Blueprint for a Public Health and Safety Approach to Drug Policy

The New York Academy of Medicine
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We are the Drug Policy Alliance.

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Executive Summary

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The New York Academy of Medicine (NYAM) and the Drug Policy Alliance (DPA) are pleased to present this *Blueprint for a Public Health and Safety Approach to Drug Policy*. An independent organization since 1847, NYAM addresses the health challenges facing the world's urban populations through interdisciplinary approaches to policy leadership, innovative research, evaluation, education, and community engagement. DPA is the nation's leading organization promoting current drug policies that are grounded in science, compassion, health, and human rights. DPA and NYAM are organizations with very different missions and histories but a shared understanding that New York's current policy approach to drugs is failing. We joined together to examine New York's current drug policies and to reimagine how those policies could realize better health *and* public safety outcomes, through a more coordinated, public health-oriented approach based on the four pillars model of prevention, treatment, harm reduction, and public safety. Believing that good public policies should be developed in collaboration with those directly affected by them, we spent over a year holding community consultations across the state asking New York residents how drug use and drug policies affected them and their neighborhoods and what should be done to move the state forward. We also met with experts, policymakers, and service providers and conducted an extensive review of the literature. This *Blueprint* is the result of these research activities.

New York's Current Approach to Drug Policy

Some of the problems with our current drug policies stem from the fact that these policies have been largely bifurcated between two different and often contradictory approaches. One treats drug use as a crime that cannot be tolerated and should be punished; the other views addiction as a chronic relapsing health or behavioral condition requiring ongoing treatment and support. Neither of these views is all encompassing—it should be recognized that there are patterns of drug use that do not result in significant harm or health problems and therefore require no intervention. The public health approach presented here takes the view that our focus should be on the harm caused by drug use and the harm caused by our policy responses to it. We have focused specifically on illicit drugs, not because they are by themselves more harmful (in fact, tobacco causes more morbidity and mortality than any illicit drug), but because it has become increasingly clear that our current policies to manage illicit drugs are failing.

Drug policy in New York is further complicated by multiple actors that all play some role in preventing or responding to drug use. Without a unified framework and better coordination, they often work at cross-purposes. For instance, while New York has grown its network of innovative harm reduction, drug treatment, and alternative-to-incarceration programs, it has also been aggressive in policing and penalizing the same population that accesses these services for possession of drugs and syringes and for relapses. The result is a system that is not working well for anyone. Drug use and its associated harms continue, and our policy responses have resulted in the mass incarceration of New Yorkers,

Figure 1

Figure 2

1 in 13

New York State residents suffer from a substance abuse condition

Illicit drug use costs the U.S more than

$193

billion a year

increased racial disparities, stigmatization of individuals and whole subpopulations, fragmented families, deep distrust between police and the communities they serve, and millions of dollars in costs during times of both economic prosperity and, more recently, fiscal crisis. In an era of limited resources, we simply can no longer afford to keep doing what we have been doing when our actions have shown to be largely ineffective and even detrimental:

- *Drug use affects New Yorkers.* The New York State Office of Alcoholism and Substance Abuse Services (OASAS) estimates that one in 13 New York State residents suffers from a substance abuse condition. An estimated 447,000 people in New York State need treatment but do not get it.[1] Statewide, over 1.8 million New Yorkers (1.77 million adults and 156,000 young people ages 12-17) have a substance abuse condition.[2] Many more are affected by the drug use of a family member, friend, or colleague.

- *Incarceration has proven ineffective at reducing drug use.* With one in every 100 U.S. adults now in prison and many more involved in the criminal justice system,[3] incarceration is increasingly seen as an important public health issue and as a social determinant of health that exacerbates

existing health disparities.[4-5] In 2011, there were 104,897 adult drug arrests overall in New York City—21,149 were felony arrests and 83,748 were misdemeanors.[6] That same year, the New York City Police Department made over 50,000 arrests for marijuana possession[7] yet overall rates of drug use, including marijuana, have remained relatively stable.[8]

- *Our drug policies are driving unacceptable racial disparities in our criminal justice system.* Despite the relative consistency in the prevalence of drug use across races, the vast majority of those arrested and incarcerated for drug offenses are people of color. In New York City in 2011, more than 85 percent of those arrested for marijuana possession were Black and Latino, mostly young men,[9] even though young white males use marijuana at comparable, if not higher, rates.[10]

- *Illicit drug use and our current policy responses to it are costly and require a revised approach.* The economic cost of illicit drug use to the U.S. is estimated to be more than $193 billion annually.[11] The average annual cost of incarceration to New York tax payers is estimated at $3.6 billion.[12] As incarceration has increased substantially over the last 40 years, illicit drug use has not seen a substantial reduction.

Attendees, New Directions New York Conference

New York is poised for change. There is much momentum to move our drug policies toward a public health-based approach. At the local level, communities around the state are actively calling for a new approach. They are challenging criminal justice-dominated strategies for dealing with drug use—such as stop, question, and frisks leading to arrests for low-level marijuana possession—and mass incarceration. At the policy level, New York in 2009 became one of the first and biggest states in the country to move away from the harsh mandatory sentencing laws that characterized drug policy in the U.S. throughout much of the past four decades. The significant reform to the Rockefeller Drug Laws was advanced by a historic conference held at NYAM in January 2009. The conference, called *New Directions New York: A Public Health Safety Approach to Drug Policy*, helped to delineate a public health and safety approach as a clear alternative to existing policy. The conference made clear that a wide array of community,

government, health, and other stakeholders agree that at the center of all our drug policies whether addressing legal or illicit drugs—should be the question, "What impact will our policies have on the public's health and safety?" This *Blueprint* seeks to outline an approach that responds to this question using the best evidence available coupled with the input of hundreds of New Yorkers.

Overview of Findings

This *Blueprint* details a number of specific findings related to the four pillars model: prevention, treatment, harm reduction, and public safety. Two clear, overarching themes emerged from our work. First, structural issues—like disparities in income, education, and opportunity—profoundly shape individual experiences of drug policies, as does the neighborhood in which a person lives. In New York, these structural issues are overlaid with issues of race and racism so that communities of color, while just as affected by problematic drug use as white communities, are far more

profoundly and detrimentally affected by our current policy responses to such use. Simply put, even though drug use is spread roughly evenly throughout the population, our responses to drug use—how we police and the services and resources available to people in need—vary tremendously. Poorer communities and communities of color generally have fewer resources with which to prevent and address drug use. They face more intensive policing, surveillance, and penalties from multiple government agencies than more affluent white communities.

Most current approaches to drug use tend to intervene at the level of the individual, failing to take into account the larger environmental, community, family, and economic contexts that contribute to harmful drug use.[13-14] The public health and safety approach we outline in this *Blueprint* includes strategies that address the individual within the context of communities. All sectors of society (not just criminal justice or treatment) need to be involved if we are to address the social factors—racial segregation, income inequality, poverty, unemployment, community norms, literacy issues, deteriorating housing, disinvestment—acknowledged as having an effect on drug use behavior, the health of people who use drugs, and the differential rates of illness among people who use drugs from different racial and ethnic groups.[15-20]

Similarly, all sectors need to address the harm that has resulted from some of the current drug policies, particularly arrests and incarceration and their concentration in certain neighborhoods and among people of color.[21-22] Enforcement practices like marijuana arrests and illegal "stop, question, and frisks" are among the most glaring examples of policies that must be reevaluated for

effectiveness and their contribution to poor life outcomes. These practices, about which community members spoke most passionately, primarily target people of color and result in the stigmatization of entire communities and groups of people.

Taking these structural issues seriously means that we must both critically examine the impact of policies and practices that create racial disparities and broaden our drug policy framework, expanding from an individual enforcement-based approach to efforts such as community development, education, and the better integration of health, mental health, drug treatment, and social service systems.

The second overarching theme is that, when problematic drug use does occur, our response should be to offer help instead of sanctions. Many of our current policies and practices reflect a "zero tolerance" view that either criminalizes or demonizes people who use drugs in ways that do little to help them or their families or to ensure that our communities are safer. In fact, responding to drug use primarily as a crime leads to a cascade of negative outcomes (e.g., breaking up families, creating barriers to employment, disqualification from student loans, denial of access to public housing, loss of children) and prevents more constructive responses. Zero tolerance policies fail to recognize that drug use is endemic (it has happened throughout history and across all populations) or that addiction is a chronic relapsing condition. When people do become addicted, they need treatment, not punishment. In place of zero tolerance, we need systems and supports that help those with drug use problems minimize problematic use of drugs and decrease the harm associated with that use. Our communities will be healthier and safer if

those who have drug use problems have access to medical care, harm reduction services, housing, and social services. Those who have quit using drugs also need ongoing support. We would never penalize someone with diabetes—a chronic condition, like addiction, that requires both medical treatment and a change in behavior. We should not penalize those who use drugs if they are not harming others. Our drug policies should not be driven by moral judgments but by the goal of improving the health and safety of individuals, families, and communities.

Overview of Recommendations

The *Blueprint* offers a series of detailed recommendations. Overall, we call for strong leadership at the state and local level to align our policies across agencies and sectors with the goal of improving the health and safety of our communities. To this end, we recommend that the Governor of New York convene a multiagency task force. It should include all of the state agencies that serve people who use drugs; state agencies involved in enforcing current drug laws; communities most affected by drug use; a variety of human service providers; community members, including people in recovery, people who currently use drugs, and formerly incarcerated people; and experts. We recommend that the task force be chaired by a senior member of the Governor's office and that it focus its attention on assessing and evaluating all state agency drug policies and programs to work toward their alignment. To be effective, the task force must include meaningful representation from and collaboration with New York City officials. We also recommend that New York City should, because of the size of its population, the complexity of its own agencies and programs, and its unique drug

policy environment, convene its own multiagency, cross-sectoral mechanism to examine city-level policies. We recommend that these entities define their charges broadly, recognizing that the state and the city's health reform efforts, economic and community development, infrastructure investments, and educational programs, as well as more traditional health and social services, all have a role to play in preventing harmful drug use, helping individuals and families involved with drugs, and strengthening our communities.

While some policy changes will require a multiagency structure to resolve competing demands and leverage existing resources, other policies will not. Therefore, we have also made a series of recommendations for specific state and city agencies to eliminate those policies and practices that penalize people who use drugs and deepen racial disparities; to work with communities to modify current or develop new policies that will help individuals, families, and communities prevent drug use; reduce the harm for those who cannot or will not stop using drugs; and offer those leaving the criminal justice system and those in recovery the ongoing services and support they need to reintegrate into their families and communities. New York can lead the nation in re-envisioning and implementing an approach to drug policy that is humane, fair, and effective. We hope that this *Blueprint* can guide a comprehensive effort to transform our drug policies from the existing, confusing mix of contradictory approaches into an integrated approach that improves the health and safety of all New Yorkers.

Background

Background
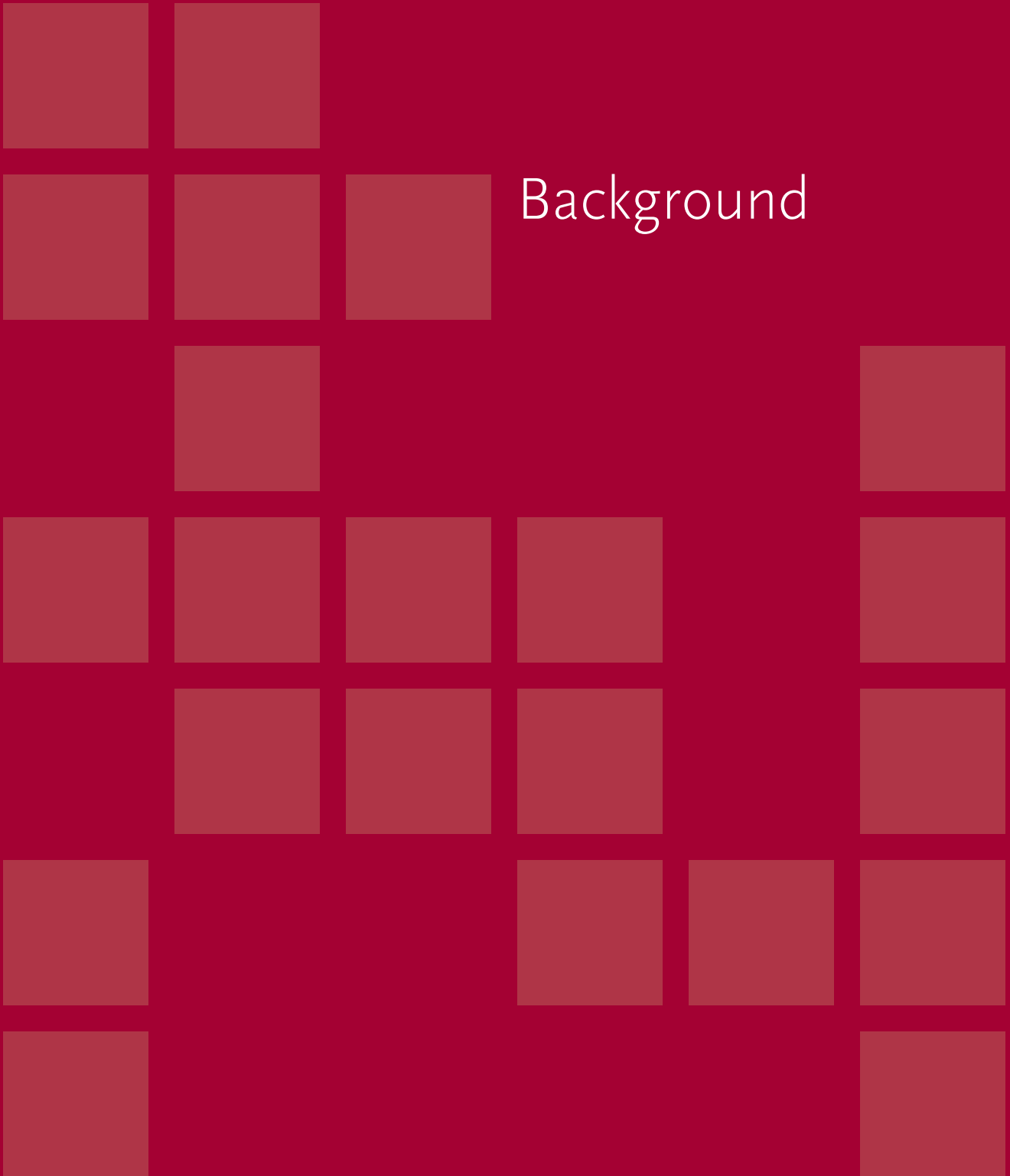
Harmful drug use and dependence in New York remain leading causes of illness and death and are among the state's most intractable public health problems. They are pervasive and costly, both financially and in terms of the damage they do to individuals, families, and communities. The Office of Alcohol and Substance Abuse Services estimates that one in 13 New York State residents suffers from a substance abuse condition.[i] Those numbers alone are significant, but there are millions more whose well being is affected by the drug use of others and by the effects of our current policy responses.

Almost everyone in New York is touched by drug use or our policy responses to it. While not all drug use is harmful, many New Yorkers do use drugs in ways that are harmful. Drug use is associated with a number of public health problems, including transmission of infectious disease, unintentional injury, and some chronic diseases. Moreover, as we discuss below, there is increasing evidence that arrests and incarceration—much of which are drug-related—are also harmful to the health of the public, especially when concentrated within specific communities.

This *Blueprint* seeks to outline steps toward a more comprehensive and effective drug policy strategy in New York. In the first section, we begin by outlining the scope of the problem, identifying the current approaches to drug policy in New York, and proposing a coordinated framework for action. We then detail how the report was developed, including its underlying principles and goals. In the next section, we present the findings from our research, which are based on a review of published evidence and consultations with hundreds of New Yorkers from across the state. In the final section, we outline our recommendations for action.

The Scope of the Problem

The New York State Office of Alcoholism and Substance Abuse Services (OASAS) estimates that statewide, over 1.8 million New Yorkers (1.77 million adults and 156,000 young people ages 12-17) have a substance abuse condition.[23] Many more are affected by the drug use of a family member, colleague, or friend. The most commonly used drugs are alcohol, tobacco, marijuana, and prescription medications.[24] Almost four percent of New Yorkers report illicit drug use other than marijuana in the past year,[25] and 4.3 percent of New Yorkers report the illicit use of a pain reliever in the past year.[26]

Drug use is a major cause of illness, injury, and death. For example, accidental drug overdose is the fourth leading cause of premature death among adults in New York City where more than 600 people die from drug overdose each year—more than by homicide.[27] Overall, people who use heroin face annual mortality rates six to 20 times higher than the rate expected among their peers who do not use drugs.[28] In addition, more than 54,000 hospital discharges were drug related in New York State in 2009.[29]

This is a significant cost burden to the health care system. In fact, a review of New York City hospitals found that two-thirds of the non-long term care Medicaid beneficiary population considered to be high cost to the health care system had a substance abuse condition. (Two-thirds to three-fourths also had a chronic health condition, almost half had more than one chronic health condition, two-thirds had a mental illness, and approximately half had a mental health and substance abuse condition). High-cost Medicaid beneficiaries account for the majority of Medicaid spending, particularly due to hospitalizations and emergency department visits. The most costly 10 percent accounts for 57 percent of all Medicaid spending—an average of $20,000 per patient—and the top one percent accounts for 20 percent of spending, with an average of $71,000 per patient.[30] See Figure 4.

However, drug use does not occur in a vacuum. The health of people who use drugs is intertwined with multiple determinants that influence the conditions in their communities and their access to services.[31] Social determinants, such as housing, education, and economic development, are

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i   When using the term 'substance abuse' in this document, we are employing the term as used by the original reference source. 'Substance abuse' specifically references a condition as determined in accordance with the procedures and criteria of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association.

Figure 3

Substance abuse conditions among New Yorkers

Over 1.8 million New Yorkers

1.77 million adults — 156,000 youth ages 12-17

Figure 4

High cost Medicaid spending*

Total beneficiaries

Total Medicaid spending

57%

20%

Top 10%

High cost Medicaid beneficiaries

2/3 have a mental health condition

2/3 have a substance abuse condition

//// **1/2** have a mental heatlh condition + substance abuse condition

*Not including long-term care recipients
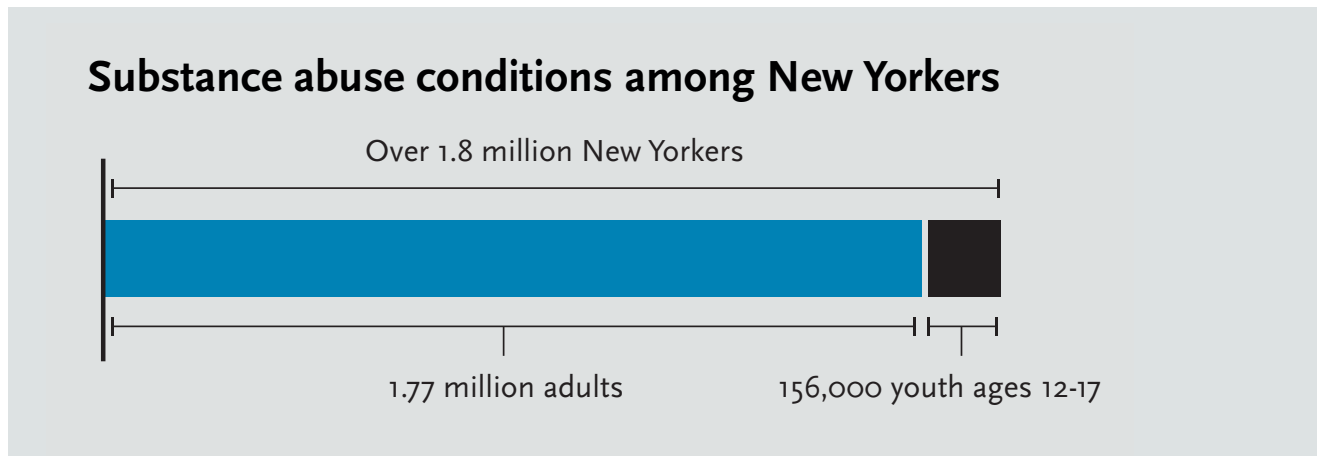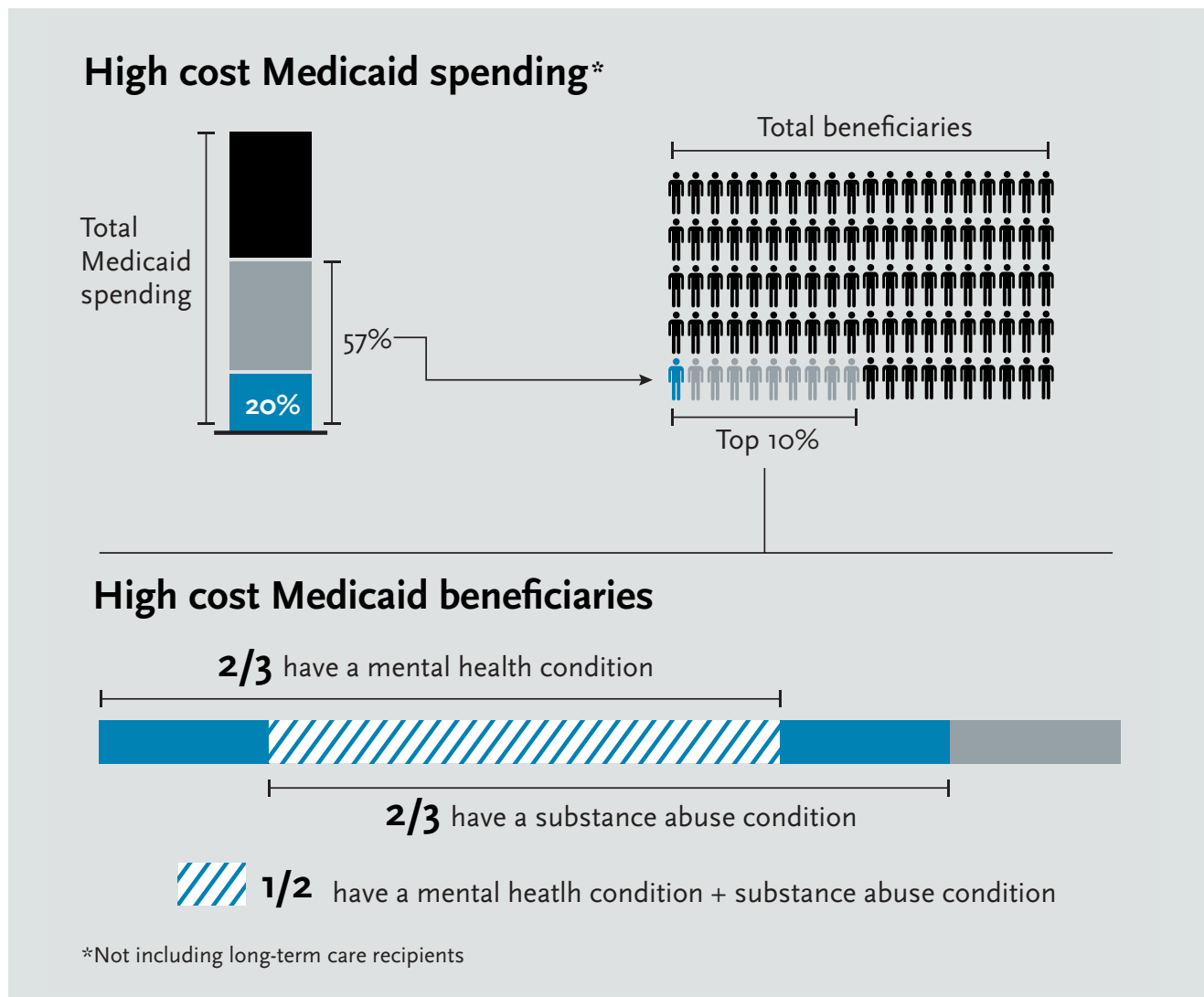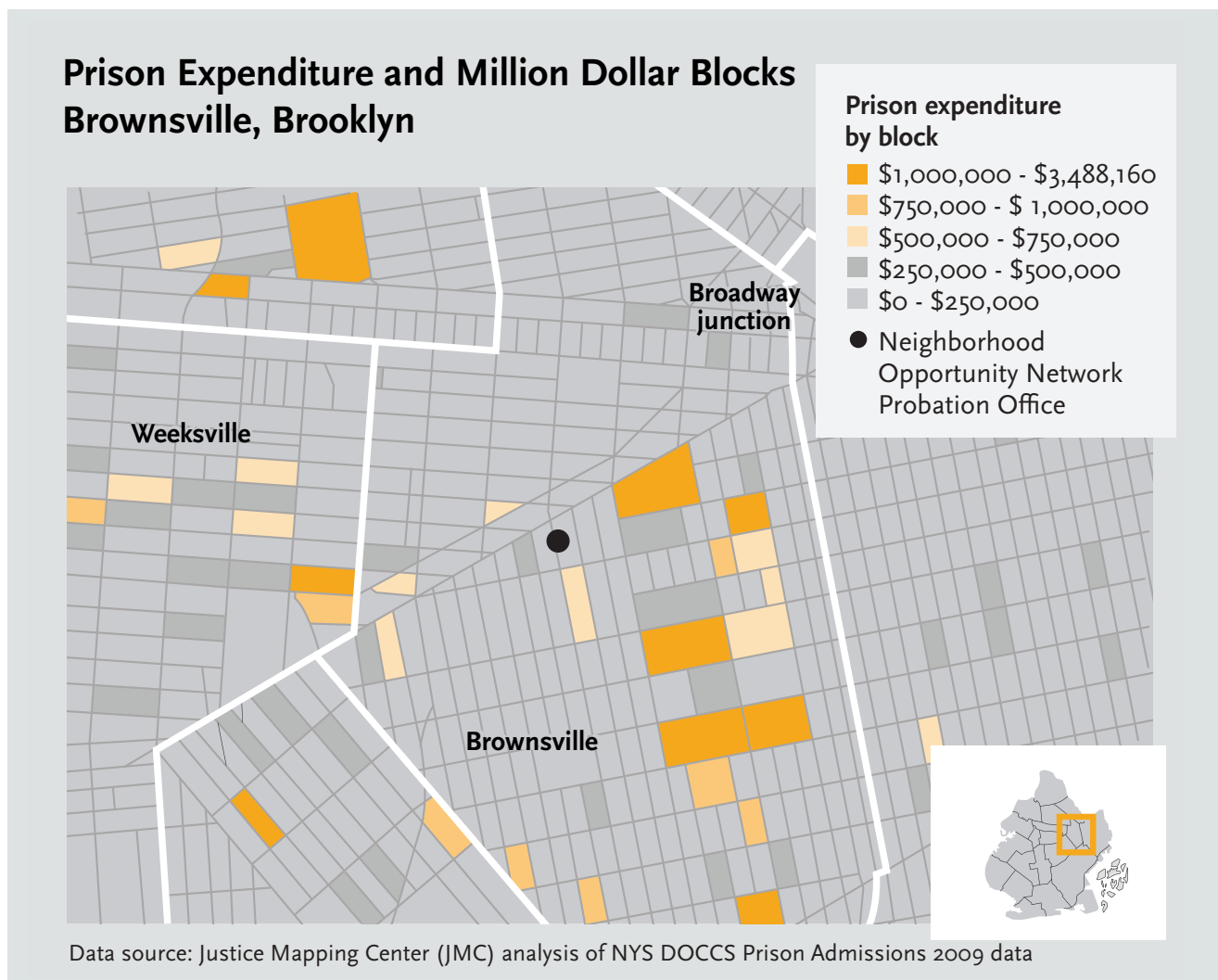
especially relevant to minorities who use drugs, and who, despite similar rates of drug use, have much higher rates of drug related morbidity and mortality including higher rates of injection drug-related HIV/AIDS and overdose deaths.[32] Only some of these disparities are explained by individual-level behavior; poverty, segregation, discrimination, and limited access to resources also play a role.[33]

It is not only excessive drug use that causes harm. Many of our drug policies—particularly those that lead to the criminalization, incarceration, and stigmatization of those who use and/or sell drugs—are also bad for both individual and the public's health. With over seven million people under the control of the criminal justice system through incarceration, parole, or probation, the incarceration and criminalization of individuals is increasingly seen as an important public health issue and as a social determinant of health.[34-36] One in every 100 U.S. adults are now in prison or jail.[37] Incarceration (as well as its impact) is not evenly distributed by race or geography and may, therefore, be exacerbating existing health disparities.[38] An analysis by the Justice Mapping Center demonstrated that a disproportionate number of men sent to prison in New York State come from relatively few neighborhoods in New York City; 14 community districts account for more than 50 percent of the men sent to prison from New York City, though they account for only 17 percent of the population.[39] In some neighborhoods, like East Harlem, one in every 20 adult men is in prison.[40] Some neighborhoods have been dubbed "million dollar blocks,"[41] denoting that the state is spending upwards of $1 million a year to incarcerate people from neighborhoods which—in addition to facing

Figure 5

**Prison Expenditure and Million Dollar Blocks
Brownsville, Brooklyn**

Prison expenditure by block
- $1,000,000 - $3,488,160
- $750,000 - $1,000,000
- $500,000 - $750,000
- $250,000 - $500,000
- $0 - $250,000
- ● Neighborhood Opportunity Network Probation Office

Data source: Justice Mapping Center (JMC) analysis of NYS DOCCS Prison Admissions 2009 data

A Public Health and Safety Approach to Drug Policy

high rates of incarceration—are also dealing with high rates of unemployment, poverty, and health disparities.[42-43] (See Brownsville, Brooklyn in Figure 5 as an example of a "million dollar block" in NYC.) A 2012 report issued by the Vera Institute states the total national cost for incarceration as $39 billion in 2010. In New York, the annual cost of incarceration to taxpayers is $3,558,711,000; the cost to incarcerate an individual is more than $60,000 per year, almost twice the national average of $31,300.[44]

In 2011, New York State reported nearly 137,000 drug-related arrests (approximately 24 percent of all arrests in New York). At 703.6 arrests per 100,000 New Yorkers per year, this is among the highest rates of drug-related arrests per capita throughout the U.S.[45-46] 50,383 of these drug-related arrests were misdemeanor marijuana arrests by the New York City Police Department; these arrests came at a cost of over $75 million a year.[47] Of these misdemeanor marijuana arrests, over 85 percent were Black and Latino young men[48]—although young white men use drugs at comparable rates.[49] Nationwide, in 2011, there were more than 1.53 million arrests for drug abuse violations in the U.S.— approximately 12.3 percent of all arrests.[50] Similar to New York State, the vast majority of these arrests (82 percent) were for possession; almost half (43 percent) were for possession of marijuana.[51]

Drug offenses are the leading causes for new commitments to New York State prisons: in 2010 they accounted for 25,478; or 25 percent of all commitments. Drug offenses are also a leading cause of recidivism, which in New York State has persisted at the rate of 40 percent.[52-53] At the beginning of 2011, there were approximately 8,664 people in New York State prisons for a drug offense—15 percent of the total individuals in prison.[54] Mirroring New York City arrests, almost 85 percent of people committed to a New York State prison for drug offenses in 2010 were Black or Latino.[55] The high numbers of arrests and incarceration driven by our drug policies are a great burden to the system. These policies have serious direct and indirect consequences that adversely affect the socioeconomic status and health of communities, particularly in low-income communities of color where policing, arrests, and incarceration are concentrated.

According to the U.S. Department of Justice National Drug Intelligence Center, the economic cost of illicit drug use to the U.S. in 2007 was estimated to be more than $193 billion[56]—an increase from the 2002 estimate of $181 billion by the Office of National Drug Control Policy.[57] In addition to spending on the provision of direct drug-related services (drug treatment, drug prevention programs, etc.), this assessment included the indirect costs and consequences associated with adverse health effects (medical care of drug-related illness and injury); criminal justice and crime (policing, adjudication, corrections, property damage, etc.); and loss of productivity due to ill health and incarceration, withdrawal from the legal workforce, disability, and premature death. The increase in costs between 2002 and 2007 can largely be attributed to increased spending on resources in law enforcement, adjudication, and incarceration. We'll revisit the issue of cost throughout this document. In a comprehensive assessment of societal costs attributable to illicit drug use, it was found that only about three percent of the total spending to address illicit drug use was invested in illicit drug use treatment and drug prevention services.[58]

In addition to economic costs, incarceration also impacts public health. While the specific mechanisms of how incarceration affects community health are poorly understood, there is increasing evidence that incarceration, especially when concentrated in particular neighborhoods, destabilizes families and social networks and contributes to poor health. In addition to the stigma of a criminal record and the loss of important relationships during incarceration, many people with criminal records face significant legal barriers to accessing health care, housing, and employment opportunities.[59-62] These laws and policies undermine sources of social and financial support and contribute to homelessness and poverty—all factors associated with poor health outcomes in an already fragile population.

Incarceration also has collateral consequences for families. Nationally, 10 percent of all minority children have a parent in prison or jail, or on probation or parole.[63] New York State is home to an estimated 105,000 children of incarcerated parents; hundreds of thousands more have experienced their parents' criminal justice involvement at some point in their lives.[64] While the negative impact of incarceration on children can be mitigated by a number of factors, reviews of the literature suggest that the incarceration of a parent is associated with low self-esteem, depression, emotional withdrawal, disruptive behavior at home and school, poor school performance, higher rates of delinquency and arrest, and increased risk of abuse and neglect.[65-66] Moreover, having a family member incarcerated significantly decreases family income; 68 percent of incarcerated fathers were the primary source of income for their families.[67] A review of the economic impact of incarceration on individuals and families by the Pew Charitable Trusts[68] found incarceration to reduce

annual earnings by 40 percent; hourly wages for men are reduced by approximately 11 percent. Furthermore, probability of upward mobility is significantly lower. Black males are most affected in their economic prospects with depressed earnings of nine percent; Hispanic males show a six percent reduction. White males experience a two percent reduction.
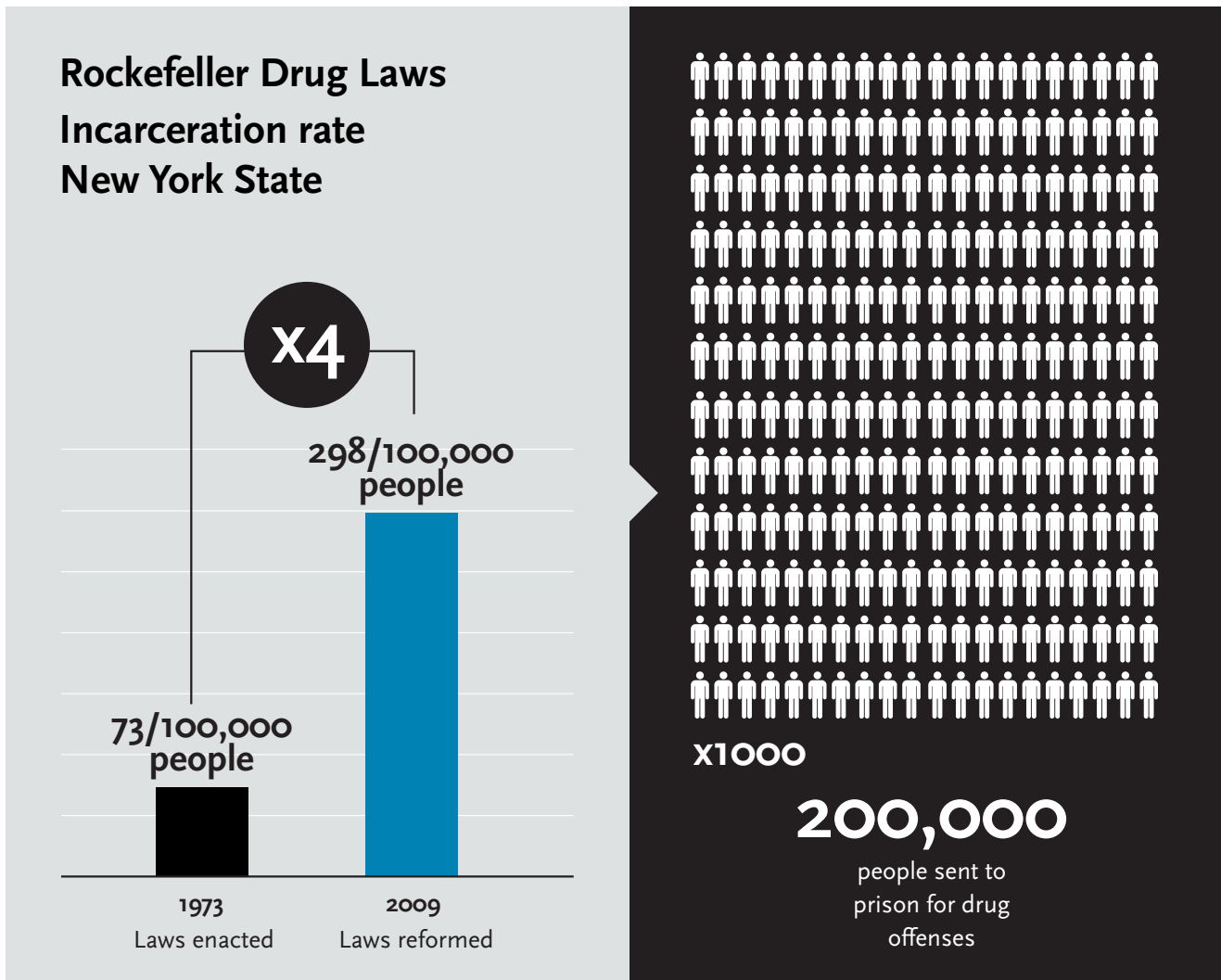
This *Blueprint* focuses attention on the links between poverty, race, the consequences of drug use and our current drug policies. However, we also want to acknowledge (as described in more detail below) that people of color from all economic backgrounds bear the brunt of our current policing and criminal justice strategies.

New York's Current Drug Policies

What is New York's drug policy strategy today? In short, there isn't a unified, coherent approach. Rather, there are multiple approaches across numerous jurisdictions to deal with a variety of related issues. But these approaches are too often uncoordinated, sometimes contradictory, and frequently lack shared objectives and metrics to determine effectiveness.

Some of the problems stem from the fact that our drug policies have been largely bifurcated between criminal justice and treatment approaches. For nearly 40 years, a predominant framework for addressing drugs and drug use in New York was the Rockefeller Drug Laws. Enacted

Figure 6

Rockefeller Drug Laws Incarceration rate New York State

x4

298/100,000 people

73/100,000 people

1973 Laws enacted

2009 Laws reformed

x1000

200,000 people sent to prison for drug offenses

in 1973, the laws required long mandatory minimum prison sentences and expanded the criminalization of relatively minor drug offenses. The incarceration rate nearly quadrupled from 73 incarcerated individuals per 100,000 residents in 1973 to 298 per 100,000 in 2009.[69] From 1973 until the 2009 reforms, nearly 200,000 New Yorkers—mostly from New York City—were committed to the New York State Department of Correctional Services prison system for drug offenses.[70-72] Indeed, the laws never achieved their stated goals of reducing the use or prevalence of drugs[73-74] and led to racial disparities in New York's criminal justice system. Despite the fact that the prevalence of drug use and drug sales are roughly equal across all racial and ethnic groups,[75] nearly 90 percent of those incarcerated under the Rockefeller Drug Laws were Black and Latino.[76]

While this criminal justice approach to drugs and drug policy dominated policy discussions in New York for nearly 40 years, the state was simultaneously leading the way in developing innovations in harm reduction, drug treatment, and alternative-to-incarceration programs, including drug courts. These included expanding maintenance programs like methadone (which originated in New York and which has been proven effective both in treating opioid dependence and decreasing infectious disease) and syringe exchange programs (which have also been shown to dramatically reduce the incidence of infectious diseases, especially HIV/AIDS). New York has also invested in a substantial treatment system that includes a range of modalities and has a well-developed network of alternative-to-incarceration (ATI) programs. Currently, the New York State Division of Probation and Correctional Alternatives funds approximately 165 ATI programs.[77]

Absent an integrated drug policy strategy, a unified conceptual framework, and better coordination, these two approaches—one aimed at enforcing criminal penalties against people who use drugs and the other treating drug use as a health condition—have led to policies and programs that work at cross-purposes. For example, departments of health across the state support syringe exchange programs as a proven method to reduce the transmission of HIV/AIDS and hepatitis C. Yet the police in many of the same jurisdictions seek to arrest syringe exchange participants for possession of syringes—even after changes were made to the law to make possession of syringes legal for syringe exchange participants.[78-79] Taken as a whole, an absence of a coordinated drug policy strategy at either the local or state level—with shared goals, objectives, and metrics—reduces the likelihood of success in any single area and often creates new problems or exacerbates existing problems.
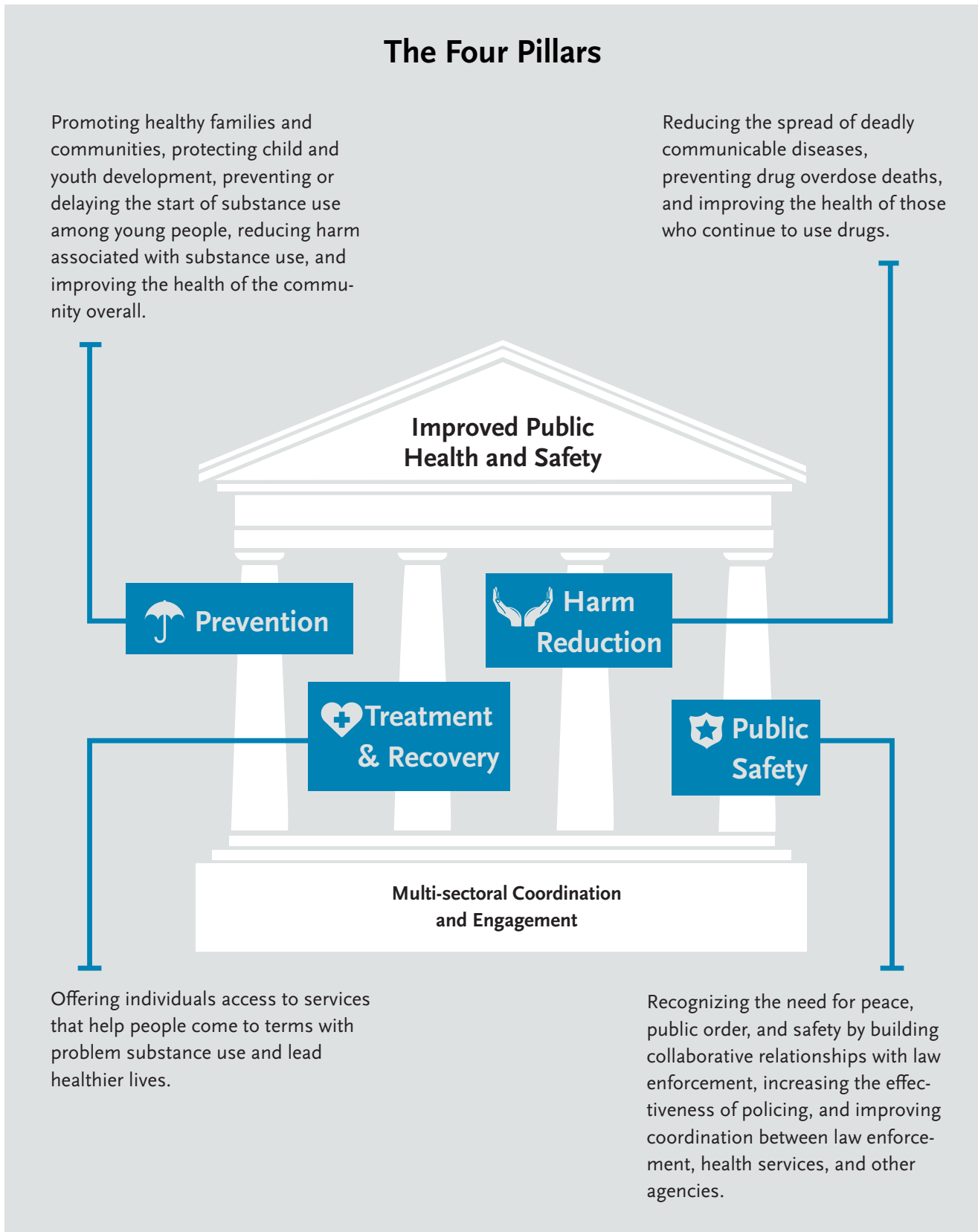
Toward a New Approach

Fortunately, New York has already begun a process to develop a new, coordinated approach to drug policy. In April of 2009, legislative leaders, advocates, and communities across New York enacted major reforms to the Rockefeller Drug Laws and called for a new public health and safety approach to drug policy. Since then, community groups, human and legal service providers, advocates, and some elected officials and leaders from state agencies have been working to shift the focus away from incarceration and toward providing individuals—who either have drug use problems and/or have become entangled with the criminal justice system—with services and support. However, these implementation efforts remain piecemeal at best. The state continues to lack a coherent policy framework.

Some of the difficulty in articulating rational drug policies stems from the different policy frameworks that have been established to manage alcohol, prescription medications,[ii] tobacco, and illicit drugs. While all of these are substances that can lead to harm, our legal, criminal justice, medical, and public health systems treat them very differently. Here, we focus on illicit drug use, not because the drugs are by themselves more harmful (in fact, tobacco causes more morbidity and mortality than any form of illicit drug use), but because it has become increasingly clear that our current policies to manage illicit drugs and illicit drug use have failed, and there is a growing consensus that a new approach is needed. Adding to the complexity of developing a new framework is the fact that there are two kinds of harm associated with drug use: the harm caused by the drugs themselves when misused or used excessively, and the harm caused by our policy responses to drugs and drug use.

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ii Prescription medication has begun to receive more attention as the rates of use, misuse, and overdose have soared in recent years, and our policy responses to illicit drugs and prescription medications are becoming more entangled as the law enforcement community takes aim at doctors and patients they believe to be misusing medications. While not the explicit focus of this document, we do discuss prescription drugs insofar as they intersect with our consideration of illicit drugs.

Figure 7

The Four Pillars

Promoting healthy families and communities, protecting child and youth development, preventing or delaying the start of substance use among young people, reducing harm associated with substance use, and improving the health of the community overall.

Reducing the spread of deadly communicable diseases, preventing drug overdose deaths, and improving the health of those who continue to use drugs.

Improved Public Health and Safety

☂ **Prevention**

🤲 **Harm Reduction**

💗 **Treatment & Recovery**

🛡 **Public Safety**

Multi-sectoral Coordination and Engagement

Offering individuals access to services that help people come to terms with problem substance use and lead healthier lives.

Recognizing the need for peace, public order, and safety by building collaborative relationships with law enforcement, increasing the effectiveness of policing, and improving coordination between law enforcement, health services, and other agencies.

The 2009 reforms present an opportunity—but one that could be lost if action is not taken. While significant, the reforms of 2009 are just the first step toward a new approach. The next step is to develop a unifying vision that would align the many sectors working to address drug related problems, reduce the fragmentation of existing systems and services, and focus attention on the upstream causes of drug use and drug dealing. A public health and safety framework provides such a vision; however, a common definition and clear delineation of what a public health approach means in practice is needed. This document frames a public health and safety approach to drug policy that orients our efforts toward the goal of reducing sickness, injury, and death; preserving and protecting families; reducing crime and violence; and building strong, healthy, and safe communities.

Policy discussions around drugs are often overlaid with a host of prejudices and misinformation about particular drugs. A public health approach must take a step back and focus on the actual harm caused by a drug and our policy responses to it. Increasingly, scholars are developing tools and models for doing just that. For example, a team of experts writing in the peer-reviewed medical journal the *Lancet* developed a method by which they calculated the relative harm of different drugs (e.g., alcohol, heroin, tobacco) by assessing the actual physical, psychological, and social harm of each drug to the person using the drug and to other people.[80] It is also important to recognize that there is a range of drug use; some use does not lead to significant health or behavioral problems for the individual or others. Many individuals who use drugs do not develop dependency and often quit using on their own. More research is needed to better understand what patterns of use and related factors indicate a need for intervention and what patterns of use do not need intervention. Focusing on the harm that drug use causes can help us better evaluate when there is a need for intervention. Dr. Steven Jonas, who has written extensively about a public health approach to drug policy, argues that the current focus on the way drugs are classified by law has created conceptual confusion in drug policy. He suggests that we should focus instead on both the harm caused by drugs and the harm caused by our policy responses to them.[81] This approach informs the *Blueprint*.

What is a Public Health and Safety Approach?

A public health and safety approach to drug policy is a coordinated, comprehensive effort to create safer, healthier communities, measuring success by the impact of drugs and our drug policies on the public's health. This approach emphasizes the need for a coordinated strategy involving multiple sectors. One successful strategy for engaging multiple sectors in transforming drug policies and improving public health is the four pillars model comprising prevention, treatment, public safety, and harm reduction. See Figure 7. We have used the model as a framework for the findings portion of the *Blueprint* because we find it to be a useful organizing principle that ensures that all of the key elements of a comprehensive drug policy strategy receive proper attention. First implemented in Switzerland[82] and Germany[83] in the 1990s, the four pillars model, explicitly or implicitly, is now employed in many cities and countries in Europe[84] as well as in Australia[85] and more than a dozen cities in Canada,[86] including Vancouver[87] and Toronto.[88] Several of these countries and cities share a common experience whereby the shift in policy began in localities and then, through a bottom-up process, expanded to the regional and national level. The four pillars approach has guided comprehensive reforms that resulted in a reduction in the number of people consuming drugs on the street, a significant drop in overdose deaths, reduction in crime, and a reduction in the infection rates for HIV and hepatitis in several cities.[89-90]

Criminal justice, treatment, prevention, and harm reduction approaches tend to intervene at the level of the individual, failing to take into account the larger environmental, community, family, and economic contexts that contribute to harmful drug use.[91-92] The public health and safety approach we outline here includes strategies that integrate prevention, treatment, harm reduction, and public safety/enforcement to make the structural changes that are needed to create communities that are safe and healthy for all. Most importantly, it addresses the individual within the context of communities. All sectors of society—not just criminal justice or treatment—need to be meaningfully involved if we are to address the social factors—racial segregation, income inequality, poverty, unemployment, community norms, literacy issues, deteriorating housing, disinvestment—acknowledged as having an effect on alcohol and drug use behavior, the health of people who use drugs, and the differential rates of illness among individuals from different racial and ethnic groups who use drugs.[93-98] Similarly, all sectors are needed to address the harm that has resulted from some of the current drug policies, particularly incarceration and its concentration in certain neighborhoods and among people of color.[99-100]

New York already has experience with comprehensive, multisector public health approaches, which have been effective in reducing the use of and the harm associated with particular drugs. For example, New York State's public health response helped reduce the rate of smoking by adults by 29 percent between 2003 and 2010. For high school students the rate decreased by 54 percent from 2000 to 2010.[101] We also have much to learn from efforts to address other public health problems, especially those surrounded by stigma. A number of health issues—ranging from breast cancer and HIV to mental illness—have taught us both that we must involve those directly affected when designing policies and programs, and that we must be vigilant about addressing stigma. To begin, service providers, policymakers, public safety personnel, and community advocates need a shared understanding of harmful drug use and incarceration associated with drugs as a public health problem. Stakeholders who could be working together to resolve these difficult issues are often in adversarial relationships that diminish their ability to make real changes to benefit those affected by harmful drug use and our policy responses to drugs. At the center of all of our drug policies—whether addressing legal or illicit drugs—should be the question, "What impact will our policies have on the public's health and safety?"

Guiding Principles

Our primary aims are to elucidate the problems inherent in our current responses to illicit drugs and illicit drug use and to communicate a vision for how drug policies in New York State might look if state and local policies and programs were reoriented to use evidence-based practices to promote the health and public safety of our communities. As such, this report does not focus on federal drug policy but rather on changes that can be made at the state and local level. Drug policy is complicated by the overlapping and sometimes contradictory federal, state, and local laws; regulations; and programs. In many ways, the federal government sets the framework—through its funding mechanisms, policy stances, and research agenda—for much of the drug policy in New York (and other states). However, the state retains considerable discretion in how it prioritizes funding; shapes the treatment, harm reduction, and prevention programs it funds and/or regulates; and sets criminal justice policies. Local municipalities also have an important role to play, particularly through the autonomy they have in dictating policies and priorities.

The development of this *Blueprint* was guided by several core principles:

1. Policy proposals should be developed in consultation with those who will be most directly affected by the proposed changes—in this case, people who previously used or currently use drugs as well as the people living and working in communities hardest hit by drug use, the illicit drug trade, and our policy responses to it.
2. Policy proposals should be based on the best available evidence about need and effectiveness.
3. Complex social problems, like drug use, will only be solved by addressing both upstream and proximate causes and employing both structural and short-term solutions. To succeed, we must engage multiple sectors of society, including government, business, academia, health, social service, treatment, and religious institutions as well as community members.
4. Different communities and groups of people have different needs and priorities. Therefore, policies must be able to take into account different local and cultural contexts.
5. Existing service systems too often exist in silos, and strategies to work across and to integrate these silos are desperately needed.

Goals

The goals of this *Blueprint* are the following:
• Identify the key problems, issues, and policy barriers facing communities and individuals affected by harmful drug use and current policy responses to it across New York State.
• Describe what a public health approach to drug policy would mean for New York and how it would help individuals and communities across the state.
• Provide a unifying vision and a common language for policymakers, service providers, and advocates concerned with reducing the harm associated with drug use and our responses to it.
• Identify effective strategies for moving toward a public health and safety approach to drug policy.
• Delineate a policy agenda and an implementation strategy for aligning existing policies with a public health and safety approach to drug policy.

How was the *Blueprint* Developed? Methods Used

This *Blueprint* was developed jointly by The New York Academy of Medicine (NYAM) and the Drug Policy Alliance (DPA) in partnership with hundreds of individuals and dozens of organizations. Our approach in developing the *Blueprint* included three key strategies:

1. Review of existing literature and policy documents
2. Consultations with experts in the field
3. Consultations with people living and working in communities most affected by drug use and drug policies

The work began in January of 2009, when NYAM and DPA convened a major conference focused on drug policy in New York. Titled *New Directions New York: A Public Health Safety Approach to Drug Policy*, and held at NYAM, the conference brought together more than 300 participants: leading experts, law enforcement, people directly affected by drug use, advocates, and policymakers. Using the four pillars model (prevention, harm reduction, treatment, and public safety) as an organizing framework, the conference was an exciting forum for a broad range of people to engage across sectors and to hear different perspectives. The conference made clear New York State's deep need for a coordinated and comprehensive approach that would help align our drug policies; participants from every sector expressed a keen interest in a fuller understanding of what such an approach would look like. The need for a coordinated approach only became more evident in the wake of the April 2009 reforms to the Rockefeller Drug Laws, when it became apparent that these reforms alone were not sufficient to realize a public health and safety approach to drug policy; while they were an important step forward, much more needed to be done.

Review of Existing Literature and Policy Documents

Both NYAM and DPA are committed to formulating drug policies based on solid evidence. Evidence-based policymaking is particularly important in a field as highly politicized and controversial as drug policy. Using the resources of both the NYAM library (one of the largest medical libraries open to the public in the country) and the Lindesmith Library at DPA (which has a collection of more than 15,000 documents and videos focused specifically on drug policy), we conducted a review of the literature to identify best practices in the U.S. and around the world and to gain information about the needs, experiences, and characteristics of people and communities impacted by drug use and policies. In addition to library and web-based searches, we asked leading organizations from around New York State to send us their policy documents for inclusion in our review. Several groups in New York have written excellent policy analyses about specific aspects of drug policy (e.g., housing, resentencing, and reentry services). Many of these documents are listed in our bibliography. We consulted both peer-reviewed and grey literature[iii] (e.g., policy briefs, white papers) to deepen our understanding of prevention, harm reduction, treatment, and public safety as well as the costs and consequences of drug use and drug policies. Since the focus of this *Blueprint* is on New York State policy, we focused on evidence relevant to state or local policy, rather than on federal drug policy.

A word about language: because we relied on secondary data in some places, we were not able to use the same racial and ethnic classifications throughout. Some researchers compare Black and white populations; others group all people of color together; while still others distinguish between Black, white, Latino, and other racial groups. While these classifications and comparisons are all problematic in some way, we felt it important to include information about the racial disparities related to drug use and drug policies to the degree they are available.

As we discuss more fully below, we lack a common language for how to talk about drug use. In fact, the definitions of drugs, substances, drug/substance use, drug/substance abuse, chemical dependency, and addiction are hotly contested.[102-103] We have chosen to use "drug use" or "harmful drug use" because we feel that these terms are more neutral than some others. In addition, when we need to make a distinction between drugs whose use is against the law and those not so designated, we use the terms illicit and licit. However, where we are relying on data or literature that uses other language, we employ the terms used by the original authors.

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iii The Fourth International Conference on Grey Literature in Washington, DC, in October 1999 defined grey literature as follows: "That which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers." In general, grey literature publications are non-conventional, fugitive, and sometimes ephemeral publications. They may include, but are not limited to the following types of materials: reports, theses, conference proceedings, technical specifications and standards, non-commercial translations, bibliographies, technical and commercial documentation, and official documents not published commercially (primarily government reports and documents).

Consultations with Experts

New York is home to some of the country's leading experts in drug policy as well as a number of professional associations serving those who provide the state's treatment, harm reduction, and prevention services. We held six group meetings with experts: 1) the legal, advocacy, treatment, and harm reduction experts that had been involved in the *New Directions New York* conference and follow-up discussed earlier; 2) members of the Human Services Council of New York City, an organization that represents more than 200 social service agencies, including many treatment providers; 3) Downstate Coalition for Crime Victims; 4) staff from the state Office of Alcohol and Substance Abuse Services; 5) members of the Coalition of Behavioral Health Agencies, Inc., which represents over 100 behavioral health agencies that serve more than 350,000 clients; and, 6) nearly three dozen young people, ages 16 – 24, from across New York City. At each of these meetings, staff led participants through a structured exercise to elicit existing assets, policies, and programs related to each of the four pillars. Participants were also asked to identify barriers, existing research, relevant literature, and where additional research was needed.

In addition to these structured consultations, staff from DPA and NYAM attended dozens of meetings and conferences of treatment providers, drug policy and policing reform advocates, reentry service providers, organizations working on the implementation of the Rockefeller Drug Law reforms, New York City Council members, and public officials working for the New York State Division of Criminal Justice Services, Office of Alcohol and Substance Abuse Services, Department of Corrections, Division of Parole, Department of Health, Office of Mental Health, and the New York City Department of Health and Mental Hygiene. We also attended hearings of state and city legislative bodies, and staff from DPA traveled to Toronto, Ontario to interview government and community stakeholders involved in the development and implementation of that city's four pillar model-based drug strategy.[104] At each of these gatherings, staff took extensive notes about issues affecting a public health and safety approach to drug policy.

Our efforts to engage law enforcement more broadly, and especially police departments, were not as fruitful as we would have liked. Staff from district attorneys' offices, courts, and drug courts (including probation and court

Hon. Ruth Hassell-Thompson, NYS Senator.

officers) attended community consultations in New York City, Long Island, and cities upstate (including Buffalo and Newburgh), and contributed insightful and instructive comments. Our invitations to police departments to participate actively were either refused or went unanswered. One response we heard was that participation would be inappropriate, as police do not make policy, they implement it. This is unfortunate; in nearly every consultation we held, participants noted—and lamented—the absence of the police in the conversation. Our difficulty in engaging police in these consultations, coupled with the strong interest on the part of consultation participants to engage the police in community discussions about drugs and drug policies, suggests that there is work to do to strengthen relationships and collaboration between police and community members in local neighborhoods around issues of drugs, drug use, and drug related violence.
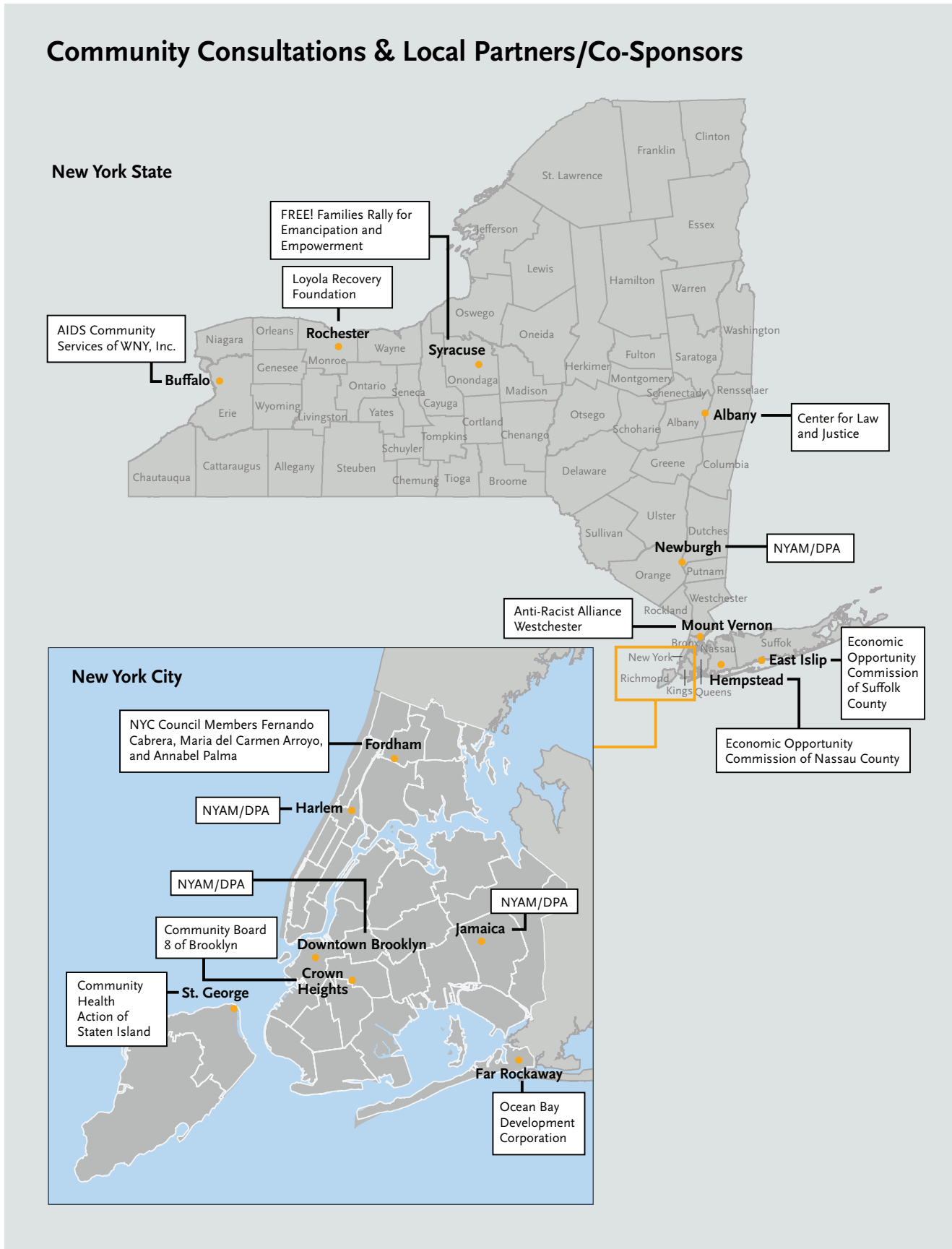
Community Consultations

Too often, policy documents are written without the input of those most directly affected by the proposed policy changes. In the case of drug policy, some communities are much more profoundly affected by drug use and responses to it, ranging from the placement of treatment programs to policing. We wanted to find out from the people living and working in communities across New York what they thought should be done to create healthy and safe neighborhoods.

From June 2010 to February 2011, NYAM and DPA co-hosted 17 community consultations throughout New York State—in Buffalo, Rochester, Syracuse, Albany, Newburgh, Mt. Vernon, the Bronx, Manhattan, Queens, Brooklyn, Staten Island, Hempstead (Nassau), and East Islip (Suffolk). See Figure 8. More than 500 people participated in these consultations. Participations included residents, people who formerly and currently use drugs, service providers, teachers, parents, and law enforcement personnel. There were nearly 200 organizations and agencies represented, which included but were not limited to resident and tenant councils; churches; drug treatment, recovery, HIV/AIDS, mental health, harm reduction, reentry, youth and family, and employment service organizations; academic institutions; policy advocates; state, city, and county agencies in the fields of health, mental health, transportation, and education; community boards and development corporations; family and drug courts; offices of elected officials, including district attorney offices; museums; and public housing authorities.

The community consultations were designed as open discussions that lasted approximately two hours and were facilitated by a NYAM and/or DPA staff member using a protocol of informal, open-ended questions. The protocol explained the purpose of these convenings and consisted of questions that guided the discussion broadly around drugs and the four pillars: prevention, treatment, harm reduction, and public safety. The discussions focused on perceptions regarding drug use and the current response to it; community needs to effectively address drug use; innovative ideas about strategies to prevent and reduce drug use and related harm; and prioritization of issues and strategies. Other NYAM and DPA staff were present to answer any questions and take detailed notes on the discussion. It was announced to participants that names of individuals and organizations would remain confidential and not be attributed to any of the ideas or beliefs discussed in these meetings. NYAM and DPA used multiple outreach strategies to recruit participants, including using established networks of organizational partners, policy makers, service providers, and community leaders to market the consultations to their respective staff and constituents. Information was distributed through word of mouth, emails, fax, and postal mail. Informational materials included flyers and a statement of purpose explaining the goal and objectives of these convenings. Similar to a snowball sampling method, stakeholders in the communities were also asked to suggest additional contacts. In regions where NYAM and DPA were less established, specific community partners were asked to assist more actively in recruiting participants. Web-based search engines, directories, and other media were also used to identify organizations and individuals for outreach. People were invited to attend sessions to express their opinions about drug policy. DPA and NYAM both purposely took a neutral stance during outreach and during the consultations so as to avoid biasing the participants in any way.

The result of our work is presented in the findings that follow and are the basis for specific recommendations for New York State and New York City to achieve a transformative shift in drug policy toward a public health model.

Figure 8

Community Consultations & Local Partners/Co-Sponsors

New York State

FREE! Families Rally for Emancipation and Empowerment

Loyola Recovery Foundation

AIDS Community Services of WNY, Inc.

Rochester

Syracuse

Buffalo

Albany

Center for Law and Justice

Newburgh

NYAM/DPA

Anti-Racist Alliance Westchester

Mount Vernon

East Islip

Economic Opportunity Commission of Suffolk County

Hempstead

Economic Opportunity Commission of Nassau County

New York City

NYC Council Members Fernando Cabrera, Maria del Carmen Arroyo, and Annabel Palma

Fordham

NYAM/DPA

Harlem

NYAM/DPA

NYAM/DPA

Jamaica

Community Board 8 of Brooklyn

Downtown Brooklyn

Crown Heights

Community Health Action of Staten Island

St. George

Far Rockaway

Ocean Bay Development Corporation

A Public Health and Safety Approach to Drug Policy

Findings

Cross-Cutting Findings

While we have organized our findings according to the four pillars of prevention, treatment, harm reduction, and public safety, there were several findings that cut across all four areas. These findings are drawn both from our review of the literature and from our conversations with experts and community members. We have tried to make clear when our conclusions are based on our consultations, the literature, or both.

Finding 1: Place And Race Matter

In Nassau County, a professional who works with young people from a nearby housing project told us that his most effective drug prevention intervention was to provide young people with a new mailing address. He and the young people with whom he worked realized that an address in the troubled public housing development meant that they faced a set of assumptions, stereotypes, and barriers that made it close to impossible for them to get jobs, enter educational programs, or access other supports that might help them get ahead. A growing body of research confirms the perceptions of the people with whom we spoke—where you live can, in fact, determine the conditions you face and the opportunities available to you.[105] For example, in a large randomized trial, low-income families housed in affluent rather than poor communities did better on a range of outcomes, including improved mental and physical health and lower rates of participation in drug selling among male youth.[106]

Scholars have also increasingly explored how neighborhood environmental factors—from economic opportunities and the physical environment to social connection and access to services—affect the health and well being of the people who live and work there.[107] Some neighborhoods have safe streets, beautiful parks, thriving commercial centers, good schools, neighbors who check on one another, and activities and spaces for young people. Other neighborhoods have high pollution levels, few services or amenities, struggling schools, limited green space, poorly maintained housing, deteriorating sidewalks and streets, few jobs, and high crime rates.

The communities in New York State that are suffering the most from drug related crime and our current drug policies are the same communities that face a host of other burdens, including deficits in their economic, social, physical, and service environments. Problems beget more problems. For example, neighborhoods with high rates of poverty are also often those with dilapidated housing, crumbling sidewalks, empty lots and garbage; factors which can also discourage an active street life and new business development. This, in turn, can contribute to crime and unemployment. These same low-income communities also face a host of health disparities and poor health outcomes associated with poverty. In fact, death rates (deaths per 100,000) are almost 30 percent higher in New York City's poorest neighborhoods than in wealthier ones.[108]

"**There are two drug policies: one for the rich and one for the poor. The rich get help, and the poor go to jail.**"
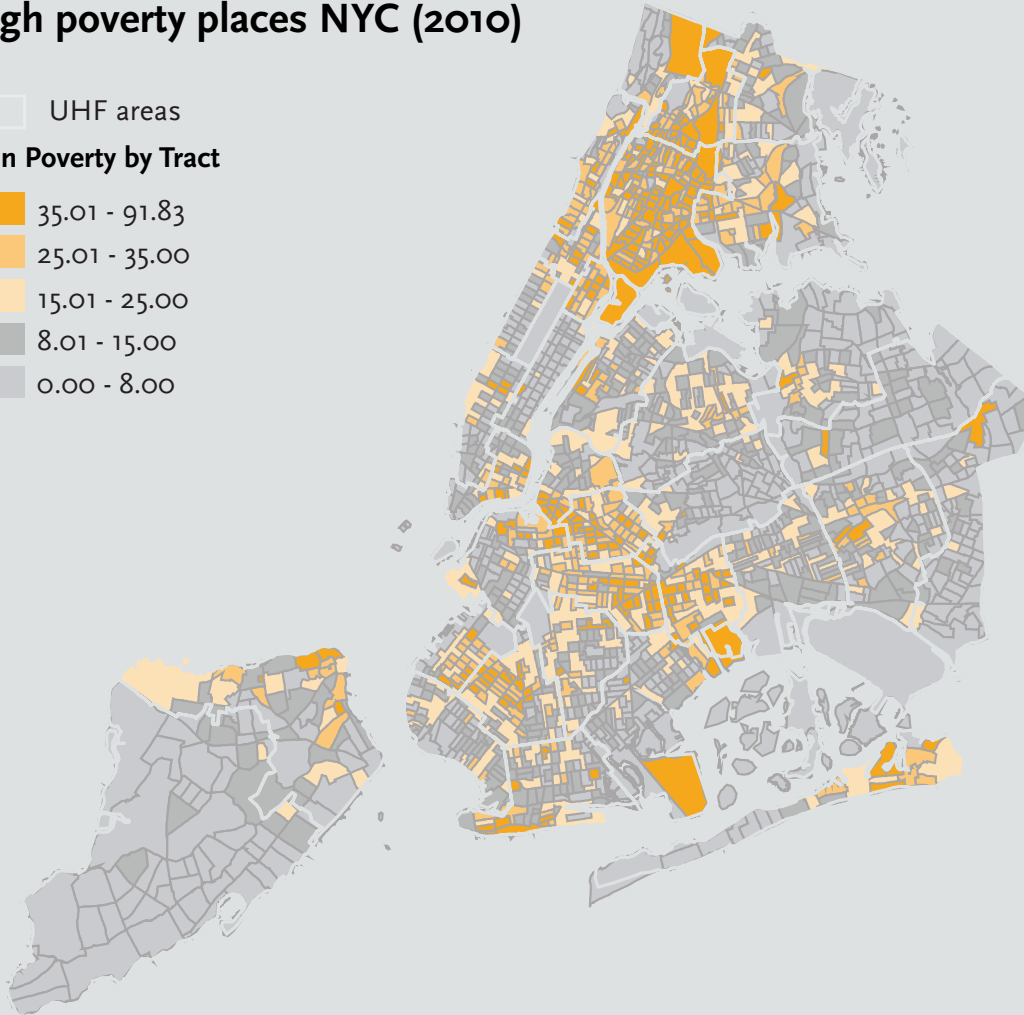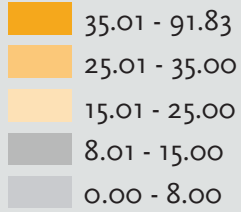— *Harlem participant*

Place and race are linked, and unfortunately, the neighborhoods with the worst economic, social, physical, and service environments are often in communities of color. According to the latest census data, New York City is one of the most racially segregated urban areas in the country, and Buffalo is not far behind.[109] As Figure 9 shows, poverty and race are highly correlated in New York City neighborhoods. In addition, race and drug related incarceration are linked. For example, even though white people use marijuana at equal or higher rates than Black or Latino people, the rates of Black and Latino people arrested for marijuana possession far exceed that of whites.[110-112] Our current approach to drug policy results primarily in the mass incarceration of men of color. Rates of incarceration vary dramatically between neighborhoods, as does the intensity of policing. Figures 14-18 in the Public Safety section illustrate this clearly. (See page 53 and pages 59-62.) As these maps suggest, your income, your address, and your race can have a big impact on your future—including your health and your risk of arrest and incarceration. As one participant noted: "We all live in the same community, but it doesn't feel that way because of skin color." Another commented, "We know it's not a fair playing field especially with people of color."
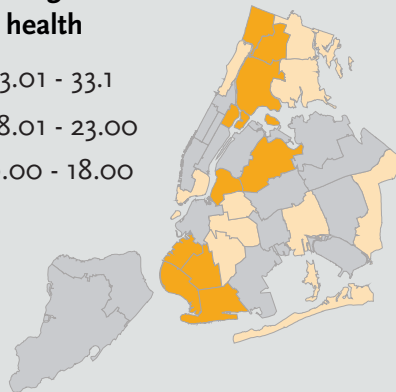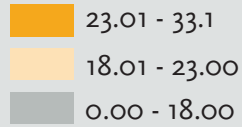
Figure 9

High poverty places NYC (2010)

UHF areas

% in Poverty by Tract

- 35.01 - 91.83
- 25.01 - 35.00
- 15.01 - 25.00
- 8.01 - 15.00
- 0.00 - 8.00

% Reporting fair or poor health

- 23.01 - 33.1
- 18.01 - 23.00
- 0.00 - 18.00

% Uninsured

- 18.51 - 29.60
- 13.51 - 18.50
- 0.00 - 13.50

Figure 9 (cont.)

Highly concentrated communities of color NYC (2010)

UHF Areas

% Non-White or Hispanic

95.01 - 100.00
85.01 - 95.00
65.01 - 85.00
50.01 - 65.00
0.00 - 50.00
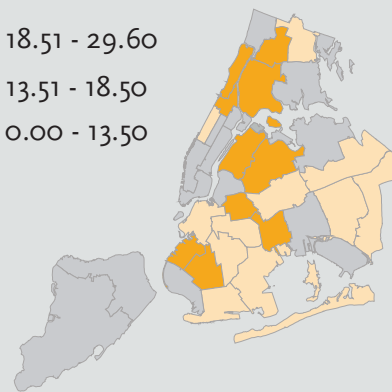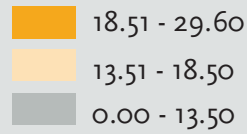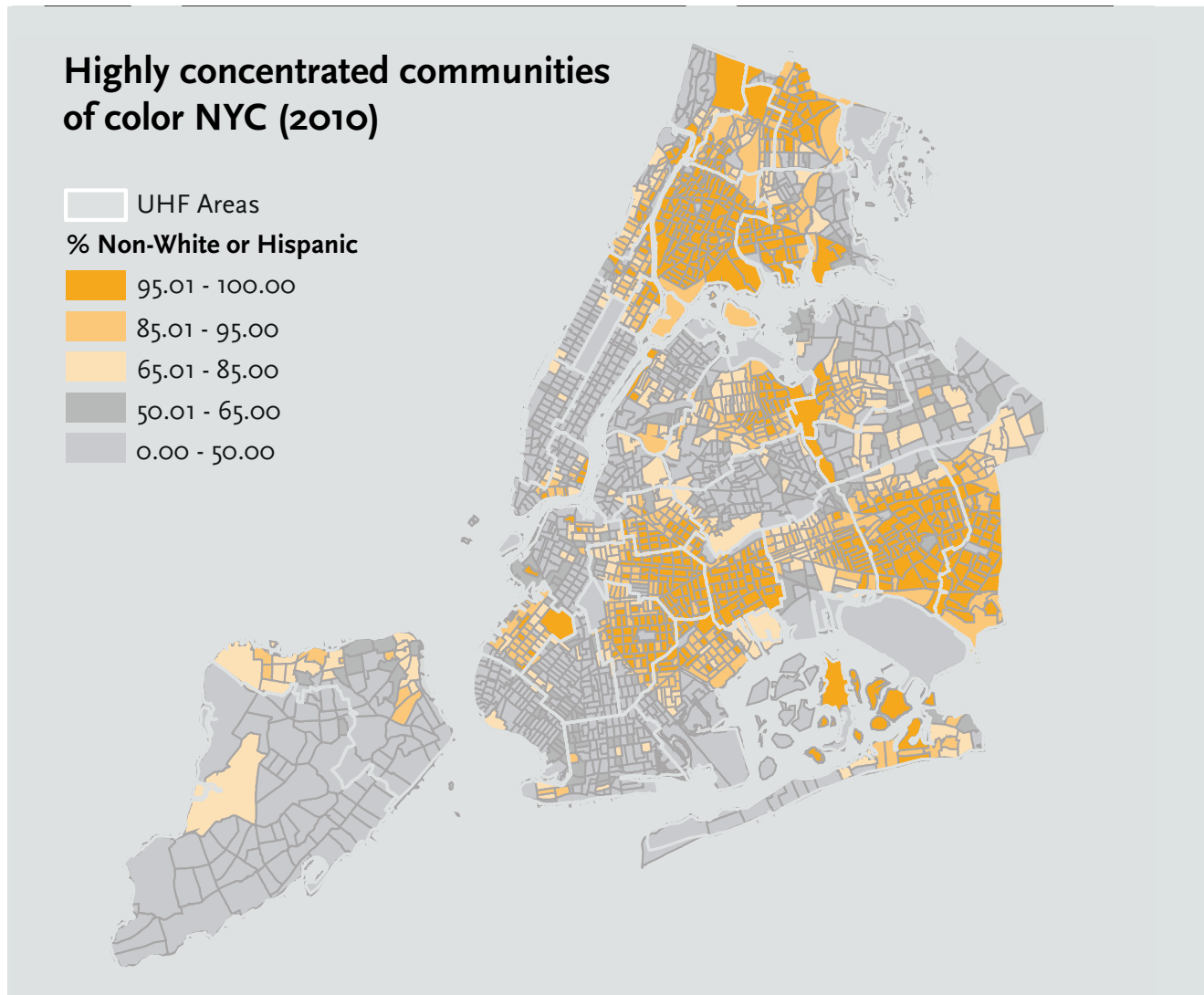
Because place, race, and the conditions in which people live are linked to drug use and our policy responses to it, this *Blueprint* takes a broad look at how communities can be transformed with an overarching focus on how our policies can help address existing racial disparities. Both our review of literature and our community consultations directed us to take a hard look at institutional racism and the role it plays in our drug policies. As a recent report by PolicyLink put it, in order to eliminate the disparities between racial groups and between neighborhoods, we must direct our policies and strategies at "dismantling the structures of racism and transforming ailing, disinvested communities into healthy places where everyone has the opportunities to prosper in every way: economically, physically, emotionally, culturally, and socially."[113]

This was perhaps the clearest message from all of our consultations—there is deep desire for a drug reform effort that addresses the issue of racism.

"We need to look at institutional racism, or we are wasting our time."
— *Bronx participant*

A Public Health and Safety Approach to Drug Policy

Finding 2: Structural Factors, Like Poverty And Racism, Contribute To Feelings Of Hopelessness And Despair And Poor Health Outcomes.

During our community consultations, many people noted that, although the topic of conversation was drug use and drug policy, the issue was a much deeper one. Many people explained that drug use, drug related crime, intensive policing, and high rates of incarceration in their communities were symptoms of broader structural problems linked to poverty, racism, and lack of opportunity. When these kinds of problems are concentrated in neighborhoods, they affect entire communities. As one person from the Buffalo consultation put it, "Communities are hurting."

Research suggests that these structural and community-level factors—such as income inequality, poverty, unemployment, community norms, literacy issues, deteriorating housing, and drug availability—affect alcohol and drug use, the health of people who use drugs, and the differential morbidity among individuals from different racial and ethnic groups who use drugs.[114-120]

We found that, in some communities, structural inequalities also led to feelings of hopelessness born out of experiences of oppression. As one person explained: "We are disenfranchised. No one cares. People are losing hope."

People also spoke powerfully about how living in under-resourced communities contributed to fraying social cohesion, a sense of despair, and generations of drug use. Some specifically described how the physical decline of their neighborhoods contributed to the deterioration of social connections and caring about the community, which in turn contributed to crime and drug use. As one participant said, "The environment affects how you see yourself." Participants also portrayed their neighborhoods as imbued with sense of desperation, where "people do what they can to survive." Another explained, "It's like urban Darwinism." This "survival of the fittest" mode not only explained why some people turned to drug use and drug selling but also led some to feel that parents and communities did not have the financial or emotional resources to nurture young people in ways that would help them thrive.

"It's important how we talk about resources for the community, about the socioeconomic issues of our community. Drugs are not an individual thing; it is a community problem. The community is socioeconomically depressed. The Bronx is the poorest urban county in the entire United States. The symptoms of a poor community are drugs and violence."
— Bronx participant

"We need to use a dialogue that begins with drugs and open it to a discussion about providing access to more comprehensive opportunities in living life."
— Newburgh participant

One man in his 50s explained how his situation as a child contributed to his drug use:

We grew up with self hate. My mother was on welfare and she raised seven kids living in a room and a half. The pressure was so great and anger builds. She would take it out on the kids. There's no hugging. None of that ain't happening. You go on the street and find something that will make you feel better.

In fact, the theme of using drugs to escape feelings of hopelessness was commonplace. Several people also described growing up in families where drug use was normalized and passed from one generation to the next:

What choice do you have when this is all you see? When I was five years old, I was told that I was the man of the house and my main obligation was to shoot my mother up with heroin. By seven years old, I was transporting needles, and my baby siblings had heroin in their diapers. I didn't make that choice at five. I didn't have the chance.

Finding 3: Low-Income And No-Income People Who Use Drugs Have A High Need For—But Poor Access To—Health, Mental Health, Drug Treatment, And Other Social Services.

Ensuring that low- and no-income people who use drugs have access to appropriate, high-quality medical and mental health services can improve both the lives of those individuals and the health of communities. People who chronically use drugs are at risk for a host of medical problems, including increased rates of HIV and other blood borne diseases as well as abscesses, tuberculosis, liver disease, injury, and pulmonary disease.[121-124] Psychiatric issues, like depression, are also common among people who use drugs.[125-126] Despite higher rates of illness, people who chronically use drugs are less likely than others to access medical care,[127] especially outpatient care.[128] People who chronically use drugs are less likely than people who don't use drugs to be insured, have a regular source of care, or receive required medical services even after adjusting for demographics and ability to pay.[129-130] Our consultations were consistent with this research. People who use drugs told us that they do not feel welcome in most medical and mental health facilities; rather, they feel that they risk being judged or punished for their drug use. As one participant put it, "punitive responses prevent individuals from seeking care."

Regular outpatient medical care has important benefits; people who use drugs and receive regular medical care are able to stop minor problems from becoming worse and have fewer hospitalizations,[131] reducing the costs of expensive inpatient care. The National Drug Intelligence Center estimates the health costs attributed to illicit drug use to have totaled over $11 billion. This figure doesn't factor in the additional cost of productivity loss due to morbidity or mortality.[132] However, this does include the cost of drug treatment. The cost of care for drug induced illnesses (overdose, hepatitis C, HIV, etc.) in hospitals and emergency departments is estimated to be over $5.5 billion. A study from the Substance Abuse Policy

Research Program examined the medical records of approximately 150,000 Medicaid recipients in six states and found that the 29 percent of patients diagnosed with alcohol or other drug addictions cost these six states alone an extra $104 million for medical care and $105.5 million for behavioral health care.[133] A study[134] in New York City examining high-cost Medicaid patients found similar results where two-thirds of the high-cost patients in their study cohorts had a substance abuse condition and about half had a substance abuse condition and a mental illness. This population was most likely to identify the emergency department as their usual source of care and averaged three to six admissions to a single hospital per year. The study discovered that in addition to facing significant barriers to care—long waits, uncoordinated care, poor communication and lack of respect from providers—these patients also faced a host of social and economic challenges including unemployment, low income, unsafe housing and homelessness, disability, domestic abuse, social isolation, and disconnectedness. Harmful drug use remains one of the top five costliest health problems in America.

The health care setting provides a window of opportunity to identify and address the complex needs of these patients. In addition, medical care facilities are important sites for identifying and intervening early with people who may not know they have a drug use problem. Screening and brief interventions in medical facilities have proven effective in reducing drug use by as much as 67 percent at six months.[135]

To improve access, some participants called for more information to help them navigate the different systems—health care, treatment, social service, and criminal justice. Others wanted to see more training for service providers about drug use (including by people who use drugs themselves); still others suggested that people who use drugs also receive training and skills so that they could better advocate on their own behalf for services.

"Addicts are the only people punished for having a disease."
– Downtown Brooklyn participant

Finding 4: Our Current Approach To Drug Policy Is Largely Counterproductive, Creating Barriers And Stigma That Prevent People From Getting The Help They Need.

People involved in our consultations characterized current drug policy as over-reliant on the criminal justice system, often creating more problems than it solves. In particular, many people shared the perception that the legal system punishes people who use drugs in ways that hurt not only those individuals but also their families and communities. They pointed to policies that bar people with drug felonies from applying for student financial aid and other benefit programs. Housing policies that bar or evict people with drug convictions from public housing were seen as particularly harmful and counterproductive. Several people noted that such policies prevent the reintegration of individuals, contribute to the disruption of family systems, and remove key support systems when they are most needed. Many spoke about the harm that came from having a significant number of men in their neighborhoods incarcerated and/or returning home from prison to communities where they are unable to access any support.

In addition to the legal and policy barriers, people felt that the stigma surrounding people who use drugs makes it harder for people to seek the help they need to overcome addiction. Participants noted that labels like "user," "addict," "junkie," and "felon" are imposed on individuals in ways that dehumanize them. As one noted, "We see the parent as a crack addict rather than as a parent who happens to smoke crack. You can use and be a good parent." Research

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"Say you need Public Assistance – they ask 'do you use [drugs] or have you used in the past 30 days?' Then they send you to an employment program to get employment-ready, but you have a criminal record, lack of education, a child payment in arrears, and have gone to treatment 10 times already, costing the city millions. You jump through all the hoops, and finally you are given an assignment. But it's cleaning the church, and you still can't afford your rent."
— Downtown Brooklyn participant

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has demonstrated that the stigmatization of drug use has material consequences, discouraging people who use drugs from seeking needed services and negatively impacting their physical and mental health.[136]

Participants also noted that many of the systems and agencies designed to help people in need contribute to stigma by adopting a punitive stance toward people who use drugs and creating disincentives for people seeking help. We heard reports of poor treatment of people who use drugs by service providers representing a spectrum of systems and services: medical, housing, treatment, social services, and child welfare. Methadone clinics, with their highly burdensome and restrictive policies, were especially criticized. People also told us that stigma was also widely perceived to affect policymaking; many people felt that moral judgments about drugs and people who use drugs, rather than evidence about effectiveness or community needs, were guiding drug policy.

Finding 5: Drug Policies And Programs Are Not Always Evidence Based And Their Effectiveness In Improving The Health And Safety Of Communities Is Not Measured.

Providers of treatment and social services were especially interested in seeing policies and programs based on evidence about need and effectiveness. In particular, many felt that the current evaluation measures for prevention, harm reduction, and treatment programs focused too much on process indicators (e.g., numbers served) without focusing sufficiently on outcomes. Similarly, community members asked for better accountability and evidence about the effectiveness of current programs and policies at the state and local level. Several people noted that current drug policies are often driven by ideology and politics. In the absence of data about how well current approaches are working, some community members and providers lacked confidence that agencies, such as law enforcement, departments of social services, and child service agencies, were implementing effective strategies. Both providers and community members also spoke about the need to revisit the definition of "effectiveness." For instance, some treatment providers felt that effectiveness in the context of treatment needed to go beyond traditional measures of retention in treatment and abstinence from drugs to include improvements in an individual's health, socioeconomic status, and well being. There was also a widespread interest in including an analysis of how policies and programs affect racial disparities and ensuring that new metrics measure how well policies and programs help address the economic, sociological, and behavioral aspects drug use.

Finding 6: More Effective Leadership, Meaningful Community Involvement And Stronger Cross-Sectoral Collaboration Are Needed To Create Effective Drug Policies At The State And Local Levels.

A common theme in consultations across the state was the call for effective leadership, comprehensive collaboration and engagement, and the meaningful involvement of community members in the development and implementation of drug policy. People spoke of the need for leadership at all levels of government as well as within local communities. Across the state, participants noted that policymakers are not having sustained and meaningful dialogue regarding drugs or the underlying socioeconomic issues within their communities. Many people felt that the criminal justice sector has dominated the little leadership that has been shown and that these efforts often lack meaningful community inclusion and accountability. Community organizations, institutions, advocates, and, most importantly, the individuals who are most affected by drug policies have felt particularly excluded. Many also called for treatment, health, and community leaders to play a stronger role in the framing, development, and implementation of drug policy.

Considering the complexity and breadth of factors affecting drug use, meaningful collaboration and engagement across multiple sectors is critical. Unfortunately, at the state level, there is no effective formal, system-wide collaboration that spans all the relevant agencies, addresses all four pillars, and includes all the necessary community stakeholders. Providers and advocates in our consultations told us that, while instances of formal collaborations between agencies and between sectors exist, there is also an abundance of siloing, inefficiency, and contradictory standards of practice among agencies as well as community organizations. Furthermore, they cautioned us to distinguish between *more* collaboration and *effective* collaboration. For instance, many participants—both community members and providers—were wary of the current relationship between the treatment sector and the criminal justice sector in particular and pointed to the ways in which criminal justice mandates were abridging clinical decisions and thwarting patient-centered care in some treatment programs (discussed further in the treatment section).

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"There is a lack of collaboration among stakeholders, especially with the police... agencies act in silos."
— *Albany participant*

Community members—especially those who use drugs and those directly affected by current drug policies—want to be more involved in setting policies and priorities for the state and for local communities. Joint planning between consumers, community members, providers, and policymakers is always difficult; in the case of drug use, these difficulties are compounded by stigma and by competing understandings of drug use as a crime or health concern. However, models for more inclusive planning, even around highly stigmatized issues, do exist. Those setting policies, making funding decisions, and designing programs addressing HIV/AIDS and breast cancer, for instance, have found ways to meaningfully include those directly affected, and in doing so, have helped to combat stigma and build more effective solutions. People who use drugs are essential participants in designing effective programs and policies and must be included in future planning efforts. They can explain the local context, offer perspective on what works, help identify potential unintended consequences, and be important allies in implementing strategies. In addition to specific mechanisms to include people who use drugs in policy and planning (e.g., membership requirements on planning groups), participants called for more training and education in advocacy and political action for people who use drugs.

Prevention Findings

Effective prevention strategies enable people to make healthy choices and improve health outcomes for themselves and their families. Prevention can delay the initiation of drug use, avert the escalation of use, and diminish engagement in drug related activities that can lead to violence and/or criminal justice involvement. Prevention, here, is conceptualized both in its traditional sense of programs that provide education and skills to avoid or address drug use and, more broadly, to encompass community development strategies that address the root causes of drug use and offer individuals meaningful alternatives to drug use and drug dealing.

Overall, regarding prevention, experts and community members told us that they wanted more investment in prevention, but in prevention construed broadly to encompass community development so that individuals had better opportunities for education, employment, and recreation. We also heard a call for more focus on opportunities and programs for young people as well as better drug education both within and beyond school. Finally, participants explained that many individuals in their communities had experiences of trauma that need to be addressed to prevent drug use.

In this section and the ones that follow, we have generally organized the findings to first address community-wide issues, then institutions and programs, and finally individuals. At the end of each findings section, we have also included some information from the literature on effective strategies and examples from other regions about promising practices.

Finding 1: More Balanced Investment In Prevention And Community Development Is Needed.

Across consultations, agencies, and organizations, we heard a call to allocate a higher proportion of drug policy funding to effective prevention efforts.[137-138] Currently, of the $25.6 billion spent by the federal government on its drug control policy, only 5.5 percent goes toward prevention (36.3 percent was allocated toward treatment and the remainder went to law enforcement and domestic and international interdiction efforts).[139] In 2005, in New York alone, estimated annual state spending due to substance abuse and addiction (including illicit drugs, prescription drugs, tobacco and alcohol) was over $13 billion, yet nearly all these resources were designated to address related health, criminal justice, and educational consequences; less than three percent was spent on prevention and treatment.[140-141] There is a large body of research on elements of effective drug prevention programming and its success in reducing the use of both legal and illicit drugs.[142] Research shows that prevention programs can also be cost effective; for each dollar spent on prevention, communities can save up to $10 in drug treatment and counseling costs.[143] Too often, however, drug prevention programs are underfunded, narrowly defined, and operate in isolation, especially from other health promotion and community development efforts. Moreover, there are few defined systems for the training and credentialing of prevention providers.[144] Community members, advocates, and experts alike emphasized the need for prevention strategies to go beyond traditional prevention education and messaging (though they did want to see more of this) to comprehensively address both risk and protective factors at the community, school, peer/social, family, and individual levels.[145-146] Specifically, as discussed in more detail below, they understood prevention to encompass family, youth, and community development efforts to build healthier environments; foster resiliency; strengthen social connections, community cohesion, and supports; and address basic needs like poor housing, low income, unemployment, and high rates of school dropout.

Finding 2: Communities Affected By Both High Rates Of Drug Use And Drug-Related Incarceration Need Equal Access To Community And Economic Development Opportunities And Services.

Prevention at the community level is grounded in the health and vitality of communities as a whole. Experts and other stakeholders emphasized the need for investments in communities that address basic needs (housing, employment, health, etc.), facilitate community cohesion and engagement, cultivate community restoration, create jobs for local residents, and promote sustainable economic development.

The need for employment was consistently highlighted in community discussions across New York. Participants reported what research also supports—lack of economic opportunities and resources promote participation in the underground economy, including the drug trade.[147-148] Since 2000, the employment rates in the U.S. have declined, with young adults and teenagers, males, and minorities faring the worst.[149] New York City's unemployment rate for Black men between the ages of 16-24 is at 33.5 percent compared to the overall jobless rate of 24.6 percent for young men of all races, ages 16 to 24.[150] Summer youth employment programs and GED programs have also had significant cuts.[151] In addition, many people face structural barriers to meaningful employment, education, and training. People with a criminal justice history, in particular, face almost insurmountable obstacles and restrictions to higher education, employment, and housing. These policies and practices systematically diminish resources in neighborhoods with disproportionately high rates of arrests and incarceration.[152-153]

Disparities between neighborhoods—particularly racial and economic disparities—were regularly cited by participants. For example, stakeholders across consultations pointed out that some communities have resources (parks, waterfronts, building facilities, businesses, etc.), while other communities are either left out of new opportunities for investment and/

"They [kids] do it [selling] for a lifestyle... It's not like 20 years ago, there's nothing for young people to do, no opportunities. Maybe if they had more mentors, more jobs, then maybe they wouldn't do this."
— Syracuse participant

or new investments are developed for private interests in ways that exclude community members from benefitting. Participants told us they want to be more involved in the planning stages of community and economic development initiatives and ensure that all communities should have equal access to resources.

Beyond investing in local economies, we also heard repeatedly from community members and service providers that they need help engaging and mobilizing their communities in ways that foster community cohesion and neighborhood attachment and ameliorate community disorganization. One suggested method (and not the only route recommended), was to create access to a continuum of socioeconomic supports and services in local communities, especially for populations that are often marginalized. This would include veterans,[154] immigrants, individuals returning home from jail or prison (and their families), young people, and LGBTQ persons. Strategies to improve awareness of and effective linkages to the services that do exist are also needed. Although we learned of many great services and programs from providers, experts, and state agency personnel, community members often spoke of not knowing what services were available, how to access them, or where to direct others that are in need. Faith-based organizations, social service providers, health providers, community-based organizations, advocates, criminal justice agencies, and businesses in local communities were seen as important resources that could be more effectively mobilized and coordinated to address some of these needs.

Finding 3: Prevention Programming Should Focus On Youth Development.

Across consultations, young people were a focal point of prevention discussions. Communities were concerned about the prevalence of drug use among young people, particularly the increased use over the years and decreasing age of initiation. Research suggests the younger a child or adolescent is when exposed to drugs the more likely he or she is to becoming dependent on a drug in adulthood.[155-156] Prevention programming that facilitates positive youth development not only decreases drug use, but also reduces delinquency, violence, drop-outs, and teen pregnancy.[157-159] Community members and academics highlight several risk factors for young people that needed to be better addressed in New York communities, including normalization of drug use and other problem behaviors by the media, peers, and, in some cases, parents; academic failure; family conflict; community disorganization; and lack of opportunities for positive involvement with family and community members.[160]

Community members were particularly concerned with engaging young people who drop out of school and all young people during the hours they are not in school. Young people who are engaged in afterschool programs, youth-based or community activities, part-time employment, and community organizations are less likely than their peers to use drugs or engage in other risk behaviors.[161] Across communities in New York, however, people reported that the availability of such programs is limited, and eligibility restrictions (e.g., age requirements, fees, exclusivity by academic performance, etc.) prevent access. The 2008 Youth Development Survey supports this observation for communities in New York City: all New York City boroughs rated poorly for opportunities that engage young people in work, volunteering, sports, and other activities that can help instill positive norms and engage them in their communities in positive ways.[162] And though other counties in the state rated well, community members noted that there are neighborhoods within most counties that have little opportunity to positively engage young people, families, and neighbors.

Finding 3A: Both Young People And The Adults In Their Lives Need More Effective Drug Education, Skills Building, And Prevention Programming.

We found a broad consensus among parents, young people, experts, and the handful of teachers who attended the consultations that more drug education is needed, particularly at earlier grade levels. Several participants, including young people, felt that current education strategies were nonexistent, under-resourced, or ineffective. During 2008, of the 484,620 participants who received prevention services[iv] in New York State (96 percent being between the ages of five and 17), less than half (47 percent) received evidence-based education programs.[163] Several community members noted that the classroom education that did occur was not based in reality. As one parent noted, "They [young people] know we are lying. We need to be real." "It's the miseducation of our kids and schools that is harming our communities," said another. They called for education that acknowledges that some drugs may be more harmful than others and that some drugs, like prescription medications,

"I think it's about community. I believe in one person helping another, sisterhood, and accountability to neighbors. We're missing a lot of that. We should share our gifts that will make us all better."
– Syracuse participant

"Our parents and children are living in the dark ages; drugs, sex – our curriculum is outdated."
– Buffalo participant

have legitimate uses. According to research, a broad health-based curriculum including drug education, along with life skills and decision-making training, can impact the choices young people make on a range of issues (drug use, gang involvement, violence, delinquency, teen pregnancy, etc.).[164]

Reinforcement and support of positive messaging and decision making must also come from families, but parents told us they need more support to do so effectively. As one said, "Parents can't do it by themselves." In our consultation with young people, they agreed that their parents didn't always have the information or skills to help them. Community members and experts called for more engagement and programming for families, particularly oriented toward helping parents influence the attitudes and behaviors of their children. Family-focused interventions have shown promise both at preventing and mitigating harms related to drug use.[165] Efforts to build life skills among parents, strengthen parent-child communication, and build positive bonds to other adults, peers, and the community have been recommended as prevention techniques as well.[166] However, community members felt such programs were not available to them. According to the OASAS directory of funded prevention programs, some counties have few to no prevention programs, and fewer still have family-oriented prevention programs.[167] Experts in prevention encourage communities to do needs assessment and evaluation of existing prevention programs and to rely on evidence-based elements of programs even as they are tailored and adapted to the local context.[168-170]

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iv OASAS-funded preventions services include "evidence-based education programs, skills development workshops, training sessions for parents, teachers, and other professionals, positive alternative activities for youth and policy change, and enforcement efforts to reduce underage drinking." http://www.oasas.ny.gov/prevention/index.cfm#

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Finding 3B: Current School-Based Approaches To Address Drug Use And Its Underlying Causes Are Not Working.

Schools were identified by community members as an important—but missed—opportunity to increase youth engagement, raise achievement expectations and outcomes, and more comprehensively address students' needs in ways that can prevent drug use and drug dealing. Participants wanted schools to go beyond health education and do more to bolster positive youth development and academic achievement.

Communities and experts were especially concerned about the increasing use of police and zero tolerance approaches as disciplinary strategies in New York public schools. Zero tolerance policies as adapted by schools are policies that confront disruptive and threatening student behavior with mandated, predetermined responses that are often severe and include suspensions and expulsions. The policies were originally developed as an enforcement approach to illicit drugs and were later applied to weapons. They have since expanded to encompass a wide array of behaviors, including those considered nonviolent or nonthreatening, and others not clearly defined (e.g., "insubordination" and "disobeying rules").[171] Both educators and parents viewed zero tolerance

policies as undermining the role of teachers and other staff and as damaging to their relationships with students. Regarding drugs, specifically, communities and experts alike were concerned that a zero-tolerance approach has not been productive but has instead prevented school officials from providing more positive interventions for students with drug related issues.

Use of suspensions as part of a zero tolerance policy is an increasing cause of concern. In New York State, five percent of students are suspended annually,[v] but these rates vary by region and by race.[172] Suspensions in New York City more than doubled between 2002 (2.9%) and 2009 (7%), while suspensions for the state only increased from 4% to 5% over the same period. In NYC, Black students, who make up 30 percent of enrollment, accounted for more than half of all suspensions for the same period. White students make up 15 percent of student enrollment in NYC and accounted for only 8% of student suspensions.[173]

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v These numbers are for all suspensions. We were not able to find data for drug-related suspensions separately.

Suspensions are associated with low achievement and dropping out of school altogether.[174] Students who have been suspended are three times more likely to drop out by the 10th grade than students who have never been suspended,[175] and dropping out triples the likelihood that a person will be incarcerated later in life.[176] Moreover, educational attainment is a strong predictor of health and risk behavior; those with more education are less likely to engage in risky behaviors and more likely to be healthy.[177]

While correlation is not causation, research that suggests zero tolerance policies are ineffective is mounting. For example, an exhaustive review of literature by the American Psychological Association found that zero tolerance policies have failed to decrease school violence, do not deter future misbehavior, disproportionately affect students of color and students with disabilities, and result in increased referrals from schools to juvenile detention facilities for infractions that were once handled by schools.[178]

Dropping out, the poor quality of much education, and the attendant feeling of hopelessness were also major concerns raised during our community consultations. One youth participant noted, "Fifty percent of my generation won't finish school." Parents also lamented the high dropout rates in their communities and students graduating ill prepared or being 'pushed out' of school. As one noted, "Many people are leaving schools but are not ready to make it on their own." While New York State has a high school graduation rate at the level of the national average,[179-180] the state racial achievement gap remains high, particularly among males, with the graduation rate at 57.2 percent among black males, 57.7 percent among Hispanic males, and 84 percent among white males.[181] Communities viewed these poor academic outcomes as reflective of the schools' larger inability to holistically address students' needs. As one member stated: "It's a failure of the school system: they don't meet students where they're at, but where they want the students to be." Participants in our consultations knew what research supports—low academic achievement is linked to host of poor socioeconomic and health outcomes, including drug dependency in adulthood.[182-183] In addition, the failure of the educational system, combined with the lack of economic opportunity and social mobility, contributes to feelings of hopelessness. While many individuals are able to overcome these disadvantages, we heard a widespread perception that no amount of hard work could lead to success. As one teacher told us, "Kids know that even if you work harder, you cannot get out of the 'hood, so there is no incentive to work."

Finding 4: Experiences Of Trauma Are Linked To Drug Use, But Our Current System Is Ill-Equipped To Help People Or Communities In Times Of Crisis.

Participants in the community consultations repeatedly mentioned trauma as one of the root causes of drug use and saw the failure to address experiences of trauma as a lost opportunity to prevent drug use. As one person stated during a consultation with victims advocacy organizations, "People use drugs to calm the body and calm the trauma they have." Community members defined trauma broadly, citing experiences of violence; incarceration; homelessness or chronic dislocation; family instability or abandonment; poverty; household mental illness; emotional or physical

> **"Our kids feel lost, misguided and uneducated."**
> *– Buffalo participant*

neglect; and/or physical, sexual, or emotional abuse. Many participants felt that the high prevalence of traumatic incidents in their communities contributed to the use of drugs. Participants also highlighted immigrants, victims of domestic violence, and people who have been incarcerated as populations in need of trauma and crisis interventions that may have been overlooked.

Research supports the view that such experiences, including incarceration, can be socially, economically, and mentally damaging both to the individuals directly involved and members of their entire household.[184-185] Research also suggests that addressing trauma early and adequately among children can help reduce drug use and a number of other problem behaviors correlated with adverse childhood experiences, such as delinquent behavior, school disconnectedness and failure, mental health problems, and unemployment.[186]

The people with whom we spoke, including providers, wanted to see more programs that help people in crisis by providing resources, like safe housing. In addition to more services, people called for more responsive and welcoming services. For example, some agencies that are supposed to help families in need, like the Administration for Child Services, were perceived by many as punitive and as destabilizing to families and communities. Several community members—including individuals who formerly used or currently use drugs—noted that people who currently use drugs are particularly made to feel unwelcome by a range of social service and medical providers.

In addition, some individuals who had been through different service systems reported that providers generally failed to recognize and address the psychological harms that result from the experience of trauma—that is, they

failed to provide trauma-informed care. Experts advised that all agencies that touch vulnerable populations—criminal justice, child and family services, immigration, housing and shelters, schools, medical providers—need to adapt a trauma-informed approach that targets the entire, affected household and helps New Yorkers to cope effectively with and rebuild resiliency following traumatic experiences.

The Way Forward: Promising Practices In Prevention

As previously mentioned, there is a plethora of research identifying effective drug prevention programming and evidence-based prevention.[187-190] We have also noted that effective prevention strategies expand beyond the explicit focus on drugs and drug-related behavior, to address socioeconomic determinants of health through community, economic, family, and youth development. Interventions designed to address poverty, increase access to services, and improve community safety may also have preventive effects on problematic drug use and improve health outcomes. There is an abundance of evidence to guide the development of an effective prevention strategy including models already present in New York.

For example, the research supports and identifies schoolwide system approaches that can serve as alternatives to punitive and exclusionary disciplinary policies. These alternatives have shown to successfully foster positive youth engagement while maintaining safe learning environments. Such frameworks include elements of social skills and behavioral interventions, academic restructuring, and collaboration. School-based restorative justice practices[191] and the Positive Behavioral Intervention and Supports (PBIS) framework, in particular, have both shown promising results in improving school engagement and connectedness as well as youth development.[192-193] PBIS is a decision-making framework that guides selection, integration, and implementation of the best evidence-based academic and behavioral practices for improving important academic and behavior outcomes for all students. PBIS is supported by the U.S. Department of Education and is implemented in schools across the country. Unfortunately, during 2007-08, less than 10 percent of public schools in the state of New York were reported to have implemented school-wide PBIS.[194]

    A Public Health and Safety Approach to Drug Policy

There are also effective interventions in the home for families. Home visiting programs have been implemented for several years with the most well designed and executed programs showing a host of positive outcomes.[195] The Pew Center on the States' inventory of state home visiting programs[196] has identified four programs operating in New York, some of which have also identified positive family and child development outcomes that serve as protective factors for prevention of harmful drug use.[197-198] The recent passage of the Patient Protection and Affordable Care Act provides an opportunity for expanded and improved implementation across states as it appropriates additional federal funds specifically to such programs.

Systemic opportunities are also available in the operations and initiatives of state and city agencies. For example, the New York City Administration for Children's Services (NYC ACS) launched its Community Partnership Initiative in 2007 to increase support and collaboration with local families, communities, and advocates and therefore improve services, transparency, and accountability.[199-200] This initiative promised to stabilize families, prevent crisis, and ensure the safety of children. However, its implementation and outcomes have been limited by lack of investment, and ultimately it fell short of its original goals. Nevertheless, the initiative provides a foundation and opportunity to increase progress toward these goals if provided with sufficient support.[201]

In an effort to address systemic racism, workshops and trainings have also been developed. The Undoing Racism/ Community Organizing workshop by the People's Institute for Survival and Beyond has been increasingly shown to have an impact on attitudes and recognition of the role of race in agencies and systems. It has been specially designed to affect child welfare systems where there is significant racial disparity in the representation of Black child victims.[202]

More recent initiatives that have potential to make a positive impact include the New York Regional Economic Development Council's initiative that will provide an opportunity to invest in economic growth at the regional and neighborhood level, therefore strengthening education, social networks, and community resources.[203-204] At the local level, burgeoning efforts are seen in Buffalo where a neighborhood has begun planning a revitalizing strategy. The Buffalo Municipal Housing Authority Perry Choice Neighborhoods Planning Initiative recently received federal grant funding through the national HUD Choice Neighborhoods program to transform specific, distressed neighborhoods into viable communities through meaningful collaborations with community members and other stakeholders. The partnership also received funding in 2011 for planning activities that will engage and empower residents and communities.[205]

The Young Men's Initiative announced in 2011 by New York City Mayor Bloomberg also marks an important shift toward comprehensively tackling the persistent racial disparities among the young men of color in New York City.[206] It makes significant progress in bringing attention to this particularly vulnerable population and opportunities on which to build. However, to be even more effective, the initiative should address practices that needlessly criminalize young men of color, like stop, question and frisk and unlawful marijuana arrests.

Treatment and Recovery Findings

In a meta-analysis of drug treatment studies, researchers concluded that effective treatment can reduce drug use, increase employment, decrease criminal activity, and lessen physical health problems and hospitalizations.[207] Treatment encompasses an array of modalities, including detoxification ("detox"), inpatient and outpatient treatment services, residential programs, methadone maintenance therapy, and buprenorphine. Treatment not only helps individuals and their families; it helps communities by reducing exposure to drug use, the harms attendant to drug use, and the dangers associated with our current law enforcement responses to drug use.

Research has repeatedly shown that investment in treatment is cost effective and, furthermore, produces better outcomes than incarceration.[208] The Justice Policy Institute reported that if an individual receives treatment while incarcerated, there is, on average, an estimated benefit of $1.91 to $2.69 for every dollar invested in prison programs. "Benefit" is measured by reduced costs, lower crime rates, and less recidivism. There is also an estimated $8.87 benefit for every dollar invested in therapeutic community treatment programs outside of prison. The same study found that other community-based drug treatment programs generate $3.30, drug courts generate $2.83, and intensive supervision programs generate $2.45 in benefits for every dollar spent.[209-210]

Increasingly, the treatment community is also recognizing the need for recovery-oriented services, which treat addiction as a chronic, relapsing condition that requires multiple treatment episodes and ongoing support. A recovery orientation is similar to approaches to other chronic conditions, like diabetes, where health professionals work with patients on secondary prevention and managing their condition over the long term in order to avoid more serious illness. Both the New York State Office of Alcohol and Substance Abuse Services (OASAS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have been working toward integrating a recovery orientation into their work. SAMHSA has defined recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[211] While not everyone embraces a disease model of addiction, a recovery orientation is consistent with a public health approach because it recognizes that the social context in which an individual lives is central to their recovery (see text box).

New York State has a large and complex drug treatment system. The New York State Office of Alcohol and Substance Abuse Services (OASAS) has primary responsibility for planning and regulating the state's system of treatment. The treatment system in New York includes crisis or detox services (both inpatient and outpatient), a range of outpatient services (including methadone and behavioral therapies), inpatient rehabilitation, and residential services ranging from intensive residential to supportive living services. Adding further complexity, each service has a different mix of potential funding sources, such as Medicaid fees for services and managed care, Medicare, private insurance, self-pay, and state funding.

Throughout New York State, many people with whom we spoke considered New York to have some excellent treatment programs. But we also heard about dissatisfaction with the current system. We heard the desire for easier access to effective treatment programs that are evidence based, comprehensive, inclusive, and responsive to patient and community needs. Concerns ranged from limited capacity and an insufficient array of modalities to fears about the increasing role that the criminal justice system is playing in determining treatment plans. In addition, as with services in other sectors, we heard from both providers and community members the need for better linkages between mental health, health care services, and drug treatment as well as the desire for less bureaucracy.

These concerns are being raised at an opportune time, since OASAS is considering many of these same issues, and Governor Cuomo has formed the Spending and Government Efficiency (SAGE) Commission whose charge is to undertake a comprehensive review of every agency of state government and recommend structural and operational changes to make state government "more modern, accountable and efficient." Moreover, the Governor's Medicaid Redesign Team (MRT) charged a Behavioral Health Reform Work group to consider the integration of substance use and mental health services, as well as the integration of these services with physical health care services, through payment and delivery models. One MRT recommendation already enacted into law allows the commissioners of the Office of Mental Health (OMH) and OASAS to contract jointly with managed Behavioral Health Organizations for services to Medicaid recipients with substance use and mental health disorders. In addition, the New York State Department of Health's Prevention Agenda, the state's health improvement plan, has identified mental health and substance abuse as a priority and is developing an action plan that includes improved collaboration across sectors and with communities, to begin addressing this issue.[212]

A comprehensive approach to drug policy also recognizes that people can stop using drugs without treatment and, therefore, supports the components of people's lives that promote the reduction and cessation of harmful drug use. Both the consultations and social science research have identified social resources and support, meaningful employment, financial stability, higher educational attainment, and engagement in life enriching activities as among the factors that facilitate drug cessation without treatment.[213-216] Evidence also supports that drug cessation occurs because individuals simply 'mature out' or 'age out,' where their progression in age and their life course prompts discontinuation of use.[217] Interventions to reduce homelessness have also been shown to reduce drug use.[218] A randomized controlled study by Milby and colleagues[219] found that the intervention groups that received housing, whether abstinence-contingent or non-abstinence-contingent, both had similar positive outcomes in reducing drug use that surpassed that of the group receiving treatment without housing. A full recognition of life situations supporting reduction of drug use should be included in recovery-oriented treatment.

As detailed below, overall we heard a call for a review of the existing system, a desire for improved access to and quality of treatment, better integration and support for ancillary services for those in recovery, and concerns about the current role of the criminal justice and child protection systems in treatment.

SAMHSA dimensions that support a life in recovery:

- **Health**: Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way.

- **Home**: A stable and safe place to live.

- **Purpose**: Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.

- **Community:** Relationships and social networks that provide support, friendship, love, and hope.

Source: www.samhsa.gov/recovery/

Finding 1: The Capacity And Accessibility Of The Treatment And Recovery System In New York State Needs To Be Reevaluated.

New York State has the largest treatment system in the country, yet analyses of how the need for treatment in New York relates to existing capacity are limited, particularly for recovery services. We do know that there have been significant budget cuts to treatment and necessary ancillary services in New York.[220-221] According to the 2009 National Household Survey on Drug Use and Health, an estimated 447,000 people in New York need treatment but do not get it.[222] The New York Association of Alcoholism and Substance Abuse Providers (ASAP) estimates that less than 15 percent of New Yorkers with a substance abuse condition receive the treatment they need.[223] These kinds of estimates are helpful but insufficient. A comprehensive analysis of how well the current system supports people in recovery is missing. New York needs a clearer picture of who needs treatment and recovery services, what kind of treatment and recovery services are needed, where there is unmet need, and how well poised the treatment system is to meet those needs in each region of the state. In talking with OASAS, providers, and community members, we found quite divergent views regarding the adequacy of the current system, suggesting that there needs to be better information (or at least better communication) about the capacity and quality of the treatment system.

OASAS directly operates 12 addiction treatment centers that provide inpatient services to 10,000 people each year. OASAS also licenses, funds, and supervises approximately 1,300 local treatment programs across the state that serve about 110,000 people on any given day. Despite the large numbers served, the perception of people across the state was that treatment was in limited supply and/or difficult to access. They raised problems like having to wait for treatment and/or not being able to access a treatment modality they most needed. Several participants emphasized that the lack of treatment capacity sometimes meant missing critical windows of opportunity during which an individual was ready to get help. "Treatment delayed is treatment denied," they explained. However, staff at OASAS told us that there was not a significant treatment gap in New York State. The differences in opinion may stem from regional variations in capacity, inadequate information about what treatment programs are available, and/or barriers to accessing existing treatment programs (discussed more below).

> "Women with kids – not enough programs for them."
> *– Bronx participant*

> "If I needed treatment today, I would have to wait two weeks to a month. I would get high waiting. There are not enough treatment centers. Sometimes you have to wait two months."
> *– Buffalo participant*

Finding 2: People Report Numerous Barriers To Accessing Treatment And Recovery Services.

Community members, speaking from their own experiences and those of others, reported numerous barriers to initiating and continuing treatment, including recovery services. The barriers they cited are also documented by research. These included: stigma associated with 'addiction;' negative perceptions about and experiences with treatment; dislike of treatment modalities (group models, faith-based, etc.); time conflicts, scheduling difficulty, and competing priorities (employment, child care, etc.); treatment unavailability (due to geographic and transportation barriers, lack of knowledge about available treatment, limited system capacity); and system-related admission difficulties (waiting lists, enrollment procedures, financing and insurance, eligibility restrictions, etc).[224-226] While Medicaid and private insurance cover some forms of treatment, people noted that gaps in Medicaid coverage (i.e., "churning"), ineligibility for Medicaid, or delays in enrollment sometimes limited access to treatment. In addition, some forms of treatment are not covered at all or have limited coverage.

Several participants also pointed to the limited gateways to treatment, particularly within the health care system, as a major barrier. For example, individuals with substance use disorders are overrepresented in emergency care,[227] yet participants told us that referrals to treatment from emergency departments were rare. This represents a lost opportunity not only in terms of helping people but also in terms of costs savings. Screening, brief intervention, and

referral to treatment (SBIRT) can identify people in need of treatment and reduce health care expenditures. One study estimated that hospitals could save $3.81 for every dollar spent on brief counseling of emergency department patients.[228] The participants in the community consultations wanted medical providers—both in emergency and primary care settings—to do more in terms of educating, screening, and referring patients with drug use problems to treatment.

Community members and providers alike also reported insufficient availability of appropriate treatment services for immigrants, non-English speaking populations, adolescents, veterans, women, parents, LGBTQ individuals, older adults, and individuals with mental illness. Two groups they especially highlighted were individuals who are incarcerated and those returning home from incarceration. This is not surprising given that in 2011, the New York State Department of Corrections and Community Supervision (DOCCS) had 56,315 inmates in its custody.[229] More than 15.4 percent of state prisoners were incarcerated on drug charges in 2010.[230] With such a significant number of incarcerated individuals affected by drug use, effective treatment within correctional facilities represents a critical opportunity to help. However, according to a recent study by the Correctional Association of New York, there are large gaps in screening, delivery, and quality of care with great variation across facilities as well as linkages to care post-release.[231]

> "Methadone programs are throwing people out for using, which makes no sense. They wouldn't be there if they weren't a drug user."
> – *Buffalo participant*

Finding 3: The Quality Of Treatment In New York State Is Variable And Needs To Be Improved.

Across consultations, advocates, experts, and community members noted the variability in treatment quality and were divided on their assessment of the current treatment system. Comments ranged from "we have excellent treatment centers" to "treatment is a joke." Providers did, however, agree that there is wide variability in treatment philosophy, cultural competency, and delivery of care across communities, modalities, and providers. There are no consistent, modern

Dr. Carl Hart,
Professor and Researcher

standards for quality of care as are found in other health care services. Much of drug treatment continues to be oriented toward the 12-step program (e.g., Alcoholics Anonymous, etc.) of self-help techniques in achieving the goal of abstinence. A modern, health-based vision of treatment and recovery goals and success has not yet been well established. Several experts agreed that more efforts (including public messaging, outreach, training, and professional development strategies) are needed to develop, communicate, and establish consistent standards for treatment as well as improve cultural competency of service providers.

SAMHSA's 2011-2014 strategic plan[232] shows promise for these issues being addressed at the national level. The plan identified several agency goals relating to quality including "creat[ing] common standards for quality of care, outcomes, measurement, and data collection to better meet stakeholder needs." Sustained advocacy, leadership, and input from stakeholders, however, remain critical at the state and local level. In addition to providing standards and guidance, providers and community members also want the quality of the treatment system to be better monitored and for treatment programs to be held more accountable for providing high quality services. While OASAS has improved their capacity to monitor contractor performance in a timely way, our consultations and a report from the Office of the New York State Comptroller[233] suggest more improvements are needed. This may mean insuring that OASAS has sufficient resources to develop and implement meaningful systems of accountability to improve quality. OASAS has recently developed public "scorecards" for their providers, which allow individuals to view data on program characteristics, compliance standings, client demographics, and retention rates for specific programs. These scorecards are a step in the right direction of improving transparency and clarifying standards. However, providers emphasized that the metrics by which we measure the quality of treatment programs need to be comprehensive and expand definitions of success beyond retention and abstinence, to include indicators of well being, such as health, employment, housing, and client satisfaction.

"**It is unimaginable, for instance, that a diabetic who failed to eat a healthy diet would be denied insulin.**"

-Bronx participant

Finding 3A: Providers And Community Members Want A Treatment System That Is Client Centered And Recovery Oriented.

There was overwhelming agreement that treatment and recovery care should be evidence based,[234] holistic, compassionate, and comprehensive. Specific quality concerns raised by providers included the rigidity of treatment plans and the lack of control individuals have in determining their course of treatment. Examples included treatment length being inflexible and too short, and an overemphasis on group interventions. Treatment providers also expressed frustration with administrative barriers on the part of insurance providers, OASAS, and the court system that they felt impeded their ability to deliver effective and individualized care.

Among community members, the biggest complaint about treatment was the punitive nature of some programs and lack of compassion they felt from some staff. "You can walk into treatment and be treated very badly," one participant from Crown Heights, Brooklyn, explained. People were especially concerned about the sanctions that treatment providers and other agencies enforce in the event of drug use or relapse during treatment, including denial or restarting of treatment, incarceration, and the dissolution of child custody. Relapse to drugs occurs at rates similar to adherence failures for other well characterized, chronic medical illnesses such as diabetes, hypertension, and asthma, but drug use is not treated with the same compassion as other chronic illnesses.[235] "It is unimaginable, for instance, that a diabetic who failed to eat a healthy diet would be denied insulin," said one Bronx participant. The individuals with whom we spoke, including some treatment providers, called on treatment providers and other stakeholders to carefully reexamine and acknowledge the limitations and potential harm of punitive practices and the continued use of coercion in treatment.

Despite the criticism with the current treatment system, we found widespread consensus on what New York's treatment system should look like. Across the board, people called for compassionate, client-centered care that helps people access the full range of services and supports they need to manage and overcome drug use problems. Moreover, there was agreement that treatment programs should go beyond simply helping people abstain from drugs and focus instead on helping them live healthy, full, and active lives. Finally, people called for wider recognition that there are many pathways to recovery and that all of them should be supported.

As mentioned above, the movement toward what many call recovery oriented care is growing. According to OASAS: "New York State's Recovery Oriented System of Care involves a transition from an acute symptom stabilization model to one that promotes recovery as the core/organizing principle of service and which can support effective management of chronic conditions over a lifetime. This system transformation requires the adoption of a continuum of care approach that accentuates the ongoing participation of the individual, the family and community in his/her care from any point of contact within the system beginning with pre-engagement through long-term sustained recovery." Like a public health approach, a recovery orientation addresses the social determinants of drug use and focuses on empowering individuals and communities. However, our community consultations suggest that this transformation has yet to take place and that government agencies need to move beyond defining new frameworks to actually changing how services are provided.

Finding 3B: People In Treatment And/Or Currently Using Drugs Require Better Service Integration And Ancillary Services To Help Address Basic Needs.

Participants emphasized that treatment must go beyond addressing drug use alone and help individuals identify and resolve other issues that may be contributing to their drug use. Experts with whom we spoke agreed that, while many excellent programs exist, the treatment system overall is riddled with bureaucratic and political barriers to delivering effective, comprehensive care and siloed from other sectors—most notably mental health and medical care. As suggested in our discussion above, helping individuals and communities most impacted by drug use access basic medical, vocational, educational, and other supports is essential to addressing some of the underlying causes of drug use that were identified by communities. Treatment, particularly with a recovery-oriented system, can be a window of opportunity to address needs such as employment, housing, child custody, benefits, and health. Moreover, addressing these needs may improve treatment outcomes. For instance, unemployment has been associated with continued drug use after treatment,[236] while providing ancillary services has been shown to improve treatment outcomes, especially for women.[237-238] These kinds of ancillary services must continue after treatment

and throughout recovery. In addition to providing ancillary services for people who enter treatment, participants wanted to see services for those who continue to use drugs and/or for people who stop using drugs without formal treatment (e.g., case management, housing, employment services).

Given the co-morbidity of drug use and mental health disorders, linkage between drug treatment facilities and mental health providers is especially critical and was raised repeatedly in our consultation, especially by providers. The state has already made some moves to improve integration of substance use, mental health, and medical care through Medicaid redesign and the implementation of the Affordable Care Act. New financing models are being developed by the OMH and OASAS through Behavioral Health Organizations, which are licensed to treat both mental health and drug use issues. At the level of financing, the state Department of Health is launching Health Homes for Medicaid recipients with multiple chronic conditions, including substance use and mental health disorders. Health Homes are designed and their reimbursement is structured to provide integrated and coordinated care for some of the state's sickest and poorest individuals. These kinds of innovations need to be evaluated and, if successful, expanded.

Finding 4: The Over-Involvement Of The Criminal Justice System Interferes With Effective Treatment.

One of the most consistent concerns voiced by both community members and providers was the growing role of the criminal justice system as the principal gateway to treatment. More than 50 percent of people in treatment in New York are referred to treatment through the criminal justice system.[239] The elements and structure of these referrals vary; however, individuals are often mandated to care, and their assessment, provider, and treatment plan are ultimately determined by court administrators or their community supervision officer. Any deviation from treatment or relapse may result in sanctions, including incarceration. The involvement of the criminal justice system in defining treatment referrals and delivery has had several unintended consequences, including: 1) more people using low levels of drugs who may not actually need treatment but who are being mandated to treatment; 2) treatment has become less available to people who may have greater need and/or who are self-referred or referred through non-criminal justice sources; 3) the effectiveness of mandated treatment has become increasingly unclear; and 4) the role of courts and other non-treatment professionals in influencing treatment options, programming, and relationships has raised skepticism.

Providers spoke from their own experiences about the dilemma they face when choosing whether to provide treatment beds for individuals who do not need them or letting those individuals face incarceration. Several treatment providers told us that increasingly they are asked to provide treatment for low level marijuana possession and use, in instances where individuals—particularly young men of color—are arrested for marijuana possession and sentenced to intensive treatment as an alternative to incarceration. According to OASAS,[240] the percentage of patients admitted to treatment who reported marijuana as their primary drug increased from 11 percent to 17 percent between 2001 and 2010. While providers welcomed the opportunity to ensure more young men were not needlessly sent to jail or prison, they questioned the appropriateness of filling treatment slots with individuals unlikely to benefit from treatment. They noted that for every slot they filled with someone who did not really need treatment, there was another person who needed treatment that went unserved. Some treatment providers felt that the focus on criminal justice referrals was leading to the disinvestment of resources from other points of access that promote voluntary initiation of care.

Some people in our consultations reported being helped by mandated treatment programs. One person from the Bronx told us, "I was 30-something years old and a judge looked at me and said, 'I'm putting you in a program because I know you can make it.' And that's all I needed. I had been in programs before but this worked." However, others did not find mandated treatment programs helpful. As another Bronx participant put it: "No court or agency is going to keep me clean."

While individuals were divided on the efficacy of mandated treatment, we heard repeated criticisms about the influence of the criminal justice system on the treatment system overall. Specific concerns included the determination of dependency and treatment/service needs by court administrators rather than by treatment professionals and clients; arbitrary and inappropriate limitations on treatment options and plans; the inefficient and unsuitable use of treatment resources for individuals not well matched to a given program; arbitrary eligibility requirements and cherry-picking of participants for drug courts; and use of sanctions in case of drug use or relapse.[241-243] (We discuss drug courts further in the section on law enforcement and public safety.)

People also expressed concern that the criminal justice sector's involvement in treatment was helping to perpetuate stigma and the continued use of punitive and coercive practices in treatment. They called instead for compassionate, patient-centered, non-punitive care within a health care context that helps alleviate the stigma of drug use and treatment.

Finding 5: Child Protective Services Are Often A Missed Opportunity For Helping Families Access Treatment.

Another system that the people with whom we spoke—especially those who used drugs—felt penalized by, rather than helped by, was child protective services. Although estimates vary, research consistently suggests that the mistreatment of children happens more frequently in homes where one or more parent has a substance use condition.[244-245] Child welfare agencies and/or courts all too often penalize parents and create environments where it is difficult for them to seek help, rather than using this co-occurrence as an opportunity to help parents access treatment and the services that might prevent further use. In fact, child welfare is one of the areas where the contradictory nature of our current drug policies comes to the fore. For example, the federal Adoption and Safe Families Act states that if a child is placed outside of the home more than 15 months in a 22 month period, child protective services must petition to terminate the parent's rights. For parents with drug use problems and/or those needing long-term treatment, and for providers who may need to navigate multiple systems to help these families, this creates an incredibly short timeline. This is especially true given the shortage of treatment options for women with children. Such regulations are even more troublesome given reports that some agencies, like New York City's Administration for Children's Services, are overburdened.[246-247]

We also heard from caseworkers who agonized over regulations requiring them to report drug use in the home (e.g., by a parent or guardian), even when it was not a danger to the children. Some individuals with whom we spoke reported that the distrust of agencies discourages community members from seeking care and services for themselves and their family, even when in crisis, and especially in cases of drug use and related activity. For example, one case manager described her misgivings about rules that mandated her to report any drug use: "For instance, with a parent who happens to smoke crack, we have the children removed—a goal is achieved, but is it really? Mom was fine and the kids were safe, but the kids were still removed—now she will smoke more and overdose." Another child services worker noted, "Removing children from the home creates more problems—education issues, instability and more." Statutorily, drug use alone does not constitute neglect if the parent is voluntarily and regularly participating in a rehabilitative program, and there are no signs of loss of control or neglect. The law does not distinguish between kinds of drugs (e.g., marijuana versus cocaine). Regardless of the letter of the law, our consultations suggest that many service providers as well as community members believe that a disclosure of any drug use could result in the loss of custody. Media reports suggest that possession of even a small amount of marijuana can trigger an investigation by child protective services.[248]

The New York State Office of Children and Family Services (OCFS), OASAS, and the New York State Unified Court System produced a guide noting that these systems often have different priorities but that finding common values and a shared purpose is critical.[249] Participants in our consultations, as well as providers, want to see the kind of systems coordination that helps parents who need treatment get it without risking the custody of their children. While many recognized cases where drug use endangers the welfare of children, the overall feeling was that too often parents who use drugs are prematurely separated from their children, causing more harm in the long term.

The Way Forward: Promising Practices In

Treatment And Recovery

As we discussed, there is an array of treatment programs, providers, and activities in New York that show promise and opportunity for the system as a whole. OASAS has begun efforts to identify and promote quality programs as part of its Gold Standard Initiative to showcase and encourage performance, which includes use of the previously mentioned scorecards.[250] In addition, OASAS trains providers and furnishes them with educational materials on best practices, evidence-based programs, and treatment elements. OASAS has worked to improve the quality and availability of different treatment modalities. This includes the recent requirement for medical directors of treatment programs to obtain federal DATA 2000 waivers (buprenorphine certification) to prescribe buprenorphine as part of their ongoing efforts to expand and improve access to medication assisted treatment. An even greater shift and opportunity for growth in treatment and recovery is the increasing momentum seen at the city, state, and federal levels toward recovery oriented systems of care. Specifically, OASAS has begun implementing a federal initiative to expand recovery oriented systems of care and facilitate access to a range of community-based support services through Access to Recovery/NY Service Opportunities for Accessing Recovery Successfully (ATR/NY SOARS).[251]

The reforms and policy efforts to improve health care financing and delivery mark important progress in expanding coverage, access to, and quality of treatment and care. This includes the previously mentioned passage and implementation of the Affordable Care Act (ACA) as well as the development of Behavioral Health Organizations and Health Homes. These emerging models of care delivery and the increasingly urgent interface of addiction and primary care settings being bolstered by efforts to address harmful prescription drug use provides an opportunity to destigmatize addiction treatment and expand capacity of the health care system to offer effective referrals and care.

Harm reduction encompasses: 1) a public health philosophy of "meeting people where they are" in their

Harm Reduction Findings

behavior choices to minimize immediate health risks; 2) a defined set of services centered around increasing the safety of drug use, particularly syringe exchange, and engaging marginalized individuals who use drugs; and, 3) a specific set of behavior interventions within drug treatment that counsels people actively using drugs on how they can reduce the negative impact of drugs in their lives.

This framework is consistent with a public health approach to drug policy, which has improving health outcomes as its primary aim. Harm reduction—both conceptually and in practice—neither condemns nor condones drug use but instead focuses on health promotion and injury/disease prevention given that some people will always use drugs. As such, this philosophy recognizes that programs that require abstinence and/or penalize drug use are not effective for many individuals and may even alienate and stigmatize people who relapse. Instead, harm reduction services can engage an easy-to-miss population and create a "critical entry point" to health care, social services, and drug treatment for those who would not otherwise access services.[252-253] These strategies may also include recovery readiness services, which welcome people who are still using but may be contemplating reducing their use or quitting all together; abstinence may be a goal but only one among many that a client might choose.[254]

Harm reduction improves the health outcomes for individuals who use drugs as well as families and communities. Harm reduction strategies have been widely studied and proven to prevent the onset or heightened dependency of drug use, facilitate access to treatment and recovery, and improve public safety.[255-269] Harm reduction interventions are also cost effective; an analysis of syringe exchange programs operating in New York State found that they saved $20,947 per HIV infection averted and had averted 80 HIV infections in a 12-month period.[270] Similarly, health care costs for chronic hepatitis C—which can also be averted through syringe exchange—range from $18,910 to $25,651.[271]

While harm reduction is aligned with the other pillars (prevention, treatment, and public safety) in the shared goals of health promotion and injury/disease prevention, harm reduction strategies have been the least effectively integrated among the different service systems. This is largely due to: 1) ambivalence about providing services and/or support to people actively using drugs; 2) confusion among service providers, policy makers, and community members about what constitutes harm reduction; and, 3) ideological tension between treatment and harm reduction providers.

While individuals and policymakers in New York and across the U.S. have struggled to accept a harm reduction strategy—both a conceptual framework and a set of practices—as it relates to drug use, it is a core public health principle and strategy in many other areas. For instance, while risks associated with driving cannot be eliminated, public health professionals promote seatbelts, road repair and safety, driver education, and drunk driving laws, all of which have greatly reduced traffic-related injury and death. Similarly, limiting the use of cigarettes in indoor spaces can be seen as an effective harm reduction strategy.

As we discuss below, the core themes to emerge from the experts and community members we spoke to range from discomfort about embracing harm reduction programs to a desire to see harm reduction services better integrated into other services (including treatment) and an expansion of services available. And, in spite of some confusion and resistance expressed by experts and community members regarding harm reduction strategies, they also revealed a common aspiration for the development of policy strategies that decrease risk of illness, injury, and death among individuals who use drugs as well as their families and communities.

Finding 1: Harm Reduction Is Not Well Understood Or Widely Accepted In Communities And Across Stakeholders.

During the consultations, participants expressed a range of feelings and understandings regarding the concept of harm reduction. Government agencies reflect this ambivalence and have been resistant to endorsing harm reduction programs—or even using the term harm reduction.[272] For instance, the federal government recently reinstituted a ban on using federal funds for syringe exchange programs despite a large body of evidence showing their effectiveness at reducing the transmission of blood borne diseases. As several participants pointed out, the discomfort surrounding harm reduction is partly due to this kind of failure of leadership at the state and national level and partly to a lack of consistent definition and sustained dialogue and education regarding harm reduction strategies, particularly among agency heads, policymakers, and community leaders.

Some of the participants struggled with the notion that harm reduction condones drug use. While many were able to understand ongoing drug use and some people's unwillingness or inability to stop using drugs through analogies to alcohol (where moderate and even heavy consumption is accepted), others felt that any illicit drug use was harmful and must be discouraged. These concerns extended to the location of harm reduction services in some communities. Many participants wanted more harm reduction services in their community. However, others felt these services exposed the neighborhood to drug use, people who use drugs, and drug paraphernalia, and conveyed a message that illicit drug use was acceptable. While no evidence supports the claim that harm reduction services encourage or result in increased drug use, these concerns point to the need for increased dialogue and efforts to build better community relationships and partnerships between service providers, residents, and clients of services.

Despite misgivings about harm reduction services by some, most people with whom we spoke recognized the need for and benefits of harm reduction programs.

"Morality, religion, and emphasis on abstinence prevent open dialogue."
— Albany participant

"Politically I support needle exchange although personally it's hard."
— Downtown Brooklyn participant

Finding 2: Harm Reduction Services And Strategies Are Not Well Integrated Into Other Service Systems.

While harm reduction providers in general—and syringe access programs in particular—have become more comprehensive in the services they provide and referrals they make,[273] both community members and providers noted a lack of integration and reciprocity of referrals by other health and social service providers. These include the criminal justice, human services, public assistance, and health care systems. Several people wanted to see harm reduction strategies promoted in criminal justice settings, including parole, probation, drug courts, and correctional facilities, where they have the potential to reach those who need these services most. In the community, many of those who use and/or are dependent on drugs are perceived to be unconnected to care. In reality, they are likely to interface with several service systems (e.g., to treat acute medical conditions, access benefits, find housing, etc.). Harm reduction providers and their clients told us that these systems also need to counsel people about harm reduction strategies and/or link them to harm reduction programs.

Another area in which some experts told us they would like to see a harm reduction approach used is within drug treatment. Providers noted that treatment programs, many of which are based on an abstinence model, and harm reduction programs sometimes consider themselves at ideological odds. However, some providers have found ways to integrate harm reduction and treatment. Harm reduction therapy or psychotherapy is an emerging field with potential as a model for integrating harm reduction into a treatment approach that enables and facilitates behavioral change in someone who is actively using drugs through a patient-centered, provider-patient relationship. Such treatment could offer an important alternative to more traditional treatment approaches that require a longer period of sobriety or complete abstinence.[274] Harm reduction practitioners work with clients to identify their objectives and then address them.[275-277] For some who are not able or not ready to quit drugs altogether, a harm reduction approach to treatment could help reduce use, mitigate any harms associated with use, and build positive supports. Importantly, a harm reduction approach to treatment shares some common elements with the client centered, recovery oriented treatment approach described in the last section.

Finding 2A: New York State Needs To Broaden Efforts To Prevent Overdose, Including Through Naloxone Distribution To People Who Use Opioids.

One area where it is particularly important to expand and further integration of harm reduction efforts is in overdose prevention. While overdose prevention did not come up often in the community consultations, overdose is the leading cause of accidental death in New York State and New York City (surpassing deaths related to accidental falls and motor vehicle accidents).[278-279] Between 1999 and 2008, over 7,600 people died from drug overdoses in New York City alone.[280] In New York City, accidental drug overdose is the fourth leading cause of premature death (after cancer, heart disease, and HIV/AIDS) and the third leading cause of all death among New York City residents ages 25 to 34.[281] In Long Island, more than 380 people died from drug-related overdose in 2011.[282] The odds of dying from an overdose are higher among Black and Hispanic males.[283-284]

New York has established opioid overdose prevention programs, in which people, as potential bystanders, are eligible to become trained overdose responders (TORs). In addition to learning how to identify an opioid overdose, TORs are trained to administer naloxone (also known by its trademark name, Narcan), which they are then provided with upon completion of their training. Naloxone is a life saving medication that can reverse opioid overdoses and therefore prevent death. It is effective for all opioids including heroin and prescription opioids (e.g., oxycodone, hydrocodone, methadone, etc.). Opioid overdose prevention has the support of many medical providers,[285] is feasible to implement,[286-287] and is effective in preventing fatal opioid overdose.[288] To date, New York has distributed naloxone largely through programs like syringe exchanges that target people who use heroin and their families. However, prescription opioid misuse is far more prevalent than heroin use, and such users—many of whom do not inject—may be unlikely to access naloxone through a syringe exchange
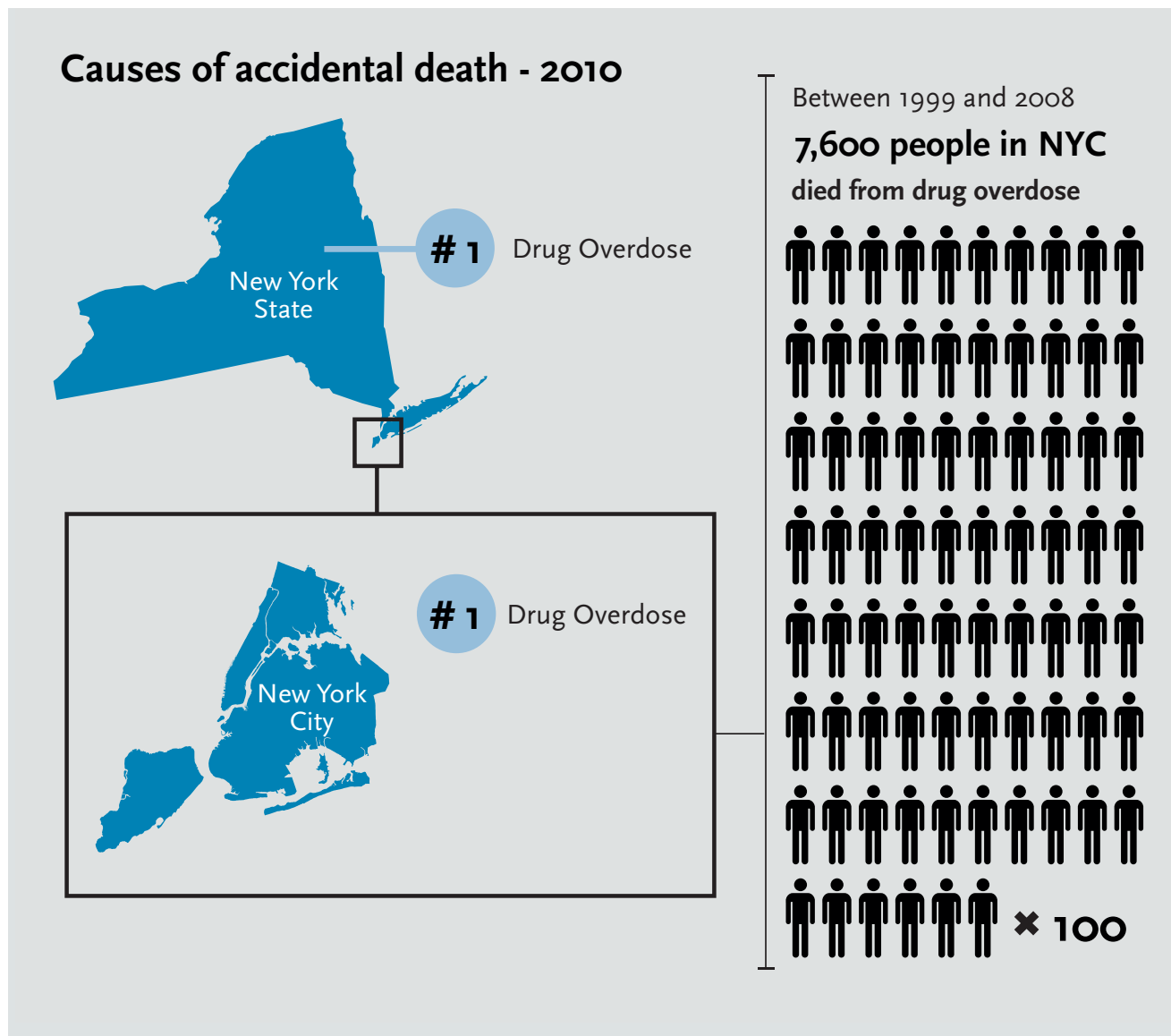
program. From 2006-2007, according to the National Survey on Drug Use and Health, a little more than four percent of New York City residents engaged in the illicit use of pain relievers compared with a little less than one percent who engage in heroin use.[289] Between 2005 and 2009, the prescription opioid poisoning death rate increased by 20 percent per 100,000 New York City residents while the heroin poisoning death rate decreased by 24 percent.[290]

Some states have implemented programs to address prescription opioid overdose by incorporating overdose prevention in health care settings by means of physician training that encourages doctors to prescribe naloxone with every opioid prescription. Other strategies include educating patients who receive opioids about naloxone and/or having pharmacists dispense naloxone under a standing order (like flu vaccine or the "morning after" pill). Under a standing order, pharmacists could make naloxone available to any client they felt might be at risk for an opioid overdose (based on their prescriptions and/or prescribing history). In 2011, New York State passed a Good Samaritan law, limiting the prosecution of people who call 911 for help during an overdose event. This law is an important step toward encouraging those who fear arrest and prosecution to call 911 during an acute crisis. The education of police, prosecutors, and the public about this law is a critical next step.

Finding 2B: Many Syringe Exchange Programs Report Difficulty In Working With Law Enforcement.

Participants felt that the criminal justice system has been the main impediment to implementing harm reduction interventions, especially syringe exchange programs, and others have suggested that law enforcement impedes the integration of harm reduction more fully into drug policies.[291-294] For example, until the recent alignment of New York State penal code with the public health code allowing for syringe exchange, New York police departments engaged in the arrests of individuals in possession of syringes, regardless of their status as syringe exchange clients. In addition, several harm reduction providers in our community consultations described the difficulties they have had establishing good working relationships with local police precincts to ensure their clients could access their services without fear of arrest or harassment. A survey of people who use injection drugs in New York City found that 22 percent of those who relied primarily on syringe exchange programs had been stopped by police outside the program.[295]

"There needs to be an acknowledgement and support for active users who do not want to be sober, and therefore more harm reduction is needed."
– Albany participant

Figure 10

Causes of accidental death - 2010

New York State — #1 Drug Overdose

New York City — #1 Drug Overdose

Between 1999 and 2008

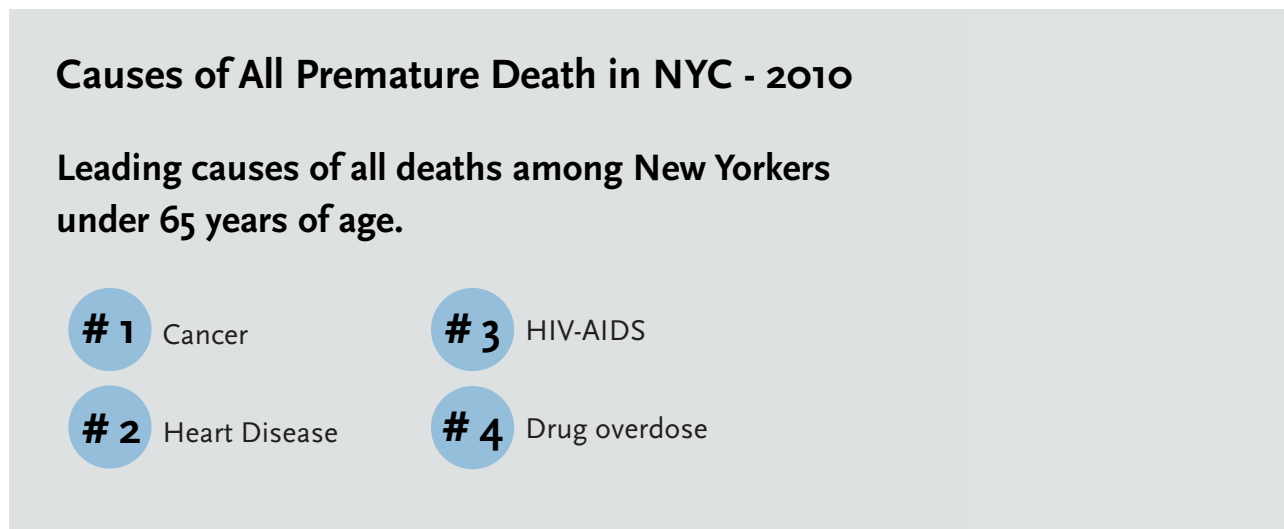**7,600 people in NYC**

died from drug overdose

✖ 100

Finding 3: New York State Service Providers And Policy Makers Need To Not Only Learn From, But Go Beyond, Syringe Exchange Programs To Encompass Additional Harm Reduction Services, Behaviors, And Populations.

Syringe exchanges are one of the more prominent harm reduction interventions in New York and the U.S., even to the degree that *harm reduction* has become a euphemism for *syringe exchange*. A large body of evidence shows that syringe exchange programs reduce the sharing and reuse of syringes, without increasing the number of people who use drugs, the number of drug injections, the number of discarded syringes, or the transmission of HIV.[296-300] Although some within the harm reduction community have expressed frustration that the field has focused primarily on syringe exchange, the lessons learned through the implementation of syringe exchange programs can be applied to other similarly effective, but controversial, interventions (e.g., crack safety kits, supervised injection sites, prescribed heroin, etc.).[301-307] These include lessons in policy, advocacy, and research as well as structure and design of programs.

Figure 11

Causes of All Premature Death in NYC - 2010

Leading causes of all deaths among New Yorkers under 65 years of age.

 # 1 Cancer   **# 3** HIV-AIDS

 # 2 Heart Disease   **# 4** Drug overdose

Community members wanted to see more services to help those who actively use drugs. A review of the literature also suggests that expanding the array of harm reductions services offered in New York could improve the health and safety of individuals and communities across the state. Harm reduction strategies can include services for safer drug use (syringe exchange or safe injection kits, crack safety kits, adulterant screening kits); overdose prevention (CPR and first aid training, naloxone opioid overdose prevention training and kits); safe spaces and supportive housing (supervised injection sites, wet houses); treatment (integrative harm reduction psychotherapy, heroin maintenance, or heroin assisted treatment); and more. The delivery and integration of physical health services has also been a large component of harm reduction strategies including referrals for delivery of medical treatment, physical screenings and disease testing, and health counseling. Participants also raised concern about other risky behaviors attendant to drug use, particularly unsafe sex. Efforts to address this are seen in the provision of safe sex tools and within counseling or education materials related to drug use. Supportive services that address basic needs—food, housing, clothing—are also part of a comprehensive harm reduction system. In general, people who use drugs can benefit from low threshold services that make access easy by allowing for drop-in appointments and by not requiring abstinence from drugs to receive services.

Participants also called for services that address the greater risk of violence and other forms of victimization faced by people who use drugs. People who use drugs often have a history of being victims of violence (including domestic violence) and a higher risk of re-victimization;[308-312] therefore, people expressed a strong interest in harm reduction services that provide the skills and support needed to help avoid further victimization.

However, many of these services simply do not exist in New York due to lack of funding, political will, and/or resistance from legislative and enforcement agencies. Similar to syringe exchange, these services face a high standard of proof to overcome to provide evidence that they are safe and do not enable or encourage drug use.

The Way Forward: Promising Practices In Harm Reduction

New York has the potential to be a leader in innovative and sophisticated harm reduction systems and models. Current harm reduction programs include the New York State Department of Health's overdose prevention program, which expanded access to naloxone, and its expanded syringe access program. These have had major success in improving health outcomes and promoting a network of harm reduction providers in New York City and other parts of the state. New York has been a national leader in several successful models in addition to syringe exchange,

including models of HIV care, low-threshold services, peer-delivery services and education, outreach, and advocacy with the inclusion and leadership of people who use or formerly used drugs illicitly. The passage of legislation in 2010 that allows syringe exchange in the penal code—bringing it in accordance with the public health law—and the passage of the Good Samaritan law in 2011 both mark an important shift in the New York political landscape. They align with and prioritize a public health approach that seeks to mitigate the harms of drugs, rather than defaulting to criminalization. More recently, the 2012-2013 budget enacted by New York State has expanded Medicaid reimbursement for "harm reduction counseling and services to reduce or minimize the adverse health consequences associated with drug use" in community-based and provider sites, as "determined by the commissioner of health." This is an important move to greatly increase access and availability of harm reduction services and providers across the state and in health care and community-based settings. It also has the potential for elevating the understanding, legitimacy, and acceptance of harm reduction in New York.

Going forward, New York and the U.S. should consider implementing more innovative harm reduction practices including supervised injection sites, which provide safe and clean spaces for drug injection for those unable or unwilling to stop using drugs. Supervised injection sites also assess clients for needed medical care and link otherwise hard to reach individuals to medical and drug treatment services. They have led to a number of public health and safety benefits (decreases in public injecting and syringe sharing and increases in the use of addiction treatment), without adverse effects.[313-315] Operating in Europe since the 1980s, there are now safe consumption facilities in Switzerland, Germany, the Netherlands, Spain, Australia, and Canada. Heroin maintenance for people with long-term heroin use who have failed at other treatments has also been shown effective in improving health and reducing crime.[316]

An effective drug policy is one that fosters safe communities in which residents of all ages can lead healthy lives and can participate fully in the community without fear. Violence and crime can make it difficult for residents and business to build community, get to work and school, exercise, and connect with friends and family. Traditionally, public safety has focused narrowly on policing and the criminal justice system. However, just as health is more than the absence of disease, safety is more than the absence of crime. A public health approach to drug policy requires a broader and more holistic perspective on public safety, with the police and criminal justice system working in partnership with communities to reduce crime, injury, and death and to promote healthy and secure neighborhoods.

Addressing the problem of drugs more effectively is not just in the interests of communities; it is also in the interest of law enforcement. The harmful use of alcohol and illicit drugs can increase the risk of violence and other criminal behavior, making the job of policing more difficult.[317] In addition, drug use and mental health issues often overlap, and the police end up being the front line responders for many people in crisis.[318] For example, it is estimated that on any given day the NYC Department of Correction has over 4,500 people with a mental health diagnosis in their custody.[319] That is over a third of the average daily inmate population of approximately 13,000.[320] More effectively addressing the problem of drugs will help police, reduce recidivism, and lower the costs associated with jail and prison time. Too often law enforcement personnel are pitted against drug policy reformers and community residents, when, in fact, they share the goal of safer, healthier communities.

In our community consultations, while there was strong desire for safer and healthier communities, there was widespread dissatisfaction with the current approach to policing in many communities. As we discuss below, we found a high level of distrust and antagonism between community members and police that is making communities feel less, rather than more, safe and likely making the jobs of law enforcement more difficult. The people with whom we spoke wanted more collaborative relationships with police and to see new policing strategies as well as new policing priorities. They also wanted to see initiatives to improve public safety that went beyond policing, like community

development. Many of the experts with whom we spoke also had concerns about drug courts and the implementation of the 2009 Rockefeller Reform Laws. Finally, people felt that community safety could be improved if people returning home from jail and prison were better supported in reintegrating into their communities.

Finding 1: Current Drug-Related Policing Practices And Incarceration Are Costly, Create Antagonism Between Police And Community Members, And May Be Making Some Communities Less Safe.

Nationally, New York ranks among the highest in state and local criminal justice system expenditures per capita—only three states spend more. New York spends $861 for every New York State resident—a total of approximately $16.7 billion.[321] Much of this spending is driven by city and state enforcement approaches to drugs. New York State had more than 35,000 felony drug arrests disposed in 2010—over 20 percent of all felony arrests disposed in the state that year.[322] In addition, there were more than 12,000 felony drug indictments and related actions—more than any other felony charge and almost a quarter of the total. However, the most staggering rate is seen in arrests for misdemeanors, especially misdemeanor marijuana possession. In 2010, the New York City Police Department made over 50,000 misdemeanor marijuana possession arrests (making that the most common arrest in the city)[323] *and* costing taxpayers an estimated $75 million per year.[324] Ironically, research suggests that police stops, arrests, and incarceration may also be making our neighborhoods less safe by destabilizing communities.[325-328] According to scholars, mass incarceration threatens community safety because it: 1) changes the capacity of social networks to resolve problems and enforce community norms; 2) weakens neighborhood ties; 3) creates disruptions in home life that may lead to delinquency; and 4) returns to already overburdened neighborhoods large numbers of individuals who have high needs but few resources.[329]

In addition to a growing body of research about the harms associated with incarceration, it became clear through our community consultations that, in some neighborhoods, policing strategies are creating antagonism between police and the communities they serve. Among the most commented upon and heavily criticized practices were the

> "Young people don't believe that leading a straight life guarantees staying out of jail, because even if they don't do anything wrong they are still harassed and arrested by the police. Obviously, there is no element of trust between young people and the police."
> – *participant, Crown Heights, Brooklyn*

high rates of stop, question, and frisks in communities of color as well as intensified police activity or "sweeps" during which communities are inundated with police officers. The people with whom we spoke resented what appeared to be the blanket targeting of particular areas instead of a focus on specific individuals who posed a threat.

The people with whom we spoke also commented repeatedly on the racial disparities they saw in policing and law enforcement strategies. The data support their view that people of color are disproportionately targeted by police. For example, nearly 90 percent of individuals who are stopped, questioned, and frisked in New York City are non-white. NYPD states that this policy—which is now the subject of a class action lawsuit—is meant to decrease violence and get guns off the streets. However, less than one percent of these stops have recovered guns. In fact, nearly 90 percent of these stops resulted in no arrest or summons.[330] Most of the arrests for marijuana possession have been a result of stop, question, and frisks. Nearly 86 percent of the New York City marijuana arrests are of Black and Latino people, even though whites use marijuana at comparable (if not higher) rates than their Black and Latino counterparts (see Figure 12).[331]

This intensive policing of marijuana persists, despite a 1977 law that decriminalized possession of small amounts of marijuana. Under New York law, possession of 25 grams or less of marijuana is a violation subject to a $100 fine for the first offense. In New York City, however, police circumvent this law by first asking individuals to empty their pockets and then use a statute about having marijuana "in open view" to justify an arrest. (Possession of any amount of marijuana in open view is a misdemeanor punishable by up to three months in jail and a $500 fine.) New York City Police Commissioner Kelly issued a memo in the fall of 2011 directing police not to make an arrest unless individuals display marijuana of their own volition.

Figure 12

Marijuana Use by Whites, Blacks and Latinos, Ages 18 to 25, 2008 - 2011

Whites ■ Blacks ■ Latinos

Ever used Marijuana in life · Used Marijuana in Past Year · Used Marijuana in Past Month
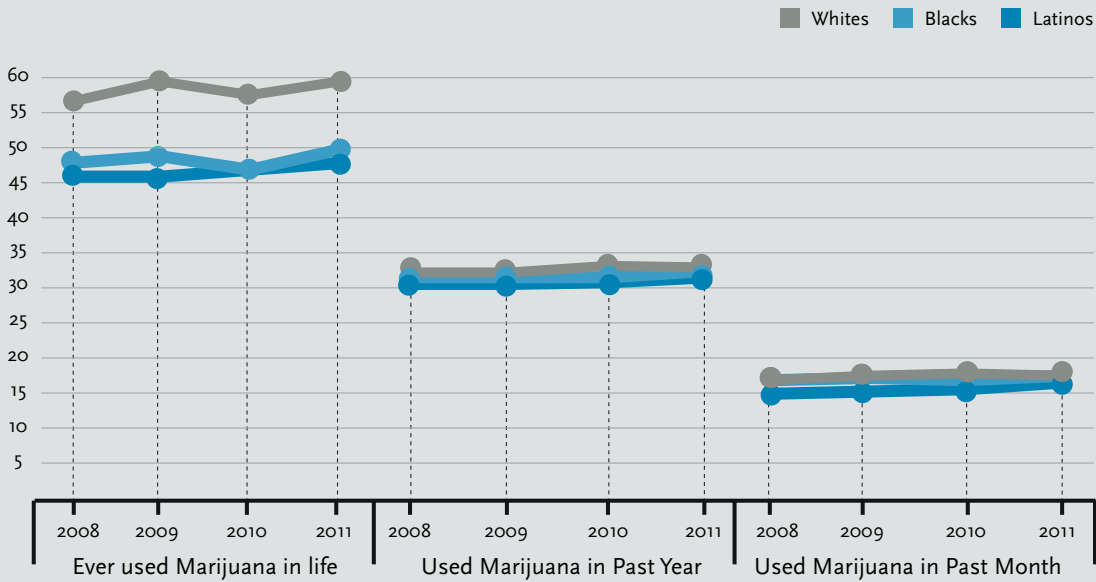
85% of NYC marijuana arrests are Black and Latino, even though Whites use marijuana at comparable, if not higher, rates than their Black and Latino counterparts.

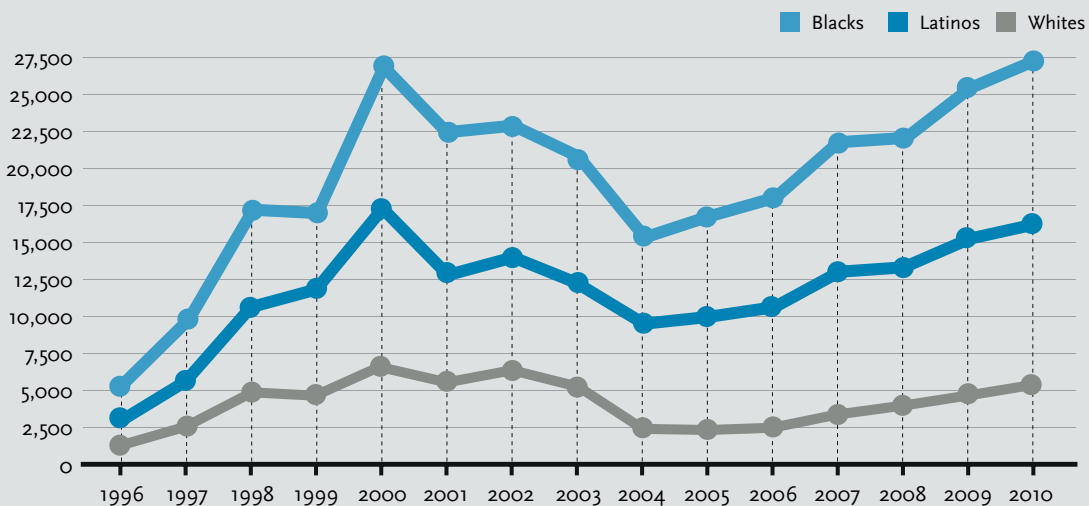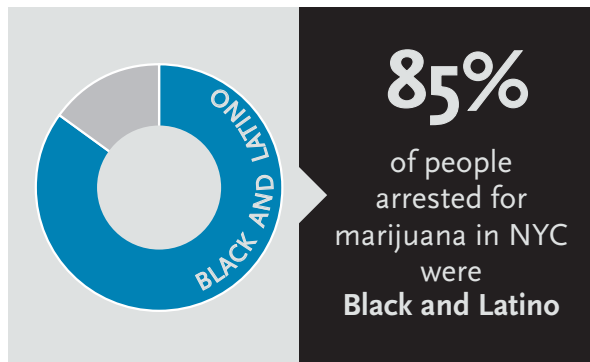## Marijuana Arrests of Blacks, Latinos and Whites in NYC, 1996 - 2010

Blacks ■ Latinos ■ Whites

Figure 13

85%

of people arrested for marijuana in NYC were **Black and Latino**

Although arrests decreased slightly following this memo, 2011 was the second-highest period for marijuana arrests in New York City history, with 50,680 arrests for the lowest level marijuana possession offense. Both stop, question, and frisks and marijuana arrests are concentrated in predominantly Black and Latino neighborhoods (see Figure 14). The generation of arrests for marijuana possession, while failing to address gun violence as intended, delegitimizes this practice and policing as a whole.

Participants explained that these kinds of policing practices, targeted primarily at people of color, contribute to the stigmatization of entire communities, schools, and groups of people. Resources expended to implement stop, question, and frisks and general surveillance operations in communities of color lead to a belief that whole communities have been systematically targeted as failures in need of supervision. Police are oriented to police crimes in poor communities differently than crimes in higher income or white communities. There is also a sense that once an individual in these communities has been labeled by the system as a "perpetrator," he or she is further targeted and kept in the system, rather than regarded as a citizen to be served and protected by the system.

Rather than viewing law enforcement officials as a resource or as contributing to their sense of safety, many explained that current policing strategies deter them from engaging officials in a time of need and/or crisis. This comment from a parent was typical of many we heard: "I don't teach my children to trust the police." Very few community members perceived any positive effects of these practices; rather they told us that they fomented alienation and distrust of police.

Moreover, people explained that experiences of antagonistic police encounters and criminalization of individuals and communities without any evidence of

wrongdoing delegitimized the role of police and undermined the rule of law. For instance, the adversarial relationship with police has the collateral consequence of making it difficult for anyone to assist the police as they will then be labeled by their fellow community members as betraying the community. This seems to be especially the case among younger community members who are also those most likely to be stopped, frisked, and arrested.

Finding 2: Communities Want A More Collaborative, Effective Relationship With Police And A Shift In Policing Priorities.

The inability of law enforcement strategies by themselves to address harmful drug use or public safety is evidenced by the fact that 25 percent of incarcerated individuals returned to prison within three years, often for technical violations that include testing positive for drug use.[332] In New York State the recidivism rate for the Department of Corrections and Community Supervision (DOCCS) is 40 percent—30 percent are parole violations versus 10 percent that are new felony convictions. Individuals that return to prison for new crimes were most often returned for new drug offenses.[333] Furthermore, some participants noted their communities have a high incidence of violence despite intensive policing. As a police chief who led reform efforts in Vancouver put it: "You cannot police your way out of this problem."

Participants in the community consultations overwhelmingly agreed that police departments and officers need to build a more collaborative relationship with the community. Dialogue, cooperation, and coordination are needed between the police, the criminal justice system at large, and the community (across sectors).[334] While police occasionally conduct community meetings, people told us that there has not been effective and engaged communication on behalf of the criminal justice system in general and the police in particular. People felt that the police had done too little to understand the community they work in or to critically self-examine their role, agency mission, and contributions to safety—and to community instability. Many participants noted that this is especially needed in areas like New York City where many police officers do not live in the communities they work in and are therefore perceived as not connected or invested in the community.

In addition to wanting more dialogue with police, some people with whom we spoke wanted a change in law enforcement priorities. They noted that the focus on low-level drug possession diverted policing resources away

Figure 14

Density Map of Stop, Question & Frisk Occurrences, NYC (2010)

UHF Areas

Stop and Frisk Density

High

Medium

Low
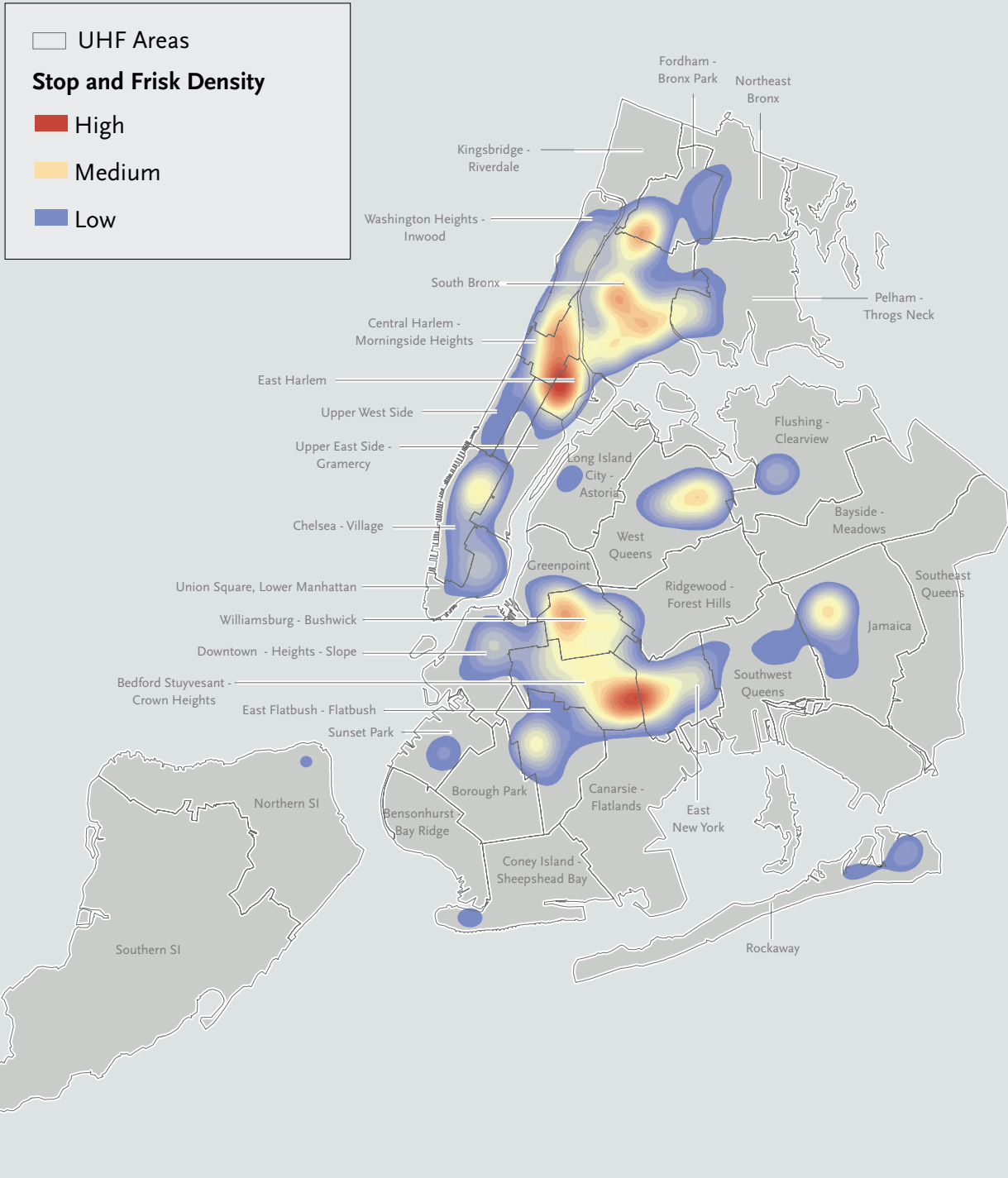
> "We are living in a militarized state... We need to start thinking about how we can have our community determine what safety is. We need social services, not government control."
>
> *— Crown Heights, Brooklyn participant*

from more pressing issues. Instead, they suggested policing priorities, especially those related to drugs, could be better focused on the harm caused by drug use rather than on the simple possession or use of a drug. Alcohol provides a useful example. Although alcohol is now legal, a number of harmful and disruptive behaviors associated with alcohol use remain penalized (e.g. drunk driving, disorderly conduct, weapons possession). Police departments elsewhere have refocused their efforts on targeting those who produce and traffic in drugs, while de-emphasizing the enforcement of possession laws except in cases where the user is engaged in harmful or illegal behaviors. For instance, the Vancouver Police Department encourages its officers to focus on the person's behavior rather than the actual unlawful possession of a drug in deciding whether to lay a charge.[335] By focusing limited resources on these priorities, rather than simple possession, police send a clear message to both users and communities about what is and is not tolerated.

We also looked to other cities for how structural changes in how police activity is valued and measured could help reorient police toward a more supportive role within communities. Traditional measures of success, like drug seizures and arrests, highlight what activities police engage in but do not assess the impact of these activities.[336] Police in New York have strong monetary as well as institutional incentives to make arrests and arraignments but no consistent protocols, incentives, or training to engage in referrals or any other alternatives to arrests. Nor do police departments in New York currently have the financial resources to train officers in alternative methods or how to make appropriate referrals. Elsewhere, police departments have been developing new performance frameworks that measure additional outcomes, such as the extent to which communities feel safe and secure as well as reductions in drug-related harm, like overdose deaths or drug-related emergency department visits.[337]

Expert and community members recognized that police—even if they were to shift their priorities and metrics—cannot alone address the drug problems in communities. One Albany participant even noted, "Law enforcement needs to help instead of lead." Prevention, particularly in

the form of community development, as well as treatment and harm reduction serve the goals of public safety by reducing both drug use and drug-related crime as well as protecting individuals most vulnerable to victimization, including people who use drugs. Officials from criminal justice agencies have themselves testified that job preparedness and referral programs have had a positive impact on reducing recidivism. Moreover, research increasingly supports that prevention, treatment, and harm reduction is more cost-effective than arrest and incarceration. For example, with every dollar spent on addiction treatment programs, there is an estimated $4 to $7 reduction in the cost of drug-related crimes.[338] With some outpatient programs, total savings can exceed costs by a ratio of 12:1.[339] By addressing the identified gaps in prevention, treatment, and harm reduction, we can also improve public safety.

Finding 3: Drug Courts Can Help Mobilize Resources And Provide Coordination Of Services, But Their Overall Effectiveness Is Questionable.

The people with whom we spoke both praised and criticized drug courts and alternative-to-incarceration (ATI) programs. ATI programs are designed to reduce reliance on pretrial detention and/or incarceration and take a number of forms (e.g., pretrial services, community service programs, treatment programs). Drug courts are programs that seek to reduce drug use through mandated drug treatment and close judicial oversight. The use of ATI programs and drug courts has grown in recent years.[340] Many community members and providers saw drug courts as a successful strategy for promoting treatment access and far preferable to sending people who use drugs to prison. However, as noted in the section on treatment, others were wary about the efficacy of

> "The failed Rockefeller Drug Laws have unfairly targeted minorities and cost the state hundreds of millions of dollars. These reforms are a giant step forward – no longer will drug addiction be seen solely as a criminal matter, but as a public health matter as well."
>
> *— New York State Assembly Speaker Sheldon Silver speaking at the signing of the 2009 Rockefeller Drug Law Reforms*

mandated treatment and felt that some drug courts were allowing the criminal justice system to influence treatment decisions in ways that were bad for individuals and for the treatment programs more generally. For example, many of the treatment providers with whom we spoke felt that some of the courts' requirements—like mandating vocational training for people in early recovery—were unreasonable and that others, like having to report relapse, jeopardized their relationships with clients and the treatment process. Research on the effectiveness of drug courts is mixed, and the components and structure between courts can be highly varied.[341-342]

Legal experts also raised concerns about conflicts between probation and parole requirements and those of drug courts. As one example, a client mandated to intensive drug treatment might have difficulty meeting parole requirements, such as finding full-time employment, applying for benefits, finding permanent housing, and meeting with his or her parole officer. Despite these criticisms, there are very few comparable systems of service coordination in any other setting, including treatment and health care. Therefore, some treatment providers and legal advocates viewed drug courts as one of the few settings that could provide the referrals and coordination of ancillary and treatment services that their clients critically

need. These experiences reinforced the perception that the criminal justice system is becoming a primary entry point for drug-related help and assistance. More research is needed to determine the effectiveness of providing the kind of care coordination and services available through drug courts in other settings. Current efforts to improve care coordination, like health homes and behavioral health organizations (described in the treatment section), may offer promising alternatives.

Finally, some question whether drug courts can address the stigma associated with a criminal justice response to drug use. For example, without the sealing of criminal records, people remain burdened by the legal barriers and discrimination associated with a criminal conviction.

Finding 4: The 2009 Reforms To The Rockefeller Drug Laws Are Not Being Fully Implemented.

In 2009, New York State enacted substantial reform to the punitive Rockefeller Drug Laws. These reforms restored judicial discretion in sentencing and removed mandatory minimum sentences for most drug offenses. The reforms were framed by lawmakers as a shift away from failed criminal justice approaches toward a public health approach. However, recent reports suggest that the reforms are not being fully implemented and are not living up to the spirit of the law, which was intended to help people with drug use problems access treatment and services instead of serve time in prison or jail. These reports, including an assessment report by Senator Klein and the New York State Senate Standing Committee on Alcoholism and Drug Abuse,[343] provide a more detailed analysis of the problems with drug law reform implementation, but some of the key issues include lack of funding, lack of statewide coordination and oversight, and a reluctance on the part of judges to use their sentencing discretion to deviate from the recommendations of district attorneys.

A New York State Division of Criminal Justice Services (DCJS) 2011 report on the impact of the 2009 drug law changes suggests that following the passage of the reform there was a spike in the number of screenings and admissions to treatment court and judicial diversion in both New York City and in the rest of the state.[344] However, participation has gradually been declining. Advocates report that judicial diversion varies widely from jurisdiction to jurisdiction and even within jurisdiction from judge to judge. According to legal experts, insufficient training for judges is one problem

Marty Horn, Former Commissioner,
NYC Department of Correction

and a lack of funding for screenings (a required step for individuals to access judicial diversion) is another. Treatment providers report that they have not received the funding they need from OASAS to increase inpatient and outpatient capacity and case management services. Lack of coordination statewide has also presented difficulties, especially in jurisdictions where relationships between court professionals and treatment providers did not previously exist. Absent centralized oversight from state agencies, there is no means either for providers and advocates to influence the process or to share information between state agencies, providers, courts, advocates and communities.

Finding 5: Those Returning To Our Communities From Prison Or Jail Face Structural Barriers To Successful Reintegration.

Community members and providers alike were concerned with the current failure to support those returning to their communities from jail or prison. They felt that one key to ending the cycle of drug use and drug-related crime was to ensure that those leaving the correctional system were able to be successfully reintegrated into the life of the community. We heard from several formerly incarcerated individuals about the importance of having family and community

supports, and some people pointed to reentry services and other programs as playing a critical role in helping them or people they knew get reestablished post-release. However, we also heard about the need for additional services in some communities as well as the need to remove the structural barriers that prevent many formerly incarcerated individuals from staying healthy, finding housing, reuniting with their families, getting an education, and obtaining employment. In New York City as well as other urban areas across the state, certain communities face particularly high rates of incarceration and thus high numbers of people returning home from prison. See Figures 15-18.

Another significant barrier that makes it difficult for many leaving the correctional system to access health care and drug treatment is the current failure to enroll individuals leaving state facilities into Medicaid prior to release. Approximately 29,000 individuals are released from a New York State correctional facility each year to return to their homes and communities across the state. Although almost all are eligible for Medicaid, many leave with no health insurance coverage and face near-insurmountable barriers to navigating a complex and fragmented health care system. The failure to link people released from prison to health care is particularly

troubling because many enter prison with a drug use problem and many have mental or physical chronic health conditions like asthma, diabetes, and hepatitis.[345-347] Although providers and advocates have been working with agency officials in New York on efforts to enroll incarcerated individuals in Medicaid prior to release, to date these efforts have largely failed in the face of administrative and bureaucratic barriers. Medicaid redesign efforts currently underway involving state assumption of local Medicaid responsibilities provide an important opportunity to address these issues, an option for states to expand Medicaid eligibility with federal funds under the Affordable Care Act, and ensure Medicaid enrollment for incarcerated individuals prior to release. In addition to improving the public's health, Medicaid enrollment could save the state money.[vi]

We also heard frustration concerning public housing policies that prevent some formerly incarcerated people from accessing affordable housing and/or reuniting with their families. The New York City Housing Authority, for instance, has the right to deny someone with any criminal record residency in order to provide a safe environment for all residents. NYCHA has also implemented a "no trespass policy," which denies access to NYCHA property to anyone arrested for a felony drug offense on or adjacent to NYCHA buildings and grounds. Federal law permits, but does not require, this policy. While NYCHA residents in other forums have been mixed on this issue (some people do support the policy), it makes it difficult for families to reunite and puts individuals at risk for drug use and re-incarceration.

Similarly, several people described the lack of employment opportunities for formerly incarcerated individuals and the continued use of job applications that require the disclosure of a conviction. Before the recession, studies suggested that the unemployment rate for formerly incarcerated people one year post-release was as high as 60 percent.[348] Nationally, "the lost earnings associated with incarceration are equal to 6 percent of the total expected Hispanic male earnings and 9 percent of the total expected black male earnings."[349] Overall, increases in incarceration since 1980

have reduced the activity of young black men in the labor force by three to five percent according to one estimate.[350] In New York City, Mayor Bloomberg recently signed an executive order to "ban the box" (i.e., a field requiring the disclosure of criminal history) on city job applications, but the practice remains widespread elsewhere in the public and private sectors. In addition, students and those seeking postsecondary education who have any drug conviction are prohibited from receiving federal financial aid, including grants, loans, or work study. (The duration of the prohibition varies depending on the kind and number of offenses.) With limited access to health care, housing, employment, and education, the thousands of New Yorkers who return home each year not only face individual hardship, they can put a strain on families and communities that are already under-resourced.

Finding 6: Immigrants Are Particularly Vulnerable Under Current Drug Laws.

As the discussion above suggests, a criminal conviction for a drug offense can have profound collateral consequences for anyone. Noncitizens, however, are even more vulnerable since they can face deportation for even minor drug-related violations. Under current immigration law, conviction of any controlled substance offense (other than a single offense of simple possession of 30 grams or less of marijuana), whether felony or misdemeanor, is a deportable offense, even for green card holders. In addition to deportation, drug offenses can make a person permanently inadmissible in the U.S.[351]

While immigration laws are set at the federal level, New York prosecutors, defense attorneys, and judges play an important role in determining the original charge and disposition of the originating crime. The complex maze of immigration law, combined with the criminal code, can lead to inadvertent deportations. For example, a well-meaning defense attorney, unfamiliar with immigration law, might counsel a client to plead guilty to a misdemeanor drug offense and pay a small fine, not realizing that this could result in deportation. Similarly, if judges and prosecutors were aware of the additional penalties confronted by an immigrant facing a conviction, they might be more inclined to offer an alternative to incarceration. Unfortunately, according to participants in our community consultations, these laws have a chilling effect on immigrants seeking services even when they are not enforced or when someone has committed no crime.

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vi Medicaid could be used to cover the costs of people in prison who receive care in the community while incarcerated (i.e., hospital or specialty care not provided by DOCCS). In addition, many of those leaving prison fall into the "eligible but previously unenrolled category," which means, if enrolled, the state would qualify for a 90 percent federal match under the Affordable Care Act. Presumably, those with Medicaid coverage would also be more likely to get primary and preventative care, avoiding more costly emergency room usage and acute care crises.

The Way Forward:
Promising Practices In Public Safety

The momentum to change current law enforcement approaches is increasing, both in New York and nationally, with growing attention to the human and economic costs of mass incarceration and racial disparities in arrest and sentencing. Community members and policymakers alike are eager for new approaches to public safety that focus on community development and capacity building, innovative policing practices, and community engagement and collaboration. New models are starting to emerge. For example, in East Harlem, several stakeholders including community members and elected officials have implemented the Youth Violence Task Force, which works across sectors (informed by community residents and based on scientific literature) to identify, develop, and implement a comprehensive strategy to reduce violence.

Also in New York, there are several areas that show promise—particularly in arenas of policing, juvenile justice, reentry, and supervision. Recent efforts in New York City related to juvenile justice reform/realignment and probation reform, both of which are integrated with more comprehensive service strategies through New York City's Young Men's Initiative, also show promise. Juvenile justice reform, and specifically the Close to Home Initiative, is expected to improve family engagement and connectedness, educational resources and attainment, and recidivism outcomes by allowing juveniles who have been convicted to be supervised in local community-based programs rather than in an upstate facility.[352-353] New York also has a robust network of reentry service and ATI providers, in addition to prison reentry units and county reentry task forces supported by DOCCS and the New York State Division of Criminal Justice Services.

Another model is Operation Ceasefire, which is also one of the effective strategies the National Network for Safe Communities has been working with communities to develop.[354] Operation Ceasefire (also referred to as a gang violence reduction strategy), and the Drug Market Intervention strategy have both resulted in reductions in violence and drug-related crime in communities.[355-356] Important elements in their design include meaningful engagement between communities and police, collaboration, and targeted investment of social services and resources. In addition, these interventions have incorporated processes to discuss and address racial disparities and race relations between community members and police. These strategies
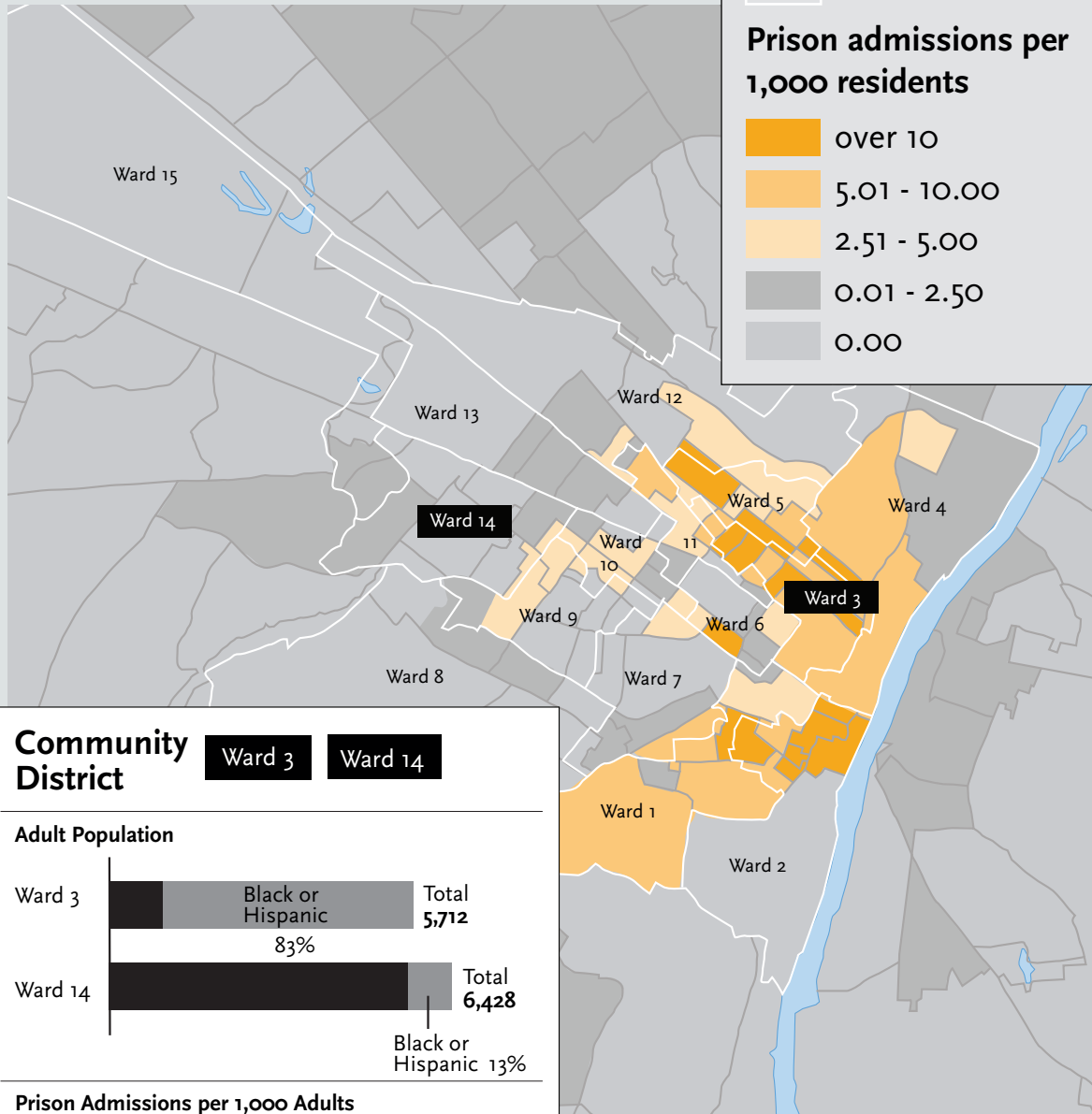
fall within the framework of problem-oriented policing and community policing—approaches that have gained wide support by experts and maintain a strong emphasis on community partnerships as well as sustained interagency collaboration.[357-360] The U.S. Department of Justice has been promoting the implementation of community oriented policing services, which also identify community partnerships and problem solving and organizational transformation as key strategies.[361]

On the frontier of new policing models into reducing low-level drug arrests is Seattle's LEAD (Law Enforcement Assisted Diversion) pilot program, which allows law enforcement officers to redirect individuals engaged in low-level drug or prostitution offenses to community-based services, rather than jail, and prior to arrest.[362] Evaluation is underway for both short-term and long-term outcomes including health, cost, crime, and socioeconomic outcomes.

Emerging models to research and reduce disparities in policing also include the Consortium for Police Leadership in Equity (CPLE), which "promotes police transparency and accountability by facilitating innovative research collaborations between law enforcement agencies and empirical social scientists"[363] in order to improve racial and gender equity both within police departments and between the departments and the communities they serve. With regard to data collection and identifying and addressing racial disparities within the broader criminal justice system, some states are beginning to use racial impact statements on criminal justice-related legislation or are creating formal mechanisms to identify and address racial disparities within their criminal justice systems.[364] Minnesota pioneered the use of racial impact statements, and other states, like Illinois and Connecticut, have begun to use the statements. Racial and ethnic impact statements present objective facts about how a proposed bill or policy may affect some racial groups more than others. Conducting such an analysis in advance can inform the consideration of alternative approaches that can address public safety concerns without exacerbating racial disparity in the criminal justice system.[365] In Wisconsin in 2007, then-Governor Jim Doyle issued an executive order creating a 24-member commission on reducing racial disparities in the Wisconsin justice system that examined that state's criminal justice system, assessing the degree to which disparity was evident at every stage (from arrest to parole), and issued its final report a year later, with 50 specific recommendations.[366]
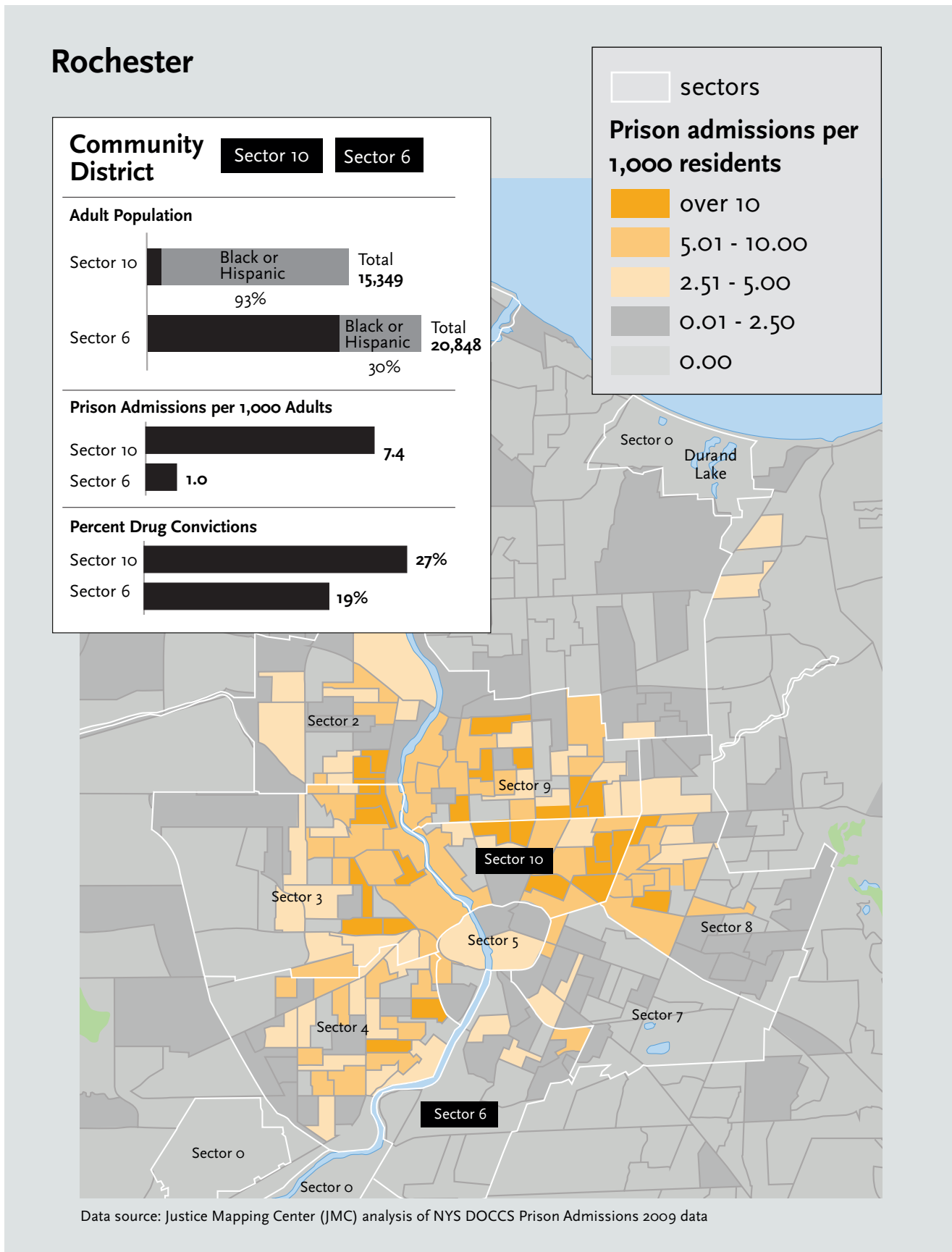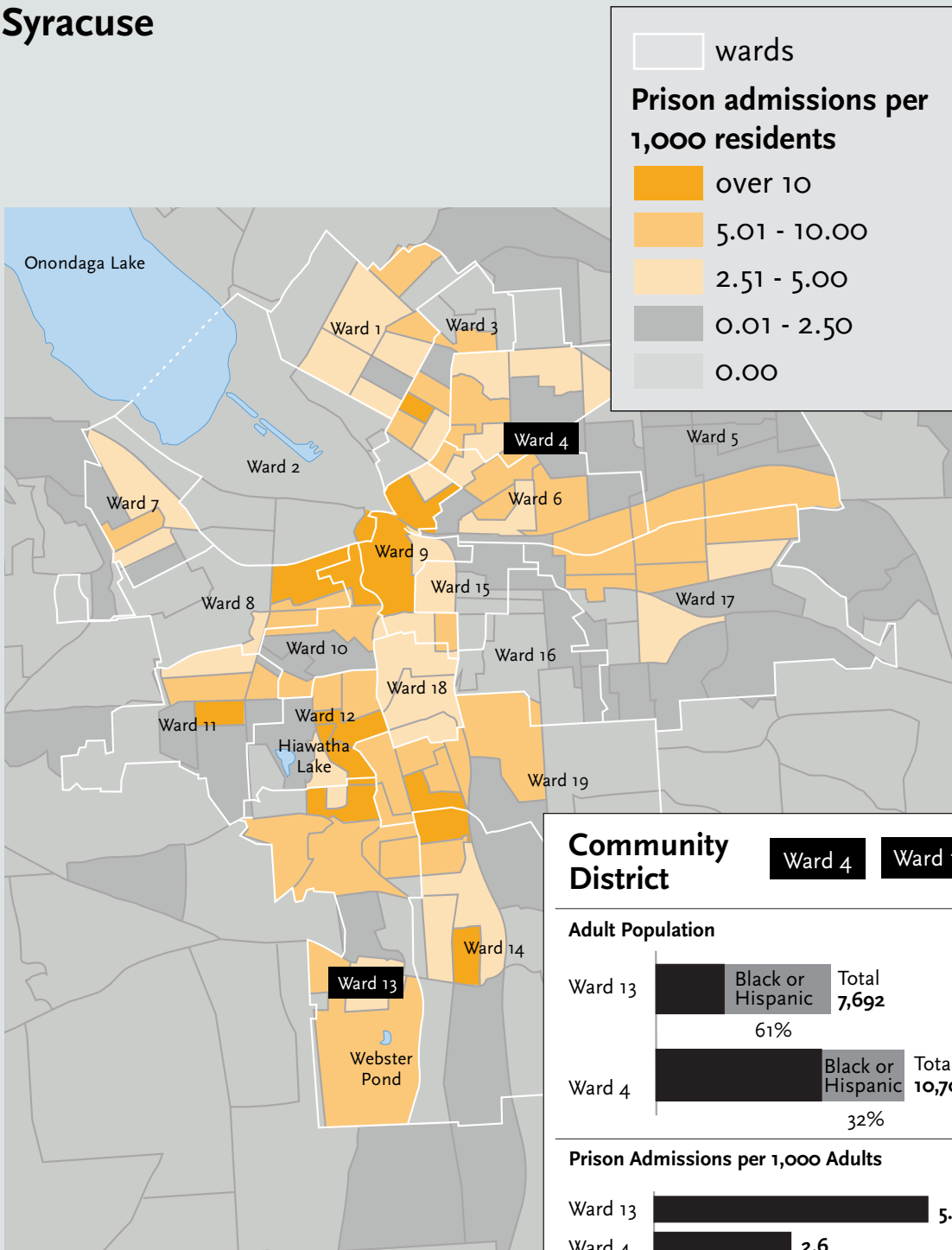
Figure 15

Albany

Prison admissions per 1,000 residents

- over 10
- 5.01 - 10.00
- 2.51 - 5.00
- 0.01 - 2.50
- 0.00

wards

Ward 15
Ward 13
Ward 12
Ward 14
Ward 5
Ward 4
Ward 10
Ward 11
Ward 9
Ward 3
Ward 6
Ward 8
Ward 7
Ward 1
Ward 2

Community District   Ward 3   Ward 14

Adult Population

Ward 3 — Black or Hispanic 83% — Total **5,712**

Ward 14 — Black or Hispanic 13% — Total **6,428**

Prison Admissions per 1,000 Adults
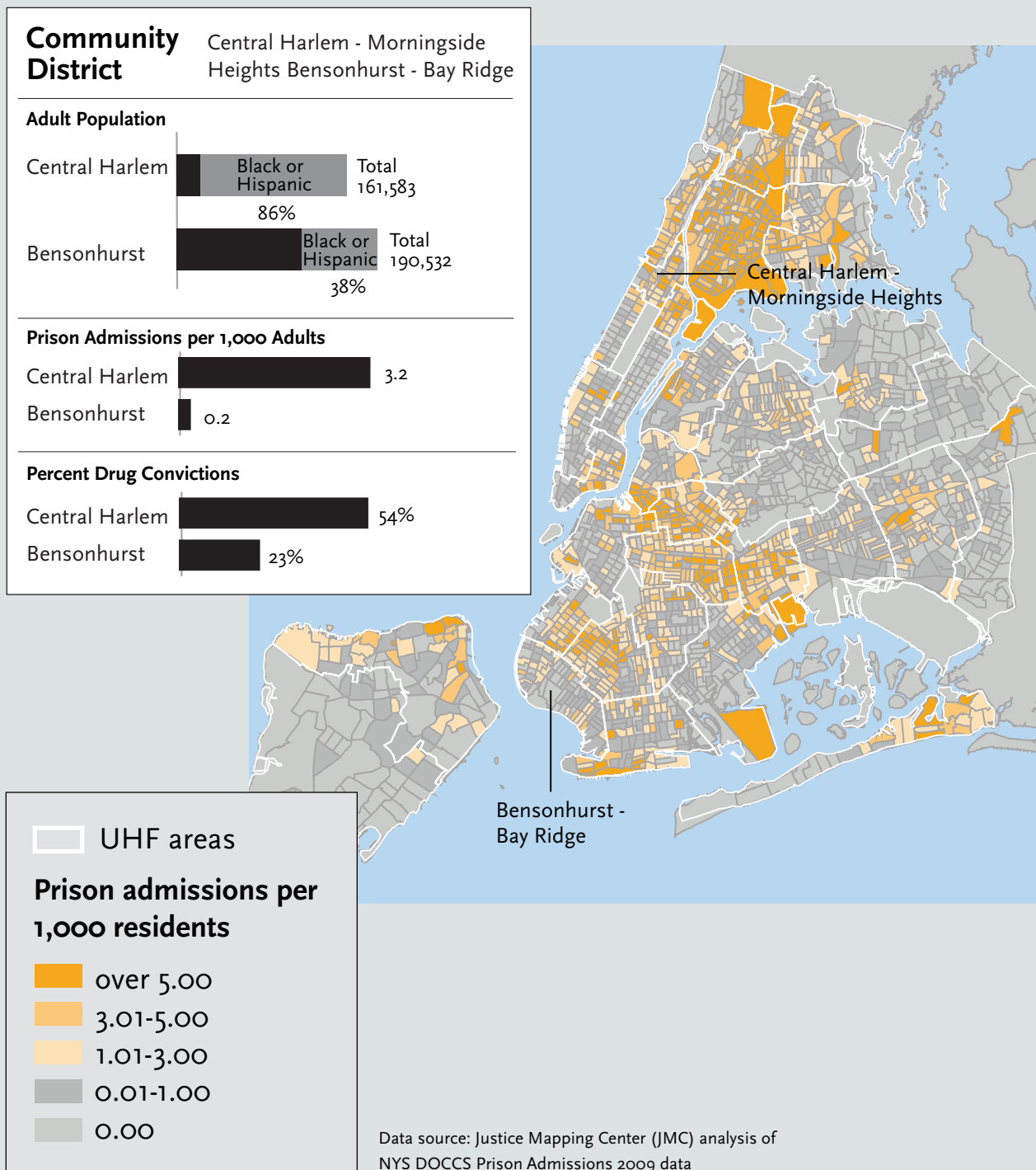
Ward 3 — **14**

Ward 14 — **0.6**

Percent Drug Convictions

Ward 3 — **41%**

Ward 14 — **25%**

Data source: Justice Mapping Center (JMC) analysis of NYS DOCCS Prison Admissions 2009 data

Figure 16

Rochester

Community District

| Sector 10 | Sector 6 |

Adult Population

Sector 10 — Black or Hispanic — Total **15,349** — 93%

Sector 6 — Black or Hispanic — Total **20,848** — 30%

Prison Admissions per 1,000 Adults

Sector 10 — **7.4**

Sector 6 — **1.0**

Percent Drug Convictions

Sector 10 — **27%**

Sector 6 — **19%**

sectors

Prison admissions per 1,000 residents

- over 10
- 5.01 - 10.00
- 2.51 - 5.00
- 0.01 - 2.50
- 0.00

Sector 0

Durand Lake

Sector 2

Sector 9

Sector 10

Sector 3

Sector 5

Sector 8

Sector 4

Sector 7

Sector 6

Sector 0

Sector 0

Data source: Justice Mapping Center (JMC) analysis of NYS DOCCS Prison Admissions 2009 data

Figure 17

Syracuse

Data source: Justice Mapping Center (JMC) analysis of
NYS DOCCS Prison Admissions 2009 data

Figure 18

New York City

Community District

Central Harlem - Morningside Heights Bensonhurst - Bay Ridge

Adult Population

Central Harlem — Black or Hispanic 86% — Total 161,583

Bensonhurst — Black or Hispanic 38% — Total 190,532

Prison Admissions per 1,000 Adults

Central Harlem — 3.2

Bensonhurst — 0.2

Percent Drug Convictions

Central Harlem — 54%

Bensonhurst — 23%

Central Harlem - Morningside Heights

Bensonhurst - Bay Ridge

☐ **UHF areas**

Prison admissions per 1,000 residents

■ over 5.00
■ 3.01-5.00
■ 1.01-3.00
■ 0.01-1.00
■ 0.00

Data source: Justice Mapping Center (JMC) analysis of NYS DOCCS Prison Admissions 2009 data

Recommendations

Recommendations

The findings presented in the preceding sections show that existing drug policies in New York State are not working well for individuals, families, or communities. Our current approach to illicit drugs reflects a deep ambivalence about whether to treat illicit drug use as a crime or a public health problem. This ideological divide has resulted in policies that are misaligned and often work at cross-purposes. As a consequence, New York State overall and many local communities have a patchwork of programs and policies to address drug use that are neither coordinated nor effective.

Fortunately, the people of New York—the hundreds of community members, providers, and experts with whom we spoke—have suggested a way forward. They didn't agree on everything, but they did agree that our drug policies can and should be realigned with the aim of improving the health and safety of our communities. To succeed, however, we must work across sectors and learn to overcome assumptions and biases that create division; to find common ground. Treatment providers must learn to talk to harm reduction providers; harm reduction providers must learn to talk to law enforcement; drug policy reformers must learn to talk to prosecutors, and so forth. Effective drug policies must be grounded in the needs and concerns of those communities and people most directly affected by drug use and by our current policy responses to it. This means developing strategies for planning that can help overcome stigma, fear, and stereotypes to include those

who use drugs, those who have been incarcerated, and those living in communities hardest hit by our current law enforcement strategies as valued individuals, community members, and human beings. For these necessary and important conversations to happen, we will have to set aside our personal prejudices and stereotypes; evaluate how our policy choices contribute to or ameliorate racial disparities; and we will also need to tackle institutional racism directly when it is identified. The recommendations below suggest the first steps toward making this vision a reality. New York State is poised to lead the nation in developing the country's first statewide public health and safety approach to drug policy.

The proposed recommendations include a set of actions to be led by New York State and a second set of actions to be led by New York City. It is critical that the New York State and New York City policies be aligned with one another, so top level representation will be required in the reciprocal processes. For both the state and the city, the recommendations are further separated into two strategies: 1) formation of a task force convened by a top executive that addresses top line policy issues and interagency coordination; and 2) recommendations for actions to be completed by a specific agency or agencies. These strategies encourage collaboration with community partners and the development of an integrated approach to drug policy based on the four pillars of prevention, treatment, harm reduction, and public safety to create communities that are safe and healthy for all.

Governance & Leadership

Goal: *Align and integrate policies and programs in New York State in order to reduce the morbidity, mortality, crime, cost, and inequities associated with illicit drugs and illicit drug use and our current response to it.*

Recommendations:

1. **The Governor should convene a multiagency task force modeled on the four pillars approach, chaired by a senior member of the Governor's staff, to conduct a review and evaluation of existing drug policies and programs and work toward their alignment toward a public health and safety approach.**

The group should be convened and charged by the Governor's office and be given authority to make recommendations across agencies. It should include all state agencies that serve people who use drugs and communities most affected by drug use, a variety of providers, those directly affected by drug use, and experts in the issue areas encompassed in the four pillars. The task force should have sufficient public and/or private funds to carry out its charge.

Specific tasks and issues for the task force to address include:

- Create uniform definitions of drug-related concepts and metrics of progress, success, and failure across state agencies to facilitate consistent policies; improve tracking clients across service systems; and establish a framework of indicators needed to measure performance, effectiveness of service systems, and unmet population needs.
- Develop information and data sharing agreements to facilitate exchanging or integrating client-level data in ways that protect privacy but improve coordination, the integration of services, and needs assessment.
- Establish an entity or process to monitor, investigate, and address racial, gender, age and geographic disparities in health and socioeconomic outcomes related to drug policy, across administrative systems. These efforts should include surveillance, research, and analysis of the different data systems (including summons, criminal procedure law violation data). Issue findings report and make recommendations to reduce unwarranted disparities.

(Continues next page)

Governance & Leadership
Recommendations (cont.):

- Identify, analyze, and assess evidence about effectiveness and cost of changes in administrative practices, rules, and regulations; contracting and financing procedures; reporting and monitoring; and legislation that will align the state's policies with a public health and safety approach to drug policy, including but not limited to:
  - Rules, regulations, and practices that result in decreased or restricted access for active or former drug users to medical, social, and housing services; employment opportunities; and educational financing and programs.
  - Criminal penalties for drug use that could be reduced or removed while bolstering public health systems, to more effectively and cost-efficiently address drug misuse, including harm reduction and treatment and recovery programs.
  - Requirements and mandates that separate agencies impose on clients that conflict with each other (e.g., parole-mandated treatment and Office of Temporary and Disability Assistance-mandated training programs).
  - Incongruities between local and state regulations or practices, including those governing parole (e.g., technical violations), drug courts, and/or alternative-to-incarceration programs.
- Identify and make recommendations to address public safety policies and practices that harm the public's health, foster distrust of law enforcement, and create or exacerbate racial disparities, including:
  - Reassess the public safety value of focusing on low-level drug possession and use over other crimes.
  - Revise use of stop, question, and frisk practices to reduce unnecessary stops and unlawful frisks and searches and expand training programs to ensure that police officers understand the different legal standards for stops, frisks, and searches.
  - Reduce unlawful marijuana possession arrests by amending the 1977 law regarding possession of small amounts of marijuana in New York so that marijuana in public view is a violation, not a criminal offense.
- Develop an integrated governmental process to evaluate the evidence base, value, and effectiveness of drug and criminal justice policies; increase data collection, including for violations (summonses); and coordinate and monitor the implementation of recent and future reforms to promote the health and safety of the public (e.g., Rockefeller Drug Law reforms, Good Samaritan law, syringe exchange programs).
- Issue a findings and recommendations report that details: 1) additional changes that can be enacted by the individual agencies; 2) executive action needed across or between agencies; 3) changes that require state legislation; and 4) changes requiring federal waivers. The report should include a timeline for enacting the recommendations, set priorities for the state, and be reviewed and reissued every two years.

2. **Involve meaningful participation of New York City representatives in the recommended statewide activities to ensure alignment of state and city policy development and planning as well as appropriate integration and coordination of parallel efforts and activities.**

3. **Require racial and ethnic impact statements on current and proposed legislation and regulations directly affecting drug policy.**

Rationale:

Prevention, treatment, harm reduction, and public safety policies and responses are all interconnected and contribute to common goals and outcomes. However, New York's policies regarding drugs remain compartmentalized and disconnected; ineffectiveness of current data systems prevents an accurate assessment of population health needs and system capacity; and there are few structural mechanisms in place to identify and reform harmful and racially disproportionate criminal justice policies and practices.

The most recent effort to coordinate drug policies, the Addictions Collaborative to Improve Outcomes for New Yorkers (ACTION) Council, was short lived and did little to involve the community and key stakeholders.[367] Other efforts have been similarly limited. But this Governor has led other successful models of working across agencies to reduce costs and improve outcomes. For example, New York State recently implemented a successful model to reform its Medicaid system—a system as entrenched and complex as our current approach to drug policy. By setting a common purpose, providing strong leadership, a clear timetable, and engaging the relevant experts and stakeholders in an efficient and transparent process, the Medicaid Redesign Team (MRT) and its work groups identified dozens of proposals to improve Medicaid and reduce costs, set priorities and moved them into action. They were able to look across agencies and policy strategies to make a series of recommendations to the Governor's office that involved changes to administrative policies, regulations, legislation, and federal waivers and to set clear priorities and timelines for implementing comprehensive reform to the state Medicaid and health care system.

The MRT, with leadership by the Disparities Workgroup and their members, has also been pursuing strategies and solutions to reduce disparities in health. These activities have included the integration of disparities impact assessments in the planning and development of the MRT action plan, which were required as part of the evaluation for each MRT proposal put forth. The disparities impact assessment consisted of a set of questions developed by the disparities workgroup to serve as a disparities impact statement. The statement is intended to facilitate consideration of current health disparities and promote a prospective assessment of the differential effects the proposals may have on health disparities going forward.

In addition to assisting in the reduction and elimination of current disparities, such efforts also help to avoid the exacerbation of disparities.[368] Considering the complexities and multiple factors affecting disparities, New York should consider expanding the MRT model and implementing assessments for relevant policies at the legislative and regulatory level. As such, we recommend the inclusion of similar evaluation mechanisms on any legislation affecting drug policy. Racial and ethnic impact statements are examples of other, relatively new and effective tools for policy development being utilized in different states as a mechanism for reducing racial disparities in other sectors.[369]

The MRT has also made the improvement of data collection and analysis for identifying and measuring disparities a priority recommendation. Similar to the recommendations we propose above, this will entail an assessment of the current data systems, expanded reporting protocol, and additional funding to support data analyses and research.[370] This is also in line with the implementation requirements of the Affordable Care Act to improve data quality and raise data collection standards across major population surveys. The MRT, Disparities Workgroup, and other stakeholders, however, are working to expand these initiatives even further to include improved standardization of data systems across different health settings and human service sectors.

Given the importance of disparities and structural racism in our findings, the drug policy task force may be able to learn and build from these current efforts in the state to assess the degree to which racial disparities are present in other distinct drug policy related systems in New York (criminal justice, child welfare, housing, economic development, etc.), assess the potential impact policy and systemic changes may have on disparities in these systems, and develop strategies to reduce them. The task force proposed here can lead efforts similar to the MRT to modernize New York's drug policies and create a venue for the agencies to thoroughly review their current policies and operations as well as to collaborate with other agencies, synergistically, toward ameliorating current barriers and implementing new strategies and efforts. It will also allow meaningful input from community stakeholders, including individuals who are actively using drugs and individuals in recovery.

Meaningful participation of New York City representatives in the statewide taskforce and recommended activities is also critical. In addition to ensuring alignment of policies and planning, collaboration will also facilitate knowledge sharing of best practices and lessons learned between New York City agencies and state agencies. For example, the New York City Department of Health and Mental Hygiene's demographic and health data system may be a guide in the task force's potential efforts for standardizing metrics across agencies and improving data systems. The data collected by NYC DOHMH are more comprehensive, refined in geographical comparisons, and easily accessible than those collected by the state and other local counties. Efforts by the task force to improve systems and policies at the state and local level can be modeled on these kinds of effective systems already available in New York.

Education

Goal: *Ensure that key professionals and New Yorkers of all ages and backgrounds have access to evidence based and effective education about drugs, preventing problematic drug use, reducing the harms associated with drug use, and helping oneself or others who have a drug use problem.*

Recommendations:

4. OASAS, DOH, and the New York State Education Department (NYSED) should co-chair an advisory group of experts to assess the current state of drug education in New York and make recommendations for improving the accessibility, quality, and effectiveness of that education in school, workplace and community-based settings. This includes education for professionals in social services, criminal justice, education, health care, and substance abuse and mental health treatment settings.

Specific tasks and issues to address include:
- Develop a set of principles and/or standards for effective addiction and drug education based on a review of the literature and/or consultations with experts in the field.
- Conduct an assessment of the effectiveness of existing addiction and drug education programs as they relate to these principles for the following groups: 1) young people; 2) family members and residents of communities most affected by drug use; 3) health care and social services professionals; and 4) criminal justice personnel.

- Publish a report that identifies gaps in our current ed ucation activities, sets benchmarks for improvement, and includes recommendations for each group identified above.
- Develop a plan and timetable and identify resource needs to implement the recommendations.
- Develop a mechanism to permit ongoing public access to the information and educational models.

5. DOH, OASAS, and NYSED should work together and with private sectors, especially professional associations involved with prevention, to improve provider and patient education to address prescription drug misuse and reduce accidental overdose through improved care coordination and interoperability of electronic medical records, and increasing access to naloxone.

Rationale:

Reviews of the literature support what we heard from stakeholders: a need for more education and training across sectors and audiences. Young people, parents, and other adults are eager for accurate information about drug use, prevention, treatment, and harm reduction. People were especially eager for improved education directed toward young people, medical providers, and criminal justice personnel. Despite existing efforts by community-based organizations and government, communities lack a centralized source of trusted information where they can ask questions and receive accurate information about drugs, particularly new drugs, drug combinations, or contaminants as well as information about prevention and treatment.

Although many community members said they were interested in getting information and assistance about drug use from their medical providers, research has consistently shown that medical providers receive minimal education about addiction as part of their formal training and that they remain uncomfortable with people who use drugs and with discussing drug use.[371] There has also been increasing attention to the need for more education and awareness around prescription drugs for both providers and patients as prescribing, misuse, and adverse reactions to prescription drugs have been on the rise in communities. Initiatives to increase public awareness of prescription misuse and develop prescribing guidelines for providers have been seen at the city and state level through the formation of prescription drug working groups and task forces. These efforts provide opportunities to not only ensure that providers are adequately equipped to prevent and address harmful prescription drug use but harmful use of all drugs. Regarding the criminal justice sector, the implementation of addiction education resources and programs is a recent development and has not been standardized or made mandatory across all relevant professionals, including the offices of district attorneys, court personnel, and prosecutors who heavily influence and determine outcomes for drug related court cases. The newly established education efforts for judges by the Office of Court Administration are needed and encouraged, but we also encourage input from stakeholders as well as an evaluation component regarding the content, structure, level of participation, and impact.

Recovery-Oriented Treatment, Harm Reduction, and Other Services

Goal: *Develop a recovery-oriented continuum of treatment and recovery services that is client centered and ensures that individuals at all stages of use and recovery can access timely, appropriate, and effective care.*

Recommendations:

6. OASAS should convene and charge an advisory group of state agency representatives, academic experts and New York City government representatives to perform an analysis of how to convert the New York State drug treatment system into a comprehensive, integrated recovery-oriented, patient-centered and evidence-based system of care. This requires the integration of drug treatment, medical, harm reduction, and social services, across agencies for people at all stages of recovery from a chronic relapsing condition as well as clear agreement on what the goals of drug treatment ought to be.

7. OASAS, DOH, and OMH should work together to improve integration, linkages/referrals, and coordination of services, programs, and best practices relating to harm reduction, including efforts to reduce death and injury from overdose, such as expanding access to naloxone, publicizing the 911 Good Samaritan law, and improving patient education.

8. OASAS—working with DOCCS, DCJS, and the Office of Court Administration—should assess the prevalence and effectiveness of mandating treatment for people based only on drug related arrests rather than a thoroughly assessed need for treatment.

9. OASAS should improve the ability of people to access treatment services through voluntary self-referral and increase the availability and accessibility of treatment programs and others services for people who are unwilling or unable to completely abstain from drugs (i.e., harm reduction oriented services).

10. Office of Children and Family Services should change regulations and practices that make it difficult for parents to seek drug treatment services without jeopardizing custody of their children.

11. DOH, OTDA, and DOCCS should enroll all people leaving prison in Medicaid prior to their release so that they can more easily access drug treatment and medical care when they return to their communities.

12. DCJS, OASAS, DOH, and DOCCS should increase the availability of pharmaceutical treatments for addiction (i.e., methadone or buprenorphine) in prison, drug courts, and mandated treatment programs.

13. DOH and OASAS should study the efficacy and feasibility of heroin maintenance therapy for people who do not respond effectively to other forms of opioid replacement therapies. [372]

14. DOH and OASAS should study the feasibility of establishing supervised injection facilities in areas with high rates of injection drug use. [373-374]

Rationale:

We heard repeatedly that the treatment and service system has gaps and that care is fragmented and disjointed depending where people are on the continuum of drug use, treatment, recovery. Consumers and providers noted that there was often a poor match between individuals in need of services and the services they received. In addition, many treatment plans developed are not assessment based, but are assigned based on existing relationships with providers or availability.[375-376] Some people who use drugs may not need or benefit from treatment and instead would benefit from harm reduction services or other supportive services; these are often not available or accessible. Given the important role that social determinants play in drug use and its health consequences, treatment systems should also include ancillary services and interventions that help people who use drugs find housing and employment and reduce incarceration and recidivism. Needs also differ by populations (e.g., women, LGBTQ, homeless, parents, etc). One problem in linking people to appropriate services is that easy access to and availability of specific modalities and services are simply lacking in many regions. Individuals who have drug use problems need access to treatment and other services at different points in the health care, human services, and criminal justice systems; currently, however, services are inadequately linked, tracked, and coordinated through the system. People who use drugs may come in and out of care as well as experience discontinuities within and across their different needs, services, and agencies. Therefore, it is essential to identify points of access and develop effective interventions during windows of opportunity where they do access medical and other services. While it will require an upfront investment, this will ultimately save money through the elimination of duplication and inappropriate utilization of services as well as by preventing minor problems from escalating into more expensive acute care crises.

OASAS has several processes and instruments for data collection and monitoring as well as work groups for developing planning tools, including SAMHSA's National Outcome Measures, the biennial surveys of treatment programs through the County Planning System, the Conference of Local Mental Hygiene Directors, the Community of Practice for Local Planners, and various subcommittees, Prevention Activity and Results Information System (PARIS), the Inter-Office Coordinating Council, and the State Epidemiological Outcomes Workgroup. However, these efforts are heavily focused on the treatment and mental health services, particularly acute care, rather than a continuum of recovery services across agencies and providers. The recommended analysis can build on these mechanisms and be expanded to inform wide-scale systems change by broadening assessments of service needs and delivery as well as assessments of data systems, performance measures, and research needs through the lens of recovery oriented perspective.

Community and Economic Development

Goal: *Support and expand existing efforts to improve youth and family development, economic vitality, built environment, and public health of communities, targeting vulnerable communities as immediate beneficiaries and ensuring that all New York communities have the same access to resources and investments.*

Recommendations:

Drug policy reform activities efforts should be more closely linked to statewide and local efforts to improve the economic vitality and health of disadvantaged communities.

15. **Community groups and organizations addressing drug use should link their activities to youth employment, job training and employment, and afterschool programs as well as business development, Regional Economic Development Councils, local health departments, Community Health Assessments and Community Health Improvement Plans (CHA/CHIP), and other efforts to improve parks, open spaces, and community infrastructure.**

16. **The statewide task force described above should look at state-level activities promoting employment and economic development, land use, and joint use as well as other public health activities, such as the State Health Improvement Plan (SHIP) and the New York State Prevention Agenda, and link those to the development of drug related policies and programs.**

17. **NYSED should work with local school districts to promote constructive alternatives to the use of zero tolerance approaches— disciplinary policies that impose automatic and severe punishments on students for particular behavioral offenses and issues (especially drug use)—that are proven counterproductive to the students' growth and achievement, disrupt student learning, and result in increased suspensions, expulsions, and dropout rates.**

Rationale:

Economic and community development greatly impacts the social determinants of health and health disparities.[377] It is not coincidental that the communities with the highest rates of poverty in New York are also those with the highest rates of diabetes, HIV/AIDS, other chronic diseases, and harm from drug use.[378] The state is already investing considerable resources in local communities. We are suggesting that these investments be made and leveraged in ways that can help address drug use and the drug trade.

Revitalizing and investing in these communities can reduce drug use while addressing a host of other public health problems that are also related to poverty. Efforts like the Regional Economic Development Councils in New York are commendable and provide a model of investing in New York for communities to build on. More needs to be done to focus attention on and address underserved communities and to equalize access to resources. Current strategies do not sufficiently benefit or target low-income communities or disadvantaged workers including young people, veterans, individuals with disabilities,[379] and individuals with criminal records. Communities with a strong local economy fare better than those without, and evidence suggests that a strong local commerce and high employment rates can ameliorate some of the collateral consequences of incarceration, including child poverty.[380] Community development efforts can strengthen community supportive services and activities, improve educational opportunities, contribute to social order, and reduce community disorganization—all of which are protective factors in drug prevention, treatment, harm reduction, and public safety. Our economic development efforts can also be opportunities to address seemingly intractable public health problems, including drug use.

Public Safety

Goal: *Develop new models and alternatives to current policing practices that can help improve relationships between communities and law enforcement and improve the public's health and safety.*

Recommendations:

Mutual assistance between community members and police is necessary to create healthy and safe neighborhoods. Illicit drug enforcement strategies that have been used have eroded those relationships, particularly in communities of color. We recommend the development of resources, strategies, and support for local communities to improve the relationships between the public and police, especially in areas most heavily affected by New York State drug policy. Additionally, the persistence of racial disparities within the criminal justice system requires attention. (Local jurisdictions reviewing the *Blueprint* may wish to review the public safety recommendations for New York City for additional tasks and action steps which may be applicable in local jurisdictions around the state.)

Specific tasks and issues to address include:

18. **The New York State Division of Criminal Justice Services (DCJS), working with community partners and its Law Enforcement Accreditation Council, should convene a conference of experts in law enforcement, community relations, drug use, and evidence-based policing to identify key local issues and explore new models.**

19. **DCJS, working with community partners and its Law Enforcement Accreditation Council, should develop principles and/or guidelines to address racial bias (real and perceived) and collaborative policing in New York State; police chiefs should consider engaging with the Consortium on Police Leadership in Equity[381] and other research groups that provide resources and support to police departments around the country.**

20. **DCJS, working with community partners and its Law Enforcement Accreditation Council, should identify resources and tools that communities can use to improve relationships and build partnerships with police, such as:**
    - Building and strengthening relationships between police and syringe exchange programs
    - Developing programs in which police are trained about drug use and dependency by people who currently use and/or formerly used drugs
    - Developing models for community response teams that assist police in addressing mentally ill people and/or disruptive or dangerous activities by people using drugs
    - Creating linkage agreements that help police make appropriate treatment and services referrals
    - Holding forums for addressing issues of race and racism
    - Piloting programs for new policing strategies, such as Seattle's Law Enforcement Assisted Diversion, where law enforcement diverts people accused of low-level drug law violations to community-based treatment and support services prior to booking or arrest.

21. DCJS, working with community partners and its Law Enforcement Accreditation Council, should develop strategies for disseminating these resources (e.g., website, volunteer speaker's bureau, trainings, funded pilot programs, tool kits).

22. DOCCS and DCJS should change practices that automatically use positive drug test results to revoke parole and, instead, develop pathways to connect people who use drugs to treatment or other appropriate services.

Rationale:

Positive relationships and trust between law enforcement officials and communities are linked to increased cooperation between police and communities. Unfortunately, the divide between community members and police is deep in some neighborhoods and towns. Existing mechanisms to facilitate dialogue between community members and police may help but do not seem to be addressing the underlying tensions. At the same time, information about alternative approaches that might foster more collaborative approaches to policing is just beginning to emerge. For example, trainings and familiarity with community services will enable police to make referrals, and the use of community crisis intervention teams or community response teams made up of civilians and service providers have been shown to facilitate access to appropriate services, decrease arrests and recidivism, and improve community relationships.[382] Some promising new programs, like Seattle's Law Enforcement Assisted Diversion pilot program and the Consortium for Police Leadership in Equity, could be used to guide new innovations in policing across New York. More detail about these programs can be found in the Public Safety Findings section of this report.

New York City

New York City is its own drug policy environment. Not only is it the most populous city in the state and the country, but the city has its own public hospital system, five counties with associated court systems, the largest police force in the country, and a health department that leads the nation in many respects and has authority over the city's mental health and drug policy and programs. New York City has been home to some of the country's earliest and most innovative harm reduction, drug treatment, prison reentry, drug research, and alternative-to-incarceration programs.

In the same vein as the New York State recommendations, the following recommendations for New York City are informed by the community members, providers, and experts of New York City with whom we spoke and are based on the findings we discuss throughout the *Blueprint*. Community and expert consultations were conducted in all five New York City boroughs to identify community needs to address drug use, innovative ideas about strategies to prevent and reduce drug use and related harm, and prioritization of issues and strategies. There was much overlap between the city and the rest of the state regarding community concerns and issues regarding drugs and drug policies, such as the persistent stigma and disparities based on income, neighborhood and race. However, consultation findings in the city differed from those elsewhere in the state in several important

ways. For instance, while upstate we heard concerns about a lack of programs, in the city, the array and number of programs often created confusion and made coordination of care across service systems more challenging. While people from all communities spoke about antagonistic relationships with police, the level of alienation from and distrust of the New York City Police Department, in particular, was notable. We also heard about how the city has been a leader in innovation, best practices, and policy development and change at the local level. New York City has a robust network of reentry service providers as well as harm reduction providers; a large safety net of health care services through its public hospital system; and an extensive network of academic medical research institutions and experts relating to drug use. Because the administration of programs is relatively centralized, the city has the ability to review (more quickly than the state can) its existing policies and programs and to pilot new models that better coordinate and integrate services across the four pillars of prevention, treatment, harm reduction, and public safety. The city also has its own models of cross-sectoral collaboration to look to including the Age-Friendly NYC initiative and the Mayor's Task Force on Obesity.

Governance & Leadership

Goal: *Align and integrate policies and programs in New York City by shifting them to a public health approach in order to reduce the morbidity, mortality, crime, cost, and inequities associated with drug use and our current response to it.*

1. **The Mayor should create a multiagency, cross-sectoral structure, based on the four pillars model and tasked to assess existing New York City drug policies and programs with the specific charge of working toward their alignment with a public health and safety model.**

   This collaborative should involve New York City's deputy mayor for health and human services, deputy mayor for operations, all relevant city agencies, and representation from various stakeholders, including continuum-of-service providers; those directly affected by drug use, those actively using, and those in recovery; formerly incarcerated people; and experts in issue areas related to drug use, abuse, and policies (academics, policy institutes, advocates, lawyers, etc.).

   We encourage the city to look at other successful municipal efforts for guidance in coordinating a comprehensive, public health drug strategy—such as Toronto and Vancouver (Canada), Frankfurt (Germany), and Victoria (Australia).[383-385]

   Specific tasks for this multiagency body include:
   - Developing mechanisms that facilitate ongoing cooperation and coordination among relevant member agencies and stakeholders to identify priorities for action in aligning policies toward a public health model based on evidence and strengthen trust and collaborative relationships between New York City agencies and the communities they serve.
   - Create an interagency team to respond to localized, drug related problems (e.g., opioid overdoses on Staten Island, high rates of drug related street arrests in Bedford-Stuyvesant), coordinate the implementation of laws passed to deal with drug related problems (e.g., Rockefeller Drug Law Reforms, Good Samaritan 911), and pilot intensive place-based initiatives.

   Specific data analysis and research activities for this multiagency body to commission should include:
   - Implement a longitudinal study of barriers and outcomes for individuals affected by drug use (people who use drugs and/or their families) that utilize or come in contact with any one or multiple New York City departments and/or their contractors. Conduct a comprehensive assessment and analysis of the causes and factors contributing to the rise in prescription drug overdose, related injury and dependency in the city.
   - Conduct cost analyses of existing drug related policies and programs as well as proposed recommendations, including implementation costs, ongoing costs, and potential costs savings across sectors and levels of government (e.g., Rikers, Medicaid, HHC, health care savings, and especially use of emergency departments).
   - Establish an entity or process to monitor, investigate and address racial, gender, age and geographic disparities in health and socioeconomic outcomes, across administrative systems. These efforts should include surveillance, research, and analysis of the different data systems (including summons, CPL violation, and data). Issue findings report and make recommendations to reduce unwarranted disparities.

2. **Involve meaningful participation of New York State representatives in the recommended citywide activities to ensure alignment of state and city policy development and planning as well as appropriate integration and coordination of parallel efforts and activities.**

Agency-Level Strategies

3. The Department of Education should convene the necessary experts to improve drug education, develop policies for appropriate referrals of students with drug use problems, and revise disciplinary policies to limit the number of expulsions and suspensions related to drug use.

4. The New York City Housing Authority should change policies that prevent families from reuniting and make it difficult for those who use drugs and/or have a drug related conviction or arrest to secure public housing.

5. The Administration of Children's Services should change policies that may impede the ability of families with drug involvement to access services and should better support young people aging out of foster care who are involved with drugs, including raising the age limit and expanding housing, other services and funding available to support young people.

6. The New York City Department of Correction (DOC) and New York City Department of Health and Mental Hygiene (NYC DOHMH) should strengthen programs for those incarcerated at DOC facilities who have drug use problems and the ability of those leaving DOC facilities to reenter the community through the expansion of Transitional Health Care Coordination services.

7. DOHMH, DOC, and the Health and Hospitals Corporation (HHC), as the major city-operated providers of substance abuse and medical services, should work together to expand implementation of recovery-oriented services that integrate harm reduction, treatment, and other services. HHC, DOC, and NYC DOHMH can build on their previous work in developing a recovery oriented model, furthering integration of services, fostering collaboration with different hospital systems, and providing provider education. Their efforts have included early adoption and expansion of electronic medical records; implementation of quality improvement initiatives (Quality IMPACT) for drug dependency programs; creation of local government plans for alcohol and drug use services; and the development of educational and guidance materials for providers as seen in their City Health Information (CHI) bulletin. Some examples of areas in need of further action include:

- Integrating drug treatment and harm reduction services and linking/co-locating them where possible, with mental health and physical health services (e.g., linkage and referral agreements, co-location of services)
- Educating medical providers about pain management, opioid and other prescribing practices, and addiction, including peer education and mentoring initiatives for primary care providers that facilitates confidence and competency in treating patients who use drugs
- Using electronic health records to identify individuals who need care coordination, drug treatment services and/or pain management and to monitor and address the racial disparities in access to pain medication and pain management—while preserving and protecting the privacy of patients

- Expanding access to naloxone, by requiring patient education and a naloxone prescription in conjunction with opioid prescription; increasing the availability of naloxone through community-based organizations; and providing overdose training and naloxone to people leaving the Department of Correction
- Expanding access to buprenorphine through a DOHMH-sponsored program[386] and/or increasing the number of physician buprenorphine prescribers in HHC facilities.

8. The New York City Police Department (NYPD) should prioritize strengthening collaborative relationships with the communities they serve:
- Reassess the public safety value of focusing on low-level drug possession and use over other crime
- Revise use of stop, question, and frisk practices to reduce unnecessary stops and unlawful frisks and searches; expand training programs to ensure that police officers understand the different legal standards for stops, frisks, and searches

- Reduce marijuana possession by bringing police practice into accordance with the 1977 law regarding possession of small amounts of marijuana in New York—such possession is a violation, not a criminal offense.
- Create opportunities for NYPD local precincts (especially in highly impacted communities) to learn as well as develop, pilot, and evaluate new and innovative policing practices and models, such as:
  - Educating police about the value and safety of syringe exchange
  - Training for police about addiction by active and/or former users
  - Community response teams that assist police in addressing mentally ill people and/or disruptive or dangerous people who use drugs
  - Linkage agreements that help police make appropriate treatment and services referrals
  - Police/community forums for addressing real and perceived issues of race and structural racism in law enforcement practices[387]
  - Law enforcement assisted division programs, where police bring people accused of low-level drug law violations to treatment instead of booking[388]
  - Instituting new metrics for evaluating police performance that promote public health and safety oriented outcomes (e.g., referrals)
  - Meetings between local police and key leaders in heavily drug affected communities aimed at curtailing violence and helping those who want an alternative to drug-selling to access employment and training services, such as the High Point model (already in use in some New York State jurisdictions)[389-390]

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The Drug Policy Alliance (DPA) is the nation's leading organization promoting drug policies that are grounded in science, compassion, health and human rights.

Our supporters are individuals who believe the war on drugs is doing more harm than good. Together we advance policies that reduce the harms of both drug use and drug prohibition, and seek solutions that promote safety while upholding the sovereignty of individuals over their own minds and bodies. We work to ensure that our nation's drug policies no longer arrest, incarcerate, disenfranchise and otherwise harm millions – particularly young people and people of color who are disproportionately affected by the war on drugs.

At both the federal and state levels, DPA is actively involved in the legislative process. We seek to roll back the excesses of the drug war, block new, harmful initiatives, and promote sensible drug policy reforms. And as part of our commitment to building a movement, DPA operates and administers an innovative advocacy grants program that seeks to promote policy change and advance drug policy reform at the local, state and national levels.