit, L., Day, L. W., & Seidman, D. (2023). In-hospital substance use policies: An opportunity to advance equity, reduce stigma, and offer evidence-based addiction care. *Journal of Addiction Medicine*, *17*(1), 10. https://doi.org/10.1097/ADM.0000000000001046

[48] Wyant, B.E., Karon, S.,S., Pfefferle. (2019, June 23). *Housing options for recovery for individuals with opioid use disorder: A literature review*. Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/reports/housing-options-recovery-individuals-opioid-use-disorder-literature-review-0

[49] Legal Action Center, Op. Cit.

[50] Baggett, T.P., Hwang, S.W., O'Connell, J.J., Porneala, B.C., Stringfellow, E.J., Orav, E.J., Rigotti, N.A. (2013). Mortality among homeless adults in Boston: Shifts in causes of death over a 15-year period. *JAMA Internal Medicine*, 173(3), 189-195. doi: 10.1001/jamainternmed.2013.1604

[51] Aurand, A., Emmanuel, D., Threet, D., Rafi, I., Yentel, D. (2021, March). *The gap: A shortage of affordable homes.* National Low Income Housing Coalition. https://reports.nlihc.org/sites/default/files/gap/Gap-Report_2021.pdf

[52] Csete, J., & Tomasini-Joshi, D. (2015, February). *Drug courts: Equivocal evidence on a popular intervention*. Open Society Foundations. https://www.opensocietyfoundations.org/publications/drug-courts-equivocal-evidence-popular-intervention

disorder.[53] Some courts only allow one medication – naltrexone – associated with increased risk of overdose.[54] Those who relapse or don't "graduate" from the court-mandated program can face a mandatory sentence, sometimes longer than the original sentence.[55] Drug courts also have a "net widening" effect because people who would typically receive little or no jail time are brought into the system, and if they relapse they may face sentences two to five years longer than conventionally sentenced defendants.[56] Ultimately, drug courts have not succeeded in lowering prison populations. They also exacerbate racial disparities through "net widening" and because Black Americans are at least 30% more likely to be expelled from drug courts than white defendants, facing jail time instead.[57]

Recently, there have been increased calls[58] for involuntary treatment, or "civil commitment" of people who use drugs.[59] More than half of US states have statutes authorizing involuntary commitment for drug use.[60] In Massachusetts, where more than 42,000 people have been involuntarily committed under their "Section 35" provision,[61] research found that the risk of fatal overdose was twice as high after Section 35 when compared to voluntary treatment.[62]

Even where drug treatment is voluntary, it is often inaccessible. Only one in eight people who could benefit are able to access opioid agonist treatment (OAT).[63] Fewer than one-third of residential treatment programs in a

---

[53] Mehta, C. (2017, June 15). *Neither justice nor treatment: Drug courts in the United States.* Physicians for Human Rights. https://phr.org/our-work/resources/niether-justice-nor-treatment/

[54] Szalavitz, M. (2023, December 13). Vivitrol, used to fight opioid misuse, has a major overdose problem. *Scientific American.* https://www.scientificamerican.com/article/vivitrol-used-to-fight-opioid-misuse-has-a-major-overdose-problem/

[55] Drug Policy Alliance. (2011, March). *Drug courts are not the answer: Toward a health-centered approach to drug use.* https://drugpolicy.org/wp-content/uploads/2023/09/Drug-Courts-Are-Not-the-Answer_Final2.pdf

[56] Ibid.

[57] Ibid.

[58] Nguyen, T. (2023, October 10). New California law aims to force people with mental illness or addiction to get help. *AP News.* https://apnews.com/article/california-newsom-mental-health-conservatorship-baef68d08e1f8fd57869f40db2f2adce

[59] Wakeman, S. E. (2023, April 25). Why involuntary treatment for addiction is a dangerous idea. *STAT*. https://www.statnews.com/2023/04/25/involuntary-treatment-for-addiction-research/

[60] The Action Lab (n.d.). *Involuntary commitment for substance use.* https://www.healthinjustice.org/involuntary-commitment-for-substanc

[61] Section 35 Commission. (2019, July 1). *Section 35 Commission report.* [PowerPoint slides]. https://www.mass.gov/doc/section-35-commission-report-7-1-2019/download

[62] Massachusetts Department of Health. (2016, September). *An assessment of opioid-related deaths in Massachusetts (2013 – 2014).* https://www.mass.gov/doc/legislative-report-chapter-55-opioid-overdose-study-september-2016/download

[63] Wakeman, S. E., Larochelle, M. R., Ameli, O., Chaisson, C. E., McPheeters, J. T., Crown, W. H., Azocar, F., & Sanghavi, D. M. (2020). Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. *JAMA Network Open*, *3*(2), e1920622–e1920622. https://doi.org/10.1001/jamanetworkopen.2019.20622

nationwide sample allowed participants to access OAT and more than 20% of the programs actively discouraged people inquiring about the program from seeking those medications.[64]

Federal and state regulations also inhibit OAT access. Methadone is only delivered (for drug dependence) via specialized clinics. People are often required to visit those far-flung clinics daily, are frequently made to submit urine drug tests, and are cut off from their medicine for small violations or for testing positive for other drugs.[65] Though recent policy changes have allowed for mobile methadone clinics,[66] it is still not dispensed for addiction treatment via pharmacies in the US.[67] There are also disparities related to race and income: Buprenorphine treatment, which is dispensed in pharmacies, is concentrated among white people with private insurance or the ability to self-pay. Methadone clinics are often concentrated in Black neighborhoods.[68]

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.*

Here we provide a few examples of innovative programming in the US (One key innovation – safe supply – is still lacking in the US, inhibited by policy barriers.[69]):

- **Drug decriminalization**: In 2020, voters approved a ballot initiative, supported by OSF grantees Drug Policy Alliance and Oregon Health Justice Recovery Alliance, to make Oregon the first US state to decriminalize possession and use of all drugs. Under the ballot initiative, possession of controlled substances now carries a maximum

[64] Beetham, T., Saloner, B., Gaye, M., Wakeman, S. E., Frank, R. G., & Barnett, M. L. (2020). Therapies offered at residential addiction treatment programs in the United States. *JAMA*, *324*(8), 804–806. https://doi.org/10.1001/jama.2020.8969
[65] Simon, C., Vincent, L., Coulter, A., Salazar, Z., Voyles, N., Roberts, L., Frank, D., & Brothers, S. (2022). The methadone manifesto: Treatment experiences and policy recommendations from methadone patient activists. *American Journal of Public Health*, *112*(S2), S117–S122. https://doi.org/10.2105/AJPH.2021.306665
[66] United States Drug Enforcement Administration. (2022, March 23). DEA's commitment to expanding access to medication-assisted treatment. [Press release]. https://www.dea.gov/press-releases/2022/03/23/deas-commitment-expanding-access-medication-assisted-treatment
[67] Marchetti, M. & Redmond, H. (Directors.) (2021). *Swallow THIS: A documentary about methadone and COVID-19*. Portico Films. https://www.porticofilms.com/swallowthis
[68] Hansen, H. B., Siegel, C. E., Case, B. G., Bertollo, D. N., DiRocco, D., & Galanter, M. (2013). Variation in use of buprenorphine and methadone treatment by racial, ethnic and income characteristics of residential social areas in New York City. *The Journal of Behavioral Health Services & Research*, *40*(3), 10.1007/s11414-013-9341–9343. https://doi.org/10.1007/s11414-013-9341-3
[69] Ivsins, A., Boyd, J., Beletsky, L., & McNeil, R. (2020). Tackling the overdose crisis: The role of safe supply. *The International Journal on Drug Policy*, *80*, 102769. https://doi.org/10.1016/j.drugpo.2020.102769

fine of US$100 which can be waived if the person calls a hotline for a health assessment. The initiative also directs funds from cannabis taxation proceeds and savings in criminal justice expenses to health and social services, including community-based interventions, for people who use drugs.

- **Overdose prevention centers**: OSF is supporting the first ever government-sanctioned overdose prevention centers in the United States located in the neighborhoods of Harlem and the Bronx in New York City. The two sites, operated by a group called OnPoint, serve majority poor, Black and Latino populations in areas with the highest rates of overdose death in the city.[70] The centers have reversed more than 1,000 overdoses and operate under a "wellness model" that also provides showers, laundry, a respite room, mental health services, and connection to other care.

- **Naloxone access:** Bureaucratic barriers and commercial determinants of health had long kept harm reduction programs in the US from getting the naloxone they needed. An OSF grantee called Remedy Alliance/For the People changed that.[71] To order naloxone from drug-makers, programs needed a prescriber with a Drug Enforcement Agency number. Recognizing this was a barrier for small harm reduction programs on the frontlines, Remedy Alliance exploited a little-known provision in the Drug Supply Chain Security Act to purchase large quantities of naloxone under the license of their own medical director and ship them to grassroots programs throughout the country. Because cost was also a barrier to programs that don't receive state funding (and disproportionately serve BIPOC communities) Remedy Alliance instituted a tiered pricing models, whereby institutional purchasers buy naloxone from them at slightly above cost, in order to subsidize free naloxone to programs that can't afford it. Since they incorporated as a nonprofit in 2022, Remedy Alliance has shipped 2 million doses of naloxone, covering nearly every US state.

- **Drug checking:** Due to the unregulated drug supply, lack of knowledge about the contents of a batch of drugs puts users at risk of overdose and other harms. North Carolina Survivors Union,[72] a health hub and OSF grantee, became the first drug user-run site in the US to offer point-of-care drug checking to participants, with a Fourier Transform Infrared Spectroscopy (FTIR) machine. They were the first to identify the dangerous adulterant xylazine in the North Carolina drug supply, allowing them to warn participants and council people appropriately about safer use and wound care. Their drug checking also helps other harm reduction programs, doctors, and public health authorities in the state keep abreast of changes in the drug supply.

[70] OnPoint NYC. https://onpointnyc.org/
[71] Remedy Alliance/For the People. https://remedyallianceftp.org/
[72] North Carolina Survivors Union. https://www.ncsurvivorsunion.org/

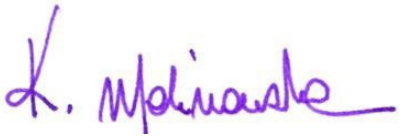
Recommendations

For far too long, the public health and human rights communities have quietly accepted the framing of prohibition as a necessary measure for countering health harms associated with drug use. Human rights institutions have tended to be agnostic on prohibition per se and have instead focused on denouncing human rights violations committed as part of its enforcement. Public health organizations, similarly, have tended to focus on the promotion of health interventions, like needle and syringe exchange, that address health needs of people who use drugs but do not challenge prohibition itself.

The cumulative work of the organizations we have supported over the last 30 years, however, leaves no doubt that the prohibition system is inherently inconsistent with the right to health and that the above-mentioned innovations can mitigate prohibition's health harms but not end it. **The work of the organizations we have supported shows that prohibition is almost always associated with human rights violations such as overincarceration, stigma, discrimination, and racially biased and neocolonial application, thus undermining the right to health**. Moreover, drug prohibition is not an effective institution for reducing health harms related to drug use as, in the words of the 2016 Lancet Commission on Public Health and International Drug Policy, the public health "harms of prohibition far outweigh the benefits."[73]

We thus urge you to use this report to move beyond the traditional approach that focuses on the abuses that result from drug prohibition—an approach that, in our view, ultimately legitimizes the continued reliance on drug prohibition—and to describe the institution itself as an oppressive structure in global health and as a human rights abuse.

Yours sincerely,



Kasia Malinowska-Sempruch, Dr. PH
Director, Drug Policy at Global Programs

[73] Csete, J., Kamarulzaman, A., Kazatchkine, M., Altice, F., Balicki, M., Buxton, J., Cepeda, J., Comfort, M., Goosby, E., Goulão, J., Hart, C., Kerr, T., Lajous, A. M., Lewis, S., Martin, N., Mejía, D., Camacho, A., Mathieson, D., Obot, I., … Beyrer, C. (2016). Public health and international drug policy. *The Lancet*, *387*(10026), 1427–1480. https://doi.org/10.1016/S0140-6736(16)00619-X