

New Directions for New York: A Public Health and Safety Approach to Drug Policy

What is a Public Health Approach to Drug Policy?

A public health approach to drug policy is a coordinated, comprehensive effort that balances public health and safety in order to create safer, healthier communities, measuring success by the impact of both drug use and drug policies on the public's health.

A public health approach emphasizes the need for a coordinated strategy involving multiple sectors. One successful strategy for engaging multiple sectors in transforming drug policies and improving public health is the *Four Pillars Model* (comprised of Prevention, Treatment, Public Safety and Harm Reduction). This model seeks to ensure coordination among various agencies, communities, levels of government, and stakeholders to achieve healthier, safer communities. First implemented in Switzerland and Germany in the 1990s, the Four Pillars Model is now employed in many cities and countries in Europe, North America, Australia and Asia, including Vancouver and Toronto. The Four Pillars approach has resulted in a dramatic reduction in the number of drug users consuming drugs on the street, a significant drop in overdose deaths, reduction in crime, and a reduction in the infection rates for HIV and hepatitis.^{1, 2}

New York is Ready for a New Direction

New York is uniquely prepared to develop more effective, coordinated drug policies. There is a growing consensus that the Rockefeller Drug Laws have failed and are in urgent need of reform. These laws exacerbate the damage caused by drug use, particularly among the poor, people of color, the homeless, formerly incarcerated individuals, and other marginalized groups.^{3, 4} New York City and State have emerged as national leaders in the fields of drug treatment and harm reduction – interventions that are often more effective and much cheaper than incarceration at reducing the death, disease, crime and suffering associated with drug use and addiction.^{5, 6} New York has an opportunity to build upon our innovative public health solutions to reduce use of other substances which adversely affect the public's health. For example, New York's public health response helped reduce rates of smoking by 11% for adults and 40% for high school students between 2000 and 2006.⁷

One barrier to making these kinds of public health gains in the arena of illicit substance use is that New York's policies for illicit drugs remain compartmentalized and disconnected. Historically, New York's drug policies have been bifurcated – with one pole focused on a criminal justice response and another focused on the treatment of people already addicted to drugs. Both of these approaches tend to intervene at the level of individual, failing to take into account the larger environmental, community, family and economic contexts that contribute to drug use.^{8, 9} We need strategies that integrate prevention, harm reduction, public safety, and treatment to create communities that are safe and healthy for all. Most importantly, we need a coordinated, comprehensive approach that addresses the

individual within the context of communities. We need all sectors of society to help if we are to address the social factors – racial segregation, income inequality, poverty, unemployment, community norms, literacy issues, deteriorating housing – acknowledged as having an effect on alcohol and drug use behavior, the health of drug users, and the differential morbidity among drug users from different racial and ethnic groups.^{10,11,12,13,14,15}

A key factor inhibiting our success is that service providers, policymakers, public safety personnel and community advocates do not all have a shared understanding of substance misuse and dependence as a public health problem. Stakeholders who could be working together to resolve these difficult issues are often in adversarial relationships that diminish their ability to make real changes to benefit those affected by substance misuse and dependence. At the center of all our drug policies – whether addressing legal or illicit substances – should be the question: *what impact will our policies have on the public's health and safety?*

New Directions New York will convene key stakeholders – government officials and community members, service providers and advocates, people directly impacted, and researchers – to begin a collaborative process whereby we answer the question of what impact our policies have on the public's health and safety and develop new policy approaches based in science and guided by reason, compassion, and justice.

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³ Galea, S. and D. Vlahov, 2002. Social determinants and the health of drug users: socioeconomic status, homelessness, and incarceration. *Public Health Rep.*, 117 Suppl 1:S135-45. (1).

⁴ Golembeski C, Fullilove R., 2005. Criminal (in)justice in the city and its associated health consequences. *Am J Public Health*, Oct;95(10):1701-6.

⁵ Substance Abuse & Mental Health Services Administration (SAMHSA), 2008. National expenditures for mental health services and substance abuse treatment 1991-2001, SAMHSA: Rockville.

⁶ Cartwright, W.S., 2000. Cost-benefit analysis of drug treatment services: Review of the literature. *J Ment Health Policy Econ* March 1;3(1):11-26.

⁷ Thomas, K. and M. Farrelly, 2007. New York tobacco tracking., RTI International: Research Triangle Park.

⁸ Galea, S. and D. Vlahov, 2002. Social determinants and the health of drug users: socioeconomic status, homelessness, and incarceration. *Public Health Rep.*, 117 Suppl 1:S135-45. (1).

⁹ Vlahov, D., et al., 2007. Urban as a determinant of health. *J Urban Health.*, 84(3 Suppl):16-26.

¹⁰ Galea, S. and D. Vlahov, 2002. Social determinants and the health of drug users: socioeconomic status, homelessness, and incarceration. *Public Health Rep.*, 117 Suppl 1:S135-45. (1).

¹¹ Ahern, J., et al., 2008. Population vulnerabilities and capacities related to health: a test of a model. *Soc Sci Med.*, 66(3):691-703.

¹² Galea, S., et al., 2003. Racial/ethnic disparities in overdose mortality trends in New York City, 1990-1998. *J Urban Health.*, 80(2):201-11.

¹³ Bernstein, K.T., et al., 2007. The built environment and alcohol consumption in urban neighborhoods. *Drug Alcohol Depend*, 91(2-3):244-52.

¹⁴ Fuller, C.M., et al., 2005. Effects of race, neighborhood, and social network on age at initiation of injection drug use. *Am J Public Health*. 95(4):689-95.

¹⁵ Ezard, N., 2001. Public health, human rights and the harm reduction paradigm: from risk reduction to vulnerability reduction. *Int J Drug Policy*, 12: 207-219.