**Campaign for a New Drug Policy**

**U.S. Programs**

**Portfolio Review**

**April 22, 2014**

**OVERVIEW OF CNDP**

The Campaign for a New Drug Policy (CNDP) is staffed to pursue an alternative response to drug use and drug markets in the United States. Its overall purpose is to establish a new paradigm for U.S. drug policy that addresses actual harm to individuals and communities, promotes health and social stability, ensures public safety and justice, and advances equality and the freedoms of an open society.

Our staff interacts with a composite field of individuals and groups working in the areas of criminal justice and law enforcement, health care and public health, civil rights and civil liberties, racial justice, harm reduction services and policy, social services, and drug policy reform. Grantmaking, both in support of the field and in pursuit of foundation initiated work, is a core aspect of the campaign’s strategy. But, equally important and work intensive is our direct engagement in the field to drive solutions-based reform and development of an infrastructure for a health-centered, nonpunitive drug policy.

CNDP’s work is pursued through three interrelated strategies: (1) grantmaking to sustain key organizations in the field, (2) grantmaking and direct engagement with the field to establish the infrastructure for a health centered drug policy, and (3) grantmaking and direct engagement with the field to establish community-level alternatives to punitive drug policies. These areas of work are discussed in greater detail below under “Strategic Approach and Program Capacity: 2011‑2014.”

Three years into the campaign, we have learned some “easy” lessons that confirmed what we already believed (e.g, that changing the roles of police in drug law enforcement is possible and essential), while other lessons were more difficult, unexpected and newly illuminating. Three overarching lessons/conclusions have been particularly influential in the campaign’s current strategic approach:

* ***Extremely strong partnerships can be formed among people with divergent perspectives and reasons for engaging in drug policy reform.*** We learned this, in large part, from our internal experience working as a team. In order to pursue CNDP’s objectives effectively, we had to first work through our internal differences in professional background and individual perspective. Until we did, it was impossible to pursue an integrated strategy. The same dynamic exists across the sectors we fund. We have seen repeatedly in our health and community-level alternatives work the need to invest in partners who recognize and are able to overcome barriers to effective collaboration.
* ***A solutions-based approach to drug policy reform is essential*.** We have seen many instances in which drug policy reform advocates argue persuasively that the “war on drugs” causes more harm than benefit, but then fail to offer a realistic alternative. In CNDP’s health and community-level alternatives work, we have increasingly focused our efforts on grantee and non-grantee partners that are prepared to participate in solutions-based efforts. Without the ability to work toward solutions, sustainable partnerships cannot be formed and reform normally cannot advance beyond the hypothetical. A central guiding concept in pursuing this solutions-based approach is our understanding that the process in which we are engaged is not a single leap from the war on drugs to new paradigm. We are involved in a policy progression with many stages of development that must be undertaken.
* ***Direct engagement by OSF in the drug policy reform field is necessary*.** OSF occupies a distinct place in the field. No other funder commits the resources and possesses the on-staff issue expertise to support the partnerships and solutions-based efforts needed to move drug policy reform forward. Similarly, CNDP’s direct engagement with the field is qualitatively different from organizations within the field, each of which has or is attempting to stake out its own space. Even the Drug Policy Alliance, with its grantmaking program, capable and relatively large staff, and high profile leader does not effectively support partnerships and solutions-based work that it does not lead.

**CONTEXT OF U.S. DRUG POLICY REFORM**

The keystone of current drug policy in the United States is a false Hobson’s choice: that society must choose either to selectively criminalize drug users and sellers or “surrender” to addiction and drug related crime. During the past four decades, this fallacy has perpetuated a punitive response to drug use that metastasized and contributes to a system responsible for massive levels of incarceration, violation of civil and human rights, political and economic disenfranchisement, denial of essential health care, and a host of other direct and collateral harms.

This system, however, has become increasingly difficult to sustain with the tightening of local, state and federal budgets and with a declining public confidence in the ability of punitive responses to reduce the potential harms of drug use and markets. Evidence of a breakdown in public support for punitive drug policies has been dramatic. Most recently a Pew Research Center poll released on April 2, 2014 found that 67% of Americans (including 51% of Republicans) favor treatment over arrest, and only 26% feel that the government should continue to emphasize arrest and prosecution of people who use heroin and cocaine. Voter approval of regulated access to marijuana in Washington and Oregon in 2012 was an even more dramatic example of the willingness of voters in certain states to try a different approach, albeit with the most commonly used illegal drug.

Other developments in recent years indicate positive movement. Implementation of national health care reform under the Affordable Care Act, for all its real and perceived stumbles, offers the first real opportunity to establish the infrastructure for a health based drug policy and the inclusion of drug users’ needs in mainstream medicine. Arguably, fundamental shifts in attitudes toward drug users are evident in the increased acceptance of sterile syringe programs at the state and local levels (although continued resistance in some regions and at the federal level), proliferation of Good Samaritan/911 overdose death prevention laws, and increasing availability of naloxone to address opiate overdose emergencies.

As shown graphically on the attached timeline, developments in drug policy reform have been largely positive, but not uniformly so. There remain decided challenges, and all controversial change remains fragile until normalized. Continued fear and stigmatization of drug users, habitual recourse to punitive drug laws to address health and social problems, and entrenched economic and political interests that rely on the criminalization of drug users are a constant threat to the work of the campaign, OSF grantees and non-grantee partners. An ever-present concern is whether the field will have sufficient resources to capitalize on what appears to be a widening range of significant opportunities.

**PARTNERS AND PHILANTHROPIC ENVIRONMENT**

The field’s capacity to transform these opportunities from innovation, to sustained programming and, ultimately, to mainstream drug policy is severely limited by the funding environment. There are still very few foundations and individual donors providing support for drug policy reform efforts. OSF remains the only major grantmaking institution that prioritizes drug policy reform, and CNDP work since its inception has had to focus, in part, on bringing new funders to the field and aligning with the efforts of others already active in supporting drug policy reform or a component field.

CNDP has partnered with a number of foundations, such as Riverstyx, Libra, Vital Projects and Ford to support the development of community level alternatives, such as Law Enforcement Assisted Diversion (LEAD), and to arrange complimentary funding, such as strategic planning support to organizations like Law Enforcement Against Prohibition, which CNDP sustains with general support funding. On the health and harm reduction side of CNDP’s portfolio, CNDP has collaborated closely with local funders in Ohio and national funders such as the Hilton Foundation to increase access to high quality addiction treatment services.

The still perceived controversial nature of drug policy reform work has created both challenges and opportunities in CNDP’s effort to bring new resources to the field and to expand the investment by funders who already have their toe in the water. Particularly in relation to funders with long track records of supporting criminal justice reform, racial justice advocacy and the prevention of poverty, there is at least a baseline understanding of the importance of eliminating the criminalization of drug use and subsistence drug selling and the potential for collaboration. In relation to funders new to the field, such as Good Ventures, CNDP staff has provided advice on drug policy reform grantmaking and strategy.

**STRATEGIC APPROACH AND PROGRAM CAPACITY: 2011 -2014[[1]](#footnote-2)**

CNDP organizes its work in three interrelated strategies, each designated by its particular objective. Grantmaking in the first category is intended (a) to ensure that a standing corps of dedicated drug policy reform advocates is available to the field and capable of responding to emergent opportunities. Grantmaking within the second and third areas of CNDP effort are intended to fill critical gaps in the field: (b) the lack of an infrastructure for a health centered drug policy and access to SUD services, including treatment and harm reduction services and (c) a failure by the field as a whole to develop realistic and solution-oriented alternatives to punitive drug policy.

CNDP’s direct engagement with grantee and non-grantee partners is intended to move the field to address these gaps. We have used a variety of tools, including CNDP led working groups, cross‑sector convenings, sustained facilitation of information sharing and relationship building, and the funding of targeted research.

As described below, reduction of the CNDP’s non-DPA grantmaking budget from $4 million in 2011 to $2.7 million in 2014 has impacted our ability to respond to emerging opportunities while also attempting to sustain the core capacity of the drug policy reform field in the U.S.

### Objective 1 – Build, diversify and elevate broad support for an alternative paradigm for U.S. drug policy by sustaining key organizations

### 2012 grantmaking budget: $1,650,000 (non-DPA); $4,000,000 DPA

### 2013 grantmaking budget: $1,080,000 (non-DPA); $5,000,000 DPA

2014 grantmaking budget: $850,000 (non-DPA); $5,000,000 DPA

Program responsibility: Andy Ko and Jamie Wood

Grantmaking in this category supports key drug policy reform organizations that are nationally active and act both as independent advocates and resources to the field. These grants are now limited by the campaign’s budget to the Drug Policy Alliance, the Harm Reduction Coalition, Students for Sensible Drug Policy and Law Enforcement Against Prohibition.

The goal of this area of grantmaking is to sustain a standing corps of drug policy reform advocates able to engage key constituencies and/or respond to emerging opportunities and challenges. The Drug Policy Alliance (DPA), with its able and comparatively large staff, national and state/local programs, independent grantmaking program, legal program and substantial budget is the acknowledged leader in the field. In 2012, as part of a 10-year commitment of $5,000,000 annually directed by George Soros, CNDP allocated $4,000,000 to a general support grant for DPA, with the remaining $1,000,000 disbursed from USP Board funds. By 2013, the USP Board contribution was ended and the entire $5,000,000 grant to DPA has since been drawn from the CNDP grantmaking budget.

The effective halving of this grantmaking budget line from 2012 to 2014 required CNDP to scale back the originally intended scope of Objective 1, which included the goal of building the capacity of organizations representing directly affected populations to undertake drug policy reform work. We designated some organizations for tie-off grants and adjusted funding among remaining grantees to ensure at least a minimal degree of financial stability. We stuck with the Harm Reduction Coalition, which is the leading advocate for harm reduction responses to drug use in the U.S. We also renewed Law Enforcement Against Prohibition for its role in bringing the viewpoint of law enforcement professional into drug policy reform, and funded Students for Sensible Drug Policy for its similar role among young people.

Certain other grants no longer in this group were either time limited projects or moved to other parts of CNDP’s portfolio. Support for The Eisenhower Project to self-distribute and build a public education campaign around the documentary film The House I Live In was time limited. This was an unusual grant for CNDP in that we review film-based advocacy proposals with a fairly strong degree of skepticism. The difference here – in addition to the film having won the Grand Jury Prize at the Sundance Film festival – was that CNDP staff already had quite a bit of contact with Eugene Jarecki, director of both the film and the grantee organization, in his capacity as a Soros Justice Fellow and while helping him and his staff develop their command of the issues and relationships within the field. We also had received very positive reports from a USP colleague regarding Jarecki’s capacity for strategic advocacy. Even if our expectations of the potential outcomes had been much higher, we likely would have been very positively surprised by how widely the film became known in the U.S. and abroad, the partners Jarecki and his team attracted, and his ability to get his message about the war on drugs heard (TED talks, Charlie Rose, John Stewart, etc.).

The Institute of the Black World 21st Century (IBW21) is an example of a grantee that we moved from this grouping to another part of the portfolio (Objective 3 – community-level alternatives). IBW21 focuses on issues that affect people of African descent. In recent years, IBW21has prioritized ending the war on drugs as one if its core civil rights and racial justice issues. Following the reductions to CNDP’s grantmaking capacity and the resulting narrowing of our definition of Objective 1, we reconsidered our understanding of the significance of IBW21. From both a strategic and Open Society values point of view, it is important to support the involvement in drug policy reform of the communities most impacted by current policy. But, rather than relying on the diversification of one area of our grantmaking, we agree that this needs to be a priority across the CNDP portfolio as a whole – with the substantive nature and quality of group’s work determining which among these groups we are able to fund. Given that the bulk of its work involves community specific efforts in Pittsburgh, the District of Columbia, and Baltimore, IBW21 was a natural fit for funding to advance its drug policy reform goals in these municipalities.

A number of grants in this category simply failed and for that reason were tied off. Funding to Mothers Against Teen Violence (MATV) was initially provided to elevate a potentially important and compelling African American voice for drug policy reform from a parent’s point of view. Following two grant cycles, it became clear that MATV was not able to move beyond its limited and isolated work in Dallas, Texas. In the case of Break the Chains, its Executive Director is a long-time and deeply respected drug policy reform advocate and former Public Policy Director of the Drug Policy Alliance. But, for all her brilliance and insight into drug policy advocacy from a racial justice perspective, it became clear that the grantee had neither the organizational capacity nor follow-through to justify renewed support. The failure of these and certain other grants is particularly distressing because participation of African American leadership in drug policy reform is currently limited to LEAP’s Executive Director and IBW21.

A last comment on this category of field support by CNDP involves our decision not to support marijuana law reform directly. This decision, made at the outset of the campaign, was not based on our sense of the relative importance of marijuana related advocacy: in our view, this area of work is critically important to overall drug policy reform. Our decision not to engage directly in funding marijuana reform was based on (a) the observation that there are a number of significant national and local funders supporting this work (although this is less true with the death of Peter Lewis), (b) the reality that OSF is already supporting this work indirectly through the substantial involvement in marijuana policy reform of DPA, LEAP, SSDP and other grantees, and (c) our sense that CNDP’s finite resources were better used to capitalize on the opportunities raised by health care reform and the development of community-level alternatives to punitive drug policies. The outcome of marijuana policy reform efforts this year and 2016 will indicate whether our reasoning was sound.

**Objective 2: Establish access to comprehensive health care for all drug users, including treatment and harm reduction services, as an alternative to punitive, coercive and “zero tolerance” policies**

### 2012 grantmaking budget: $1,850,000

### 2013 grantmaking budget: $1,280,000

2014 grantmaking budget: $1,300,000

Program responsibility: Dr. Kima Taylor and Ruzana Hedges

Advocates have argued persuasively for at least two decades for drug policies that prioritize health and social supports as a better alternative to punitive approaches. But, in the absence of an adequate health care system that includes drug users and includes a full range of accessible substance use disorder (SUD) services, this discussion has been hypothetical. CNDP recognized passage and implementation of national health care reform, pursuant to the Affordable Care Act, as likely a once in a lifetime opportunity to establish the material infrastructure for a health-based drug policy in the U.S. and simultaneously provide health services to a previously disallowed segment of the population.

Implementation has continued through 2014 and will likely extend beyond. The Campaign’s ambition has been to take the greatest possible advantage of relevant and realistic openings to advance reforms that impact drug user health, reduce criminal justice involvement, and develop related economic opportunities. Since late 2012, much of the Campaign’s grantmaking has supported:

* + National and state level reforms to ensure meaningful access to SUD services and integration of drug users health in mainstream, evidence based health care;
  + Defense of current and expansion of Medicaid as a way to increase access to SUD services for low-income SUD populations; and
  + Support for national and state level consumer and provider coalitions as a constituency for health care reform that addresses drug use as a health issue.

Provisions of the ACA and prior law that require insurance providers, including the government, to provide a substance use disorder benefit and other health benefits prompted CNDP to structure its grantmaking portfolio and programmatic work across fields to support the development of a health care infrastructure for drug policy reform. Following passage of the ACA, the Campaign funded advocacy to ensure that national and select state regulatory implementation would require a comprehensive, evidence based SUD benefit for diverse populations. The team originally supported existing SUD advocates including Legal Action Center, Harm Reduction Coalition, State Association of Addiction Services, and Faces and Voices of Recovery – assuming that they were best prepared to educate policymakers.

We learned however that, having always been a part of the public health and justice system structures, these groups initially did not have the experience or necessary relationships to advocate successfully within the health care system policymaking structure. They were also reluctant, for a variety of reasons, to work in effective coalitions with each other or other non-SUD health advocates. Some of the groups failed to fully engage in this work because – at least initially – they did not see opportunities for drug policy reform (e.g. DPA and some harm reduction groups). Others did not think health care reform could ever really address “their” populations’ needs (some harm reduction, treatment and recovery groups). Still others saw health care reform implementation as a threat to their existence (some drug treatment advocates). Rather than advocate for health care reform that appropriately served SUD clients, they ignored or vilified the “health system.” Considerable CNDP time was spent educating groups on the possibilities of reform, the reality that public health funding could be a source of revenue and stability, and the need to work in coalition to share expertise and capacity. This trust building and education process is important, but it was consuming time and we were in danger of missing critical opportunities, such as the chance to provide effective guidance to regulators on the structuring of health insurance exchanges.

It became clear to us that the portfolio needed to pivot. We gave the George Washington University health policy group (GW) a grant to assist SUD groups and the Coalition for Whole Health in drafting comments for key regulations and to introduce coalition leadership to important Health and Human Services decision makers. The Coalition for Whole Health is a group of SUD and Mental Health advocates whose purpose is to ensure that health care reform provides full and quality access to behavioral health services. It is staffed by Legal Action Center, which runs the meetings, sets the agendas and issues regulatory comments in the name of the Coalition. This provision of clearly needed assistance by GW was not received well by the Coalition – particularly SUD advocates, who appeared to feel threatened and found creative ways to avoid meeting with or using work produced by GW.

CNDP continued to provide funding to these existing advocates to help them maintain their advocacy capacity (excluding completely ineffective grantees, such as SAAS), but with smaller grants. Rather than rely exclusively on these grantees, we began funding and introducing our SUD work to effective non-SUD focused health care groups that were capable of effecting immediate change with policymakers and to build a more diverse field of health groups calling for community based SUD services. The primary grantee in this grouping was Community Catalyst, which had strong executive branch relationships and a strong network of capable state affiliates.

Though early grants (2010-2012) were less effective than hoped and the field missed opportunities to influence important components of ACA implementation, such as exchanges and navigators, we would have lost even more opportunities without the pivot. This transition in CNDP’s grantmaking required an enormous programmatic commitment of campaign staff time to (a) bring mainstream health advocates up to speed on SUD care and drug policy and (b) bring SUD services advocates up to speed on broader health policy, health systems and funding, advocacy, and how to work in effective coalitions in order to successfully meet their grant commitments.

CNDP also continued funding to three previous grantees in Closing the Addiction Treatment Gap (CATG) states: New York, New Jersey and Wisconsin. These grantees already understood the importance of coalitions, but the participation of the newly engaged health advocates made their work stronger. This reconfiguration of CNDP’s health portfolio led to a number of outcomes. The hybrid advocacy of SUD and health groups led to successful coalitions that, in our view, achieved more than either set of advocates could have working separately. For example, New York’s Medicaid redesign will include a full range of SUD services including harm reduction programs and innovative Medicaid pilots with health and wrap around services for those leaving prison (ASAP-NY, Community Catalyst, harm reduction groups and Mental Health advocates). Furthermore, coalitions of SUD and health advocates secured various degrees of expansion of Medicaid in several wavering states, including New Jersey, Arkansas, Ohio and Wisconsin.

In this effort, the direct engagement of CNDP’s Kima Taylor with the field was essential. Dr. Taylor’s command of the vast legislative and regulatory framework of the ACA and national health care reform overall encouraged grantees and non-grantee partners to pursue difficult, but necessary opportunities. However, this degree of involvement has potential pitfalls. Given the reliance of many of the SUD services advocacy groups on OSF for funding, several grants failed because organizations attempted to do what they assumed we wanted, rather than finding their own path toward achieving the objective of CNDP’s grant. The early CNDP grant supporting Legal Action Center to work with George Washington is one example of this dynamic. Tasked with submitting the regulatory comments of a CNDP funded working group during federal ACA implementation, LAC accepted technical assistance that, in retrospect, the organization clearly did not want or think it needed. It then ignored the advice of a mainstream health care grantee that CNDP had funded to assist LAC and, as a result, sent weak comments that did not truly have group consensus.

Other grants also failed. A grant to Brandeis University and an effort with Hunter College failed because, notwithstanding these grantees’ high level of expertise and access to government, they were operating without a constituency. We learned how essential this was to the success of their projects. We had a hard time, generally, integrating academic partners’ work into the national field strategies. SUD and drug policy partners were often resistant to these partnerships and sometimes appeared to fear that their own expertise was being questioned and, as a result, their standing with OSF put in jeopardy. At other times, advocacy grantees simply seemed to not see the relevance of collaboration. Ultimately, we interacted with academic partners differently and either use their work internally (GW paper covering new and unusual health allies led to a grant to Association for Community Affiliated Plans ) or offered their work to newer grantees (GW work on existing Medicaid services used by Community Catalyst). While these grants did not achieve what we had intended, we gained from them an appreciation of the importance of experience and an understanding of the need to objectively assess the trajectory of CNDP’s work in real-time and to be prepared and willing to change course promptly when necessary.

One conclusion that we have reached from the experiences described above is that the drug policy reform field needs new voices and fresh perspectives. Times have changed. Long-active groups formed their outlook and approach to advocacy in a more hostile environment than we are dealing with today. Even well-established groups, such as DPA, have had to spend enormous amounts of time and energy over the years defending their space. An unfortunate effect of this decades-long struggle is that, when these groups encounter opportunities, they sometimes perceive those opportunities as threats. For a long time, leadership at DPA seemed convinced that health care reform would only support abstinence-based, non-medication assisted treatment. DPA failed to engage in the health care reform conversations to move forward even its own drug policy agenda– maybe because it could not see the opportunity, but maybe because it sensed it lacked the deep expertise to talk in health language about evidence based harm reduction and treatment over a full range of illicit and non-illicit drugs.

Sustained support for established advocates is important in order to ensure the availability of their historical knowledge, insights, strategies and organizational capacity. But, we also need to be prepared to embrace new organizations and support new voices within existing organizations to diversify the field and make it more responsive and able to take advantage of a rapidly changing drug policy landscape.

The health component of the CNDP portfolio looks to the future with this understanding of the field and seeks to work on three key goals: (1) to continue work that promotes Medicaid expansion, (2) to continue support of National and state level reform efforts to ensure meaningful access to substance use disorder services and integration of drug user health in mainstream, evidence based health care and to then assess outcomes, and (3) to utilize the pilots and payment reforms outlined in the ACA to support pilots that promote health based responses to drug use, including for women of child bearing age.

## Objective 3: Support community-level alternatives to punitive drug policies

## 2012 grantmaking budget: $500,000

## 2013 grantmaking budget: $450,000

## 2014 grantmaking budget: $550,000

Program responsibility: Andy Ko and Jamie Wood

Our objective here is to begin the process of dismantling the false Hobson’s choice by elevating solutions-oriented alternatives to punitive responses to drug use and subsistence level drug markets. Practical experience with a different way of responding to drug related public safety and order concerns could be transformative for arrestees, police, advocates for reform, and the public. Experience can greatly alter what is viewed as “normal.” In this work, success would be policy in which the practice of funneling people suffering with addiction into the criminal justice system is no longer considered normal.

It seems clear to us that the development of alternative drug law enforcement policies is most viable where that process is grounded in the needs of local communities. It is at the local level, that the negative impacts of both drugs and current drug policies are most directly experienced. At the local level, community interests are also most likely to prevail over the political and financial interests that perpetuate punitive policies on the state, national and international levels. The U.S. Department of Justice’s recent attention to criminal justice reform and the threat posed by high levels of incarceration doesn’t alter our analysis, but might signal a role for the federal government in supporting this work at the community level. Our expectations overall have, to date, been confirmed by CNDP’s investment in the development, local and national profile, and adaptation/replication of the Law Enforcement Assisted Diversion (LEAD) approach devised in Seattle.

Piloted in Seattle’s Belltown neighborhood and recently expanded to the city’s entire downtown business district, LEAD is a “pre-booking” diversion program developed and implemented by local stakeholders, including the Seattle Police Department, Public Defender Association, King County Prosecutor, King County Sheriff’s Department, ACLU of Washington, city and county executives and legislatures, service providers and Business Improvement District leaders. Based on a memorandum of understanding among community stakeholders and a negotiated referral protocol, people arrest for drug possession, low-level drug distribution and prostitution in Seattle’s LEAD implementation area are offered a choice between managed services (LEAD) or traditional processing through the criminal justice system – i.e., jail, prosecution and a possible prison sentence. Based on harm reduction principles, the LEAD collaborators do not require participants to end their drug use as a condition of participation. The only requirement is participation and the utilization of services to reduce the negative impact on the community of the individual’s drug related activities.

While a comprehensive outcomes evaluation will is not be available before 2015, when the program will have four years of operating data, certain impacts are already directly observable. Homeowners and business leaders in the pilot area – the same groups that have for years called for police crackdowns on street level drug use and markets in the neighborhood – now are among the strongest proponents of LEAD. They explain that, for years, calling for targeted arrests was the only option they were offered to reduce disruptive street life. Similarly, the attitudes of patrol officers and brass have undergone an interesting transformation. Not long after the program became operational, street level officers requested authorization to make LEAD referrals based on community contacts with drug users in situations where they did not (yet) have probable cause to arrest. When told that was not the purpose of LEAD, their reported response was, “You’re telling us that we have to arrest someone to get them help?” The transformation of outlook among police executives and prosecutors is similarly significant. In particular, former interim Police Chief James Pugel and Prosecutor Dan Satterberg incorporated harm reduction principles into their work to a degree that would have been unimaginable a few years before their participation in the development of LEAD.

A challenge specific to our community-level focus is the risk that a groundbreaking or transformative program will be a tree falling in the forest: never heard beyond the isolate confines of the local jurisdiction and even more likely to disappear with a change of elected and/or law enforcement leadership. CNDP staff has played an important role here by ensuring that our grantees and non-grantee partners’ place-specific work is noticed in other jurisdictions and among other actors in the field. OSF network partners International Harm Reduction Development Program (IHRD) and Global Drug Policy Program (GDPP), as well as OSF grantees International Drug Policy Consortium (GDPP) and Harm Reduction Coalition (CNDP, IHRD and GDPP), have also supported and adapted the LEAD experience and enlisted the Seattle stakeholders in United Nations and other international processes. OSF’s drug policy programs have also facilitated site visits by our grantees and partners to observe LEAD in operation, including a recent two-day session by Chinese officials organized and supported by IHRD.

This deep engagement by the campaign and other OSF programs, like our health care reform work, has had an interesting effect. The Drug Policy Alliance was initially wary of LEAD and the risk it saw for the reinforcement of law enforcement control over drug policy. Our first substantive engagement was with DPA’s state offices, which were the first to see the potential of working toward the transformation of the role of local police from enforcers of punitive drug laws to that of first responders. DPA’s New Mexico office successfully built local support for adaptation of LEAD to Santa Fe’s local conditions and implementation began earlier this year. DPA’s state programs are also working in other jurisdictions, such as Albany and San Francisco, to adapt LEAD to local conditions. USP grantees VOCAL-NY, Racial Justice Action Center, Texas Criminal Justice Coalition, Institute of the Black World 21st Century and Community Renewal Society are exploring similar adaptations in New York City, Atlanta, Houston, Pittsburgh, the District of Columbia, and Chicago.

The lesson we draw from this is that small local innovations can, with adequate support, resonate far beyond a community’s borders. We were initially concerned that LEAD would be received as a “model” rather than an approach founded on harm reduction principles and adaptable to local conditions. At least with the second LEAD program in Santa Fe, that concern appears to have been unwarranted. LEAD, as implemented in New Mexico, was built in close consultation with the Seattle stakeholders, but it is distinct and tailored to the specific concerns of the local community (property crime related to opiate addiction).

We are very conscious that interest from within the field could be driven by groups’ perception of a significance that OSF attaches to LEAD specifically, rather than to attempts to establish community-level alternatives more broadly. Beyond assuring grantees and potential grantees that our commitment is to supporting a different paradigm, not a particular program, this is a risk that we need to manage. It seems unlikely that we can eliminate this dynamic entirely and still effectively pursue our objectives.

A remaining challenge we face is the question of adequately scaling our and funding partners’ support to the level of apparent interest and opportunity, which is a longer discussion with USP leadership. Ensuring sustainability through the commitment of public resources to replace private startup funding is possibly the greatest challenge.

Finally, within our community-level alternatives work, we have begun to explore opportunities for other approaches beyond LEAD. We have made grants to Treatment Alternatives for Safe Communities (TASC) and to the Harm Reduction Therapy Center for its San Francisco Drug Users Union (SFDUU). The TASC grant funded “No Entry: A National Survey of Criminal Justice Diversion Programs and Initiatives” as a tool for the field to research the various ways that communities across the country are attempting to reduce local levels of incarceration. The SFDUU grant, co-funded with IHRD, supports the organization and activism of drug users in San Francisco’s Tenderloin neighborhood. SFDUU works in close collaboration with DPA’s San Francisco office and other advocates in the Bay Area and is particularly focused on options for establishing a safer injection site in San Francisco, which is another approach to establishing a community-level alternative to punitive drug enforcement in that it would create a safe haven from arrest as well as a portal to service and overdose prevention for active drug users. This grant is unlikely to yield all of the outcomes specified in the grant proposal, but it is a modest investment and we and IHRD saw an important opportunity to elevate drug users’ direct involvement in seeking solutions to the policies that threaten their freedom and lives.

**QUESTIONS FOR FURTHER CONSIDERATION:**

1. Are we correctly identifying the key organizations and constituencies in the field under Objective 1? If so, are we appropriately allocating resources given CNDP’s grantmaking budget – i.e., are we effectively helping to raise their voices alongside DPA? If we have not identified the right constituencies and/or organizations, what questions should we be asking ourselves to arrive at the right mix?
2. Having identified the importance of enabling new, sometimes oppositional, partners to participate in this work, who else should we include that we are not (e.g., organized labor, parent organizations, etc.)?
3. Is CNDP’s work strengthened by the degree of our direct engagement with the field? If so, why? If not, what could we do differently, given the range of possible approaches (from solely hands-off grantmaking to solely direct advocacy in OSF’s name)?

1. CNDP was staffed by late November, 2010 and fully operational by January, 2011. [↑](#footnote-ref-2)