WHITE PAPER

Temple University
Beasley School of Law

Center for
Public Health
Law Research

A Transformative Whole-of-Government Model to Reduce Opioid Use Harms and Deaths

THE LEGAL PATH TO A WHOLE OF GOVERNMENT OPIOIDS RESPONSE: PART 1

November 2023

Nicolas Terry, LLM
Sterling Johnson, JD
Jonathan Larsen, JD, MPP
Scott Burris, JD

Introduction

The 2016 US Surgeon General's Report, *Facing Addiction in America*, provided an extraordinarily thorough and essentially irrefutable diagnosis of the country's drug problem. It also suggested a possible inflection point for drug policy: a transition from a (drug control policing) "war on drugs" to the embrace of (public health and health care) policies aimed at harm reduction, prevention, and treatment. Since then, the myriad of published federal and state strategies to combat substance use, including the Biden administration's 2022 National Drug Control Strategy (The White House Executive Office of the President, 2022), have agreed on some central tenets or policies that deploy resources to both supply side (law enforcement combating of production and trafficking and public safety) and demand side (prevention, harm reduction, treatment, and recovery) strategies.

However, the inflection point has not been fully embraced. Notwithstanding three decades of the overdose epidemic and renewed federal emergency declarations entering their sixth year (Administration for Strategic Preparedness and Response, 2022), drug harms and deaths keep increasing, with overdose drug deaths now exceeding 100,000 per year (Ahmad et al., 2023). The "war on drugs" continues, bringing with it law enforcement overreaching, disproportionate sentencing, overwhelmingly unequal consequences for people of color, and collateral consequences that linger long after incarceration (Drug Policy Alliance, 2015). During the past six years, successive federal and state administrations have expended considerable resources studying the problem and increasing public expenditures across the conventional policies. We know what to do to move beyond the lost war, but lack the political will to move decisively (New York Times Editorial Board, 2023). There have been some successes: innovations in treatment (Brooklyn & Sigmon, 2017), the deregulation of some treatment drugs (Substance Abuse and Mental health Administration, 2023), the elevation of harm

> "Despite decades of expense and effort focused on a criminal justice–based model for addressing substance use–related problems, substance misuse remains a national public health crisis that continues to rob the United States of its most valuable asset: its people."
>
> – *Facing Addiction in America*, Office of the Surgeon General, 2016

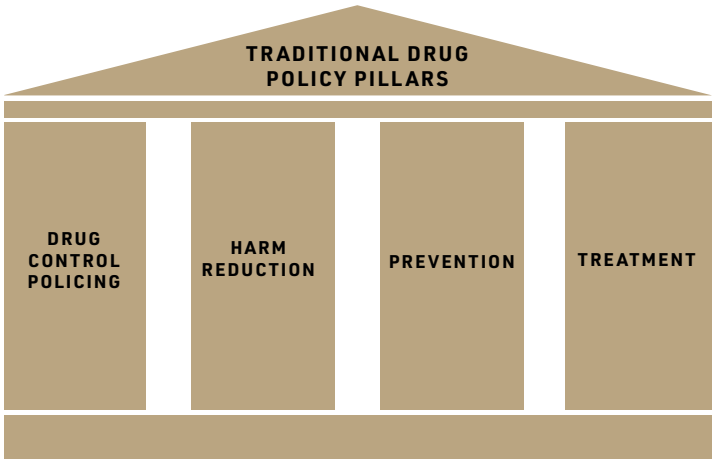

Figure 1: Traditionally, US drug policy has adopted a four-pillar approach to address harm: drug control policing, harm reduction, prevention, and treatment.

reduction (Weiland, 2022), and a better understanding of the role of social and structural determinants of health (Cohen et al., 2022; Galea, 2022; WHO Commission on Social Determinants of Health, 2008). However, given the resources expended, overall progress has been glacial (Gottschalk, 2023).

In this paper we introduce the Whole-of-Government (W-G) approach to reducing opioid use harms and deaths and how it should lead us to replace or seriously recalibrate conventional governmental drug strategies. These strategies embrace the coexistence of the traditional pillars — prevention, harm reduction, treatment, and drug control policing (Macpherson, 2001; Government of Canada, 2016) (Figure 1). As currently implemented, these pillars frequently are oppositional, such that, to build on the public health funding paradox (Fleming et al., 2021), many of our drug policies are causing the very harms that other policies seek to address and, even when policies across (horizontal) and between (vertical) levels of government are not outright antagonistic, frequently they are seriously misaligned. Whether oppositional or misaligned, these strategies and the laws or policies through which they operate must be transformed.

The Whole-of-Government Model

Through the W-G approach, we gain an improved understanding of the design and implementation of conventional drug policy. The W-G perspective provides both a lens through which to critique current levels of alignment and misalignment between different levels of government or agencies at the same level, and a normative tool designed to structure reforms. Recognizing that the opioid crisis is the result of a poorly functioning complex ecosystem, lacking effective integration and riddled with contradictions, is accurate but incomplete (Bingham et al., 2016; Stein et al., 2023). The key is to understand how the dysfunction is largely caused by legal barriers and fundamental policy misalignments.

Complex, particularly "wicked problems" (Lee, 2018) such as addiction attract attention and regulation from multiple agencies distributed across one level of government, across different levels of government, or both. They are also dependent on multiple funding streams, not only in their sources (such as federal or state) but also their type (mandatory or discretionary), and their stability (such as consistent funding streams versus episodic grants). Not surprisingly, these multiple interrelationships and interdependencies at the least create friction, and at worst actively work against solving hugely complex problems. What is required is effective, comprehensive, coordinated government action across the different agencies at one level of government (be it federal or state), what we term *horizontal* W-G, and between different levels (federal,

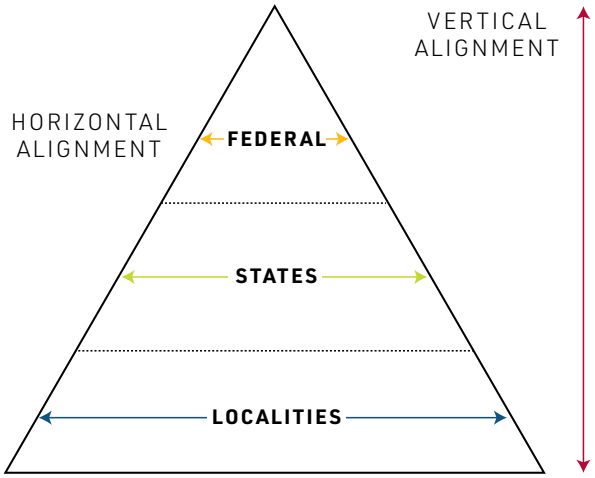

Figure 2: The Basic structure for Whole-of-Government alignment of laws and policies.

state, tribal, and local), what we term *vertical* W-G. Such co-ordination is essential "to eliminate situations in which different policies undermine each other, to make better use of scarce resources, to create synergies by bringing together different stakeholders in a particular policy area and to offer citizens seamless rather than fragmented access to services" (Christensen & Lægreid, 2017) (Figure 2).

What we find in practice are fundamental exceptions from the W-G ideal. It is tempting to dismiss many of these as structural. It is of course the case that we have a complex governmental structure in which the federal government owns policymaking, financing, and implementation in relatively few domains. As a result, most of the time Congress funds policies or strategies but implementation devolves to state, local, and often, private actors. However, this does not excuse incoherence across multiple federal agencies, particularly their failures to agree on the nature of the problem and its causes (Worzala et al., 2018). Nor does federalism excuse repeated failures of federal, state, and local governments to work together and prioritize the removal of law and policy barriers that frustrate the downstream or upstream implementation of their policies. How else are we to interpret federal strategies that finally accept the overwhelming evidence-base supporting the funding of Syringe Services Programs (SSPs) (Centers for Disease Control and Prevention, 2022) but then condition state implementation on a certificate of need and prohibit the use of federal funds for purchasing syringes (Centers for Disease Control and Prevention, 2019)? Meanwhile, downstream, while most states begrudgingly have legalized SSPs, how many have fully rethought their drug paraphernalia laws to remove structural disincentives to using SSPs (Singer & Heimowitz, 2022)? Finally, why have state legislatures given veto powers to county health commissioners that encourages NIMBYism in the siting of SSP facilities (Ind. Code §16-41-7.5-5, 2021) (Figure 3)?

These fundamental derogations from W-G strategic alignment and the persistence of legal barriers inevitably cause failures to continue to mount. The response has been to double-down on the conventional strategies while occasionally recalibrating the percentage increases allotted to each, such as when one administration favors harm reduction over interdiction. That approach has led to unconscionable waste. The United States has spent more than $1 trillion on the "war on drugs;" even as drug prices drop, the illegal drug supply gets more dangerous, and the deaths keep going up (Pearl & Perez, 2018).

Different and more ambitious thinking is needed. We must understand that there are better ways to fund initiatives and how conventional strategies hide conflicting or overlapping agencies, policies, and laws. And we must accept that many of the conventional approaches will be ineffective (or at least severely limited) without addressing upstream structural and social determinants. If federal or state agencies continue to press inconsistent or incoherent strategies that get in each other's way, they must be brought to heel by a central coordinating body. Further, both federal and state agencies must commit to performing gap analyses to root out policy misalignments and legal barriers. It is important to recognize progress such as the Biden administration's embrace of harm reduction. But, by itself, that represents only a pyrrhic victory if it is not accompanied by turning down the law enforcement heat (Schwartzapfel, 2021). Equally, if we were to decriminalize possession and stop warehousing drug users in our prisons, we will need to ramp up our treatment and social services while finding ways to allow those who use drugs and those who don't to share spaces in our cities.

A Transformative Model

Calling out legal barriers and policy misalignments while exhorting governmental and private actors to do better will not be enough. It is time to fundamentally rethink drug policies and implementation models. Many government agencies and commissions have set out policy frameworks built on a set of supposedly mutually supportive pillars, most commonly harm reduction, prevention, treatment, and drug control policing. These pillars are not complementary, but antagonistic. Once we accept that criminalization of drugs and drug users is not a supportive pillar, it is possible to suggest a very different, transformative model. The key component of transforming the drug policy landscape is decriminalization. The politicization of drug policy and the stigma surrounding drug users and those who treat them suggests that this will be a slow and likely decentralized process (in some places just turning down the heat on the "war on drugs" will be a victory. However, it is crucial to understand that ending the harm of criminalization must be accompanied by a difficult and process of building a new approach that does better. As we move away from warehousing drug users in prisons and the minimal treatment they receive, we must invest in the treatment, harm reduction, and safety net services they will require.

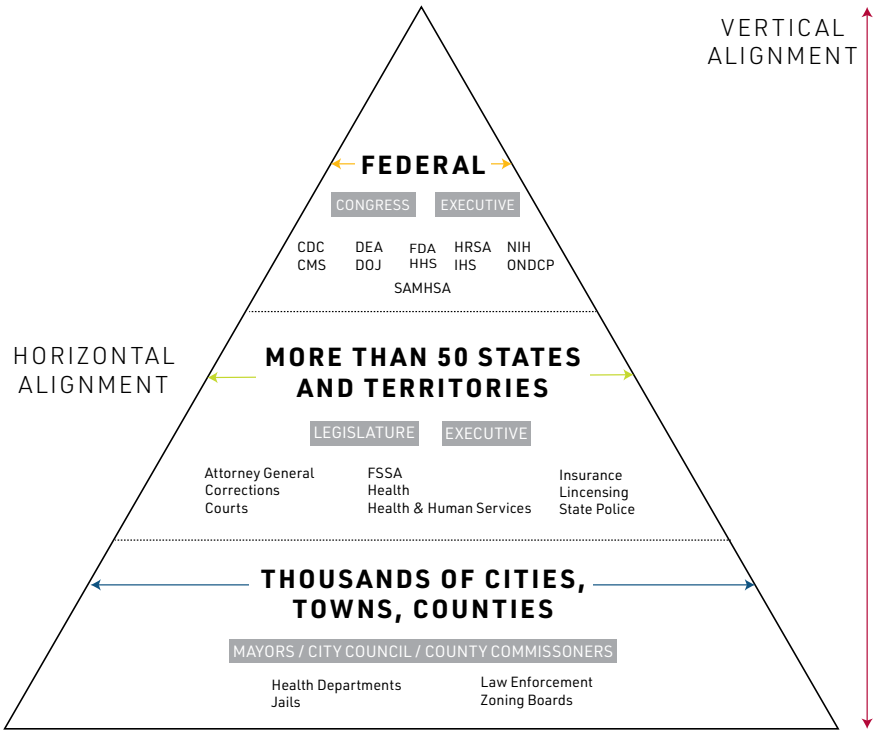

Figure 3: Examples of federal, state, and local government agencies that should interact to promote a Whole-of-Government approach.

This transformative model reflects an interrelated set of approaches based in collaborative policymaking and a real, compassionate understanding of the nature of drug use (Figure 4). The components of the model are:

1. Reimagine federal funding of substance use strategies to promote long-term state strategies and coordinated spending.
2. Remove the final "war on drugs" impediments from the treatment domain.
3. Accept that harmful substance use is not only a chronic condition but one that requires redesigning health care.
4. Build a modern harm reduction system and allow it to do its job with sharply reduced interference from contrary federal policies, inconsistent state laws, and structural barriers.
5. Identify and remedy the upstream social and structural determinants that operate both as root causes of SUD and impediments to treatment and recovery.

1. Reimagine federal funding of substance use strategies to promote long-term state strategies and coordinated spending

Conventional policies of substance use amelioration are primarily funded by the federal government. A considerable share of that funding is spent on law enforcement (The 2021 federal budget for criminal justice responses to substance use was $17.5 billion) and health care (in 2021 federal and state governments spent almost $750 billion on Medicaid, by far the most important source of funds for state-provided opioid use disorder (OUD) treatment and improving social determinants). However, funding of harm reduction, treatment for the uninsured or underinsured, and reduction in social stressors such as lack of affordable housing, well-paying work, or education are more likely to be delivered under grant programs such as those operated by the Substance Abuse and Mental Health Services Administration (SAMHSA) (e.g., the Substance Abuse Prevention and Treatment Block Grant). This latter approach leads to states — and thereafter local communities and harm reduction organizations — receiving episodic and inconsistent funding. Funding

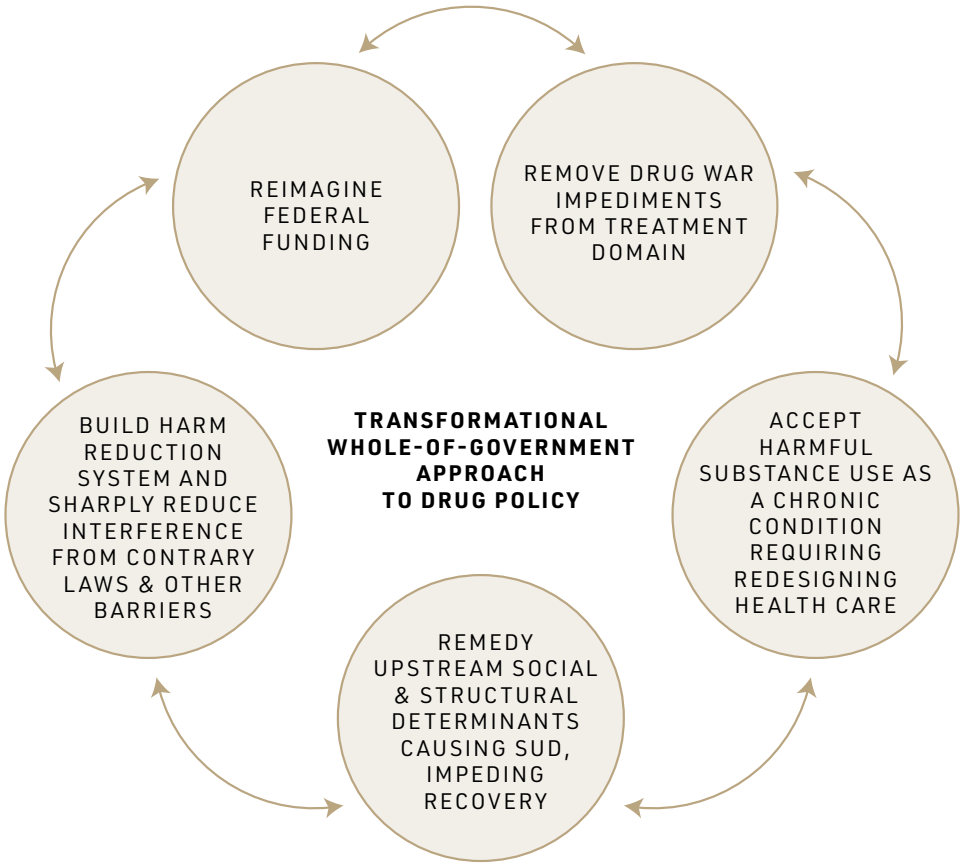

Figure 4: The components of a transformational Whole-of-Government approach to drug policy.

models should move away from annual applications and allow for longer spending horizons to encourage state spending on long-term plans and infrastructure. The federal government should also adopt the "braiding" approach to enable a coordinated spending framework for states (Bipartisan Policy Center, 2022). Recognizing that reimbursement gaps will persist in public and private insurance, attention should also be paid to designing a funding model for substance use disorder (SUD) prevention, treatment, and recovery services modelled on the "payer of last resort" used in the Ryan White HIV/AIDS Program (Kaiser Family Foundation, 2022).

2. Remove the final "war on drugs" impediments from the treatment domain

Continued criminalization of drug use creates a daunting barrier to real progress. In the meantime, at least some of the negative drug war impediments to treatment and harm reduction must be addressed. Federal drug policies on pharmacological treatments for substance use have dramatically lagged the evidence-base. The mindset and practices of criminalization have proliferated virtually every aspect of the overdose response, limiting the bounds of possible action with legal and attitudinal roadblocks rooted in the belief that supportive, public health approaches to drug use merely encourage or reward drug use. The Drug Enforcement Agency (DEA) and SAMHSA have moved too slowly in permitting mainstream prescribing of buprenorphine and methadone, resulting in unnecessary barriers faced by emergency room and general practitioners, while stigma and state laws continue to limit the number of providers. The DEA also needs to demonstrate that it is not the victim of agency capture by the opioid treatment programs (OTPs) industry. The Food and Drug Administration (FDA) was years behind the evidence in allowing over-the-counter naloxone (FDA News Release, 2023), but how access will be funded going forward is unclear. In parallel, new federal and state initiatives are erecting new barriers to pharmacy access to needed drugs (Jewett & Gabler, 2023). These "war on drugs" vestiges, that feed moral defect judgments and perpetuate stigma, also have permeated other institutions such as residential facilities, specialty courts, prisons, and jails where abstinence has been the preferred policy to the normalization of medication for opioid use disorder (MOUD) (Macomber, 2020).

3. Accept that harmful substance use is not only a chronic condition but one that requires redesigning health care

The challenge here is not limited to outdated federal and state policies "getting out of the way" of treatment, but that accepting that our legacy policy architecture is unable to meet the challenges of access for and management of mental and behavioral health. Redesigning must occur in parallel to fixing other challenges facing healthcare. We must repair public and private health insurance to improve access; reduce care/recovery fragmentation with improved coordination of care, and upgrades in care delivery that focus on parity and equity (Levey et al., 2012). We must be prepared for the further coalescence of harm reduction and treatment services (Behrends et al., 2018). Syringe services increasingly will become valuable points of entry into the care continuum while some will morph into professionally staffed overdose prevention centers. Similarly, emergency department interventions are being reevaluated as being more than lifesaving but as opportunities to move patients toward treatment with, for example, early initiation of buprenorphine. Providers are also acting more like harm reduction services, meeting those who need treatment outside of traditional health care facilities using community mobile crisis intervention or rapid response teams. This transformational strategy also requires that we recognize that drug use, even illegal drug use, is not inherently dangerous or harmful, and so does not present a major threat to users or society. Our public aim should be to reduce the prevalence of harmful drug use through mechanisms that do not themselves produce harm.

4. Let harm reduction do its job without undue interference from contrary federal policies, inconsistent state laws, and structural barriers

The priority is to remove or minimize the federal and state laws and policies that make harm reduction strategies more difficult or illegal. Federal "crack-house" laws and outdated restriction on syringe funding, overbroad state paraphernalia laws, and layers of bureaucratic decision-making need to be excised. The priority must be to save lives and reduce sickness by meeting people who use

ACCESS THE OTHER PAPERS IN THIS SERIES

Scan the QR code to access the full series of white papers addressing the W-G approach to opioid policy in the United States.

drugs where they are, without interference. Getting to this state will require not only rethinking health care and its interface with public health strategies but also the role of law enforcement. Public safety initiatives such as providing amenity in civil spaces, teaming up with social services and gaining behavioral health skills must replace arrests and incarceration (Waal et al., 2014).

5. Identify and remedy the upstream social and structural determinants that operate both as root causes of SUD and impediments to treatment and recovery

While a realignment among federal agencies and between federal funding and state implementation across domains such as harm reduction, treatment, and interdiction will be considerably more successful in tackling SUD than narrow or uncoordinated government interventions, a true W-G approach also must identify and wield policy levers that address the deeper social drivers (or social determinants) of dangerous substance use. There is strong evidence of negative social determinants that impede improvements in the "Whole of Society," including structural racism (Miron & Partin, 2021) and educational attainment affecting population health, while differences in women's mortality between states correlate with social cohesion and economic conditions and education (Montez et al., 2016). There is also emerging research on the relationship between substance use and social vulnerabilities caused by stressors such as poverty, homelessness, and discrimination. We must "address the fundamental causes that create barriers to health and well-being" (Fleming et al., 2021) and recognize the multiplying effect of criminalization on adverse determinants. Often referred to as the "collateral consequences of conviction," state and federal law impose continuing barriers to successful reentry and the avoidance of recidivism. One of the many structural determinants that impede improvements in the "Whole of Person" is access to health care. Given the crucial role of Medicaid in providing health care to those with SUD, Medicaid expansion clearly decreased the number of uninsured low-income adults with SUD although, given the racial composition of non-expansion states, disparities among African Americans and Native Americans with substance use disorders increased.

Moving Forward

84 Steps Policymakers Can Take Today to Knock Down Legal Barriers to a Whole-of-Government Opioids Response

"Wicked problems" are wicked because they resist resolution through traditional approaches and often intersect with or are a part of another wicked problem (Camillus, 2008). W-G analysis supports this diagnosis of our national drug policy, highlighting inconsistent and inadequate funding, the destructive criminalization fault line between harm reduction and drug policing, a deeply-flawed healthcare system, and determinants that stand in the way of improvements in both the "Whole of Society" and the "Whole of Person." Resetting our policies and tactics with this suggested transformational model suggests a way forward.

The federal, state, and local governments are not sufficiently coordinating their efforts against OUD and overdose, either internally or with each other. Our White Papers explain how a "whole of government" effort should work vertically – better linking federal, state, and local efforts, and horizontally – linking efforts across governments at each level. An effective W-G approach requires improvements to the mechanisms used to fund state and local OUD projects with federal funding, the abandonment of the worst aspects of the discredited "war on drugs," and building a supportive, therapeutic, and preventive public health approach that embraces the whole person and addresses drivers of substance use across the whole society.

Our project has looked across our federal system to identify specific legal barriers and facilitators of this whole-of-government response. In conjunction with the fuller analysis of collaborative policymaking and a real, compassionate understanding of the nature of drug use in our White Papers, we have compiled a list of "shovel-ready" legal changes that policymakers can introduce tomorrow to promote effective cross-government action to reduce dangerous opioid use and its human and community toll.

OPPORTUNITIES TO KNOCK DOWN LEGAL BARRIERS TO A WHOLE-OF-GOVERNMENT OPIOIDS RESPONSE			
Opportunity	Domain	Secondary Domain	Government Level
DRUG POLICING			
Given the resources required and lack of general deterrence, **DOJ** can instruct federal prosecutors to abandon "Charging the Death," 21 U.S.C. § 841(b) (1)(C), in cases of low-level dealers or users who sell some of their own drugs.	Drug Policing	Decriminalization	Federal
Congress can amend 18 U.S. Code § 983 (civil forfeiture proceedings) as proposed by the Fifth Amendment Integrity Restoration Act of 2023 (FAIR), H.R.1525, 118th Congress (2023-2024), to change the burden of proof to "clear and convincing" evidence and reduce numerous abuses commonly associated with drug arrests.	Drug Policing	Civil Forfeiture	Federal
States can repeal or amend their mandatory minimum sentencing laws to stop incarcerating hundreds of thousands of nonviolent, low-level drug offenders, often with no chance of parole.	Drug Policing	Decriminalization	State
States can amend their drug possession laws to make offenses at most a misdemeanor (e.g., Colo. Rev. Stat. § 18-1.3-501) and enact other reforms to encourage probation or diversion sentencing (e.g., Massachusetts General Laws Part I Ch. 94C, § 34).	Drug Policing	Decriminalization	State
States can follow Oregon and decriminalize low-level drug possession in favor of a civil citation model, see the Drug Addiction Treatment and Recovery Act (Measure 110) passed as a ballot measure in November 2020. Approximately 10 states have seen bills introduced to decriminalize possession, see e.g., Vermont House Bill 423.	Drug Policing	Decriminalization	State
States can encourage help-seeking behavior during overdose events by repealing or providing immunity to Drug Induced Homicide (DIH) laws.	Drug Policing	Decriminalization	State
States can move away from War on Drugs policing practices such as pretextual stops, stop and frisk, and home invasions.	Drug Policing	Municipal Policing	State
States can reform child welfare laws and enforcement so that pregnant drug users are not afraid to seek prenatal and other care.	Drug Policing	Family Policing	State
States can abandon civil forfeiture in minor drug cases (See e.g., N.M. § 31-27-4).	Drug Policing	Civil Forfeiture	State
States can establish consistent appropriations policies to fund Law Enforcement Deflection Programs and consider enacting the Model Law Enforcement and Other First Responder Deflection Act. This model law encourages first responder deflection programming as well as related training, meant to steer people with SUD from the criminal justice system to evidence-based treatment.	Drug Policing	Deflection	State

States can remove barriers to layperson immunity (including "Good Samaritan"), such as requirements for calling or providing identities to law enforcement. See e.g., Indiana Code § 16-42-27-2(g).	Drug Policing	Good Samaritan	State
Local governments can establish law enforcement assisted diversion programs, to focus on better addressing unmet behavioral health needs or needs stemming from poverty, e.g. King County, Washington's Law Enforcement Assisted Diversion Program.	Drug Policing	Deflection	Local
HEALTH CARE			
The federal government can designate a single source of contact for the states within ONDCP to provide horizontal alignment across federal agencies and work with the states in aligning vertical implementation through amendments to the Office of National Drug Control Policy Reauthorization Act of 1998, 21 U.S. Code § 1701 et seq.	Health care	Agency Coordination	Federal
Congress can continue to provide additional fiscal incentives, as in the American Rescue Plan Act of 2021, amending Section 1905 of the Social Security Act (42 U.S.C. 1396d), to encourage the remaining 10 "hold-out" states to expand Medicaid under the Affordable Care Act (ACA).	Health care	Medicaid	Federal
Congress can extend the Support Act's mandate (42 U.S.C.1396d(a)(29)) that Medicaid plans should cover Medication-Assisted Treatment beyond 2025.	Health care	Medications for Opioid Use Disorder	Federal
CMS can enforce its reporting requirements and oversight of state Medicaid actions during the unwinding of the continuous enrollment condition attached to Families First Coronavirus Response Act § 6008 FMAP increases as provided by the Consolidated Appropriations Act of 2023 § 5131.	Health care	Medicaid	Federal
Congress can make permanent the SUPPORT Act's state plan amendment option (132 Stat. 3894 § 5052) to provide medical assistance for certain individuals who are patients in defined institutions for mental diseases (IMD) beyond the sunset date of September 30, 2023, by amending 42 U.S.C. § 1396n(l).	Health care	Institutions for Mental Diseases Exclusion Waiver	Federal
CMS can refuse to approve 1115 waiver applications that reduce enrollment, such as work requirements or block grants as inconsistent with Medicaid's primary purpose of provide health care coverage to populations that otherwise could not afford it (*Gresham v. Azar*, 950 F.3d 93 (D.C. Cir. 2020), vacated and remanded sub nom. *Becerra v. Gresham*, 212 L. Ed. 2d 576, 142 S. Ct. 1665 (2022), and vacated and remanded sub nom. *Arkansas v. Gresham*, 212 L. Ed. 2d 576, 142 S. Ct. 1665 (2022)).	Health care	Medicaid	Federal
DOJ can continue to enforce the Americans with Disabilities Act, 42 U.S.C. §§ 12101, et seq., against public and private entities (including hospitals, prisons, jails, and nursing homes) that unlawfully discriminate against people in recovery from opioid use disorder (OUD) who are not engaging in illegal drug use, including those who are taking legally-prescribed medication to treat their OUD pursuant to the current DOJ Guidance.	Health care	Americans with Disabilities Act Discrimination	Federal

CMS can enforce The Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S. Code § 1395dd, against hospital emergency departments that fail to stabilize patients with evidence-based services.	Health care	Emergency Departments	Federal
Congress can extend the liberalization (Consolidated Appropriations Act of 2023 (Public Law 117-328) § 4133) of telemedicine policies beneficial in the treatment of substance use and other behavioral health needs (including qualifying providers, geographic and originating site restrictions, and audio-only telehealth services) beyond the sunset date of December 31, 2024.	Health care	Telehealth	Federal
The **DEA** can extend the 72-hour rule (21 CFR 1306.07(b)) to allow emergency department doctors to prescribe and not merely administer buprenorphine or methadone to prevent pre-treatment withdrawal.	Health care	Medications for Opioid Use Disorder	Federal
Pursuant to the court's ruling in *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021), overturning the Trump administration's decision to cease oversight of network adequacy for marketplace plans pursuant to 42 U.S.C. § 18031(c)(1), **CMS** can publish national standards for network adequacy for marketplace plans and Medicare and Medicaid managed care plans, particularly for behavioral health services, adopting the three most common metrics for network adequacy, geographical distance, appointment wait time and provider-enrollee ratios, and also develop qualitative standards.	Health care	Private Health Insurance	Federal
Although the Consolidated Appropriations Act of 2021 amended to prohibit non-quantitative treatment limitations (NQTL) with respect to Mental Health or Substance Use Disorder SUD benefits, **HHS** and **DOL** can enact their proposed regulation on NQTLs and **Congress** should further strengthen the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), 42 U.S.C. 300gg–26(a), by granting the Department of Labor authority to impose civil monetary penalties on non-compliant health plans.	Health care	Private Health Insurance	Federal
Congress can repeal the monopoly enjoyed by certified and accredited opioid treatment programs (OTPs) as the only places permitted to dispense methadone for opioid use disorder treatment under the Controlled Substances Act (21 U.S.C. 823(g)(1); 42 CFR § 8.11) by permitting, for example, licensed physicians to prescribe methadone as provided for in the Modernizing Opioid Treatment Access Act, S.644 118th Congress (2023-2024). In the interim or alternative **SAMHSA** can remove other regulatory limitations on methadone treatment, such as the requirement to provide counselling as part of the treatment regime (42 CFR § 8.12(f)(5)) and move further than its current proposed changes, 87 FR 77330, to a default "take-home" approach to methadone maintenance treatment.	Health care	Medications for Opioid Use Disorder	Federal

To ensure that buprenorphine is available in free-standing and hospital pharmacies and to accelerate the reduction of stigma surrounding its prescribing, the **DEA** can amend its Suspicious Orders Report System (SORS) to "green light" rather than "red light" buprenorphine prescribing and the **FDA** can add the drug to the List of Essential Medicines, Medical Countermeasures, and Critical Inputs, Executive Order 13944.	Health care	Medications for Opioid Use Disorder	Federal
States can extend or make permanent Medicaid telehealth flexibilities adopted during the COVID-19 Public Health Emergency (PHE). Expanded coverages can include telephone and asynchronous services and allow the home to be the originating site.	Health care	Telehealth	State
States can address gaps in coverage from citizens returning from correctional settings by applying for Section 1115 waivers to expand Medicaid pre-release services. See e.g., California's 1115 waiver.	Health care	Medicaid	State
State correctional agencies can adopt policies assisting inmates in applying for applicable public or private health insurance and other expanded services pre-release including automatic Medicaid enrollment, peer Medicaid educators, building transition plans, and the transfer of medical records. (See: Ohio Department of Rehabilitation & Correction, Medicaid Pre-Release Program, 2023).	Health care	Medicaid	State
Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and **Wyoming** have yet to approve expansion of Medicaid under the Affordable Care Act. These states can do so to increase access to needed treatment for opioid use disorder. Where possible, those in favor of expansion can consider leveraging ballot initiatives.	Health care	Medicaid	State
State Medicaid agencies can take steps to minimize disenrollment to ensure access to Medicaid coverage caused by the termination of the COVID Public Health Emergency, particularly taking the health needs of high-risk populations into account when unwinding the emergency maintenance of eligibility rules.	Health care	Medicaid	State
State Medicaid agencies can submit 1115 waivers that include comprehensive services aimed at addressing health-related social needs (HRSNs), including but not limited to care coordination, peer support services, improved integration of behavioral health services, mobile crisis response services, and supportive housing services. (See: California's CalAIM Section 1115 waiver).	Health care	Medicaid	State
States can set aside special funds to assess and potentially supply treatment and other services to those unable to afford them modelled on Minnesota's so-called "Rule 25 Assessment" pilot that provided SUD health care services based on clinical and financial eligibility requirements. The Maine Office of Behavioral Health directly funds services for uninsured Maine residents and those not supported by federal grant programs or Medicaid.	Health care	Uninsured	State
States can dramatically increase their funding of equitable and data-driven behavioral health, e.g. see behavioral payment reforms in Maine, Me. Stat. tit. 22, § 3173-J.	Health care	Private Health Insurance	State

States can enact the National Association of Insurance Commissioners' Health Benefit Plan Network Access and Adequacy Model Act or enact a law like Colo. Rev. Stat. § 10-16-704, requiring health insurers to maintain an adequate provider network to assure access to all covered benefits without unreasonable delay.	Health care	Private Health Insurance	State
States can enact legislation to limit or ideally remove prior authorizations for SUD services and medications such as that passed in New York, see New York Insurance Law § 4303.	Health care	Private Health Insurance	State
States can enact strong parity laws requiring, for example, insurers to submit reports detailing its criteria in assessing and applying limitations on mental health and substance use disorder benefits as provided for in Connecticut, An Act Concerning Mental Health And Substance Use Disorder Benefits, Pub. L. No. CT 19-159 (2019).	Health care	Private Health Insurance	State
States can revise their laws regulating physician and mid-level practitioner (e.g., nurse practitioner) dispensing of controlled substances to ensure their alignment with federal OUD strategies and policies. See Colo. Rev. Stat. § 12-255-112.	Health care	Scope of Practice	State
States can increase the effectiveness of their workforce by developing hub and spoke models of care (integrated care model for delivery of MOUD treatment) such as in Washington where federal funds were leveraged.	Health care	Medications for Opioid Use Disorder	State
States can modify any laws and regulations that create indirect barriers to or friction in providing methadone treatment, such as certificate of need laws and local zoning.	Health care	Medications for Opioid Use Disorder	State
States can reconsider any restrictions on opioid agonist therapy (OAT) prescribing by nurse practitioners particularly in rural areas that face a shortage of qualified prescribers.	Health care	Scope of Practice	State
States can pass legislation or amend regulations to permit disaggregated facilities ("medication units") to expand treatment options beyond fixed OTP locations (See Ohio Administrative Code Rule 5122-40-15).	Health care	Medications for Opioid Use Disorder	State
States can consider enacting the Model Expanding Access to Peer Recovery Support Services Act, which enables peer support to help people with SUD to recover through a peer support worker credentialing program and new funding.	Health care	Peer Support	State
States and localities can reconsider policies that hinder treatment with buprenorphine and methadone in prisons and jails.	Health care	Medications for Opioid Use Disorder	State
States can remove barriers to naloxone distribution, such as requirements that recipients provide their name and address, see required documentation from the West Virginia Department of Health and Human Services relating to naloxone distribution.	Health care	Naloxone Access	State
States can enact telecom fee laws to fund their 988 crisis services. See Colo. Rev. Stat. § 40-17.5-102, establishing dedicated funding for the 988-crisis line, which serves behavioral health crises. States having trouble funding and staffing their call centers can enact NASMHD Model Bill for Core State Behavioral Health Crisis Services Systems or legislation like Va. Code Ann. §§ 37.2-311.2, 37.2-311.3, and 37.2-311.4.	Health care	Mental Health Crisis	State

States can enact laws requiring pharmacies to maintain stocks of buprenorphine and naloxone. (See, e.g., Philadelphia, Pennsylvania Municipal Code § 9-637).	Health care	Medications for Opioid Use Disorder	State
States can establish consistent appropriations policies to fund Law Enforcement Deflection Programs and consider enacting the Model Law Enforcement and Other First Responder Deflection Act. This model law encourages first responder deflection programming as well as related training, meant to steer people with SUD from the criminal justice system to evidence-based treatment.	Health care		State
States can enact laws requiring pharmacies to maintain stocks of buprenorphine and naloxone. (See, e.g., Philadelphia, Pennsylvania Municipal Code § 9-637).	Health care	Medications for Opioid Use Disorder	State
Local governments can enact ordinances requiring pharmacies to maintain stocks of buprenorphine and naloxone. (See, e.g., Philadelphia, Pennsylvania Municipal Code § 9-637).	Health care		Local
HARM REDUCTION			
Congress can address gaps in access to OUD health care caused by a lack of public or private insurance by enacting a funding program similar to the Ryan White HIV/AIDS Program by which services are provided through "payor of last resort" federal funds for low-income people, the uninsured or underserved, 42 U.S. Code § 300ff–27(b)(7)(F).	Harm Reduction	Funding	Federal
SAMHSA and **CMS** can issue joint guidance to establish a "braiding" framework for federal funding of state substance use services working with single agency points of contact in the states to reduce funding gaps and improve coordination as recommended by the Bipartisan Policy Center. *Combating the Opioid Crisis, 'Smarter Spending' To Enhance The Federal Response*. 2022.	Harm Reduction	Funding	Federal
Congress can repeal the prohibition on the use of federal funds to purchase syringes for the injection of illegal drugs contained in The Consolidated Appropriations Act of 2018 § 520.	Harm Reduction	Syringe Access	Federal
Congress can amend 21 U.S.C.A. § 856 (the "crack-house" prohibition on "Maintaining drug-involved premises,") to permit overdose prevention centers (OPCs) or the DOJ can issue guidance on how it intends to use its prosecutorial discretion.	Harm Reduction	Overdose Prevention Centers	Federal
HHS can issue guidance that private insurance plans must cover OTC and Rx formulations as part of the ACA's Essential Health Benefits (EHB) package.	Harm Reduction	Private Health Insurance	Federal
States can consider enacting the Model Expanded Access to Emergency Opioid Antagonists Act that would expand access to, and the availability of, emergency opioid antagonists such as naloxone.	Harm Reduction	Naloxone	State
States can reform their drug laws by repealing paraphernalia laws (Minn. Stat. § 152.092, repealed by SF 2909) or, at the least, amend them exclude testing strips (e.g., Colo. Rev. Stat. 18-18-426) and needles, syringes, or other supplies obtained from or returned to an SSP (e.g., N.C. Gen. Stat. § 90-113.27(c)).	Harm Reduction	Syringe Access	State

States can repeal "one-for-one" syringe exchange laws, e.g., Fla. Stat. § 381.0038(4)(b)(3).	Harm Reduction	Syringe Access	State
States can enact the Model Syringe Services Program Act that includes expanded SUD treatment provision and referral, measures to reduce needlestick injuries, data collection and reporting requirements for SSPs, immunity for criminal arrest, charge, and prosecution for possession, distribution, and furnishing of hypodermic needles and syringes, as well as harm reduction training for first responders, and funding to support programming.	Harm Reduction	Syringe Access	State
States can remove veto power or other review processes for operation of SSPs held by localities such as those found in, e.g., Ind. Code § 16-41-7.5-5r; W. Va. Code §16-64-2.	Harm Reduction	Syringe Access	State
States can enact legislation permitting Overdose Prevention Centers (OPCs) and hold participants harmless under state-controlled substances laws. (See e.g., R.I. Gen. Laws §23-12.10-1; New Mexico House Bill 263 (2023).	Harm Reduction	Overdose Prevention Centers	State
States can remove cost barriers by requiring Medicaid and private insurance to cover Naloxone, placing it in the lowest cost tier of formularies, etc., e.g., Mo. Rev. Stat. § 191.1165.	Harm Reduction	Naloxone Access	State
States can remove various barriers to access to naloxone and enact legislation based on the Model Expanded Access to Emergency Opioid Antagonists Act, that increases access to emergency opioid antagonists, including provisions for immunity for administering opioid antagonists, insurance coverage of opioid antagonists, and education to support use of opioid antagonists among other provisions.	Harm Reduction	Naloxone Access	State
States can pass legislation requiring naloxone co-prescribing with opioids. See e.g., Ariz. Rev. Stat. § 32-3248.01(D); Cal. Bus. & Prof. Code § 741.	Harm Reduction	Naloxone Access	State
Municipalities can use local health authority to authorize the use of OPCs, offering people who use drugs safe access to clinical services, like the center established in New York City.	Harm Reduction	Overdose Prevention Centers	Local
Local governments can integrate SSPs and remove any special zoning requirements for SSPs and OTPs.	Harm Reduction	Syringe Access	Local
City and County prosecutors can reduce prosecution of low-level crimes, e.g. See Baltimore, Maryland's efforts to not prosecute low-level drug possession or prostitution.	Harm Reduction	Decriminalization	Local
SOCIAL DETERMINANTS OF HEALTH			
CMS can encourage states to take advantage of optional Medicaid benefit categories that serve those with OUD/SUD such as rehabilitative or case management services, 42 U.S. Code § 1396n and apply for § 1115 waivers identified as supportive of substance use prevention or treatment and care transitions for incarcerated people.	Social Determinants of Health	Medicaid	Federal

Congress can broaden federal expungement to include more nonviolent crimes such as in the proposed Fresh Start Act of 2022, H.R.6667, 117th Congress (2021-2022).	Social Determinants of Health	Criminal Records	Federal
HUD can amend 24 CFR §982.553 to narrow public housing exclusions linked to drug use to situations in which a person's use of illegal drugs is causing observable harm to the premises or the community, and tighten key definitions to better guide local public housing agencies.	Social Determinants of Health	Housing	Federal
Congress can permanently expand the child tax credit that was first enacted temporarily by the American Rescue Plan Act of 2021.	Social Determinants of Health	Childcare Tax Credit	Federal
Congress can enhance the federal Earned Income Tax Credit (EITC) (26 U.S. Code § 32) by making the tax credit monthly.	Social Determinants of Health	Earned Income Tax Credit	Federal
States can increase expungement rates by amending laws to apply automatic expungement to minor drug possession convictions and seal the records. See N.Y. Crim. Pro. § 160.50 which automatically expunges certain cannabis possession and sale records.	Social Determinants of Health	Criminal Records	State
States can enact strong protections against predatory lending and high bank overdraft fees. See N.Y. Comp. Codes R. & Regs tit 3 §§ 32.1-32.2 for example of high bank overdraft protections. See N.M. Stat. 58-7-7 for example of predatory lending protections, including a 36% maximum annual interest rate cap on small loans.	Social Determinants of Health	Banking	State
States can provide sufficient funding for municipal and local court operations and can strictly limit excessive fees and fines or provide alternatives. (See e.g., Mo. Rev. Stat. §353; Cal Penal Code §688.5; Wash. Rev. Code §10.01.160; Tex. Crim. Proc. Code §45.049; Wash. Rev. Code §10.01.170; R.I. Gen. Laws §12-18.1-3).	Social Determinants of Health	Legal Administrative Fees	State
States can remove cash bail requirements, especially for low-level offenders in pretrial detention, See Washington D.C., Bail Reform Amendment Act of 1992 that ended cash bail for most justice-involved individuals.	Social Determinants of Health	Pretrial Detention	State
States can adopt "Ban the Box" laws, which give applicants with criminal records an opportunity to be considered for jobs based on their qualifications, not their conviction history. Access to stable employment is a driver of health. See D.C. Code § 1:620-42 and D.C. Code § 32:1342. DC prohibits any employer with more than eleven employees from asking about criminal history on a job application.	Social Determinants of Health	Criminal Records	State
States can establish earned sick leave laws. See N.Y. Lab. Law § 196-b, where employers must provide a certain amount of sick leave based on their size, following mandated accrual rates.	Social Determinants of Health	Employment	State
States can establish minimum wage laws to a level sufficient to allow a full-time worker to rise above the poverty line and obtain stable housing. See N.J. Stat. §34:11-56a et seq. **States** can also remove barriers to local governments setting a livable local minimum wage. See Colo. Rev. Stat. § 8-6-10.	Social Determinants of Health	Employment	State

Local governments can provide sufficient funding for municipal and local court operations, and can strictly limit excessive fees and fines. See, e.g., San Francisco Ordinance Number 131-18, which eliminated county criminal administrative fees, such as probation fees, electronic monitoring, and booking fees.	Social Determinants of Health	Legal Administrative Fees	Local
Localities can end cash bail, especially for low-level offenders in pretrial detention, See Washington D.C., Bail Reform Amendment Act of 1992 that ended cash bail for most justice-involved individuals.	Social Determinants of Health	Pretrial Detention	Local
Public housing agencies can narrowly specify grounds for denying housing based on drug-related behavior.	Social Determinants of Health	Housing	Local
Local governments can increase their minimum wage to a level sufficient to allow a full-time worker to rise above the poverty line and obtain stable housing.	Social Determinants of Health	Employment	Local
Local governments can provide temporary guaranteed income programs. See Stockton, California's SEED Program, providing no-strings-attached guaranteed income of $500 a month for 24 months.	Social Determinants of Health	Universal Basic Income	Local

ACKNOWLEDGEMENTS

The authors thank their colleagues Elizabeth Platt, Bethany Saxon, and Hope Holroyd for their substantial contributions to this project.

We also recognize the contributions of the Expert Advisory Committee (EAC), who provided valuable feedback while developing the white paper series over the course of this project. The EAC includes Daniel Blaney-Koen, American Medical Association; Fred Wells Brason, Project Lazarus; Jessica Breslin, ChangeLab Solutions; Nabarun Dasgupta, University of North Carolina at Chapel Hill Injury Prevention Research Center; Corey Davis, Network for Public Health Law; Jeremy Douglas, Housing Works; Taleed El-Sabawi, Florida International University; Tracie Gardner, Legal Action Center; Daliah Heller, Vital Strategies; Kelli Komro, Emory University; Matthew Lawrence, Emory University; Dave Lucas, Center for Court Innovation; Emma (Beth) McGinty, Weill Cornell Medicine; Keli McLoyd, City of Philadelphia; Jennifer Karas Montez, Syracuse University; Kate Nicholson, National Pain Advocacy Center; Anand K. Parekh, Bipartisan Policy Center; and Louise Vincent, Urban Survivors Union.

This work was funded by the Foundation for Opioid Response Efforts (FORE). The views and conclusions contained in this document are those of the authors and should not be interpreted as representing the official policies or stance, either expressed or implied, of FORE. FORE is authorized to reproduce and distribute reprints for Foundation purposes notwithstanding any copyright notation hereon.

ABOUT THE AUTHORS

Nicolas Terry, LLM is the Hall Render Professor of Law at the Indiana University Robert H. McKinney School of Law and executive director of the Hall Center for Law and Health.

Sterling Johnson, JD is a Law and Policy Analyst at the Center for Public Health Law Research at Temple University Beasley School of Law.

Jonathan Larsen, JD, MPP is a Legal Program Manager at the Center for Public Health Law Research at Temple University Beasley School of Law.

Scott Burris, JD is a professor at the Temple University Beasley School of Law and College of Public Health and director of the Center for Public Health Law Research at Temple University Beasley School of Law.

References

Administration for Strategic Preparedness and Response. (2022). *Renewal of Determination that a Public Health Emergency Exists*. HHS-ASPR. https://aspr.hhs.gov/legal/PHE/Pages/Opioid-22Dec2022.aspx

Ahmad, F., Cisewski, J., Rossen, L., & Sutton, P. (2023). *Provisional drug overdose data*. CDC. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Behrends, C. N., Nugent, A. V., Des Jarlais, D. C., Frimpong, J. A., Perlman, D. C., & Schackman, B. R. (2018). Availability of HIV and HCV On-Site Testing and Treatment at Syringe Service Programs in the United States. *Journal of Acquired Immune Deficiency Syndrome*, *79*(2), e76-e78. https://doi.org/10.1097/qai.0000000000001792

Bingham, K., Cooper, T., & Hough, L. (2016). *Fighting the opioid crisis: An ecosystem approach to a wicked problem*. In: Deloitte University Press.

Bipartisan Policy Center. (2022). *Combating the Opioid Crisis, 'Smarter Spending' To Enhance The Federal Response*. Bipartisan Policy Center. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2022/04/FINAL-Combating-the-Opioid-Crisis-Smarter-Spending-to-Enhance-the-Federal-Response.pdf

Brooklyn, J. R., & Sigmon, S. C. (2017). Vermont hub-and-spoke model of care for opioid use disorder: development, implementation, and impact. *Journal of Addiction Medicine*, *11*(4), 286.

Camillus, J. C. (2008). Strategy as a wicked problem. *Harvard Business Review*, *86*(5), 98-101.

Centers for Disease Control and Prevention. (2019). *Federal Funding for Syringe Services Programs*. CDC. https://www.cdc.gov/ssp/ssp-funding.html

Centers for Disease Control and Prevention. (2022). *Syringe Services Programs*. CDC. https://www.cdc.gov/hiv/effective-interventions/prevent/syringe-services-programs/index.html

Christensen, T., & Lægreid, P. (2017). *Transcending new public management*. Taylor & Francis London.

Cohen, A., Vakharia, S. P., Netherland, J., & Frederique, K. (2022). How the war on drugs impacts social determinants of health beyond the criminal legal system. *Annals of Medicine*, *54*(1), 2024-2038.

Drug Policy Alliance. (2015, June 2015). *The Drug War, Mass Incarceration and Race*. Drug Policy Alliance. https://www.unodc.org/documents/ungass2016/Contributions/Civil/DrugPolicyAlliance/DPA_Fact_Sheet_Drug_War_Mass_Incarceration_and_Race_June2015.pdf

FDA News Release. (2023, March 29, 2023). *FDA Approves First Over-the-Counter Naloxone Nasal Spray*. FDA. https://www.fda.gov/news-events/press-announcements/fda-approves-first-over-counter-naloxone-nasal-spray

Fleming, P. J., Spolum, M. M., Lopez, W. D., & Galea, S. (2021). The public health funding paradox: how funding the problem and solution impedes public health progress. *Public Health Reports*, *136*(1), 10-13.

Galea, S. (2022). Moving Beyond the Social Determinants of Health. International *Journal of Health Services*, *52*(4), 423-427.

Gottschalk, M. (2023). The opioid crisis: The war on drugs is over. Long live the war on drugs. *Annual Review of Criminology*, 6. https://www.annualreviews.org/doi/full/10.1146/annurev-criminol-030421-040140

Government of Canada. (2016, December 12). *Pillars of the Canadian drugs and substances strategy*. Government of Canada. https://www.canada.ca/en/health-canada/services/publications/healthy-living/pillars-canadian-drugs-substances-strategy.html

Ind. Code §16-41-7.5-5, (2021).

Jewett, C., & Gabler, E. (2023). *Opioid Settlement Hinders Patients' Access to a Wide Array of Drugs*. The New York Times. https://www.nytimes.com/2023/03/13/us/drug-limits-adhd-depression.html#:

Kaiser Family Foundation. (2022). *The Ryan White HIV/AIDS program: the basics*. Kaiser Family Foundation. https://www.kff.org/hivaids/fact-sheet/the-ryan-white-hivaids-program-the-basics/

Lee, J. C. (2018). The opioid crisis is a wicked problem. *American Journal of Addictions*, *27*(1), 51.

Levey, S. M. B., Miller, B. F., & deGruy, F. V., III. (2012). Behavioral health integration: an essential element of population-based healthcare redesign. *Translational Behavioral Medicine*, *2*(3), 364-371. https://doi.org/10.1007/s13142-012-0152-5

Macomber, S. (2020). The Right to Medication-Assisted Treatment in Jails and Prisons. *U. Mem. L. Rev.*, 51, 963.

Macpherson, D. (2001, January 2001). *A Four-Pillar Approach to Drug Problems in Vancouver*. Researchgate. https://www.researchgate.net/publication/242480594_A_Four-Pillar_Approach_to_Drug_Problems_in_Vancouver

Miron, J., & Partin, E. (2021). Ending the war on drugs is an essential step toward racial justice. *The American Journal of Bioethics*, *21*(4), 1-3.

Montez, J. K., Zajacova, A., & Hayward, M. D. (2016). Explaining inequalities in women's mortality between US States. *SSM-population health*, *2*, 561-571.

New York Times Editorial Board. (2023, February 22). *America Has Lost the War on Drugs. Here's What Needs to Happen Next*. The New York Times. https://www.nytimes.com/2023/02/22/opinion/harm-reduction-public-health.html?

Office of the Surgeon General. (2016). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health*. US Department of Health and Human Services. https://store.samhsa.gov/sites/default/files/d7/priv/surgeon-generals-report.pdf

Pearl, B., & Perez, M. (2018, June 27, 2018). *Ending the war on drugs: By the numbers*. The Center for American Progress. https://www.americanprogress.org/article/ending-war-drugs-numbers/

Schwartzapfel, B. (2021). *Biden Could Have Taken the War on Drugs Down a Notch. He Didn't*. The Marshall Project. https://www.themarshallproject.org/2021/06/16/biden-could-have-taken-the-war-on-drugs-down-a-notch-he-didn-t

Singer, J. A., & Heimowitz, S. (2022). Drug Paraphernalia Laws

Undermine Harm Reduction. CATO Institute. https://www.cato.org/sites/cato.org/files/2022-06/PA_929.pdf

Stein, B. D., Kilmer, B., Taylor, J., & Vaiana, M. E. (2023). *America's Opioid Ecosystem*.

Substance Abuse and Mental health Administration. (2023, January 25, 2023). *Removal of DATA Waiver (X-Waiver) Requirement*. Substance Abuse and Mental health Administration. https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement

The White House Executive Office of the President. (2022). *National Drug Control Strategy*. The White House. https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf

Waal, H., Clausen, T., Gjersing, L., & Gossop, M. (2014). Open drug scenes: responses of five European cities. *BMC Public Health*, *14*(1), 853. https://doi.org/10.1186/1471-2458-14-853

Weiland, N. (2022, July 26, 2022). *Biden's Drug Czar Is Leading the Charge for a 'Harm Reduction' Approach*. The New York Times. https://www.nytimes.com/2022/07/26/us/politics/biden-drug-czar-rahul-gupta.html

WHO Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health: Commission on Social Determinants of Health final report*. World Health Organization.

Worzala, M., VanDevelde, C., & Kuntz, J. (2018). *Deploying the whole of government: how to structure successful multi-agency international programs*. Deloitte. https://www.deloitte.com/us/en/pages/public-sector/articles/deploying-the-whole-of-government.html