



ASAM American Society of
Addiction Medicine

Public Policy Statement on Racial Justice Beyond Health Care: Addressing the Broader Structural Issues at the Intersection of Racism, Drug Use, and Addiction

Purpose

Stigma and racism at the societal level, driven and reinforced by culture and laws, are root causes of health inequities that affect people who use certain drugs or struggle with addiction, with particularly acute consequences for people of color. This policy statement considers the role of various structural conditions on health and well-being and includes recommendations to address the broader structural issues at the intersection of racism, drug use, and addiction. Such recommendations are expected to create systems that benefit all people.

Background

In this final public policy statement of a three-part series on advancing racial justice in the context of addiction medicine, ASAM continues its analysis of systemic racism as a social determinant of health that disproportionately damages the health and lives of Black, Indigenous, and People of Color (“BIPOC”) who use substances or have substance use disorder (SUD). The first statement in this series set forth ASAM’s recommendations for addiction medicine professionals to improve the quality of full-spectrum addiction care delivered to BIPOC who need SUD services.¹ The second statement broadened the focus of the analysis to include actions that healthcare systems, institutions, organizations, professional medical entities, researchers, and health professional educators should take to reduce the detrimental impact of systemic racism on BIPOC who use substances or have SUD.² In this third statement, ASAM describes the role of structural conditions that create inequities for people who use illegal substances or have SUD, with particularly acute consequences for BIPOC.

Below, ASAM describes how structural stigma related to SUD and to race create health inequities. That description is followed by policy recommendations that seek to address structural issues that negatively impact health and well-being, including recommendations related to decriminalization. It is important to note upfront, however, that the decriminalization recommendations in this statement focus on the elimination of criminal and onerous civil penalties for drug and drug paraphernalia* possession for personal use. They intentionally do not

* A [recent paper](#) notes that the term “drug paraphernalia” is defined in the Drug Enforcement Administration’s 1979 Model Drug Paraphernalia Act as follows: “All equipment, products and materials of any kind which are used, intended for use, or designed for use, in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling or otherwise introducing into the human body a controlled substance in violation of [the state’s Controlled Substances Act].”

include designing a framework for regulated access to currently illegal drugs for non-medical use given that even slight changes in the legal supply of certain drugs can pose great risk of increased use and harm, especially to marginalized people, and the current gaps in drug policy research.

How Structural Stigma and Racism Similarly Function to Define Cultural Views of People Who Use Illegal Drugs or Have SUD

Stigma is a structural determinant of health and a fundamental cause of health inequities that affects marginalized people, including people with SUD and BIPOC.³ Stigma is often narrowly conceptualized as occurring between two people but, like racism, is actually multilevel and multifaceted.^{4,5} Interpersonal stigma is how individuals more commonly experience disempowerment and discrimination on a day-to-day basis. Conceptualized as a structural determinant, stigma represents a collective environment created through labeling, stereotyping, isolating, and removing power and status from a group of people through policies and practice. These power structures create differential access to social and material resources that can influence health and wellness, like housing, education, social support, and employment opportunities.

While some may contend that drug-related stigma helpfully discourages drug use, structural stigma related to SUD is more complex,⁶ and perpetuating stigma is distinct from improving preventive risk and protective factors.⁷ Moreover, the negative consequences of stigma far outweigh any positives.⁶

For more than a century, drug policy in the United States of America (U.S.) has labeled possession of certain drugs for personal use as a crime, thereby designating people who use those drugs (and people who engage in drug use due to a chronic illness) as deviants⁸ and criminals. The label of “criminal” carries with it negative stereotypes, perceived license for punishment and social isolation, ongoing discrimination and disenfranchisement, and “us-versus-them” narratives.³ The criminal designation of possession of certain drugs for personal use justifies the “othering” of people who use those drugs.⁹ Overly punitive drug policies, including drug paraphernalia laws, have exacted substantial collateral harm upon the lives of people who use illegal drugs, the functioning of their families, and their broader communities.^{10,11} Indeed, the U.S. Government Accountability Office noted at least 641 collateral consequences of a nonviolent drug conviction that include exclusions from employment, housing, loans, licensure, civic participation, family rights, and more.¹² While the perception of deviance of certain drug use may have, in some cases, preceded the assignment of criminality, it is through policies and practice that society perpetuates this stigma.

Like stigma, structural racism functions through othering mechanisms and transcends the prejudicial beliefs and discriminatory behavior of any one person. Federal, state, and local policies have propagated, promulgated, and reinforced racial stereotypes¹³ and restricted access to housing, education, employment, and other social and material goods through state-sponsored housing discrimination that led to residential segregation and present-day concentrated poverty.¹⁴ Racial covenants¹⁵ – where Black individuals and other marginalized groups were

excluded from purchasing homes – and structural forms of discrimination against BIPOC seeking fair access to resourced communities have had a lasting impact on the U.S.¹⁴

Residential segregation persists today such that racially minoritized[†] people are more likely to experience concentrated poverty, greater negative exposures from police surveillance, higher housing cost burden, limited financial safety nets, and lack of economic opportunity, which creates challenges in meeting basic needs for all individuals, but especially those challenged with a chronic illness.¹⁴ In addition, these unjust conditions unfairly expose youth to adverse childhood experiences associated with SUD,¹⁶ further perpetuating the impact of decades-old structural determinants into the next generation.

Many BIPOC communities are still experiencing the damaging effects of the “wars” on crime, and then on drugs, which diverted needed resources from these communities and into the law enforcement apparatus, thus eroding social determinants of health for those populations.¹⁷ Although the letter of the laws do not target BIPOC, U.S. drug laws are a form of structural racism today because the laws are inequitably implemented^{1,2} in ways that reinforce power structures, reduce access to opportunity, and amplify disadvantage.¹⁸ For example, enforcement and consequences of drug paraphernalia laws fall disproportionately on BIPOC communities and are the primary legal barrier to the uptake of evidence-based harm reduction interventions that prevent the spread of disease and reduce drug overdoses.¹⁹

How Stigma Related to Race and Certain Drugs Changes Structural Conditions for People Who Use Those Drugs or Have SUD

The structural stigma and racism that embody the othering processes have spawned policy initiatives that continue to have tangible, disproportional, deleterious consequences for BIPOC who use illegal drugs or have SUD and for their families and communities. Dating back to 1914, with the enactment of the Harrison Narcotic Tax Act, and moving through the Controlled Substances Act of 1970, the Sentencing Reform Act of 1984, and the Anti-Drug Abuse Act of 1986 – U.S. drug policy has reflected and exacerbated the othering of BIPOC that was the deliberate intent of redlining policies, Jim Crow laws, and mass incarceration.²⁰

One of many examples of the enduring legacy of the Anti-Drug Abuse Act of 1986 is that in 2022, people who use certain drugs can be – and frequently are – denied access to public housing because of a history of criminal legal system involvement with 20-year or even lifetime lookback periods, or they can be evicted from housing because of suspected illegal drug use of any individual within the household.²¹ The U.S. Department of Housing and Urban Development (HUD) guidance states that blanket policies refusing housing solely based on criminal history are likely a violation of the Fair Housing Act of 1968 due to the disparate impact on racially minoritized people.²² Structural changes are needed at the federal level to reverse the harms of historical housing policies and hold local housing authorities and private and public housing providers accountable for following the HUD guidance and equitable practices.²²

[†] Scholars have advocated for use of the term “minoritized,” which is used to refer to the same shared experience of exposure to systemic and individual racism in health and beyond and provides an understanding that people are actively minoritized by others, rather than naturally existing as a minority, as the terms racial or ethnic minorities imply.

Even the Drug Addiction and Treatment Act of 2000 (DATA 2000), which was an effort to medicalize and normalize treatment for opioid use disorder (OUD), has fallen victim to the social landscape of the U.S. drug policy response. Though DATA 2000 allowed certified physicians to prescribe buprenorphine in their own offices, it failed to address criminalization, the restriction of methadone to opioid treatment programs (OTPs), or other variables limiting geographic accessibility to treatment for OUD. It resulted in a “two-tier” treatment system,²³ with ultimately greater accessibility of office-based buprenorphine treatment for White people with OUD.²⁴

Racial inequities also exist in child protection system responses to pregnant and parenting people, particularly when substance use is involved as the cause of removal. Despite similar rates of illegal drug use among Black and White individuals,²⁵ Black families are more likely to be tested for substances and reported to the child protection system, with healthcare professionals serving as the primary source of reports to the child protection system.² Black families are more likely to have a child removed (despite being assessed at a lower risk) for longer periods of time, to undergo family separation, and are less likely to be reunified.²⁶ In states that criminalize prenatal substance use, the reunification of Black families is even less likely.²⁷

The Present-Day Manifestations of Race-, Drug-, and SUD-Related Stigma

In the U.S., racial tropes and exaggerations or outright fabrications about the harms of certain drugs have been used to stoke fear among the public and promote drug policies that demoralize and disenfranchise people who use those drugs. Few broad-reaching attempts have been made in earnest to correct the excessively criminal response to SUD or the severe inequities in drug law implementation, because drug policies have been aligned with dominant cultural attitudes that associated crime and drugs with Blackness, and certain drug use with criminality.²⁸ However, such punitive drug policies have been criticized more recently; it may be no coincidence that the shift occurred as the public face of addiction began to look more White.

Starting about two decades ago, the U.S. has been in the throes of an opioid overdose crisis,²⁹ which has often been characterized by the media as a problem for White rural America.³⁰ Going against decades of criminal legal policies, rhetoric such as “we are not going to arrest our way out of this” began to surface as dominant views responded to the cognitive dissonance induced by replacing the stereotype of a person that uses certain drugs. What once was easily identified as “them” when the media overrepresented Black faces in drug-related stories,³¹ now looked more like “us.”³² Typical of the “White exceptionalism” of drug war politics, shifts in the deviancy narratives emerged.³³ Suddenly, harsh penalties became less palatable to the American public, which increasingly adopted the previously dismissed notion of addiction as a medical condition for which affected individuals deserved compassion, understanding, and effective treatment rather than vilification, scorn, and incarceration.

2020 marked a peak in the collective awareness and dialogue of the American public regarding racial justice. The aftermath of George Floyd’s murder at the hands of law enforcement serves as a compelling example of how SUD stigma and structural racism can intersect, amplify, and override progress if either social driver is left unaddressed. In the days and months following George Floyd’s death, his history of drug use emerged in public rhetoric as a justification for his brutal murder, as if the use of drugs somehow disqualified him from due process.^{34,35} Much of America defaulted to once again compartmentalizing inhumanity, reserving justice and

compassion only for “us” when the face of the person who used certain drugs was Black. Structural solutions to address race-, drug-, and SUD-related stigma are needed for lasting change.

Advancements in Structural Change

Drug policy in the U.S. has served as the foundation of the legitimized oppression of both BIPOC and people with SUD. Because SUD stigma and structural racism exist at the societal level and persist beyond any interpersonal encounters, structural solutions are needed. Reducing the criminal legal consequences of some or all drug possession for personal use is an emerging strategy for reducing stigma and advancing racial justice. Scholarship examining changes in public opinion on gay marriage support that changes in policy can rapidly shift, albeit not eliminate, stigma.³⁶ In fact, laws that provide protections to stigmatized groups may positively impact the mental health and general health of those provided protection.³⁷ While SUD and racial stigma can be helped by policies that attack the racist legacy of prohibition, more work must be done to complement structural change and challenge social ideologies.³⁸

Delinking criminality from drug and drug paraphernalia possession for personal use – while offering access to treatment and supportive services - will help reduce imprisonment and its collateral consequences, which serve as a tool for BIPOC oppression. In 2019, over 1.5 million people in the U.S. were arrested for drug offenses, more than any other category of crime, and nearly 90% of those arrests were for drug possession³⁹ Moreover, research shows that U.S. states with higher rates of drug imprisonment do not experience lower rates of self-reported drug use.⁴⁰ However, elimination of such criminal penalties is not likely to eliminate racism and systemic disinvestment in BIPOC communities. Societal stigma can still persist and compensatory policies and street-level politics can counteract progress.⁴¹ For example, while arrests have decreased following cannabis policy reform, substantial racial differences in rates of arrest still exist, and in some states,⁴² arrests increased for drugs other than cannabis. Similar research on drug court and diversion programs suggest that BIPOC benefit less from these drug policy reforms.⁴³

While some may highlight that such decriminalization efforts will not address the nation’s toxic, illegal drug supply, ASAM recognizes that any changes in laws that would increase legal access to currently illegal drugs would need to be carefully thought out, implemented gradually and sequentially, and scientifically evaluated at each step of implementation. Additionally, given that the current U.S. political environment does not seem well-poised to take quick action to rein in for-profit interests, as well as the risks associated with any significant increase in unhealthy drug use and the current gaps in drug policy research⁴⁴, there is currently no path for firm and sustainable regulation to prevent consumer expansion and exploitation, of which BIPOC are historically among the most common targets.^{45,46} By way of contrast, evidence from Portugal suggests that eliminating the criminality of drug possession for personal use, as part of a larger set of public health reforms, investments, and norms, can lead to improvements in health without offering legal means of obtaining regulated drugs for non-medical use.⁴⁷

In 2020, Oregon passed Measure 110, which decriminalized possession of scheduled substances for personal use and invested in expanding access to services. While it may be too soon to evaluate Oregon’s approach, and such evaluations must endeavor to ask the right research

questions,^{48,49} the experience of Portugal and other decriminalization initiatives showcase the value of therapeutic responses to drug possession for personal use.^{47,50} However, eliminating criminal penalties for drug possession for personal use is not sufficient for addressing the overdose crisis, as communities need sufficient capacity for timely delivery of non-compulsory clinical, social, and economic services with humane accountability.⁵¹

Importantly, drug policy reforms must not only eliminate the overreliance on criminal law but must also promote reparative justice – strategies that seek to repair the harms caused by decades of overly punitive drug policies and hundreds of years of state-sponsored discrimination against BIPOC. Restorative strategies include policies such as the 2014 Clemency Initiative,⁵² appropriate expungement, and financial investments in social determinants of health,⁵³ particularly targeting communities heavily impacted by the drug war.⁵⁴

The drug war has been wielded as a tool of oppression against people with SUD and BIPOC. For over a century, investments have been made in ineffective strategies that have cost far too many lives. Reparative investments and structural policy changes are crucial for addressing the root causes of health inequities.

Recommendations

1. **ASAM supports shifting the nation's response to personal substance use away from assumptions of criminality towards health and wellness; BIPOC disproportionately bear the brunt of criminal legal responses to personal drug use, notwithstanding that White people use illegal drugs at similar rates.**⁴⁷
 - a. Policymakers should eliminate criminal and onerous civil penalties for drug and drug paraphernalia possession for personal use as part of a larger set of related public health and legal reforms designed to improve carefully selected outcomes.⁵⁵ In the interest of harm reduction, policymakers should also eliminate criminal penalties for the manufacture and delivery of drug paraphernalia. Those decriminalization efforts should (i) include consideration of expungement of records of such prior offenses, so that people do not remain marginalized for them and (ii) prioritize eliminating the over-policing of BIPOC who use illegal drugs and racial disparities in related civil enforcement. Concurrently, policymakers should support robust policies and funding that facilitate people's access to evidence-based prevention, early intervention, treatment, harm reduction, and other supportive services – with an emphasis on youth and racially and ethnically minoritized people – based on individualized needs and with availability in all communities.
 - b. Policymakers should consider new clemency efforts that encourage people who are incarcerated in federal or state prison for nonviolent drug offenses – many of whom are BIPOC⁴² – to petition authorities for appropriate sentence commutations or reductions.
 - c. Federal lawmakers should pass legislation that would eliminate the federal crack and powder cocaine sentencing disparity and apply it retroactively to those already convicted or sentenced.
 - d. Policymakers should support robust investments in research efforts that aim to evaluate alternative public health approaches to drug use, with a focus on different types of drug policies, laws, and law enforcement practices.^{44,56-58}

- e. The criminal legal system should not be used to interfere with, or influence, the assessment, diagnosis, or treatment decisions of those with SUD. Given that the criminal legal system has had inequitably detrimental effects on BIPOC, reforms within this system are particularly needed to achieve racial justice.
 - f. Evidence-based addiction care, including the use of medications for addiction treatment, should be available to all in need, including people in prisons, jails, drug courts, child protection systems, or on probation or parole. Engaging in addiction treatment should not be a precondition for people who use illegal drugs or have SUD accessing other medical care or support services, including housing.
- 2. ASAM supports policies and programs that help address underlying structural and social determinants of addiction; such policies and programs are critical to advancing racial justice and improving access to high-quality addiction care for all people, especially BIPOC.**
- a. Policymakers should support interagency collaborations and cost-effective programs that address social determinants of addiction⁵⁹ – with a particular focus on determinants that impact racially and ethnically minoritized people.
 - b. Policymakers should eliminate drug conviction bans⁶⁰ and drug testing requirements⁶¹ for public assistance programs, such as the Supplemental Nutrition Assistance Program and the Temporary Assistance for Needy Families program, and for programs providing financial aid for education.
 - c. Policymakers should end evictions and remove housing bans based solely on nonviolent, drug-related activities and support policies that promote the safety and well-being of all people.⁶²
 - d. Policymakers should implement universal health care coverage that will support equitable access to evidence-based or evidence-informed addiction care for all, regardless of ability to pay. Initial federal reforms should include expanding Medicaid and Medicare coverage to include people who are in carceral settings or under community correctional control⁶³ and who are otherwise eligible.
 - e. Policymakers should ensure that existing mental health and addiction parity laws are vigorously enforced and support federal policies that fully extend mental health and addiction parity and benefits to Medicare, all of Medicaid, and TRICARE.⁶⁴
 - f. Accreditation and licensing bodies should work towards improving accountability for evidence-based, patient-centered, and culturally competent addiction care that includes addressing social determinants of addiction.
- 3. ASAM supports policies and programs that equip addiction medicine and other professionals, as well as people with lived experience, with the data, knowledge, and skills that are necessary to engage in effective advocacy for dismantling structural racism and advancing racial justice and health equity for all people.**
- a. Philanthropic organizations and persons should invest in advocacy infrastructures and organizations that can advance racial justice in addiction care.
 - b. Training programs for addiction medicine professionals should review their curricula to identify gaps related to structural competency, racial understanding, and advocacy. Clinical educators should develop and promote addiction medicine training courses that communicate the impact of stigmatizing language on people with SUD,

- the necessity of harm reduction tools and interventions, and the benefits of addiction medications.
- c. Policymakers and program developers should engage people with lived experience with substance use in the development of policy and services related to addiction and its social determinants, and the positive contributions of people with lived experience should be compensated and recognized.
 - d. Public health agencies should report and widely disseminate data related to substance use and SUD by race and ethnicity and monitor for improved, equitable outcomes.

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1. American Society of Addiction Medicine. *Public Policy Statement on Advancing Racial Justice in Addiction Medicine.*; 2021. Accessed September 30, 2022. https://www.asam.org/docs/default-source/public-policy-statements/asam-policy-statement-on-racial-justiced7a33a9472bc604ca5b7ff000030b21a.pdf?sfvrsn=5a1f5ac2_2
2. American Society of Addiction Medicine. *Public Policy Statement on Advancing Racial Justice in Health Care through Addiction Medicine.*; 2022. Accessed September 30, 2022. https://sitefinitystorage.blob.core.windows.net/sitefinit-production-blobs/docs/default-source/advocacy/2022-pps-on-advancing-racial-justice-in-health-care-through-adm---final.pdf?sfvrsn=3ba5e94f_3
3. Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a Fundamental Cause of Population Health Inequalities. *Am J Public Health.* 2013;103(5):813-821. doi:10.2105/AJPH.2012.301069
4. Lin Q, Kolak M, Watts B, et al. Individual, interpersonal, and neighborhood measures associated with opioid use stigma: Evidence from a nationally representative survey. *Social Science & Medicine.* 2022;305:115034. doi:10.1016/j.socscimed.2022.115034
5. The White House, Executive Office of the President, Office of National Drug Control Policy. National Drug Control Strategy. Published online April 19, 2022. <https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf>
6. National Academies of Sciences. *Understanding Stigma of Mental and Substance Use Disorders.* National Academies Press (US); 2016. Accessed November 2, 2022. <https://www.ncbi.nlm.nih.gov/books/NBK384923/>
7. SAMHSA. Risk and Protective Factors. Published online 2019. <https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf>
8. El-Sabawi T. Defining the Opioid Epidemic: Congress, Pressure Groups, and Problem Definition. Published online February 26, 2018. Accessed October 24, 2022. <https://papers.ssrn.com/abstract=3130449>
9. Askew R, Salinas M. Status, stigma and stereotype: How drug takers and drug suppliers avoid negative labelling by virtue of their 'conventional' and 'law-abiding' lives. *Criminology & Criminal Justice.* 2019;19(3):311-327. doi:10.1177/1748895818762558
10. Bluthenthal RN, Kral AH, Erringer EA, Edlin BR. Drug Paraphernalia Laws and Injection-Related Infectious Disease Risk among Drug Injectors. *Journal of Drug Issues.* 1999;29(1):1-16. doi:10.1177/002204269902900101
11. Davis CS, Carr DH, Samuels EA. Paraphernalia Laws, Criminalizing Possession and Distribution of Items Used to Consume Illicit Drugs, and Injection-Related Harm. *American Journal of Public Health.* 2019;109(11):1564-1567. doi:10.2105/AJPH.2019.305268
12. U. S. Government Accountability Office. Nonviolent Drug Convictions: Stakeholders' Views on Potential Actions to Address Collateral Consequences. Published 2017. Accessed May 10, 2022. <https://www.gao.gov/products/gao-17-691>

13. Phelan JC, Link BG, Tehranifar P. Social Conditions as Fundamental Causes of Health Inequalities: Theory, Evidence, and Policy Implications. *Journal of Health and Social Behavior*. 2010;51:S28-S40.
14. Rothstein R. *The Color of Law*.; 2018. Accessed May 12, 2022. <https://www.norton.com/books/9781631494536>
15. University of Minnesota. What is a Covenant? | Mapping Prejudice. Published 2022. Accessed October 5, 2022. <https://mappingprejudice.umn.edu/racial-covenants/what-is-a-covenant>
16. Bryant DJ, Coman EN, Damian AJ. Association of adverse childhood experiences (ACEs) and substance use disorders (SUDs) in a multi-site safety net healthcare setting. *Addictive Behaviors Reports*. 2020;12:100293. doi:10.1016/j.abrep.2020.100293
17. Hinton E. From the War on Poverty to the War on Crime: The Making of Mass Incarceration in America. Published 2016. Accessed June 2, 2022. <https://www.hup.harvard.edu/catalog.php?isbn=9780674979826>
18. Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000;90(8):1212-1215.
19. Repealing State Drug-Paraphernalia Laws – The Need for Federal Leadership | NEJM. Accessed October 24, 2022. <https://www.nejm.org/doi/full/10.1056/NEJMp2207866>
20. Alexander M, West C. *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. The New Press; 2012.
21. Purtle J, Gebrekristos LT, Keene D, Schlesinger P, Niccolai L, Blankenship KM. Quantifying the Restrictiveness of Local Housing Authority Policies Toward People With Criminal Justice Histories: United States, 2009–2018. *Am J Public Health*. 2020;110(S1):S137-S144. doi:10.2105/AJPH.2019.305437
22. Weiss E. Housing Access for People with Criminal Records. Published online 2018. https://nlihc.org/sites/default/files/AG-2018/Ch06-S06_Criminal-Records_2018.pdf
23. Netherland J, Hansen H. White opioids: Pharmaceutical race and the war on drugs that wasn't. *Biosocieties*. 2017;12(2):217-238. doi:10.1057/biosoc.2015.46
24. Lagisetty PA, Ross R, Bohnert A, Clay M, Maust DT. Buprenorphine Treatment Divide by Race/Ethnicity and Payment. *JAMA Psychiatry*. 2019;76(9):979-981. doi:10.1001/jamapsychiatry.2019.0876
25. SAMHSA. Racial/Ethnic Differences in Substance Use, Substance Use Disorders, and Substance Use Treatment Utilization among People Aged 12 or Older (2015-2019). Published online 2021:191.
26. National Academies of Sciences, Engineering, and Medicine. *The Promise of Adolescence: Realizing Opportunity for All Youth*. The National Academies Press; 2019. Accessed September 12, 2022. <https://nap.nationalacademies.org/download/25388>

27. Sanmartin MX, Ali MM, Lynch S, Aktas A. Association Between State-Level Criminal Justice-Focused Prenatal Substance Use Policies in the US and Substance Use-Related Foster Care Admissions and Family Reunification. *JAMA Pediatrics*. 2020;174(8):782-788. doi:10.1001/jamapediatrics.2020.1027
28. Nunn K. Race, Crime and the Pool of Surplus Criminality: Or Why the “War on Drugs” Was a “War on Blacks.” *The Journal of Gender, Race, and Justice*. Published online Fall 2002:67.
29. Opioid Data Analysis and Resources | Opioids | CDC. Published June 1, 2022. Accessed November 4, 2022. <https://www.cdc.gov/opioids/data/analysis-resources.html>
30. Bechteler SS, Kane-Will K. *Whitewashed: The African American Opioid Epidemic*. Chicago Urban League, Research and Policy Center; 2017. Accessed September 10, 2022. https://chiul.org/wp-content/uploads/2019/01/Whitewashed-AA-Opioid-Crisis-11-15-17_EMBARGOED_-FINAL.pdf
31. Spencer-Blume A. Media Bias & the War on Drugs – AFRI 0090 S01: An Introduction to Africana Studies. Published October 3, 2019. Accessed October 5, 2022. <https://blogs.brown.edu/afri-0090-s01-2019-fall/2019/11/03/media-bias-the-war-on-drugs/>
32. Netherland J, Hansen HB. The War on Drugs That Wasn’t: Wasted Whiteness, “Dirty Doctors,” and Race in Media Coverage of Prescription Opioid Misuse. *Cult Med Psychiatry*. 2016;40(4):664-686. doi:10.1007/s11013-016-9496-5
33. El-Sabawi T, Oliva JD. The Influence of White Exceptionalism on Drug War Discourse. Published online June 4, 2022. Accessed October 29, 2022. <https://papers.ssrn.com/abstract=4128076>
34. Mann B. Critics Say Chauvin Defense “Weaponized” Stigma For Black Americans With Addiction. *NPR*. <https://www.npr.org/2021/04/16/987613819/critics-say-chauvin-defense-weaponized-stigma-for-black-americans-with-addiction>. Published April 16, 2021. Accessed September 30, 2022.
35. Brody JK, Jordan A, Wakeman SE. Excited delirium: valid clinical diagnosis or medicalized racism? Organized medicine needs to take a stand. *STAT*. Published April 6, 2021. Accessed September 30, 2022. <https://www.statnews.com/2021/04/06/excited-delirium-medicalized-racism-organized-medicine-take-a-stand/>
36. Herek GM. Beyond “homophobia”: Thinking more clearly about stigma, prejudice, and sexual orientation. *American Journal of Orthopsychiatry*. 2015;85(5):S29-S37. doi:10.1037/ort0000092
37. Hatzenbuehler ML, O’Cleirigh C, Grasso C, Mayer K, Safren S, Bradford J. Effect of same-sex marriage laws on health care use and expenditures in sexual minority men: a quasi-natural experiment. *Am J Public Health*. 2012;102(2):285-291. doi:10.2105/AJPH.2011.300382
38. Reid M. A qualitative review of cannabis stigmas at the twilight of prohibition. *Journal of Cannabis Research*. 2020;2(1):46. doi:10.1186/s42238-020-00056-8

39. Pew Charitable Trusts. Drug Arrests Stayed High Even as Imprisonment Fell From 2009 to 2019. Published February 15, 2022. Accessed November 7, 2022. <https://pew.org/3GzjeVI>
40. Pew Charitable Trusts. More Imprisonment Does Not Reduce State Drug Problems. Published March 8, 2018. Accessed November 3, 2022. <http://pew.org/2tszeZI>
41. Latimore AD, Bergstein RS. "Caught with a body" yet protected by law? Calling 911 for opioid overdose in the context of the Good Samaritan Law. *International Journal of Drug Policy*. 2017;50:82-89. doi:10.1016/j.drugpo.2017.09.010
42. American Civil Liberties Union. A Tale of Two Countries - Racially Targeted Arrests in the Era of Marijuana Reform. Published 2020. Accessed September 11, 2022. https://www.aclu.org/sites/default/files/field_document/tale_of_two_countries_racially_targeted_arrests_in_the_era_of_marijuana_reform_revised_7.1.20_0.pdf
43. Social Science Research Council. Drug Courts in the Americas. Published October 2018. Accessed September 17, 2022. <https://www.wola.org/wp-content/uploads/2018/11/DSD-Drug-Courts-English-ONLINE-FINAL-10.25.18.pdf>
44. Kleiman M, Caulkins JP, Hawken A, Kilmer B. Eight Questions for Drug Policy Research. *Issues in Science and Technology*. Published July 1, 2012. Accessed November 7, 2022. <https://issues.org/kleiman-drug-policy-research-questions/>
45. Centers for Disease Control and Injury Prevention. Unfair and Unjust Practices and Conditions Harm African American People and Drive Health Disparities | Smoking and Tobacco | CDC. Published August 16, 2022. Accessed November 7, 2022. <https://www.cdc.gov/tobacco/health-equity/african-american/unfair-and-unjust.html>
46. Alaniz ML. Alcohol Availability and Targeted Advertising in Racial/Ethnic Minority Communities. *Alcohol Health Res World*. 1998;22(4):286-289.
47. Csete J, Kamarulzaman A, Kazatchkine M, et al. Public health and international drug policy. *The Lancet*. 2016;387(10026):1427-1480. doi:10.1016/S0140-6736(16)00619-X
48. Netherland J, Kral A, Bluthenthal R, et al. OREGON'S MEASURE 110 PRINCIPLES AND METRICS FOR EFFECTIVE EVALUATIONS. :10.
49. Netherland J, Kral AH, Ompad DC, et al. Principles and Metrics for Evaluating Oregon's Innovative Drug Decriminalization Measure. *J Urban Health*. 2022;99(2):328-331. doi:10.1007/s11524-022-00606-w
50. Waal H, Clausen T, Gjersing L, Gossop M. Open drug scenes: responses of five European cities. *BMC Public Health*. 2014;14(1):853. doi:10.1186/1471-2458-14-853
51. Selsky A. After rocky start, hopes up in Oregon drug decriminalization. AP NEWS. Published September 25, 2022. Accessed September 30, 2022. <https://apnews.com/article/health-oregon-drug-addiction-treatment-government-and-politics-cd6710deb7fced5b2721323fd1975362>

52. U.S. Department of Justice. Obama Administration Clemency Initiative. Published January 12, 2015. Accessed September 30, 2022. <https://www.justice.gov/archives/pardon/obama-administration-clemency-initiative>
53. Executive Office of the Mayor. Mayor Bowser, CareFirst, and DC Appleseed Announce New \$95 Million Fund Targeting Health Equity for Underserved DC Residents | mayormb. Published October 4, 2021. Accessed October 5, 2022. <https://mayor.dc.gov/release/mayor-bowser-carefirst-and-dc-appleseed-announce-new-95-million-fund-targeting-health-equity>
54. California S of. California Community Reinvestment Grants Program. Published September 16, 2022. Accessed October 5, 2022. <https://business.ca.gov/california-community-reinvestment-grants-program/>
55. Stevens A, Hughes CE, Hulme S, Cassidy R. Depenalization, diversion and decriminalization: A realist review and programme theory of alternatives to criminalization for simple drug possession. *European Journal of Criminology*. 2022;19(1):29-54. doi:10.1177/1477370819887514
56. Volkow ND. Addiction should be treated, not penalized. *Neuropsychopharmacol*. 2021;46(12):2048-2050. doi:10.1038/s41386-021-01087-2
57. Yopez E, Medicine RDEY is EE for, Journals LS, et al. Addiction Should Be Treated, not Penalized: An interview with Nora D. Volkow. On Health. Published August 25, 2021. Accessed November 11, 2022. <https://blogs.biomedcentral.com/on-health/2021/08/25/addiction-should-be-treated-not-penalized-an-interview-with-nora-d-volkow/>
58. Scheim AI, Maghsoudi N, Marshall Z, Churchill S, Ziegler C, Werb D. Impact evaluations of drug decriminalisation and legal regulation on drug use, health and social harms: a systematic review. *BMJ Open*. 2020;10(9):e035148. doi:10.1136/bmjopen-2019-035148
59. The AIR Center for Addiction Research and Effective Solutions. AIR CARES Webinar Series: Social Determinants of Addiction. American Institutes for Research. Published 2022. Accessed October 5, 2022. <https://www.air.org/webinar-series-social-determinants-addiction>
60. The Center for Law and Policy. No More Double Punishments: Lifting the Ban on SNAP and TANF for People with Prior Felony Drug Convictions. CLASP. Published April 2022. Accessed October 5, 2022. <https://www.clasp.org/publications/report/brief/no-more-double-punishments/>
61. The Center for Law and Policy. Drug Testing and Public Assistance. CLASP. Published February 2019. Accessed October 5, 2022. <https://www.clasp.org/publications/report/brief/drug-testing-and-public-assistance/>
62. Local Progress: The National Municipal Policy Network. Ending Drug-Related Evictions in Public Housing. Published online January 2019. <https://localprogress.org/wp-content/uploads/2019/01/Endingn-Drug-Related-Evictions-in-Public-Housing.pdf>

63. Medicare Learning Network, Centers for Medicare and Medicaid Services. Patients in Custody Under a Penal Authority. Published online July 2022.
<https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/items-services-furnished-to-beneficiaries-in-custody-under-penal-authority-fact-sheet-icn908084.pdf>
64. American Society of Addiction Medicine. Third-Party Payment for Addiction Treatment. Default. Published April 22, 2020. Accessed October 24, 2022.
<https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2020/04/22/third-party-payment-for-addiction-treatment>