Title
In Support of a Public Health Approach to Drug Policy: Position Statement of AMERSA, Inc. (Association for Multidisciplinary Education and Research in Substance use and Addiction)

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Position statements clarify key issues that are in alignment with the vision, mission, and values of AMERSA, Inc. This Position Statement, endorsed by their Board of Directors on August 25, 2025, amplifies the position of the organization, guides their activities, and informs the public and policy makers on the organization's stance on this issue.

We thank the AMERSA Board of Directors for their review of various drafts of this position statement and endorsement of the final version. The Board of Directors has been deemed not to have any conflicts of interest with the approved Position Statement. Potential conflicts of interest of the AMERSA Board of Directors are on file with AMERSA office and accessible upon request.

Executive Summary
The United States faces a profound overdose crisis and a volatile unregulated drug supply. Despite the availability of effective treatments and harm reduction strategies, many individuals who use drugs have limited access to evidence-based interventions. Punitive approaches to people who use drugs have worsened the situation. In this position statement, we assert that there is a critical need for drug policies to be grounded in public health evidence rather than punitive measures. We focus on two case studies to exemplify this idea: (1) xylazine scheduling laws and (2) drug-induced homicide laws. Ultimately, AMERSA advocates for a public health approach to drug policy that is based in the tenets of harm reduction. The organization opposes

punitive measures and promotes policies that improve access to healthcare and harm reduction services.

Background

The contemporary overdose crisis in the United States (US) is now in its third decade, with over 107,000 preventable deaths recorded in 2022 alone.[1,2] This enormous toll on human life has progressed despite long-standing evidence of effective practices and treatments to reduce overdose incidence and mortality. For instance, it is estimated that as few as 20% of individuals with opioid use disorder currently receive any treatment for their condition.[3] Further, many communities lack access to harm reduction resources such as drug checking services, naloxone distribution, overdose prevention sites, syringe services programs, and safer supply distribution programs. A lack of harm reduction infrastructure not only increases the risk of overdose and death, but also serious and preventable health conditions such as infective endocarditis and hepatitis C.[4] Federal, state, and local policies and laws that promote increased and equitable access to these evidence-based public health interventions are urgently needed.

While it may seem self-evident that policies aimed at surmounting the many health issues that disproportionately affect people who use drugs should be informed by evidence from the field of public health, this has often not been the reality. Rather, U.S. drug policy is characterized mainly by punitive and non-evidence-based approaches. For instance, decades of policy-making under the banner of the 'War on Drugs' have led to immeasurable harm to individuals, families, and communities, disproportionately affecting Black people and communities of color.[5] Not only has the War on Drugs created immense societal damage, but overdose rates have increased exponentially despite the government's substantial and costly efforts, most of which are focused on punishing those who use or possess drugs.[6,7] Sadly, the consequences of such an 'iron law of prohibition' (i.e., where intense law enforcement practices increase the volatility and potency of the drug supply) were both predictable and predicted.[8] However, policymakers continue to repeat the mistakes of the past with draconian proposals that risk driving people who use drugs away from healthcare and harm reduction services, forcing them to confront an increasingly unpredictable drug supply alone.

In this position statement, **we advocate for policymakers to take a public health approach when developing drug policy**. Drug policy must start with the premise that drug use is fundamentally a public health concern that can only be addressed via compassionate and evidence-based public health approaches. To help demonstrate the need for such a practice, we highlight two modern examples: (1) xylazine scheduling laws and (2) drug-induced homicide laws.

Case Study 1: Xylazine Scheduling Laws

Xylazine, an alpha-2 adrenergic agonist like clonidine, was first developed in 1962 and promoted as an antihypertensive.[9] While approved as a veterinary tranquilizer, xylazine is not approved for use in humans by the Food and Drug Administration due to excessive hypotension, bradycardia, and central nervous system depression.[10–14] Since 2019, xylazine's prevalence has increased in the unregulated drug supply in the United States as an adulterant to fentanyl and other opioids.[15–17] Emerging literature describes how exposure to xylazine can lead to serious adverse health outcomes for people who use drugs, including prolonged sedation, overdose, and the onset of severe skin wounds and ulcers that may progress to necrosis.[15,18–24] Further, people who use drugs are concerned about possible exposure and related risks, reporting fears of acute effects, increased tolerance, more severe and unique withdrawal symptoms, reduced efficacy of medications for opioid use disorder, wounds, and overdose risks.[25] Due to the harms associated with xylazine exposure, the federal government declared xylazine-contaminated fentanyl an emerging threat to the United States in 2023.[16,26,27]

Currently, xylazine is not a federally controlled substance – meaning it is not scheduled under the Controlled Substances Act.[28] This means that the Drug Enforcement Administration does not have the authority to control xylazine (e.g., it cannot seize xylazine imports, prosecute those who use or sell xylazine, etc.). However, many states have moved to permanently or temporarily schedule xylazine, including Pennsylvania, West Virginia, Ohio, Delaware, and New Jersey.[29–34] Most states that have moved toward scheduling xylazine have declared this adulterant to be a schedule III substance (i.e., falling in the middle of the five-scale scheduling scheme, indicating the substance has moderate or low potential for dependence).[35]

Scheduling xylazine will likely be ineffective at improving health outcomes for people who use drugs. Conversely, scheduling xylazine may lead to numerous unintended harms, including: 1) causing individuals to avoid or delay healthcare because of fear of arrest, surveillance, and/or harassment, 2) creating barriers to the use of harm reduction resources such as drug checking services due to fear of arrest, surveillance, and/or harassment 3) further marginalizing people who use drugs through criminalization and stigma, 4) exacerbating inequitable and racist profiling practices by law enforcement, and 5) imposing barriers to conducting imperative xylazine research. Such investigation is urgently needed to answer key questions about xylazine's mechanism of action and effective strategies for treatment, wound care, withdrawal management, drug checking, and overdose prevention and reversal. Additionally, xylazine is used extensively in pre-clinical studies for conditions such as Alzheimer's disease; a disruption to xylazine via scheduling will also likely disrupt and thus hinder the ongoing health research unrelated to drug use.

Drug policies that aim to reduce the negative outcomes associated with xylazine should be informed by public health and harm reduction. These could include (a) opposing policies that schedule xylazine at the federal and/or state levels, (b) increasing funding for xylazine-related research, (c) educating healthcare providers, harm reductionists, and people who use drugs on the risks of xylazine exposure and evidence-based practices to reduce associated harms, and (d) supporting the creation of International Classification of Diseases-10 codes that are xylazine-specific to improve patient care management and public health research.

Case Study 2: Drug-Induced Homicide Laws

Arrests and other law enforcement actions are associated with negative health outcomes for people who use drugs. One cross-sectional study, using data from January 2020 to September 2023, demonstrated that drug seizures by law enforcement were significantly associated with an increase in the relative risk of fatal opioid-involved overdose the day after the drug seizure in the surrounding area.[36] Another cross-sectional study demonstrated that the misdemeanor arrest rate was associated with higher overdose death rates, even after adjusting for rates of drug use.[37] Further, increased police activity has been shown, in multiple studies, to reduce the number of people who access syringe service programs and low-barrier buprenorphine, and to increase risky drug use behaviors.[38–43] Unfortunately, law enforcement officers and many prosecutors have utilized – and continue to utilize – the punitive approaches used in the War on Drugs to respond to the overdose crisis.

Perhaps most notably, there have been increased efforts to punish those who provided the substance that someone overdosed on, both by increasing enforcement of existing laws and passing new ones.[44] While there are variations between states, these "drug induced homicide" laws generally criminalize the act of providing a drug to someone who later dies from using that drug, even where the drug was not sold and the person providing it had no intent to harm. Such laws have become especially prevalent with the introduction and proliferation of fentanyl in the unregulated drug supply.[45–47]

Federally, a section of the Controlled Substances Act stipulates that someone who provides a controlled substance that results in serious bodily injury or death can face a sentence of up to life in prison.[48] While some states do not explicitly have drug-induced homicide laws, prosecutors often bring charges such as felony-murder, voluntary manslaughter, involuntary manslaughter, or other similar charges upon drug delivery resulting in death.[44] Drug-induced homicide laws demonstrate yet another punitive approach ostensibly designed to address the overdose crisis that is not informed by public health experts, healthcare professionals, or people who use drugs. Theoretically and practically, laws that attempt to punish people who provide drugs fail in numerous ways.

Firstly, there is *no evidence* that such laws are effective at meeting their supposed goal of decreasing the number of overdose deaths through discouraging the provision and subsequent consumption of drugs.[44] Ultimately, this is the same failed mindset that created the War on Drugs; decades of evidence demonstrate that it is ineffective and infeasible to arrest our way out of this health issue.[49,50] Not only will people almost certainly continue to use drugs and seek out a new supplier if theirs is incarcerated (which has been associated with increased overdose risk), the fear of prosecution will interfere with evidence-based public health tools.[44,51–54] The threat and implementation of drug-induced homicide laws will only deter people from seeking help and calling for medical support in the event of an overdose, even if there are overdose Good Samaritan laws in place.[55–60]

Secondly, people who sell drugs do not want to kill the people they sell drugs to; not only would this be bad for business, but this misconception creates a false dichotomy between people who sell drugs and people who use drugs (i.e., people who sell drugs are often using drugs themselves and/or have a substance use disorder).[53,61–63] Rarely do law enforcement arrest high-level drug manufacturers or distributors; instead, they arrest people who (a) sell a small amount of drugs to help fund their own drug use and (b) are often not aware of the exact composition of the drugs they are selling.[64–67] As such, people will often buy enough drugs to share with a friend or family member.[61,68] Indeed, nearly all drug-induced homicide laws do not require a sale at all, only that drugs are transferred from one person to another.

Of the cases that have been publicized widely in recent years, many of those arrested and sentenced for drug-induced homicide are the spouse, friend, sibling, parent, or cousin of those who have died.[44] For instance, consider a case in Oregon wherein a 24-year-old was arrested for ‘delivery resulting in the death’ of her longtime best friend who she had sold a gram of heroin the night before; she only learned of his fatal overdose upon her arrest.[69] As a person who used drugs herself, she had previously sold to *and* bought from this friend as they helped each other manage heroin withdrawal symptoms.[69] After many years of imprisonment, she stated “the federal government poured resources into convicting five people for his accidental overdose… [yet] the flow of heroin in our city, Portland, continued without a moment’s interruption.”[70] In this way, drug-induced homicide laws harm people who use drugs through the impacts of incarceration without actually achieving their goal of reducing overdoses through limiting the flow of the drug supply.

The event of an overdose is tragic, leaving irreparable grief in its wake. Drug-homicide laws exacerbate this trauma. As individuals – often the friends or family members of the person who overdosed – are prosecuted and convicted for providing the drugs that caused the harm, communities mourn both the fatal overdose of one person and the incarceration of another – increasing harm for all involved. Drug policies aimed at reducing the overdose crisis should not be driven by law enforcement agencies with poor theoretical and practical bases of support.

Instead, funding should be directed to evidence-based interventions, and policies should be directed at supporting and increasing utilization of such interventions. Such evidence-based options include community-based drug checking programs, overdose prevention centers, strong overdose Good Samaritan laws, and other public health approaches to decreasing overdose fatalities instead of utilizing the criminal legal system.[71,72]

AMERSA's Position

AMERSA supports taking a public health approach to decisions in state and national drug policy. Accordingly, AMERSA supports the prioritization of harm reduction as a framework to scaffold policies that impact people who use drugs, in direct contrast to current punitive policies that often promote increased criminalization and thus unintended consequences (e.g., increased overdose mortality). Drug use is a public health concern, not a criminal one. As such, public health experts, healthcare professionals, and community organizations led by people with lived and living expertise should guide all policies that impact the health and wellbeing of people who use drugs. Drug policies that do not prioritize public health are likely to hurt the very individuals they aim to help, intensify racial and social inequities, and exacerbate overdose-related harms. As such, policymakers must support policies that (a) are informed by and preserve the autonomy of people who use drugs, (b) are evidence-based and effective at improving health, and (c) increase equitable access to medical care and harm reduction services.

Recommendations

Given the aforementioned examples, we propose that we leverage the position of AMERSA as interdisciplinary leaders in substance use education, research, care, and policy to work towards a future where drug policy takes a public health approach. As such:

- AMERSA supports the advancement of policies directly focused on improving access to healthcare and harm reduction services for all individuals who use substances. This includes policies on drug scheduling, access to healthcare and harm reduction services, and funding for drug-related research, community-based drug checking programs, and overdose prevention services.
- AMERSA supports inclusion of and collaboration with people with lived and living expertise of drug use in drug policy making at the federal, local, and state levels.
- AMERSA supports inclusion of and collaboration with interdisciplinary healthcare experts in drug policy making at the federal, local, and state levels.
- AMERSA supports the prioritization of anti-racism and Diversity, Equity, and Inclusion in drug policy making at the federal, local, and state levels.
- AMERSA supports policies that promote public health education, research, and care innovation related to improving the lives of people who use substances.
- AMERSA opposes policies that impose criminal penalties for substance use-related infractions, including mandatory minimum sentencing and drug-induced homicide laws.

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