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# A "Whole of Government" Approach to Reforming Opioid Use Disorder Legal and Policy Strategies

## THE LEGAL PATH TO A WHOLE OF GOVERNMENT OPIOIDS RESPONSE: PART 2

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## Executive Summary

The Whole-of-Government (W-G) perspective provides both a lens with which to critique current levels of alignment between different levels of government or agencies at the same level and a normative tool to drive reforms. Elsewhere we have applied a W-G lens to drug policing, harm reduction, and OUD treatment. A "wicked problem," such as the increase in serious opioid use disorder (OUD) and overdose deaths, requires multiple levels of government to mobilize their resources and expertise in an aligned and coordinated fashion. This should occur across multiple agencies either at one level of government (horizontal) or between different levels of government (vertical). It is clear that even when drug laws and policies across (horizontal) and between (vertical) levels of government are not outright antagonistic, frequently they are seriously misaligned.

A successful W-G strategy, particularly in a federal system with multiple overlapping agencies at different levels, requires agreement as to the problem and understanding the problem along with its causes. However, both the historic identification of the problem (people using drugs) and its cause (moral defect) have been proven false and created a stigmatizing feedback loop. The fallout has included impediments to treatment and harm reduction. The simplistic incarceration/moral defect approach also has slowed serious examination of how upstream factors such as structural and social determinants have caused or at least exacerbated our drug problem. An effective W-G strategy should identify the determinants that have the greatest impact on OUD issues and ensure that there is alignment between, for example, federal funding and state implementation in how they are approached.

W-G requires coordination and that is difficult when multiple agencies are involved. The natural coordinating agency is the Office of National Drug Control Policy (ONDCP). Yet, to be successful in that role ONDCP's director needs to be elevated to cabinet rank and the agency's priorities moved away from "control" with a commitment to a public health and social welfare approach. Whichever coordinating agency is established or chosen, its brief must include vertical alignment between federal, state, tribal, and local governments and across multiple dimensions. Consistent policies and turning down the "heat" of the "war on drugs" will be key. There must be a concerted effort to improve the way the federal government funds and the states implement programs. Grant programs with time-limited spending horizons should be replaced with longer-term funding and increased coordination is required to "braid" multiple mandatory and discretionary funding streams to be more effective. Finally, attention must be paid to the many legal reforms that are overdue. For example, numerous state laws frustrate federal policies such as funded of Syringe Service Programs (SSPs). In contrast, states or municipalities wishing to innovate by establishing Safe Consumption Sites (SCSs) are looking to the federal government to remove barriers such as the "Crack House" statute.

## Introduction

The Whole-of Government (W-G) approach to major health, social, or environmental challenges supposes that all the public agencies with something to contribute can help solve a recognized social problem if their efforts are aligned and coordinated. Sometimes referred to as "joined-up government" (Moseley, 2009), W-G connotes a systems-oriented conception of the matter at hand, in which many factors and agents drive problems, solutions, or both. Invoking W-G should be a sign of robust commitment from multiple levels of government and a potentially powerful model for mobilizing resources and expertise in a way that is attentive to side effects, feedback loops, and unintended consequences. Typically, it rests on and requires a clear, shared vision of the nature of the problem to be solved and the kind of action necessary to solve it.

We are now in the third decade of an overdose epidemic, and the fifth year of renewed federal emergency

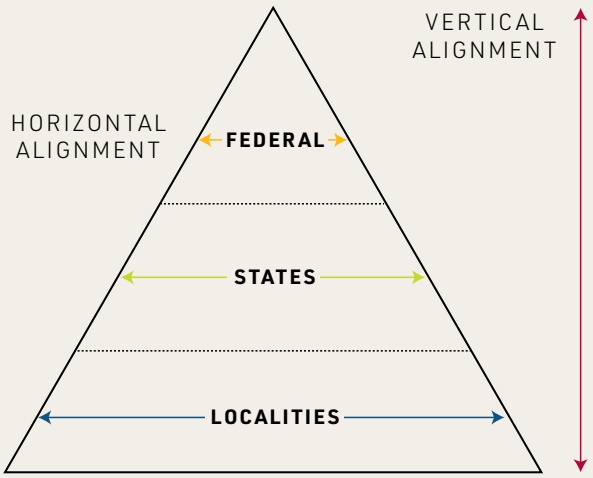
declarations, yet drug harms and deaths keep increasing (Spencer et al., 2023). As the demographics of the overdose epidemic shift from predominantly low-income white communities with sharp increases in deaths among individuals of color the opioid crisis becomes part of our racial justice debate (Friedman & Hansen, 2022; Joseph, 2022). Across our federal system, government agencies continue to follow narrow, partial visions of what to do, squandering precious resources as they get in each other's way. More than ever, it is imperative that we have effective, comprehensive, coordinated government action. In this article we describe key elements of an ideal W-G approach to opioid use disorder and drug problems generally, where W-G actually stands now, and how it needs to evolve.

## Elements of an Effective Whole-of-Government Strategy

Few, if any major social problems are solved by a signature on an executive order or the bipartisan passage of legislation. Because of the systemic nature of "wicked problems" (Lee, 2018), the authority to address them tends to be distributed across multiple agencies either at one level of government (horizontal), across different levels of government (vertical), or both. W-G should be the counterweight to governmental "siloization" (Moseley, 2009). However, responses to OUD have too often demonstrated how decisions made by one agency or level of government can frustrate the work of others. W-G requires "horizontal and vertical co-ordination in order to eliminate situations in which different policies undermine each other, to make better use of scarce resources, to create synergies by bringing together different stakeholders in a particular policy area and to offer citizens seamless rather than fragmented access to services" (Christensen & Lægreid, 2017). This, in turn, requires agencies not only to work cooperatively but to think coherently about how the levers they can turn interact with the levers of the other agencies in the system and the evidence of what actions produce harms and what actions prevent or effectively prevent them. At the outset, we also must recognize that our call for aligned W-G will not sit well with many who view government as the problem rather than the solution.

In our federal system, central government attracts a lot of attention because of its visibility and how it sets and funds broad policies for the country. But most of the actual lifting on "federal" policy is done by state and local agencies, which take federal dollars and put them to work. However, the federal government cannot coerce states into accepting their largesse (*National Federation of Independent Business v. Sebelius*, 2012). This has led to substantial gaps in Medicaid expansion (Kaiser Family Foundation, 2023) and individual states, like Tennessee, pushing back against other types of federal health care funding (Edwards,

### DEFINING WHOLE-OF-GOVERNMENT




The Whole-of-Government (W-G) perspective provides both a lens through which to critique current levels of alignment and misalignment between different levels of government or agencies at the same level, and a normative tool designed to structure reforms. What is required for effective policy making is comprehensive, coordinated government action across the different agencies at one level of government (be it federal or state), what we term *horizontal* W-G, and between different levels (federal, state, tribal, and local), what we term *vertical* W-G.

2023). Across a broad range of substance use policies, the federal government's role is limited to discretionary funding, typically via grants administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) (Substance Abuse and Mental Health Services Administration, 2020b). States and localities also bring to bear their own resources (NY Division of Budget, 2021) (sometimes reluctantly) and policies beyond and sometimes counter to what the federal agencies devise. That means that an ideal W-G strategy not only must be "horizontal" across governments at different levels but also "vertical," such that federal agencies are working well with their counterparts in states and devolved entities below.

The essence of W-G is independent but increasingly coordinated action by many different agencies toward the same goal. The biggest challenge for a W-G approach to OUD and drugs in the United States is finding that workable consensus. That consensus and so an effective W-G approach depends on several components, including agreement as to the problem, and understanding the problem along with its causes (Worzala et al., 2018). Effective coordination across a system as complex as

American federalism does not respond to top-down management. Rather, the many agencies at the different levels of government need a shared sense of what the problem is and the broad strategy for addressing it. Only then, with this shared "big idea," can they harmonize their work without direct day-to-day oversight.

## Defining the Problem

For decades, drug policy in the United States has started from the explicit or implicit premise that certain drugs are illegal because they are bad, and therefore drug control depends on stopping the dealers and deterring (and punishing) the users. It follows, all too commonly, that people who use drugs are regarded as both criminal and morally defective. This deeply stigmatizing view has long powered a vertical (federal-state-local) criminal justice cooperation to suppress supply and demand while increasing incarceration. Criminalization has consistently put barriers in the way of harm reduction programs (Burris et al., 2009). More broadly, the continued acceptance of the flawed premises of criminalization has shaped a stunted, overly legalized approach to evidence-based treatment for Opioid Use Disorder (OUD) (Massing, 2000), added to the individual and community-level risks of drug use (Burris et al., 2004), and sucked billions of dollars from government budgets that might have been put to better use in a public health-based campaign (Gottschalk, 2023). Treatment to manage the consequences appears only late in the narrative and, in many corrections settings, not at all (Wakeman & Rich, 2015). Links between mental health and substance use disorders, and between social conditions and the prevalence of substance use, too frequently have been ignored (Interlandi, 2022).

The current overdose crisis stands as the best evidence that a punitive approach just does not work. Despite trillions of dollars spent over decades on police, courts, and prisons, criminalizing drugs and their possession has not suppressed supply or reduced demand (Pearl & Perez, 2018). Worse, reliance on criminal justice has itself been a tragic cause of harm, perpetuating racial subordination and disparities, coarsening our society and putting daunting barriers of stigma in the path of treatment and prevention (Human Rights Watch, 2016). Access to the most effective medications — methadone and until very recently buprenorphine — is still hampered by the stigma and regulatory strictures that are the legacy of criminalization. Harm reduction, a pragmatic, person-centered approach respects the choices and value of each individual — and it works to prevent the spread of diseases like HIV and to give drug users tools like overdose-reversing naloxone to save lives. But like treatment, harm reduction measures are hobbled or blocked by the moral defect narrative and the punitive drug laws that were built to express that disdain (Williams, 2019). Our current state, therefore, is that of a public health paradox as government both funds a "war on drugs" that creates inequities and stigma and the harm reduction and treatment policies that are somehow meant to deal with them (Fleming et al., 2021).

## Understanding the Problem and its Underlying Causes

Drugs are complicated. Most US adults use legal drugs, and about one-fifth of all adults in the United States use illegal drugs (Substance Abuse and Mental Health Services Administration, 2020a). People have always used drugs because they offer pleasure and dull pain and anxiety. Drugs pose a public health problem because along with these benefits come risks, but this risk is not tightly correlated with whether a drug is legal or illegal (Lachenmeier & Rehm, 2015; Nutt et al., 2007). Nor does the character of the drug — or its legal status — determine the impact it will have on any particular user. America's drug problems cannot be solved with a call for abstinence, or prohibition, or just saying "no." Rather, we need a smart, multifaceted and sustained campaign based on pragmatic — and attainable — public health and social welfare goals: reduce overall consumption of all drugs, reduce the harmfulness of the drugs and drug use, treat those with all types of substance use disorders (SUD) — and understand and address the root causes of unhealthy drug use.

The basic resources necessary for health include economic stability (including employment), a healthy environment (including secure, affordable housing), quality education, food security, social support networks, and access to health care (Artiga & Hinton, 2019; Hummer & Hernandez, 2013; Link & Phelan, 1995). Recent research has shown that directly addressing economic stress through mechanisms like the minimum wage (Komro et al., 2016), TANF, and the earned income tax credit can have life-saving impact on threats like low birth weight, women's health (Spencer et

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al., 2020), suicide (Kaufman et al., 2020), and HIV/AIDS (Cloud et al., 2019). More broadly, a compelling study from a team of demographers and political scientists found that life expectancy at the state level was tied to person-centered, supportive policies (Karas et al., 2020). Our drug crisis is a whole-of-society problem that calls on the whole of government to do all it can to create the conditions in which people have better options than unsafe drug use — to replace deaths of despair with lives of opportunity and hope. Though it runs directly counter to the sort of wholesale punitiveness of prohibition, the best way to turn back the long-term tide of SUD and overdose in America is to invest in making life easier, less humiliating, and less painful for those who have been shut out of security and prosperity over the past 50 years (Piketty, 2014; WHO Commission on Social Determinants of Health, 2008).

## Coordination Across the Federal Government

Almost 20 federal agencies and departments are involved in drug policy. The national Commission on Combating Synthetic Opioid Trafficking (Trafficking Commission), established by Congress, reported that "Existing agencies retain specific areas of focus related to drug policy, but the sense of urgency of this quickly changing problem makes gaps in coordination more apparent" (US Department of Homeland Security, 2022). There is a twofold problem here: At the more micro level, a lack of coordination between agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare & Medicaid Services (CMS) and the Food and Drug Administration (FDA) within a single department (Health and Human Services (HHS)), and the more macro question across departments, including HHS, the Department of Justice (DOJ) and the Drug Enforcement Agency (DEA). As has been noted, "[t]here's this tension between the federal agencies, where you've got SAMHSA and the ONDCP [Office of National Drug Control Policy] saying medications for opioid-use disorder are good... and then you've got the DEA, which it's just in its DNA to try and control controlled substances" (Mahr K, 2022). Therein lies one of the great ironies of the federal and state governments and how they have approached our drug problem; 50 years of drug policing has provided conclusive proof that W-G can be an effective model, as horizontally and vertically a wide range of agencies at all levels have exhibited considerable agreement as to what the problem is (drug possession and use) and its cause (the moral defectiveness of those who use drugs).

Recently, the Trafficking Commission recommended ONDCP "should establish itself more firmly as the central authority for policymaking and interagency coordination on all drug control policy matters" and that its director should be returned to cabinet level (US Department of Homeland Security, 2022). This might make sense if ours was a "drug control" problem. ONDCP was established by the Anti-Drug Abuse Act of 1988 and is very much part of the "war on drugs" narrative. Today, our story is more complex. OUD and overdose are also health care stories, housing stories, stories of social mobility, education, and economic opportunity. They are stories of people who can't get housing at all, or whose housing comes with the monthly stress of paying a high rent on a low income. The Biden Administration's National Drug Control Strategy, also published in 2022, noted that ONDCP will lead the interagency process to implement its approach (The White House Executive Office of the President, 2022). As such the anointment of ONDCP as the point of coordination seems more like the culmination of a game of "you're it" than a well-thought exercise in choosing command and control based on regulatory powers, expertise, or influence. However, the need for horizontal and vertical alignment is chronic and a more robust ONDCP may succeed if it fully embraces harm reduction as a facet (or "pillar") of drug strategy, advocates for dramatic increases in treatment, and crucially starts to edge "drug control" through criminal law away from the center of the federal strategy. In short, the federal government should rebuild its hub as an Office of National Drug Policy, jettisoning the "control" and committing to a public health and social welfare approach. That rebuilt and restaffed office (with crucial staffing-up on budgetary policy) should have a single source of contact for the states that provides horizontal alignment and works with the states in aligning implementation.

## Coordination Between the Federal Government and the States

There is much more to be done to enlist capacities across the federal government, but an effective W-G strategy demands more than horizontal alignment of policies and coordination of implementation across federal stakeholders. Vertical alignment also is required between federal, state, tribal, and local governments and across multiple dimensions. As a result, states also should institute cross-agency coordination specifically tasked with aligning state policies with federal initiatives and maximizing the use of federal funds.

While states do have their own initiatives and funding streams, most major programs are designed and funded by the federal government acting through distinct agencies. Although the federal government can attach conditions to its funding (e.g., Medicaid mandatory service categories) or refuse reimbursement for certain services (e.g., the frequently waived Institutions for Mental Disease (IMD) exclusion), application, implementation, and even program design (e.g., eligibility and services) typically is left to the states. Furthermore, in the OUD treatment domain,

states will frequently operate through private entities such as Medicaid Managed Care Organizations and Opioid Treatment Programs (OTPs).

The lack of vertical alignment between federal funding and state implementation pervades a number of domains. For example, while the federal government has earmarked funds for harm reduction strategies such as SSPs (Centers for Disease Control and Prevention, 2019), state and locality antipathy remain such that the majority have states have zero or some derisory number of facilities. Arguably, the most notable misalignment between federal policy and state implementation is the refusal by 10 states to expand Medicaid (Kaiser Family Foundation, 2023), funding to low-income adults notwithstanding evidence that coverage expansion has improved access and outcomes for persons with OUD (US Department of Health and Human Services, 2017). The so-called coverage gap in the non-expansion jurisdictions denies access to care for some two million people living in populous states such as Florida, Georgia, and Texas (Garfield et al., 2021).

## Inconsistent Policies

Even as policymakers pivot toward emphasizing demand-side strategies, they find it difficult to leave behind decades of prohibitionist policies and their consequences of "racial discrimination by law enforcement and disproportionate drug war misery suffered by communities of color" (Drug Policy Alliance). Inconsistencies also can be tracked within individual agencies. The Biden administration's Drug Enforcement Agency (DEA), while beginning to dismantle some of the barriers it had erected to MOUD access (Drug Enforcement Agency, 2022) (although it took Congressional action to deregulate buprenorphine prescribing (Consolidated Appropriations Act, 2023)) at the same time launched a major interdiction effort targeting "hotspots" characterized by criminal behavior and overdoses (Drug Enforcement Administration, 2022). While the rhetoric has shifted toward saving lives and funneling funds into treatment, for people who use drugs, law enforcement "solutions" (and budgets) still outpace harm reduction strategies (Gottschalk, 2023).

In addition to agreed-upon policies, governments at any level must have consistent strategies. However, in the world of substance use and, particularly, when it comes to harm reduction there are glaring inconsistencies. Take for example, federal funding of syringe services programs (SSPs). The Consolidated Appropriations Act of 2018 (Consolidated Appropriations Act, 2022) finally allowed federal funds to be used for SSPs yet the federal syringe rider (Centers for Disease Control and Prevention, 2019) contained in Continuing Appropriations legislation prohibits federal funding for syringes used for intravenous drug consumption but not, apparently, intramuscular administration of naloxone (Substance Abuse and Mental Health Administration, 2022).

## Law and Policy Barriers

The misalignment between federal and state policies and the inability or failure of states to spend down federal monies are not always the most serious impediments to W-G approaches. Federal initiatives can find themselves blocked by antagonistic state laws or policies (downstream barriers) while state initiatives may run into federal barriers (upstream barriers).

For example, the federal government supports (at least to some degree) harm reduction initiatives, such as funding SSPs, Fentanyl test strips, or overdose reversal drugs, that are frequently impeded by state laws or practices. These include over-restrictive drug paraphernalia laws (Singer, 2023), impractically stringent conditions for opening an SSP (W. Va. Code §16-64-3, 2021), or even the attitudes of local prosecutors to people who use drugs possessing naloxone (Chernoby & Terry, 2020). Although the federal government has recently deregulated the partial agonist buprenorphine, opening up a far larger pool of prescribers, a handful of states prohibit nurse practitioners (NPs) from prescribing buprenorphine even though those same states allow NPs to prescribe other drugs when in collaborative arrangements with physicians (Vestal, 2017). In some states, the vertical barriers can run deeper when, for example, federally funded SSPs, while legal under state law, are subject to final approval from county-level health directors (Ind. Code §16-41-7.5-5, 2021) or otherwise deterred by NIMBYism (Tempalski et al., 2007).

While federal-funded SSPs can be derailed by state of local downstream barriers, the opposite is true of safe consumption sites (SCSs). Underground, unsanctioned SCSs (Kral et al., 2020) have shown considerable potential for harm reduction. In 2019, after Philadelphia approved Safehouse, an SCS to be opened by a non-profit, the federal government sued to block the opening, arguing that it was unlawful under the so-called "Crack House Act" ("Maintaining drug-involved premises," 1986). A federal appellate court agreed noting, "(a)lthough Congress passed § 856 to shut down crack houses, its words reach well beyond them. Safehouse's benevolent motive makes no difference (*United States v. Safehouse,* 2021). Recently Rhode Island (R.I. Gen. Laws § 23-12.10-1, 2022) and New York City (Khurshid, 2022) have launched pilot programs, and the Biden administration has signaled a less combative approach (Peltz J, 2022), but this is a far cry from removing all barriers and adopting a vigorous positive policy. The "crack house law" remains on the books and could well be enforced again by a subsequent administration that recalibrates the federal supply-side/demand-side strategy. In its shadow, the New York City

facilities are facing a budget debacle, and Rhode Island's facility has yet to open (Wernau, 2023). In California, successive governors have vetoed legislation that would allow cities to experiment with safe consumption sites (Cowan, 2022).

## Reimagining Whole-of-Government

If a whole-of-government approach to SUD has not yet materialized, what should we be looking to build from the current law and policy wreckage? Clearly and at root, preventing and treating unhealthy drug use requires a new consensus on the drug problem and its solutions. We need a better "big idea" to guide the whole system than drug use as crime and the solution as punishment. In addition to agreement as to the problem, and understanding the problem and its upstream causes, we know that an effective W-G approach also depends on consistent funding, and coordination across stakeholders (Worzala et al., 2018).

### Placing Social and Structural Determinants at the Heart of the Conversation

The assumption behind the W-G model is that alignment and coordination between federal agencies and between federal funding and state implementation across domains such as harm reduction, treatment, and interdiction is likely flawed because it fails to identify and wield policy levers that address the upstream social drivers (or social determinants) of dangerous substance use. When one person develops a substance use disorder, it is a tragic chapter in a hard life story (Eyre, 2020). When millions of people are using dangerous drugs and overdose is a leading cause of death, it is a failure of society to provide better options. Successful societies don't point fingers; they solve problems.

There is compelling evidence of the role of social determinants of health such as poverty, race, housing insecurity, lack of transportation and structural determinants such as stigma, and health care access or treatment (DiMario, 2022). As a result, any workable W-G strategy requires identifying the determinants that have the greatest impact on OUD issues and ensure that there is alignment between, for example, federal funding and state implementation to address those. The Biden administration's National Drug Control Strategy recognized that "[a]ddressing SDOH … will require all sectors of Government and society to identify and improve factors that influence health outcomes" (The White House Executive Office of the President, 2022).

Indeed, some are openly skeptical about the linkage. For example, the Trafficking Commission report (US Department of Homeland Security, 2022) and the Stanford–Lancet Commission seemed to minimize the role of social determinants in their recommendations. The latter went further, arguing that "Policy makers should attempt to alleviate poverty and inequality because of the human misery they cause. But they should not put forward the false promise that macroeconomic policy is a powerful or specific lever for reducing the prevalence of addiction" (Humphreys et al., 2022).

This is short-sighted. In an epidemic that has lasted two decades, it is folly to focus on short-term solutions that have not worked. There is strong evidence that negative social determinants, such as educational attainment (Kemp & Montez, 2020), lie behind the pejorative descriptors applied to regions of the country such as "tobacco nation" (Truth Initiative, 2019) or the "stroke belt" (Howard & Howard, 2020). States, reflecting polarized politics and policies, also operate as structural determinants (Krieger et al., 2022; Montez, 2020). For example, differences in women's mortality between states correlate with social cohesion and economic conditions (Montez et al., 2016) and education (Hummer & Hernandez, 2013), while disability rates are lower in states with greater income equality (Montez et al., 2017). Those indicators track to studies of overdose deaths. Generally, deaths are lower in counties with stable public-sector employment and higher levels of social cohesion and interaction (Monnat, 2018) and higher in areas of declining opportunities in the manufacturing sector (Seltzer, 2020). There is also emerging research on the relationship between substance use and social vulnerabilities caused by stressors such as poverty, homelessness, discrimination, and collateral consequences of conviction (Amaro et al., 2021).

A major structural determinant of substance use treatment is access to health care. Given the crucial role of Medicaid (Centers for Medicare & Medicaid Services) in providing health care to those with OUD, Medicaid expansion clearly decreased the number of uninsured low-income adults with SUD (Olfson et al., 2021), although, given the racial composition of non-expansion states, disparities among African Americans and Native Americans with substance use disorders increased (Andrews et al., 2015). Overall, however, Medicaid expansion appears to be associated with meaningful reductions in opioid-related hospital use (Wen et al., 2020), suggesting improved care in other settings. There is also a correlation between Medicaid expansion and uptake of buprenorphine and methadone medication-assisted treatment (Sharp et al., 2018).

The Biden administration's 2022 National Drug Control Strategy accepts the evidence, stating, "[A]ddressing SDOH is necessary to help improve health and reduce inequities in health outcomes—including in youth substance use, and this effort will require all sectors of Government and society to identify and improve factors that influence health outcomes" (The White House Executive Office of

the President, 2022). However, the "strategy" is silent as to how these goals should be pursued (or funded). Once again, this is a W-G problem requiring a W-G solution.

## An Improved Funding Model

Given the importance of federal money, how the federal government chooses to deliver funding for harm reduction and treatment initiatives is crucial. The federal government's preferred approach has been through grant programs with time-limited spending horizons, such as those introduced by the 21st Century Cures Act, the SUPPORT Act, or the American Rescue Plan (Substance Abuse and Mental Health Services Administration, 2021). The grant-like mechanisms used in these initiatives favor short-term "fixes," making it difficult for states or smaller entities to build out necessary infrastructure or engage in long-term planning. These mechanisms also impose administrative burdens, and human service agencies typically juggle the administrative demands of applying for and spending funds from many uncoordinated government sources (Jaramillo et al., 2019). Furthermore, too many of the projects eschew bold, direct, and timely intervention (e.g., convene expert groups, request and fund studies, research, or reports), while favoring demonstration programs or pilot programs rather than long-term, sustainable W-G strategies, such as those addressing social determinants of health. Individual clients of government programs also have to cope with and overcome unnecessary administrative burdens (Fox et al., 2019). These mechanisms should be rethought, with the emphasis placed on longer-term, consistent, and coordinated resources provided to the states.

As we have discussed elsewhere, the Bipartisan Policy Center has recommended that SAMHSA and CMS provide states with a braiding framework whereby multiple mandatory and discretionary funding sources can be coordinated to support similar objectives and align programs (Bipartisan Policy Center, 2022). A successful vertical W-G strategy also must address funding gaps. Hundreds of thousands of people with OUD lack health insurance (Orgera & Tolbert, 2019). Congress should design a reimbursement model for OUD services modeled on the "payer of last resort" used in the Ryan White HIV/AIDS Program; a program specifically designed to fill funding gaps (Kaiser Family Foundation, 2022). The states also must step up investment of their own funds in improved behavioral health programs; few have made truly major investments (Maine Department of Health and Human Services, 2023; Washington Health Care Authority, 2023). As opioid litigation settlement funds become available, this is an opportunity to act, and the majority of states that have undertaken to spend their funds on opioid abatement and other approved uses (Distributor Settlement Agreement Schedule B Approved Uses, 2022) should be held to their promises (Vital Strategies, 2023).

Tackling social and structural determinants is a far more complex task than addressing their downstream effects. Taking on drivers of unhealthy drug use like economic inequality, housing, employment, education, and economic development dramatically implicates a wide range of legal levers and agencies. It demands that the system recalibrate to deal with individuals suffering from drug use as people who also have other economic, social, and medical needs. A W-G approach is essential not only because of the interaction of federal funding and state implementation and the need for alignment of policies but also because there must be a framework that aligns upstream levers addressing social determinants and downstream federal and state levers. Moving the emphasis upstream and placing the responsibility on the federal government rather than merely funding initiatives through block grants, while politically challenging, provides an opportunity to reverse the results of devolution and preemption that enabled state governments to have the dominant influence on the health of their citizens with profoundly negative consequences for the safety net, economic well-being, risky behaviors, and health care access in many states. Moreover, tackling OUD issues upstream signals that the problem is systemic or institutional, thus minimizing the individual responsibility, moral defect narrative and focusing attention on the necessary whole-of-government approach.

## Removing Legal Barriers

A challenging pivot toward prevention, harm reduction, and treatment is absolutely necessary but it will also be insufficient. As we have detailed at length, healthier policies will not be successful until we reform our criminal justice approach to people who use drugs. That means aiming not just to reduce the harms of substance abuse, but also to reduce the harms caused by substance abuse policies. As long as we continue to criminalize drugs and their possession we will perpetuate stigma, disparities, and racial inequities. Without basic drug policy reforms, the W-G approach is in jeopardy. There will be continuous agency turf wars among those tasked with supply-side and those with demand-side strategies, while the inconsistent policies that inevitably follow further slow progress. The new "big idea" of unhealthy drug use as a health and social problem cannot co-exist with criminalization: it must replace it.

Job one for ONDCP should be to address all the law and policy barriers to the various parts of its OUD strategy that we have identified, particularly those impeding harm reduction and treatment, determine where the legal barriers lie — at federal, state, or local levels — and how

best to remove them. Given the complex nature of this "wicked problem" the remedies will have to be flexible and varied. But the federal government has a range of policy levers it can use, regulations, waivers, sub-regulatory guidance, DOJ non-prosecution memoranda, nudges from the bully pulpit, and so on.

## Conclusion

Legal interventions such as broad harm reduction legislation (Good Samaritan Act, 2022), the Model Syringe Services Program Act promoted by the Biden administration, or even narrower provisions such as allowing naloxone standing orders (Meyerson et al., 2018) can have a positive impact on OUD and overdose deaths. However, many of the most needed legal interventions are more accurately viewed as corrective, necessary to reverse decades of unhelpful, even destructive policies. Characterizing drug addiction as a moral defect not only cruelly justifies criminalization and incarceration but also deprecates treatment for OUD in justice settings. Removing the legal and administrative legacy of Prohibitionist drug policy is a long-overdue way to improve delivery of interventions and services across government. It will also take a powerful cause of harm out of the system.

W-G as a solution is itself fraught with issues — competing bureaucracies, turf warfare, and fundamental disagreements as to policy. However, it is a positive step forward. Our complex, intertwined layers of laws and policies have to be reformed and for that federal, state, and local governments must commit to a W-G framework. That framework is complex and requires a far broader approach that looks at W-G from both horizontal and vertical perspectives. However, even with such a W-G commitment, federal and state stakeholders likely will achieve incomplete or short-lived success without also addressing the upstream social and structural drivers of OUD and overdose deaths. ◆


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# References


21st Century Cures Act, Pub. L. No. Pub. L. 114–255, (2016).

Amaro, H., Sanchez, M., Bautista, T., & Cox, R. (2021). Social vulnerabilities for substance use: Stressors, socially toxic environments, and discrimination and racism. *Neuropharmacology*, 188, 108518.

Andrews, C. M., Guerrero, E. G., Wooten, N. R., & Lengnick-Hall, R. (2015). The Medicaid expansion gap and racial and ethnic minorities with substance use disorders. *American Journal of Public Health*, *105*(S3), S452-S454.

Anti-Drug Abuse Act of 1988, Pub. L. No. Pub. Law. No. 100-690 21 U.S.C. § 856 (1988).

Artiga, S., & Hinton, E. (2019). Beyond health care: the role of social determinants in promoting health and health equity. *Health*, *20*(10), 1-13.

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

Burris, S., Anderson, E. D., Craigg, A., & Davis, C. S. (2009). Racial disparities in injection-related HIV: A case study of toxic law. *Temple Law Review.,* 82, 1263.

Burris, S., Blankenship, K. M., Donoghoe, M., Sherman, S., Vernick, J. S., Case, P., Lazzarini, Z., & Koester, S. (2004). Addressing the "risk environment" for injection drug users: the mysterious case of the missing cop. *The Milbank Quarterly*, *82*(1), 125-156.

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

Centers for Medicare & Medicaid Services. *Substance Use Disorders*. Centers for Medicare & Medicaid Services. https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/substance-use-disorders/index.html

Chernoby, K., & Terry, N. (2020). *Opinion: Naloxone saves lives. Tainting it with criminality will mean people die*. Washington Post. https://www.washingtonpost.com/opinions/naloxone-saves-lives-tainting-it-with-criminality-will-mean-people-die/2020/03/03/15df512e-5ccf-11ea-9055-5fa12981bbbf_story.html

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

Cloud, D. H., Beane, S., Adimora, A., Friedman, S. R., Jefferson, K., Hall, H. I., Hatzenbuehler, M., Johnson, A. S., Stall, R., & Tempalski, B. (2019). State minimum wage laws and newly diagnosed cases of HIV among heterosexual black residents of US metropolitan areas. *SSM-population health*, 7, 100327.

Consolidated Appropriations Act, Pub. L. No. Pub. Law 117-103, § 526 (2022).

Consolidated Appropriations Act, Pub. L. No. Pub. L. 117–328, § 1262 (2023).

Cowan, J. (2022, August 22). *Governor Newsom Vetoes Bill for Drug-Injection Sites in California*. The New York Times. https://www.nytimes.com/2022/08/22/us/gavin-newsom-vetoes-drug-injection-sites.html

DiMario, A. (2022). To Punish, Parent, or Palliate: Governing Urban Poverty through Institutional Failure. *American Sociological Review*, *87*(5), 860-888.

Distributor Settlement Agreement Schedule B Approved Uses. (2022). https://nationalopioidsettlement.com/wp-content/uploads/2022/03/Final_Distributor_Settlement_Agreement_3.25.22_Final.pdf#page=119

Drug Enforcement Administration. (2022). *Overdose and Violence Reduction Enforcement Initiative. DEA Operation Overdrive fact sheet: safeguarding communities from drug-related harm*. Drug Enforcement Administration. https://admin.dea.gov/sites/default/files/2022-02/20220207-DEA_Operation_Overdrive_Fact_Sheet.pdf

Drug Enforcement Agency. (2022). *DEA's commitment to expanding access to medication-assisted treatment*. Drug Enforcement Agency. https://www.dea.gov/press-releases/2022/03/23/deas-commitment-expanding-access-medication-assisted-treatment

Drug Policy Alliance. (2016). *Race and the Drug War*. Drug Policy Alliance. https://drugpolicy.org/issues/race-and-drug-war

Edwards, E. (2023). *Tennessee says it's cutting federal HIV funding. Will other states follow?* NBC News. https://www.nbcnews.com/health/health-news/tennessee-says-cutting-federal-hiv-funding-will-states-follow-rcna66689

Eyre, E. (2020). *Death in Mud Lick: A coal country fight against the drug companies that delivered the opioid epidemic*. Simon and Schuster.

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

Fox, A., Feng, W., & Reynolds, M. (2019). The Effect of Administrative Burden on State Safety Net Participation: Evidence from SNAP, TANF and Medicaid. *Public Administration Review*.

Friedman, J., & Hansen, H. (2022). Far From a "White Problem": Responding to the Overdose Crisis as a Racial Justice Issue. *American Journal of Public Health*, *112*(S1), S30-S32. https://doi.org/10.2105/ajph.2021.306698

Garfield, R., Damico, A., & Orgera, K. (2021). *The coverage gap: Uninsured poor adults in states that do not expand Medicaid*. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

Good Samaritan Act, 745 ILCS 49 (2022).

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

Howard, G., & Howard, V. J. (2020). Twenty years of progress toward understanding the stroke belt. *Stroke*, *51*(3), 742-750.

Human Rights Watch. (2016). *Every 25 Seconds*. Human Rights Watch. https://www.hrw.org/report/2016/10/12/every-25-seconds/human-toll-criminalizing-drug-use-united-states

Hummer, R. A., & Hernandez, E. M. (2013). The effect of educational attainment on adult mortality in the United States. *Population Bulletin*, *68*(1), 1.

Humphreys, K., Shover, C. L., Andrews, C. M., Bohnert, A. S., Brandeau, M. L., Caulkins, J. P., Chen, J. H., Cuéllar, M.-F., Hurd, Y. L., & Juurlink, D. N. (2022). Responding to the opioid crisis in North America and beyond: recommendations of the Stanford–Lancet Commission. *The Lancet, 399*(10324), 555-604.

Ind. Code §16-41-7.5-5, (2021).

Interlandi, J. (2022, June 24). *Experts say we have the tools to fight addiction. So why are more Americans overdosing than ever?* The New York Times. https://www.nytimes.com/2022/06/24/opinion/addiction-overdose-mental-health.html

Jaramillo, E. T., Willging, C. E., Green, A. E., Gunderson, L. M., Fettes, D. L., & Aarons, G. A. (2019). "Creative financing": funding evidence-based interventions in human service systems. *The Journal of Behavioral Health Services & Research*, *46*(3), 366-383.

Joseph, A. (2022). *Two deadly days in St. Louis: An overdose cluster kills 8 Black people — and shows the new shape of the addiction crisis*. STAT. https://www.statnews.com/2022/07/25/st-louis-drug-overdose-cluster-black-lives-fentanyl/

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

Kaiser Family Foundation. (2023). *Status of State Medicaid Expansion Decisions: Interactive Map*. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

Karas, M. J., Jason, B., Kemp, C. J., & al, e. (2020). US state policies, politics, and life expectancy. *The Milbank Quarterly*, 1-32.

Kaufman, J. A., Salas-Hernández, L. K., Komro, K. A., & Livingston, M. D. (2020). Effects of increased minimum wages by unemployment rate on suicide in the USA. *Journal of Epidemiology Community Health*, *74*(3), 219-224.

Kemp, B. R., & Montez, J. K. (2020). Why does the importance of education for health differ across the United States? *Socius*, 6, 2378023119899545.

Khurshid, S. (2022, March 14). *'Clear proof lives have been saved': will New York expand on first Overdose Prevention Centers?* Gotham Gazette. https://www.gothamgazette.com/state/11167-new-york-city-expand-overdose-prevention-centers

Komro, K., Livingston, M., Markowitz, S., & Wagenaar, A. (2016). Increased minimum wage linked with decreased infant mortality. *American Journal of Public Health*, *106*(8), 1514-1516.

Kral, A. H., Lambdin, B. H., Wenger, L. D., & Davidson, P. J. (2020). Evaluation of an Unsanctioned Safe Consumption Site in the United States. *New England Journal of Medicine, 383*(6), 589-590. https://doi.org/10.1056/NEJMc2015435

Krieger, N., Testa, C., Chen, J. T., Hanage, W. P., & McGregor, A. J. (2022). Relationship of political ideology of US federal and state elected officials and key COVID pandemic outcomes following vaccine rollout to adults: April 2021–March 2022. *The Lancet Regional Health-Americas*, 16, 100384.

Lachenmeier, D. W., & Rehm, J. (2015). Comparative risk assessment of alcohol, tobacco, cannabis and other illicit drugs using the margin of exposure approach. *Scientific Reports*, *5*(1), 1-7.

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

Legislative Analysis. (2021). Model Syringe Services Program Act. Legislative Analysis. https://legislativeanalysis.org/model-syringe-services-program-act/

Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, 80-94.

Mahr K, L. B. (2022). *'Untreated': patients with opioid addiction could soon lose access to virtual care*. POLITICO. https://www.politico.com/news/2022/06/20/opioid-addiction-telehealth-00040568

Maine Department of Health and Human Services. (2023, January 11). *Maine DHHS Announces Historic Payment Reforms for Behavioral Health*. State of Maine. https://www.maine.gov/dhhs/blog/maine-dhhs-announces-historic-payment-reforms-behavioral-health-2023-01-11

Maintaining drug-involved premises, 21 U.S.C. § 856 (1986).

Massing, M. (2000). *The Fix*. Berkeley. University of California Press.

Meyerson, B. E., Agley, J. D., Davis, A., Jayawardene, W., Hoss, A., Shannon, D. J., Ryder, P. T., Ritchie, K., & Gassman, R. (2018). Predicting pharmacy naloxone stocking and dispensing following a statewide standing order, Indiana 2016. *Drug and Alcohol Dependence*, 188, 187-192. https://doi.org/10.1016/j.drugalcdep.2018.03.032

Monnat, S. M. (2018). Factors associated with county-level differences in US drug-related mortality rates. *American Journal of Preventive Medicine*, *54*(5), 611-619.

Montez, J. K. (2020). US state polarization, policymaking power, and population health. *The Milbank Quarterly*, *98*(4), 1033.

Montez, J. K., Hayward, M. D., & Wolf, D. A. (2017). Do US states' socioeconomic and policy contexts shape adult disability? *Social Science & Medicine*, 178, 115-126.

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

Moseley, A. (2009). Joined-up government: rational administration or bureaucratic politics. Public Administration Committee Annual Conference.

National Federation of Independent Business v. Sebelius, 132 S.Ct. 2566 (2012).

Nutt, D., King, L. A., Saulsbury, W., & Blakemore, C. (2007). Development of a rational scale to assess the harm of drugs of potential misuse. *The Lancet*, *369*(9566), 1047-1053.

Office of Addiction Services and Supports. (2021). *NY Division of Budget*. State of New York. https://www.budget.ny.gov/pubs/archive/fy21/exec/agencies/appropdata/AddictionServicesandSupportsOfficeof.html

Olfson, M., Wall, M., Barry, C. L., Mauro, C., Feng, T., & Mojtabai, R. (2021). Medicaid expansion and low-income adults with substance use disorders. *The Journal of Behavioral Health Services & Research*, *48*(3), 477-486.

Orgera, K., & Tolbert, J. (2019). *Key Facts about Uninsured Adults with Opioid Use Disorder*. Kaiser Family Foundation. https://www.kff.org/uninsured/issue-brief/key-facts-about-uninsured-adults-with-opioid-use-disorder/

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

Peltz J, B. M. (2022, February 8). *Justice Dept. signals it may allow safe injection sites*. AP News. https://apnews.com/article/business-health-new-york-c4e6d999583d7b7abce2189fba095011

Piketty, T. (2014). *Capital in the twenty-first century*. Harvard University Press.

R.I. Gen. Laws § 23-12.10-1, (2022).

Seltzer, N. (2020). The economic underpinnings of the drug epidemic. *SSM-Population Health*, 12, 100679.

Sharp, A., Jones, A., Sherwood, J., Kutsa, O., Honermann, B., & Millett, G. (2018). Impact of Medicaid expansion on access to opioid analgesic medications and medication-assisted treatment. *American Journal of Public Health*, *108*(5), 642-648.

Singer, J. (2023). *Fentanyl Test Strips Save Lives, Yet Most States Ban Them As "Drug Paraphernalia."* CATO Institute. https://www.cato.org/blog/fentanyl-test-strips-save-lives-yet-most-states-ban-them-drug-paraphernalia

Spencer, M. R., Warner, M., Cisewski, J. A., Miniño, A., Dodds, D., Perera, J., & Ahmad, F. B. (2023). *Estimates of Drug Overdose Deaths involving Fentanyl, Methamphetamine, Cocaine, Heroin, and Oxycodone: United States, 2021*.

Spencer, R. A., Livingston, M. D., Woods-Jaeger, B., Rentmeester, S. T., Sroczynski, N., & Komro, K. A. (2020). The impact of temporary assistance for needy families, minimum wage, and Earned Income Tax Credit on Women's well-being and intimate partner violence victimization. *Social Science & Medicine*, 266, 113355.

Substance Abuse and Mental Health Administration. (2022, September 21). *Letter to State Authority for Mental and Substance Use Disorders*. Substance Abuse and Mental Health Administration.

Substance Abuse and Mental Health Services Administration. (2020a). *Results from the 2020 national survey on drug use and health: detailed tables. Book Results from the 2007 National Survey on Drug Use and Health: Detailed Tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020.htm

Substance Abuse and Mental Health Services Administration. (2020b, October 9). *SAMHSA grant awards by state*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/grants-awards-by-state

Substance Abuse and Mental Health Services Administration. (2021). *HHS announces $3 billion in American Rescue Plan funding for SAMHSA block grants to address addiction, mental health crisis*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/newsroom/press-announcements/202105181200

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, Pub. L. No. Pub. Law No. 115-271, (2018). https://www.congress.gov/bill/115th-congress/house-bill/6

Tempalski, B., Friedman, R., Keem, M., Cooper, H., & Friedman, S. R. (2007). NIMBY localism and national inequitable exclusion alliances: The case of syringe exchange programs in the United States. *Geoforum*, *38*(6), 1250-1263.

Terry, N., & Burris, S. (2023a). Leveraging a Whole of Government Model to Improve Opioid Use Disorder Healthcare

Terry, N., & Burris, S. (2023b). Whole-of-Government and Drug Policing.

Terry, N., & Burris, S. (2023c). Whole-of-Government and Harm Reduction.

Terry, N., & Burris, S. (2023d). Whole-of-Government and Harm Reduction.

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

Truth Initiative. (2019, Jun. 6, 2019). Tobacco Nation: an ongoing crisis.

United States v. Safehouse, 985 225 (3d Cir. 2021), cert. denied sub nom; Safehouse v. Department of Justice, 142 S. Ct. 345 (2021).

US Department of Health and Human Services, O. f. C. R. (2017). *Continuing Progress on The Opioid Epidemic: The Role of the Affordable Care Act*. US Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/private/pdf/255456/ACAOpioid.pdf

US Department of Homeland Security. (2022). *Commission on Combating Synthetic Opioid Trafficking. Final report*. US Department of Homeland Security. https://www.rand.org/pubs/external_publications/EP68838.html

Vestal, C. (2017). Nurse licensing laws block treatment for opioid addiction. The Pew Charitable Trusts, *Stateline*.

Vital Strategies. (2023). *Opioid Settlement Funds: State-Level Guides for Community Advocates*. Vital Strategies. https://www.vitalstrategies.org/resources/opioid-settlement-funds-state-level-guides-for-community-advocates/

W. Va. Code §16-64-3, (2021).

Wakeman, S. E., & Rich, J. D. (2015). Addiction treatment within US correctional facilities: Bridging the gap between current practice and evidence-based care. *Journal of Addictive Diseases, 34*(2-3), 220-225.

Washington Health Care Authority. (2023). *Ensuring access to vital behavioral health care Proposed 2023-25*. State of Washington. https://ofm.wa.gov/sites/default/files/public/budget/statebudget/highlights/budget23/05-Humans.pdf

Wen, H., Soni, A., Hollingsworth, A., Freedman, S., Benitez, J., Simon, K., & Saloner, B. (2020). Association between Medicaid expansion and rates of opioid-related hospital use. *JAMA Internal Medicine*, *180*(5), 753-759.

Wernau, J. (2023, January 2). *Sanctioned Drug-Use Sites Reach a Crossroads as Funding Runs Out*. The Wall Street Journal. https://www.wsj.com/articles/sanctioned-drug-use-sites-reach-a-crossroads-as-funding-runs-out-11672625580

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

Williams, J. (2019). *A Fight to Do No Harm*. US News. https://www.usnews.com/news/healthiest-communities/articles/2019-01-24/opioid-crisis-harm-reduction-struggles-for-acceptance-in-us

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