March 31, 2023

The Honorable Rahul Gupta, MD, MPH, MBA
Director
Office of National Drug Control Policy
Executive Office of the President
1800 G Street, NW
Washington, DC 20503

Delivered via email

Dear Director Gupta,

The Drug Policy Reform Working Group of the Justice Roundtable is pleased to offer input for the Office of National Drug Control Policy's 2024 National Drug Control Strategy.

The Drug Policy Reform Working Group of the Justice Roundtable is an active collaboration of organizations and advocates working at the federal level to eliminate drug criminalization and promote public health approaches to drug use, including policies that are grounded in racial equity, advance drug user health, and protect the humanity and dignity of people impacted by the war on drugs.

This letter offers three sets of uniquely focused policy recommendations developed from convenings held among active participants of the Drug Policy Reform Working Group. Members directly impacted by the overdose crisis and punitive drug policies provide recommendations that apply both to the 2024 Strategy and the implementation of drug policy across the federal government. The Drug Policy Reform Working Group's two standing subgroups — *Harm Reduction* and *Decriminalization* – each provide their own set of policy recommendations for the 2024 Strategy. Both of these subgroups actively collaborate in monthly meetings to advance federal policy reforms consistent with the Drug Policy Reform Working Group's vision statement.

Organizations that participate in meetings of the Drug Policy Reform Working Group, and its Harm Reduction and Decriminalization Subgroups, were invited to endorse each set of recommendations provided in this letter. Endorsements from organizations are listed above each set of recommendations. Many organizations endorsed all three sets of recommendations while others signed on to fewer than three. Our working group appreciates the opportunity to provide input to ONDCP for its 2024 Drug Strategy.

Directly Impacted Member Recommendations

Endorsing Organizations: The Action Lab at the Center for Health Policy and Law; AIDS Alabama (AL); AIDS Foundation Chicago (IL); Center for Disability Rights; Center for Housing & Health; Center for Popular Democracy; Community Catalyst; Drug Policy Alliance; Elephant Circle (CO); Faces & Voices of Recovery; Faith in Harm Reduction; Legal Action Center; Lighthouse Learning Collective; Live4Lali (IL); NASTAD; National Council on Alcoholism and Drug Dependence- Maryland Chapter; National Harm Reduction Coalition; National Health Care for the Homeless Council; National Pain Advocacy Center; National Survivors Union; National Viral Hepatitis Roundtable (NVHR); New York Recovery Alliance (NY); NEXT Distro; PAIN; The Porchlight Collective SAP (IL); StoptheDrugWar.org; Treatment Action Group

The needs of individuals and families directly impacted by the overdose crisis may be best addressed by a public health population-based interventions approach. This approach is designed to improve the health of specific populations that are at high risk for a health condition or disability, such as substance use disorders or chronic pain. Using surveillance data, population-based interventions focus on the prevalence of substance use in entire communities. By also assessing social determinants of health to identify service and policy priorities, public health officials can target resources to high-risk populations. Invariably, socioeconomic, racial/ethnic and geographic disparities and a lack of access to prevention or treatment services are among social determinants that exacerbate substance use disorder and impede recovery. Because the focus of population-based interventions is on the entire community, it is important to reach out to communities that have been greatly impacted by opioid and other substance use and work to include directly impacted individuals as partners in responding to national public health crises such as substance use and related harms. Along those lines, facilitators of the Drug Policy Reform Working Group of the Justice Roundtable convened a meeting to hear from directly impacted members from diverse racial, geographic and gender backgrounds for their input. The recommendations from this convening are:

- Create an ONDCP Advisory Committee Comprised of People Who Use Drugs (PWUD). For too long, people who use drugs and have endured the brunt of punitive drug policies have not been invited to participate in policy making decisions. This results in government "solutions" that are too little, too late, and uncoordinated with what people on the ground need now to save lives. For example, methadone reform is critically necessary at this moment, but the government must include policy advisors who are people with lived experiences versus only listening only to stakeholders in the clinical community. Creating an advisory committee composed of PWUD and their allies supports effective policymaking in the drug policy space and reduces barriers to ONDCP's policymaking process for underserved communities and individuals from those communities, the subject of a RFI from ONDCP in 2021. Using population-based public health principles, the proposed advisory committee will be an autonomous group that will advise the government and hold it accountable while making ONDCP's policymaking decisions more equitable. It is important that individuals who participate on such an advisory committee be granted total and complete immunity from criminal or civil penalties that may follow as result of their self-identification and/or participation in the advisory committee.

- ONDCP should support and work with the National Institute on Drug Abuse (NIDA) to solicit and fund research that examines the implementation of interventions designed to reduce public health harms from drugs and drug criminalization, including deaths and infections associated with drug use. NIDA funded research should examine interventions to create a safer supply of drugs and recommendations for ways the government should invest in safer supply interventions to save lives and reduce infectious diseases associated with injection drug use, such as providing pharmaceutical alternatives to illicit opioids and other drugs to people at high risk of co-morbidities or mortality from illicit drug use, and the impact of drug criminalization on public health and the human and fiscal cost of drug criminalization.

- Make racial justice and People-First language a priority in federal drug policy. The government must recognize that this nation's drug policy has historically been rooted in racism. Since its inception, the war on drugs has been a war on people and communities of color, primarily Black people. This legacy carries on today as evidenced by who gets access to health services and who gets jail time. The government must acknowledge past

and current harms as well as the racism embedded in our policy-making structures in order to truly reverse the drug war and reach people most impacted by criminalization and stigma. Alongside incorporating racial justice throughout its policies, the government must also use people-first language, which centers the humanity of individuals, when describing PWUD and people with lived experiences. After all, people feel the impacts of policy-making decisions.

Harm Reduction Subgroup Recommendations

Endorsing Organizations: The Action Lab at the Center for Health Policy and Law; AIDS Alabama (AL); AIDS Foundation Chicago (IL); The AIDS Institute; AIDS United; Center for Disability Rights; Center for Housing & Health; Center for Popular Democracy; Community Catalyst Drug Policy Alliance; Elephant Circle (CO); Faces & Voices of Recovery; Faith in Harm Reduction; Legal Action Center; Lighthouse Learning Collective; Live4Lali (IL); NASTAD; National Council on Alcoholism and Drug Dependence- Maryland Chapter; National Harm Reduction Coalition; National Health Care for the Homeless Council; National Pain Advocacy Center; National Viral Hepatitis Roundtable (NVHR); New York Recovery Alliance (NY); NEXT Distro; OpioidSettlementTracker.com; Overdose Crisis Response Fund; PAIN; The Porchlight Collective SAP (IL); StoptheDrugWar.org; Treatment Action Group; Vital Strategies

Harm Reduction is an effective public health approach that emerged in the 1980s as a means to prevent HIV, viral hepatitis and other blood borne disease for the millions of people who found it difficult to maintain abstinence but were at risk for such disease. Although harm reduction is inclusive of abstinence it does not require abstinence-only interventions for people with substance use disorders. Harm reduction has gained currency with drug policy reform, public health and medical advocates and organizations (including many government agencies) as a critical public health approach to mitigating physical and emotional harms caused by addiction. The importance of harm reduction interventions and service provision to reducing morbidity and mortality from infectious diseases is evidenced by research that show that syringe services programs can significantly decrease HIV and viral hepatitis prevalence.

The Harm Reduction Subgroup of the Drug Policy Reform Working Group is comprised of a broad cross-section of drug policy experts, public health advocates, impacted individuals and other stakeholders. The Subgroup's recommendations are as follows:

- Prioritize and Strengthen the Administration's Response to the Overdose Crisis.
    - The declared public health emergency regarding overdose should be continued and expanded to include all drugs, not just opioids, given substantial increases in overdoses due to cocaine, methamphetamine and benzodiazepines. The Administration's response must focus on evidence-based Harm Reduction and eliminating criminal law-based responses such as increased penalties for possession or border patrol.
    - Because polysubstance use is the norm, not the exception, the Administration should not have a singular focus on opioids. We recommend that the administration develop guidelines for a person-centered continuum of care that withstands changing drug trends. This continuum of care approach to drug policy should address:

        - The social determinants of health for people who use drugs, including housing, employment, transportation, education and job training, food security and childcare in ways that foster health and build strong communities.
        - Orienting budgets and strategies around substance use generally rather than specific drug crises.
        - Supporting funding, guidance and relevant legislation for local harm reduction drug checking efforts to monitor rapidly changing drug trends and coordinating community-based response.

- Establish an emergency public health task force or commission led and directed by people who use drugs and comprised of external stakeholder organizations and people with lived experience and other experts in the fields of substance use disorder, behavioral health, harm reduction, pain management, and public health to develop policy and budgetary recommendations for the Biden-Harris Administration to prioritize internally and with Congress. It must include meaningful involvement from people who use drugs. Such recommendations should build upon the Administration's overdose prevention strategy and explore emerging public health interventions and strategies for mitigating drug-related harm. The task force or commission should work within set time constraints with a mandate to release recommendations, and a travel budget in order to ensure that task force or commission members are able to explore public health interventions related to ending overdose across the globe.

- Develop a Biden-Harris Administration drug strategy that fully reflects the Administration's statement of priorities, including "Advancing racial equity issues in our approach to drug policy" and "Enhancing evidence-based harm reduction efforts."

- Inform both the national drug strategy and a harm reduction strategic plan that addresses harm across government agencies, including dramatically scaling up syringe services programs, through input from experts, advocates, and directly impacted people, including people who use drugs. We note that the National Survivors Union (formally urban survivors union) is working on this. NSU and any other drug user unions or individual PWUD MUST make up 51% (at the least) of the deciding group to make a national harm reduction strategy. Allies and intersectional groups are crucial but it should be drug users that decide this national strategy.

- Develop and support a mechanism for ONDCP and HHS to regularly communicate and solicit ideas and input from directly impacted people, their representatives and harm reduction services providers.

- Create a national strategy to support the health of people who use drugs that centers harm reduction as an essential strategy. Although there is an HHS Overdose Prevention Strategy, this strategy does not center people who use drugs or their health. The Subgroup recommends that there be a specific strategy to address people who use drugs. This strategy should be directed by people who use drugs. People who use drugs should be decision makers in strategies that concern them.

- Support and Expand Access to Harm Reduction Services.
    - Include in the FY25 President's Budget request $150 million for CDC's Infectious Diseases and Opioid Epidemic program. Most of this funding should support and scale up harm reduction services, including syringe services programs. Additionally, the Budget should continue to support lifting the ban on federal funding for syringes to help reduce transmission of infectious diseases, such as HIV and viral hepatitis, and oppose new burdens on harm reduction organizations such as bans of safer smoking kits, including glass pipes.
    - ONDCP should advocate for a substantial increase in funding to CDC's Infectious Diseases and Opioid Epidemic program for harm reduction programs and ensure the consultation of CDC and the agency's harm reduction experts in decision-making regarding harm reduction services and policy.
    - The Executive Office of the President, ONDCP, HHS, SAMHSA, NIDA and other key actors within the Administration should leverage harm reduction expertise at CDC, including technical assistance resources, to inform the Administration's response to the overdose crisis.
    - HHS, including CMS, SAMHSA, CDC, and HRSA, should work to improve equitable access to culturally and linguistically effective harm reduction services, including those provided by SSPs; this should involve an examination of barriers that community-based SSPs may face in applying for federal funds (including reporting requirements that incorporate personal identifiable information about the people they serve) and adoption of policies that minimize those barriers.
    - Ensure that SAMHSA incorporates harm reduction into its current and future programming, including into its Substance Abuse Prevention and Treatment (SAPT) block grant awards and other SAMHSA grants, both competitive grants and awards administered at the state level by Single State Agencies. SAMHSA should also prioritize low threshold grants and prioritize community-based harm reduction providers, particularly CBOs that are staffed by people with living in lived experience.
    - SAMHSA should emphasize that Single State Agencies should seek to increase substance use disorder-related funding that will reach harm reduction providers. SAMHSA should also look to CDC for best practice grantmaking for accessible, low barrier harm reduction grants, including to CBOs that are staffed by people with living in lived experience.
    - SAMHSA must also lower barriers to federal funding opportunities created by reporting requirements. In particular, SAMHSA (in conjunction with OMB) should remove the GPRA ("Government Performance and Results Act") reporting requirement from SAMHSA funding and treatment dollars for low-threshold harm reduction organizations. The complexity of the GPRA reporting requirement is seen as a major barrier to care by harm reduction and substance use disorder treatment providers and administrators. GPRA for harm reduction should utilize non-identifiable high-level data to maintain confidentiality and reduce administration burden.

- Promote the decriminalization of syringes and other paraphernalia and help ensure its ready availability through pharmacies, harm reduction services and other relevant community-based programs.

- ONDCP's strategy to increase the use of drug checking equipment and activities related to drug checking should be decriminalized, funded, and eligible under CDC, SAMHSA or related grants per the national drug control strategy. Technologies to test for drugs beyond fentanyl must be funded and increased and at minimum xylazine test strips should be in the same category as fentanyl testing strips for approval for SAMHSA funds.

- Prioritize NIDA funded research that supports development of more advanced drug checking technologies. Test strips are a critical tool for detecting fentanyl and other substances in a drug sample, but cannot determine the purity and potency or presence of multiple substances. NIDA should prioritize research and development projects that can deliver more sophisticated drug checking devices that are affordable, portable and intended for community member use.

- Deploy federal resources to provide education and training of pharmacists, first responders and other community-based leaders and service providers about drug use and overdose and how to respond, including through effective harm reduction services and approaches, and the importance of expanding these services nationwide. Academic and in-service training are both critical. Federal resources to provide this education and training should include but not be limited to:
    - CDC/SAMHSA Harm Reduction TA Center
    - SAMHSA Center for Substance Abuse Prevention (CSAP)
    - SAMHSA Center for Substance Abuse Treatment (CSAT)
    - HRSA HIV/AIDS Bureau AIDS Education and Technology Centers (AETCs) and other HRSA programs
    - SAMHSA Addiction Technology Transfer Centers (ATTCs)
    - National Institute on Drug Abuse

- The Centers for Medicare and Medicaid's Center for Medicaid and CHIP Services should issue guidance to states, making clear that harm reduction services are effective, evidence-based health services, and identifying specific ways for states to utilize federal Medicaid dollars to support harm reduction services.

- The Biden-Harris administration should examine the impact, particularly on BIPOC communities, of policies that require coordination between harm reduction services (including those provided through SSPs) and law enforcement entities.

- ONDCP should engage the Indian Health Service to increase funding for harm reduction given the combined impacts of the COVID-19 pandemic and the overdose crisis on Native communities.

- HHS should promulgate mandatory standards for grant recipients' workplace rights and conditions with compensation for all staff, including those designated as "peers" or other positions for which lived drug-use experience is a pre-

requisite, with at least the local prevailing minimum wage, but ideally compensation comparable to other staff. Harm reduction and addiction treatment providers are most successful and effective when people who use or used drugs are employed as staff.

- Scale Up Access to Naloxone to Prevent Drug Overdose.

    - Scale up access to naloxone widely throughout the United States, and make naloxone cost-free to people who use drugs, their community of families and friends, local organizations that help to distribute naloxone and other people directly impacted by drug use. Creating such wide and free access to naloxone is akin to the cost-free availability of COVID-19 testing and vaccines to combat the pandemic. Similar supports are needed immediately to address the overdose crisis and to prevent more overdose deaths.

    - Having moved forward with the March 2023 approval of over the counter naloxone in nasal spray form, the FDA should next move to remove the prescription-only requirement for at least one formulation of intramuscular naloxone so that it too can be purchased by harm reduction programs without requiring physician and pharmacy oversight. FDA has the authority to either reclassify intramuscular naloxone to remove the prescription-only requirement, or to publicize enforcement discretion directing pharmaceutical manufacturers and distributors to sell and provide donations of intramuscular naloxone to harm reduction programs in a low-threshold manner. ONDCP should work with HHS and FDA to achieve this, and with national pharmacy and physician organizations to garner support of their membership.

- Support Local Implementation of Overdose Prevention Centers.

    - Make a public statement in support of the scale up of overdose prevention centers (OPCs).

    - Ensure that support and funding for demonstration programs are available to any jurisdiction that would like to host OPCs.

    - Suspend federal legal actions by the Department of Justice (DOJ) to prosecute or undermine OPCs.

    - ONDCP should work with DOJ to clarify federal law to permit OPCs. In 2013, the Department of Justice announced a policy of non-interference with state marijuana legalization. The administration determined that prosecuting violations in these states would be “an inefficient allocation of federal resources.” The Administration should adopt a similar approach to OPCs.

- Remove Barriers to Medication-Assisted Treatment, particularly methadone.

    - The current Drug Enforcement Administration (DEA) regulations and restrictions have made mobile delivery of methadone cost prohibitive even though the ban

was lifted. The regulations still limit access to this treatment. To improve the situation, further regulatory changes are necessary - particularly in regards to Section 11.2 of the Guide for Narcotic Treatment Programs which sets out requirements for safes that contribute significantly towards raised costs associated with providing such service remotely. This must be revised if we want greater accessibility to methadone.

- Identify and remove barriers (beyond just the X-Waiver) to buprenorphine and methadone, including barriers that sustain and exacerbate racial disparities.

- ONDCP should work with SAMHSA and DEA to make permanent the temporary waivers for methadone and buprenorphine that enable more stable patients to take home medications and enable buprenorphine induction to happen via audio-only telehealth (and not requiring an in-person visit to start the medication. This is especially important given the digital divide and lack of access to audio-visual technology for many populations that would benefit from buprenorphine treatment). Clinics should be encouraged to fully adopt audio-only telehealth.

- ONDCP should work with DEA to withdraw the proposed rule requiring an in-person examination for telehealth patients who want to stay on buprenorphine for longer than 30 days. This rule will deter many from continuing treatment.

- End federal rules that prevent health practitioners from using telehealth technologies to initiate buprenorphine treatment and affirm that telephonic services are an important part of ensuring equitable access to evidence-based opioid use disorder treatment. Using the drug overdose public health emergency to extend telehealth prescribing under Ryan Haight is one way of achieving this.

- Require both state Medicare and Medicaid agencies to adopt telehealth reimbursement and ensure State Medicaid reimbursement rates for telehealth and telephonic appointments for buprenorphine treatment as some states are discontinuing telehealth/audio-only access to buprenorphine treatment because of low or no reimbursement.

- Ensure medication-assisted treatment providers may practice across state lines, especially in state border regions, such as the Washington, D.C. metropolitan region.

- Individuals using methadone treatment should have an option to receive it from primary care doctors rather than solely through methadone treatment clinics.

- Address racial and geographic inequities in buprenorphine and methadone access, which has been extensively documented and researched, laying bare systemic discrimination in both criminal legal and health providers that creates barriers to life saving medicines.

- Leverage new broadband resources from the bipartisan Infrastructure Investment and Jobs Act (P.L. 117-58) to expand access to medication-assisted treatment services.

- Ensure that the BOP and other carceral settings provide access to all forms of FDA-approved medication-assisted treatment (as required under the Rehab Act per DOJ) and other SUD support services as well as HIV and hepatitis C screening, prevention and treatment services both during incarceration and upon reentry. BOP and other carceral settings should screen, test and fully treat viral hepatitis during incarceration and should additionally fast track viral hepatitis point of care testing with RNA confirmatory tests. BOP should also allow naloxone to be available for people in custody and provide it upon release.

- Require that state and local governments provide access to all forms of FDA-approved MAT as a condition of eligibility for federal (such as DOJ) funding allocations. Jurisdictions should also demonstrate adequate plans for individual continuity of opioid use disorder care upon release.

- Implement guidance for state and local jurisdictions on providing MAT and/or continuity of care during all stages of criminal legal involvement, including in/direct provision of technical assistance to support implementation and sustainability of these programs and to navigate requirements (SAMHSA, DEA, CDC, others).

- Support, through provision of guidance, elevation of best practices, or program recognition, the expansion of jail and prison-based harm reduction programs and resources alongside MAT access to improve health, reduce recidivism and improve post-release connections and transition. This includes but is not limited to overdose prevention and health education classes, access to harm reduction supplies, pre-release insurance enrollment, distribution of naloxone upon release and other services provided in collaboration with harm reduction programs.

- Increase access to Medicaid and other health insurance coverage prior to reentry from incarceration. This is a critical, life-saving resource as people are 129 times more likely to overdose after leaving a carceral setting.

- Expand access to contingency management, currently the most effective intervention for stimulant use, which is already being used extensively by the Department of Veterans Affairs.

- Create and execute an inter-agency strategy organized by ONDCP that directs the: A) NIDA to fund clinical research into agonist medications (namely, dextroamphetamine, lisdexamfetamine, methylphenidate) for stimulant use disorder; B) FDA to secure regulatory approval of agonist medications for stimulant use disorder; C) SAMHSA to swiftly promulgate tentative clinical guidance for practitioners to prescribe agonist medications off-label for stimulant use disorder, and then finalized guidance upon the FDA's approval of the indication; D) DEA, upon FDA's approval of the indication, to evaluate and accordingly adjust the agonist medications' Aggregate Production Quotas to accommodate their likely-increased demand for treatment of stimulant use disorder, and to clarify for registrants that prescriptions of agonist medications for stimulant use disorder are not, alone, "suspicious" or evidence of diversion.

- Consider that barriers to care for people who require access to controlled medication, including people with pain or other chronic conditions are, according

to studies, increasingly resulting in increased risk of overdose and suicide, and integrate a comprehensive stakeholder approach to addressing controlled medications as a harm reduction measure.

- Support and facilitate authorization and funding for demonstration projects to implement legal, regulated access to hydromorphone and fentanyl, respectively, as medication treatments for people with opioid use disorder, and to amphetamine-type stimulants as medication treatments for people with stimulant use disorder.

- Support families, including children, youth and parents, affected by familial substance use disorder.

    - Substance use by parents or caregivers does not constitute maltreatment or neglect on its own. Families and children affected by substance use disorder may experience complex health or social needs and should receive services and supports that are trauma-informed and person-centered, including:
        - Addressing in a comprehensive manner the immediate and long-term health and social needs of children and families impacted by substance use.
        - Supporting research into early childhood trauma of children directly exposed to substance-related maltreatment and neglect and prioritizing funding necessary to expand evidence-based behavioral health interventions to treat such trauma.
        - Emphasizing that the social determinants of health related to socio-economic status and racial/ethnic and geographic disparities need to be addressed in child-welfare policies pertaining to substance use disorder.
        - Prioritizing strategies and interventions that keep families together.

    - The Administration should bring to scale programming that is effective in addressing Adverse Childhood Experiences, including for the children of parents with SUD, building resiliency, and promoting restorative justice and non-punitive disciplinary practices in schools.

    - The Administration should work with Congress to amend the Child Abuse Prevention and Treatment Act and the Adoption and Safe Families Act to be better aligned with evidence and best practices for substance use in families. This includes shifting federal funds used for surveillance and family separation to supporting families, including through evidence-based substance use disorder treatment and community-based solutions, and barring states from prohibiting pregnant and parenting people from accessing addiction medications when a health professional has prescribed or recommended them.

Decriminalization Subgroup Recommendations

Endorsing Organizations: AIDS Alabama (AL); AIDS Foundation Chicago (IL); AIDS United; Center for Disability Rights; Center for Housing & Health; Center for Popular Democracy; Community Catalyst; Communities United; Drug Policy Alliance; Elephant Circle (CO); Faces & Voices of Recovery; Faith in Harm Reduction; Law Enforcement Action Partnership; Legal

Action Center; Lighthouse Learning Collective; Live4Lali (NY); NASTAD; National Council on Alcoholism and Drug Dependence- Maryland Chapter; National Harm Reduction Coalition; National Health Care for the Homeless Council; National Pain Advocacy Center; New York Recovery Alliance (NY); NEXT Distro; OpioidSettlementTracker.com; PAIN; The Porchlight Collective SAP (IL); StoptheDrugWar.org; Treatment Action Group; Vital Strategies

The Decriminalization Subgroup of the Drug Policy Reform Working Group is focused on the elimination of federal laws, policies and regulations that impose or support criminal penalties for drug use and possession. The Decriminalization Subgroup is comprised of a cross-section of organizations and individuals who have expertise on and are impacted by criminalization. The Subgroup's recommendations are as follows:

- Remove or deprioritize enforcement of criminal penalties for drug possession of personal use quantities at the federal level.
    - Articulate an official policy position in support of eliminating criminal penalties for drug use and possession. This should include non-prosecution of drug related offenses under federal law in jurisdictions that have decriminalized or legalized.
    - Create by executive order a Commission on Substance Use, Health and Safety. This commission should be modeled on the Drug Policy Reform Act, include the participation of directly impacted individuals, and should be responsible for establishing benchmarks for what constitutes personal use quantities.
    - Support passage of the Drug Policy Reform Act in Congress, as well as incentivize states to end arrests for personal use drug possession, as has been implemented in Oregon. This action is necessary because drug criminalization targets marginalized and economically disadvantaged groups. Moreover, the current overdose crisis is occurring in the context of the criminalization of drugs, which perpetuates the stigmatization and marginalization of people who use drugs in ways that exacerbate negative public health outcomes of drug use including overdose.
    - Support the transfer of drug classification authority, and all drug-related research responsibilities, away from the DEA to HHS.
- While Federal laws do not criminalize simple possession of harm reduction tools commonly criminalized by state paraphernalia laws, such as snorting and smoking drug use equipment that minimizes drug-related injuries, the Administration should urge and incentivize states to end the criminalization of all harm reduction tools.
- Work with Congress to identify and repeal collateral consequences that result from drug possession arrests and convictions, such as the drug felony ban on SNAP and TANF eligibility.
- Despite the child welfare system's intended role to protect children and families, one of its primary functions is to investigate possible child abuse and neglect and relies on punitive approaches to addressing pregnant and parenting people struggling with substance use disorder that disrupt and harm families. Congress, federal agencies, and courts must consider the short and long-term impact on children when a parent is incarcerated for simple possession or use of drugs.

- Work with Congress to modify and/or eliminate provisions of the Child Abuse Prevention and Treatment Act (CAPTA) and the Comprehensive Addiction and Recovery Act (CARA) that spur punitive state approaches to substance-affected infants. Incentivize states to prohibit child removal solely on the basis of parental substance use.

- Work to ensure that child welfare services offered to infants and families are non-punitive and grounded in science, compassion and health. This includes ensuring that child welfare systems do not bar access to medication-assisted forms of treatment when a health professional has prescribed or recommended it, and ensuring that child welfare systems do not separate mother and child simply because of Neonatal Abstinence Syndrome (NAS).

Thank you for reviewing and considering these three sets of recommendations for the development of ONDCP's 2024 Drug Strategy and the implementation of drug policy across the federal government. We welcome the opportunity for the Drug Policy Reform Working Group to meet with ONDCP to discuss these recommendations. Please contact us with questions and we look forward to additional opportunities to provide input to ONDCP and the Biden-Harris Administration on matters of drug policy.

Sincerely,

Grant Smith, Co-Chair, Drug Policy Reform Working Group
Mel Wilson, Co-Chair, Drug Policy Reform Working Group
Bill McColl, Chair, Harm Reduction Subgroup
Hanna Sharif-Kazemi, Chair, Decriminalization Subgroup