The Network for Public Health Law

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MECHANISMS FOR ADVANCING HEALTH EQUITY

Policy Brief

Seven Policies that Advance Overdose Prevention and the Health of People Who Use Drugs

Introduction

International Overdose Awareness Day is held every year on August 31 and is considered the world's largest campaign to end overdose since its initiation in 2001.[1] On International Overdose Awareness Day, people, communities, and organizations remember their loved ones who died from drug overdose and hold events that aim to promote overdose awareness without stigma and provide opportunities to connect with one other over our shared desire for a future free from overdose.

Over one million people have died from an overdose since 2003.[2] While overdose rates have begun to decrease in recent years for some populations, they have continued to increase for others.[3] Now is the time to continue proven strategies to prevent overdose deaths and support targeted and tailored interventions towards populations that continue to experience the highest rates of overdose.

In recognition of International Overdose Awareness Day, Network attorneys and staff have identified seven policies with the potential to improve overdose prevention and advance the health of people across the United States who use drugs. This policy brief covers a wide range of areas, including well known, evidence-based harm reduction strategies and frameworks, as well as more novel policies that intersect climate change and drug policy. As evidence-based and community-based policies and practices to reduce overdose deaths are increasingly under scrutiny and facing defunding efforts, this policy brief is designed as a resource for public health professionals, leaders, and partners as well as a reminder of the need for continued and increased support during hostile times.

Overview of Policies

Chart Title

POLICY	DESCRIPTION	EVIDENCE IN ACTION
Applying LGBTQ+, HIV/AIDS, and Black Community-	Recognizing harm reduction's roots in Black and LGBTQ+ communities to center community-led,	Over the past fifty years, harm reduction has evolved from grassroots responses within Black and LGBTQ+ communities during the HIV/AIDS crisis into its own recognized public health framework. This legacy offers important lessons for today's harm reduction, overdose prevention, and

Based Harm Reduction Histories	non-judgmental, and effective harm reduction, overdose prevention, and mental health strategies	mental health strategies, including the continued need for more equitable and effective policies that are community-driven, anti-stigma, and recognize the role of advocacy and activism.
Don't Forget the Basics – Protecting Tried and True Harm Reduction Practices: Syringe Services Programs	Public health professionals at all levels must continue to support syringe services programs in the face of increasing animus.	Syringe services programs, long a staple of harm reduction, are seeing an uptick in local opposition or neglect across the country, despite decades of evidence supporting the programs. Public health professionals must continue to learn from on-the-ground harm reductionists and support these critical programs that are so central to saving the lives of people who use drugs.
Establish and Protect Overdose Prevention Centers	Establishing and protecting overdose prevention centers will prevent overdose deaths by allowing safe places for people to use substances.	Overdose prevention centers operate around the world with a proven track record of preventing overdose deaths. In the United States, centers currently operate in New York City, Rhode Island, and will soon operate in Vermont. These lifesaving centers allow people to use substances in a place where trained staff can intervene in an overdose to save lives as well as provide new, safe supplies to reduce the risks of infection and disease that can occur from sharing or re-using supplies. Expanding the availability of these centers throughout the United States will allow more people to access and benefit from lifesaving services.
Provide Access to Naloxone in Schools	Increasing access to naloxone in schools and among youth can save lives and normalize the availability and use of lifesaving medications such as naloxone.	In recent years, many states and school districts have expanded access to naloxone in schools. Reducing barriers to naloxone and providing evidence-based education to students saves lives and empowers youth to support harm reduction efforts in their communities.
Improving Medicaid Access for People Who Are Incarcerated and Formerly Incarcerated	Increasing access to Medicaid coverage and benefits during and after incarceration can mitigate serious overdose risk in the post-release period.	Individuals returning to their communities after incarceration face markedly elevated rates of overdose due in part to unsafe conditions of confinement and the criminalization of substance use disorder (SUD). Access to SUD treatment and wraparound services after release is impeded by a statutory provision that has historically prohibited the use of federal Medicaid funds to pay for most care received while incarcerated. However, recent federal- and state-level policy changes, as well as several proposed policies, seek to narrow this federal Medicaid exclusion or otherwise improve continuity of care during reentry. These policies, though only a step in the right direction, expand access to necessary services to prevent overdose in the particularly high-risk period post-release. Diverting funding away from punishment and instead investing in critical support like Medicaid builds health-affirming systems that prevent overdose and disrupt structural drivers of health inequity.
Implement Heat Surveillance Mechanisms that Track Heat Related Deaths of People Who Use Drugs	Substance use makes people more vulnerable to heat-related deaths; as such, better data and response to heat-related deaths should be a part of overdose prevention strategies.	There currently exists no uniform method of tracking heat related deaths and illnesses, and what does exist often lacks a cross-sectional public health approach. Existing data, however, shows that substance use combined with exposure to high temperatures can be deadly, as drugs interfere with bodily functions like the ability to cool off. One jurisdiction that has taken a more comprehensive approach to heat surveillance is Maricopa County, Arizona, which issues yearly reports on heat-related deaths that examine several factors including the intersection of heat and substance use deaths. As extreme heat becomes more common, other jurisdictions must follow this model to advance equitable harm reduction efforts and climate justice.

Maintain Access to Medications for Opioid Use Disorder Following Natural Disasters	These policies authorize pharmacists to issue emergency refills of medications, including buprenorphine, needed to sustain life or treat a chronic condition in specific emergency conditions, when contact with health care providers and established pharmacy services may be disrupted.	In North Carolina, in the aftermath of Hurricane Helene, several policies came together to enable continued access to buprenorphine, even in the context of inaccessible, flooded, and closed pharmacies. Relying upon the governor's declaration of a statewide state of emergency, the North Carolina Board of Pharmacy issued an administrative rule, Emergency Prescription Refill Due to Interruption of Medical Services, 21 N.C. Admin Code sec. 46.1815. The federal Drug Enforcement Administration concurred in the application of the administrative rule to enable pharmacists to provide emergency refills of buprenorphine. This policy helped to maintain access to buprenorphine for people who already had prescriptions to treat opioid use disorder during a time of increased stress and corresponding increased risk of drug overdose.

Applying LGBTQ+, HIV/AIDS, and Black Community-Based Harm Reduction Histories

In the 1980s, harm reduction was forged by Black and LGBTQ+ activists facing the twin crises of HIV/AIDS and punitive drug policy. Half a century later, harm reduction must remain a community-centered framework that remembers how stigma and shame were transformed into survival tactics; how communities built mutual aid infrastructures; and how advocacy shaped an enduring, life-saving health paradigm that ensures more humane, inclusive, and effective harm reduction, overdose prevention, and mental health services, often in the face of hostile public reaction.

Harm reduction developed as mutual aid, often in defiance of systemic neglect, among people with HIV and people who were using drugs — and thus emerged from disproportionately affected LGBTQ+ and Black communities.[4] It was LGBTQ+ communities that constructed syringe exchanges, naloxone access, and peer education during the 1980s and 1990s that laid the foundation for what is now recognized as modern harm reduction.[5] During the early AIDS crisis, LGBTQ+, Black, and other individuals endured intense discrimination and stigmatization—from governmental, medical, and other public and private institutions—that fueled shame and invisibility. This propelled marginalized groups to create their own interventions such as syringe exchange programs and peer-led safer-sex education.[6] Pioneering HIV/AIDS activist groups like ACT UP used civil disobedience and direct action to demand access to HIV treatments, safe supplies, and respect—transforming harm reduction into a political strategy as much as a public health practice.[7]

The bold use of activism has continued into harm reduction and overdose prevention advocacy, with LGBTQ+, drug-user, and racial justice organizers continuing to push for safe consumption sites, naloxone access, and decriminalization.[8] There should be continued support and respect for organizing and advocacy by people with lived and living experience—ensuring that policy frameworks include funding for grassroots engagement, mobilization, legal defense, and community leadership development.

Many current day overdose prevention centers connect their core mission to practices started by Black and LGBTQ+ activists fighting for survival during the AIDS epidemic.[9] Programs and policies should continue to embed peer-led structures, culturally informed service models, and community rooted institutions—especially in Black, LGBTQ+, and low-income neighborhoods. Peer-driven syringe services, naloxone distribution, and safer-use education that center intersectional identities and lived experience should be funded. Community advisory structures and cultural responsiveness that reflect the heritage of Black and LGBTQ+ community members should be adopted.[10]

Current overdose and drug-use programs and policies that use shame, stigma, and moralizing will continue to impede much needed individual and community engagement with health systems. Harm reduction policies must continue to be built on community-led, non-judgmental care. Funding should support harm reduction

services and policies that are designed by and for those with lived and living experienceand reject moralizing or abstinence-based models. Core harm reduction principles of non-judgment, autonomy, and peer support should be integrated into mental health services and policies for Black, LGBTQ+, and other marginalized groups. Shame and trauma associated with drug use identity and policing should be addressed using holistic and culturally attuned approaches, including alternative and traditional healing methods that draw from Black and LGBTQ+ community care traditions.[11] Centering the values of community-led, non-judgmental advocacy, policy, and services not only honors the legacy of Black and LGBTQ+ harm reduction pioneers, it helps us move forward as we consider expanded strategies to prevent overdose, support healing, and dismantle stigma across systems of care.

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Don't Forget the Basics—Protecting Tried and True Harm Reduction Practices: Syringe Services Programs

Since the 1990s, in response to unprecedented numbers of deaths from HIV/AIDS in communities of people who inject drugs, a core tool of harm reduction has been the syringe services program (SSP, also known as syringe exchange or needle exchange). These programs have deep roots,[12] building from distributing bleach to disinfect syringes, to 1:1 needle exchange, to grassroots naloxone distribution,[13] and up to today's distribution of syringes, pipes, drug checking equipment, and myriad other supplies that people who use drugs (PWUD) use to protect themselves from transmissible disease, injury, and death. SSPs provide all this and more, building community and stigma-free spaces for PWUD.

Unfortunately, these programs are still, after over 30 years of research proving their efficacy and safety,[14] constantly having to re-prove their worth. PWUD are an easy target for politicians who cannot imagine a world where drug use is not criminalized. Instead of expanding treatment for people who want to stop using drugs, homes for people who are unhoused, and comprehensive physical and mental healthcare for all, city and county councils nationwide have instead blamed the local SSP for any community problems. Over the past few years, there has been an increase in attacks on harm reduction programs, from California[15] to West Virginia[16] and in many places in between.[17] We even recently saw Idaho repeal its law authorizing SSPs, the first state-level repeal of its kind.[18] Some programs have seen support from their communities, national organizations, or private attorneys. This, however, is unfortunately the exception and not the rule. Further, advocacy for policies like drug decriminalization and overdose prevention centers, while extremely necessary, has sometimes resulted in a lack of attention paid to protecting basic harm reduction practices at SSPs.

Support for these crucial institutions is necessary at all levels of government. Recent communication from the federal government indicates that they do not fully appreciate the work that harm reductionists do and the lifesaving properties of the services they provide.[19] Harm reduction supplies have changed over the years, but the love and care that people who use drugs receive at SSPs have always been crucial to preventing overdose death. Community-based SSPs, employing people with lived and living experience of drug use, can connect with the populations most at risk of overdose, adjust to a frequently changing drug supply, and respond immediately when people are in need. It is imperative that public health continues to support grassroots SSPs and not lose the progress harm reduction has made that has resulted in decades of lives saved.

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Establish and Protect Overdose Prevention Centers

Overdose prevention centers (OPC), sometimes also known as supervised consumption sites, safe consumption sites or safe injection sites, are places where people who use drugs can use safely without fear of stigma or shame. They are comprehensive harm reduction programs providing wrap-around services including drug checking, access or referrals to clinical and mental health treatment, case management, and outreach. OPCs can also act as community hubs, operating drop-in centers where individuals can get a meal, a snack, or a shower, depending on the center.[20] OPCs have staff trained to recognize the signs of an overdose and to reverse an overdose using oxygen and naloxone. Safer use supplies are provided to help reduce the risk of infectious disease, like Hepatitis C and HIV, that can occur from the re-use or sharing of supplies. Drug checking services are available on site, allowing individuals to know what is in the substance that they have brought in to use before using it, reducing the risk of harm from using an unintended substance.

These centers help keep people from having to use on the street where they may face police interaction and incarceration or from using alone when they may experience an overdose with no one able to respond. OPCs provide a judgement-free environment that includes people who use drugs, peer support workers, and harm reduction workers, which builds community and create opportunities for more social connection and relationship building.[21]

Overdose prevention centers have been operating since the 1970's and legally sanctioned overdose prevention centers have existed since at least 2003, with Insite in Vancouver, Canada being credited as the first[22] and nearly 200 operating worldwide.[23] In the United States, two OPCs formally operate in New York City, one operates in Rhode Island and another center is soon to open in Vermont. State legislatures in Rhode Island and Vermont authorized OPCs by statute in 2021 and 2024 respectively and are regulated by the state.[24] More state legislatures should formally authorize overdose prevention centers and allow this lifesaving intervention to operate in their state.

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Access to Naloxone in Schools

Abstinence-only education does not prevent drug use among youth.[25] The reality is that young people are using drugs — and some of them experience overdoses. Overdose deaths among adolescents rose sharply in 2020 during the height of the COVID-19 pandemic; fortunately, overdose deaths began decreasing in 2023, but the number of deaths remains far higher than in 2019 and prior.[26] Empowering youth with the knowledge and tools they need to safely use drugs can save their lives and the lives of their peers.

In 2023, the Biden Administration approved naloxone, an opioid antagonist, for over-the-counter use in 4mg and 3mg nasal spray formulations.[27] In addition to federal efforts to improve access to naloxone, states have passed legislation to expand access. In at least 30 states, that includes access to naloxone in schools.[28] In some states, the law explicitly allows students to possess or administer an opioid antagonist at school. For example, Colorado enacted a law in 2024 that allows students to possess or administer an opioid antagonist on school grounds, on a school bus, or at school-sponsored events.[29] In Minnesota, state law requires school districts and charter schools to maintain a supply of opioid antagonists.[30] States and school districts are also expanding overdose prevention education and/or providing training on the use of naloxone.[31] In some jurisdictions, local school boards may authorize schools to maintain a supply of naloxone.[32]

Beyond serving students and employing teachers and staff, school facilities are used for athletics, community events, polling places, and other activities. Improving awareness of and access to naloxone in schools supports the broader community and school-based initiatives can be one part of community-wide interventions to address overdose deaths.[33] Naloxone is a safe and effective method of reducing overdose deaths. Reducing barriers to naloxone access and providing evidence-based overdose education to youth and families saves lives.[34]

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Improving Medicaid Access for People Who Are Incarcerated and Formerly Incarcerated

After being released from confinement, formerly incarcerated individuals experience a host of health risks fueled by the unsafe conditions in carceral facilities and compounded by the trying challenges of reentry. Drug overdose is one of the most serious of these risks and a leading cause of death during the reentry period.[35] The two-week window after release is exceptionally dangerous, with research finding that recently released individuals are tens of times more likely to overdose than the general population.[36] Numerous factors contribute to the risk of overdose, including the criminalization of substance use and the high incidence of substance use disorder (SUD) among people who are incarcerated.[37] During incarceration, access to behavioral health care, including medication for opioid use disorder (MOUD), is seriously deficient.[38] And, following release, untreated SUD combined with decreased tolerance due to not using or using less drugs during confinement leaves people dangerously vulnerable to overdose.[39] Given that the U.S. incarcerates people of color, particularly Black and Indigenous people; people with disabilities; and other systemically marginalized groups at vastly disproportionate rates, the adverse health outcomes experienced after release are urgent health equity concerns.[40]

A major impediment to continuous, affordable care to reduce overdose risk during reentry is lack of Medicaid coverage stemming from a harmful statutory provision that has historically prohibited use of federal Medicaid funds to pay for most health care received during incarceration (the “federal Medicaid exclusion”).[41] Increasing access to Medicaid coverage during incarceration can help to ensure that returning community members have active coverage. Further, it can enable providers to assess needs and develop care plans during incarceration and to link individuals to community-based care like SUD and peer support services immediately after release.[42]

Numerous policy pathways exist to improve Medicaid access through dismantling or working around the federal Medicaid exclusion:

- Nineteen states are implementing time-limited Medicaid section 1115 waivers to expand federal Medicaid coverage to incarcerated people up to 90 days pre-release.[43] States with such waivers must provide certain services, including MOUD, prior to release, and many have opted to provide additional behavioral health services and to focus on people with SUD as a target population.[44,45]
- Recent federal legislation lifts the federal Medicaid exclusion for certain incarcerated youth for a limited period and requires that services be provided pre- and post-release.[46]
- Proposed legislation seeks to further expand Medicaid coverage by lifting the federal Medicaid exclusion for incarcerated individuals who are awaiting disposition of charges and for people within 30 days of release.[47,48]

- Starting in 2026, states will be required to suspend rather than terminate Medicaid benefits during incarceration to prevent dangerous lapses in care in the high-risk period post-release.[49]
- States can also use state funding (not subject to the federal Medicaid exclusion) to advance access to services and prevent overdose during reentry.

These changes, while important, are only a step in the right direction. Mitigating overdose risk during reentry necessitates elimination of the federal Medicaid exclusion in its entirety and investment in wraparound care for returning community members experiencing the many deleterious health effects of criminal legal system involvement.

Even as the federal Medicaid exclusion is narrowing, detrimental Medicaid cuts in the recently passed "One Big Beautiful Bill Act" will pose barriers to essential services for incarcerated and formerly incarcerated people in the form of burdensome eligibility checks, work requirements, and increased co-pays, among other hurdles.[50] As they navigate the changing Medicaid landscape, health departments, community organizations, and advocates must support people at risk of overdose during reentry by helping incarcerated and formerly incarcerated individuals obtain and keep coverage, ensuring appropriate application of exemptions from work requirements and co-pays, advocating for increased access, and pursuing alternative pathways to provide needed services. Moreover, recognizing that incarceration itself devastates health, the public health field can reduce overdose risk by concurrently working towards dismantling carceral systems, diverting funding away from punishment and to health-affirming services and social safety nets, and shrinking the incarcerated population.[51] Investing in vital support like Medicaid and decreasing reliance on the criminal legal system together form a crucial path forward for protecting vulnerable populations from overdose and disrupting systemic drivers of health inequity.

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Public Health Surveillance is Needed to Understand the Intersection Between Overdose and Extreme Heat Deaths

The intersection of substance use and climate-driven extreme heat presents a pressing yet underrecognized public health threat, one that disproportionately harms individuals already made vulnerable by structural inequities in housing, healthcare, and emergency response. Structural racism, economic divestment, and housing exclusion have created environments where people who use drugs are overrepresented among the unhoused, medically underserved, and over-policed.[52] [53] [54] These same systems amplify the health consequences of climate change, including the increase in heat-related illness and death.

People who use drugs face elevated risks of heat-related illness and death due to both the physiological effects of substances and the social conditions that increase their exposure to extreme temperatures.[55] Stimulants such as methamphetamine and cocaine are particularly dangerous in high-heat environments. These substances raise core body temperature, accelerate heart rate and increase metabolic activity, placing additional stress on the body's ability to regulate heat. Methamphetamine, for example, has been linked to a disproportionate number of heat-related fatalities. Nationally, methamphetamine is associated with around 20 percent of all heat-related fatalities.[56]

Other substances also interfere with the body's thermoregulation. Opioids may blunt normal physiological responses to heat by suppressing respiration and impairing the body's ability to cool itself.[57] Alcohol acts as a diuretic and contributes to dehydration. These risks are compounded for young people with co-occurring

chronic illnesses, such as cardiovascular disease or respiratory illness;[58] and for individuals with mental health or developmental conditions, who may face additional psychological vulnerability and systemic exclusion from care. A systematic review found that for people with mental health conditions, mortality increased by nearly 5.5 percent for every 1°C rise in temperature.[59]

These physiological risks are intensified by structural factors.[60] Many people who use drugs experience housing insecurity or may be unhoused, limiting access to air conditioning, potable water, and/or shaded environments. Legal exclusion from public space further compounds exposure: in many jurisdictions, sit-lie ordinances, public loitering bans, and anti-camping laws criminalize the very presence of people seeking shade, rest, or relief from the heat. These local laws not only increase exposure but also produce legal precarity, forcing individuals to avoid formal cooling centers for fear of arrest, harassment, or forced displacement.[61] In turn, these same laws often bar people from accessing cooling centers that impose sobriety or behavioral requirements, undermining harm reduction principles and contributing to unnecessary deaths.

Although there is some data, these deaths often become misclassified or underreported, due to fragmented surveillance systems that fail to track or analyze the intersection of substance use, housing status, and heat-related deaths. This lack of accurate data is an equity issue. When public health systems fail to capture the lived realities of people, they fail to meet their obligations to the public's health and prevent harm. Data invisibility leads to other forms of invisibility, and ultimately, to legal and policy neglect that can have deadly results for overlooked populations. Death certificates and hospital coding practices often attribute deaths to underlying conditions, omitting heat as a contributing factor.[62] This could lead to the misclassification of heat-related deaths among people who use drugs. Moreover, there is no standardized national requirement to track or publicly report nonfatal heat illness,[63] let alone to disaggregate such data by substance use status, housing status, or behavioral health conditions.

The Maricopa County Department of Public Health (MCDPH) provides one model for how other jurisdictions can start to change this trend. Maricopa County is the largest county in Arizona. This region has for years now consistently broken records for high day and nighttime temperatures, leaving less opportunity for people to cool off, even at night.[64] The number of heat deaths in which drugs were either a primary cause or a contributing factor to a person's death have also risen.[65] MCDPH issues annual reports that track heat-related deaths defined to include both heat-caused and, more uniquely, heat-contributed deaths.[66] In determining cause of death, substance use and other factors like housing status, gender, race, and access to working air conditioning, are some of the non-heat factors assessed. Understanding the intersectional nature of heat and substance use is a part of overdose prevention because it provides further insight into factors that contribute to overdose related deaths.

In 2024, heat-related deaths involving substance use accounted for 57 percent of heat-related deaths in Maricopa County.[67] This vulnerability is consistent with prior trends. Although in 2024 the reports started using a different method for measuring whether substance use was a factor in heat-related deaths, prior years also showed that substance use was linked to around 50 percent of heat-related deaths.[68] In fact, these deaths have consistently increased since 2011 from 11 percent to 58 percent in 2023.[69] Many of these deaths involve drugs like methamphetamine, which individuals may not realize makes them more vulnerable to heat illness and death as there is little public health messaging or recognition of such harms.[70] Understanding the intersection between heat and drug-related deaths, whether heat or drugs are primary or contributing factors, must be a part of overdose prevention strategies, especially as the U.S. gets hotter.

The purpose of this data should be to prevent deaths and make the lives of people who are subjected to heat and extreme heat better. In 2023, a black youth in Phoenix who was trying to navigate a 115-degree day, while

using drugs and unhoused, unnecessarily died when he was not allowed to cool off in a business and then forced to sit handcuffed outside by the police, despite being in clear medical distress.[71] For this youth, not only were drugs, heat, and pneumonia a deadly combination in terms of what was happening in his body, but so were the social circumstances that left no safe place for him to cool off or the crisis response that was needed. His life was unique, but the circumstances of his death were not: in Phoenix, substance use factors into about 75 percent of heat related deaths.[72] Understanding the data, the risk to people who use drugs, and the real-life experiences of these individuals is only the first step in taking an approach that will prevent overdose deaths of people who have multiple vulnerabilities. Local governmental action can be a powerful tool in this space. Phoenix's 2025 Heat Action Plan includes training staff at designated cooling spaces on overdose signs and response.[73] Localities can also train businesses on the signs of overdose and heat distress, who to call, how to respond, and the dangers of not allowing individuals to stay in a cool space during such emergencies.

It's time for local governments and others to be intersectional and change the way they do things, particularly as the federal government has shifted in the opposite direction.[74] Heat is the deadliest form of climate-related extreme weather in the United States, and it is only getting worse. Taking an informed intersectional approach to data collection is a necessary step to reforming the structural factors contributing to unnecessary overdose-related deaths.

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Maintain Access to Medication for Opioid Use Disorder Following Natural Disaster

Natural disasters like hurricanes, floods, and wildfires can make it difficult for people to fill their prescriptions for medications if the disasters cause pharmacies and clinics in a community to be inaccessible, closed, or have reduced staff or hours. People may also face challenges if they travel across state lines because of a natural disaster. The difficulties are often compounded for people who are receiving medications for opioid use disorder (MOUD) such as buprenorphine, methadone, or similar medications. MOUD is an effective form of treatment for people who use drugs, but even in non-emergency situations, it is estimated that only 25 percent of people who need OUD treatment receive MOUD.[75]

Access to buprenorphine and methadone can be extremely difficult for many reasons, including stigma and that they are themselves classified as controlled substances. Until the Consolidated Appropriations Act of 2023 removed the federal "X-waiver" requirement, the ability of providers to prescribe buprenorphine has been limited based upon the type of provider, receipt of specialized education by the provider, provider registration, and an in-person physical examination of the patient by the provider.[76] Some limitations on the ability to prescribe buprenorphine had previously been relaxed during the COVID-19 pandemic, such as the ability to prescribe via telemedicine.[77] However, restrictions in state laws related to prescribing buprenorphine remain a barrier.[78] Methadone may only be dispensed from a licensed opioid treatment program, which many patients must be able to visit in person nearly every day, a challenge with respect to many natural disasters.[79]

Substance use and overdose risk may increase following a natural disaster due to the stress and uncertainty associated with events of this kind, so it is critical to maintain or expand the ability of providers to prescribe MOUD.[80] Some strategies which have been used include: (1) including treatment and medications for opioid use disorder in disaster and emergency preparedness plans[81] (2) expanding telehealth, including setting aside any requirement that a patient receive an in-person examination prior to issuance of a prescription;[82] (3) utilizing an existing medication assisted treatment consultation hotline to assist healthcare providers and patients during natural disaster,[83] (4) authorizing take-home doses of methadone and mobile methadone

services,[84] and (5) providing prescription flexibility for emergency refills, including under the Emergency Prescription Assistance Program.[85]

The response to Hurricane Helene in North Carolina illustrates how several legal interventions came together to provide prescription flexibility for emergency refills.[86] First, the governor issued an executive order declaring a state-wide state of emergency due to the anticipated effect of the hurricane and ordered implementation of the North Carolina Emergency Operations Plan.[87] The North Carolina Board of Pharmacy relied upon this authority to publish two administrative rules, which authorized pharmacies to dispense one-time emergency refill prescriptions for 30 or 90 days of medications necessary to sustain life or to continue therapy for a chronic condition.[88] In response to an inquiry from the North Carolina Board of Pharmacy, the federal Drug Enforcement Administration responded with a letter relying upon its own exception authority to concur with the application of the recently adopted state administrative rules to provide authority for pharmacists to provide emergency refills of buprenorphine.[89]This was an important policy modification for people who already had buprenorphine prescriptions, but who were unable to fill them using their normal process. However, it was unclear to those in the harm reduction community following Hurricane Helene how many people were able to take advantage of the emergency refills.[90] The removal of the "X-waiver" requirement is relatively recent and may have yet to achieve its full impact. Expanding provider abilities to prescribe and reducing prescribing restrictions at the state level increases access to MOUD for people who use drugs. This, in turn, may increase the population who may benefit from prescription flexibility during a natural disaster.

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Conclusion

This policy brief explored a non-exhaustive selection of policies that can advance overdose prevention and the health of people who use drugs, which in turn promotes the health of all communities. There is much more that can and should be done to support harm reduction in the areas of law and policy. This brief is intended as a start, not an end. It highlights the importance of remembering the history of harm reduction and overdose prevention efforts and the need for continued and increased support for these movements. By doing so, we can take steps to make sure there are far less lives lost to remember on International Overdose Awareness Day. We invite you to reach out to the Network contributors with any questions, comments, or ideas to further support your efforts.

This document was developed by Amy Lieberman, April Shaw, Ashleigh Dennis, Emma Kaeser, Jill Krueger, Nina Belforte, Quang "Q" Dang and Susan Fleurant for the Network for Public Health Law. The Network promotes public health and health equity through non-partisan educational resources and technical assistance. These materials provided are provided solely for educational purposes and do not constitute legal advice. The Network's provision of these materials does not create an attorney-client relationship with you or any other person and is subject to the Network's Disclaimer.

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