



Uncovering Policies That Prevent Syringe Services and Related Harm Reduction Programs from Meeting Community Needs

By Stacey McKenna

As the overdose crisis persists in the United States, a growing number of federal, state and local lawmakers are embracing harm reduction—a proven approach that mitigates the risks associated with “risky” behaviors, including illicit drug use.

Executive Summary

To combat rising rates of drug overdoses, the United States government has begun to embrace a public health response that has been saving lives for decades: harm reduction.¹ This pragmatic public health approach aims to mitigate the health risks associated with a range of behaviors rather than insisting people quit them altogether.²

1. Don C. Des Jarlais, “Harm reduction in the USA: the research perspective and an archive to David Purchase,” *Harm Reduction Journal* 14:51 (July 26, 2017). <https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-017-0178-6>.

2. “Principles of Harm Reduction,” National Harm Reduction Coalition, last accessed June 13, 2022. <https://harmreduction.org/about-us/principles-of-harm-reduction>.

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Despite the benefits of harm reduction programs, stigma, paraphernalia laws and weak or inconsistent protections from such laws can undermine the uptake of their services.³ In addition, a small but growing body of evidence indicates that, despite the legalization and expansion of these programs, successful implementation may also be limited by outdated local, state and federal policy.⁴

To better understand how outdated policy might create barriers to providing optimal harm reduction services, we interviewed 10 harm reduction providers serving diverse populations across the United States. These interviews revealed two primary areas of concern that harm reduction providers perceived as hindering the services they offered, both of which relate to government overreach: the overregulation of operations and the excessive restrictions on how funding can be used.

To remove these barriers and enable harm reduction organizations to save more lives, we suggest that—instead of supporting legislation that regulates the details of harm reduction practice—lawmakers support bills that emphasize organizational autonomy for these groups. Doing so would allow harm reduction providers to tailor programs as needed, remain flexible in the face of changing science and provide more effective services to their communities.



\$30 million

was designated by the Biden Administration in 2021 to combat the overdose crisis.

Introduction

did you know?

Harm reduction recognizes that abstinence-based approaches to drug use, misuse and addiction are not effective at the population level. As such, the pragmatic goal of this public health strategy is to reduce risks associated with certain behaviors, including substance use.

Source: “Principles of Harm Reduction,” National Harm Reduction Coalition, last accessed June 13, 2022. <https://harmreduction.org/about-us/principles-of-harm-reduction>.

In spring 2021, the Biden administration designated \$30 million to harm reduction in an effort to combat the overdose crisis.⁵ One year later, the Office of National Drug Control Policy released a National Drug Control Strategy that embraced this approach.⁶ While such broad and public support of harm reduction by a U.S. presidential administration is unprecedented, harm reduction has been saving American lives for decades, from methadone maintenance programs that appeared in the 1960s to grassroots syringe exchanges implemented in the 1980s.⁷

When they began to appear, many of these programs were illegal, operating under the radar within insular, historically marginalized communities.⁸ The first publicly funded syringe exchange program opened in the United States in 1988, and, since then, harm reduction has gained traction as an effective tool in combating the health risks associated with drug use.⁹ Indeed, many syringe services programs (SSPs) now offer a range of

3. Jeffrey A. Singer and Sophia Heimowitz, “Drug Paraphernalia Laws Undermine Harm Reduction,” CATO Institute Policy Analysis No. 929, June 7, 2022. <https://www.cato.org/policy-analysis/drug-paraphernalia-laws-undermine-harm-reduction-reduce-overdoses-disease-states#introduction>; Logan S. Baker et al., “Community Perceptions of Comprehensive Harm Reduction Programs and Stigma Towards People Who Inject Drugs in Rural Virginia,” *Journal of Community Health* 45 (Sept. 9, 2019), pp. 239–244. <https://link.springer.com/article/10.1007/s10900-019-00732-8>; Corey Davis, “Overdose ‘Good Samaritan’ Laws Should Protect, Not Punish,” *The Network for Public Health Law*, Jan. 26, 2020. <https://www.networkforphl.org/news-insights/overdose-good-samaritan-laws-should-protect-not-punish/#:~:text=Overview,discourage%20people%20from%20seeking%20help>.

4. Amanda Sharp et al., “Community Perceptions of Harm Reduction and Its Implications for Syringe Exchange Policy,” *Journal of Drug Issues* 50:4 (July 3, 2020), pp. 507–523. <https://journals.sagepub.com/doi/10.1177/0022042620932289>.

5. “Biden-Harris Administration Calls for Historic Levels of Funding to Prevent and Treat Addiction and Overdose,” The White House, May 28, 2021. <https://www.whitehouse.gov/ondcp/briefing-room/2021/05/28/biden-harris-administration-calls-for-historic-levels-of-funding-to-prevent-and-treat-addiction-and-overdose>.

6. Office of National Drug Control Policy, *National Drug Control Strategy*, The White House, 2022. <https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf>.

7. H. Joseph et al., “Methadone maintenance treatment (MMT): a review of historical and clinical issues,” *Mount Sinai Journal of Medicine* 67:5–6 (Oct–Nov 2000), pp. 347–364. <https://pubmed.ncbi.nlm.nih.gov/11064485>; Mary Hawk et al., “Harm reduction principles for healthcare settings,” *Harm Reduction Journal* 14:70 (Oct. 24, 2017). <https://link.springer.com/article/10.1186/s12954-017-0196-4>; Des Jarlais. <https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-017-0178-6>.

8. Des Jarlais. <https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-017-0178-6>.

9. S.G. Sherman and D. Purchase, “Point Defiance: a case study of the United States’ first public needle exchange in Tacoma, Washington,” *International Journal of Drug Policy* 12:1 (April 1, 2001), pp. 45–57. <https://pubmed.ncbi.nlm.nih.gov/11275503/#:~:text=The%20first%20publicly%20funded%20needle,%2C%20Washington%2C%20in%20August%201988;Substance%20Abuse%20and%20Mental%20Health%20Services%20Administration,%20Harm%20Reduction,%20U.S.%20Department%20of%20Health%20&%20Human%20Services,%20last%20updated%20June%208,%202022>. <https://www.samhsa.gov/find-help/harm-reduction>.

services not only to reduce infectious disease transmission but also to prevent and reverse overdose and connect people with treatment providers.¹⁰ The education and services offered by these organizations have been shown to reduce the incidence of HIV and hepatitis C virus (HCV) by as much as 50 percent.¹¹ In addition, the overdose reversal drug naloxone, which is often provided through SSPs, has been shown to have an efficacy rate between 75 and 100 percent.¹²

Harm reduction approaches offer taxpayers a massive return on investment. A cost-effectiveness study of a New York needle exchange program found savings of approximately \$3,000 per client, and research from both low- and high-income settings around the world has found SSPs to be highly cost-effective.¹³ In addition, medication-assisted treatment (such as methadone or buprenorphine) saves between \$3 and \$15 for every dollar spent, and models suggest that overdose prevention centers could generate an annual savings of \$3.5 million to \$7.8 million.¹⁴ Of note, research suggests that comprehensive harm reduction programs (i.e., those that offer a variety of services and approaches) are more successful and cost-effective than those that offer only partial services.¹⁵

Highly Cost-Effective Programs

\$3 ↔ \$15
Medication-assisted treatment
savings for every dollar spent

\$3.5 million ↔ \$7.8 million
Overdose prevention centers
possible annual savings

Even with increased harm reduction efforts, people across the United States continue to die of drug-related causes. In 2021 alone, more than 107,000 Americans lost their lives to an overdose.

Source: Mike Stobbe, "CDC says more than 107,000 Americans died of drug overdoses in 2021, setting 'staggering' record," PBS, May 11, 2022. <https://www.pbs.org/newshour/health/cdc-estimates-more-than-107000-americans-died-of-drug-overdoses-in-2021-setting-staggering-record>.

Given harm reduction's cost effectiveness and well-documented success at saving lives and improving health, it is no surprise that as ultrapotent opioids such as fentanyl and other synthetics infiltrate the illicit drug market, even more states are considering implementing the approach.¹⁶ In addition to the federal government's recent vocal support, the number of states explicitly allowing SSPs almost doubled between 2014 and 2019; in fact, as of August 2019, 39 U.S. jurisdictions allowed SSPs.¹⁷

Despite this progress, many SSPs must still operate illegally or in legal gray area, much as they did in the late 20th century.¹⁸ Even in states in which SSPs and other harm reduction services are legal, significant challenges exist related to their widespread implementation and use. Factors such as stigma and a lack of protection from drug-related laws (i.e., those pertaining to paraphernalia, overdose and more) can undermine even the best

10. "Syringe Services Programs (SSPs) Fact Sheet," Centers for Disease Control and Prevention, May 23, 2019. <https://www.cdc.gov/ssp/syringe-services-programs-factsheet.html#:~:text=SSPs%20are%20associated%20with%20an,in%20HIV%20and%20HCV%20incidence.&text=When%20combined%20with%20medications%20that,reduced%20by%20over%20two%20thirds>.

11. Ibid.

12. "Syringe Services Programs (SSPs) Fact Sheet." <https://www.cdc.gov/ssp/syringe-services-programs-factsheet.html#:~:text=SSPs%20are%20associated%20with%20an,in%20HIV%20and%20HCV%20incidence.&text=When%20combined%20with%20medications%20that,reduced%20by%20over%20two%20thirds>; Rachael Rzasa Lynn and J.L. Galinkin, "Naloxone dosage for opioid reversal: current evidence and clinical implications," *Therapeutic Advances in Drug Safety* 9:1 (Dec. 13, 2017), pp. 63-88. <https://journals.sagepub.com/doi/10.1177/2042098617744161>.

13. Hrishikesh K. Belani and Peter A. Muennig, "Cost-Effectiveness of Needle and Syringe Exchange for the Prevention of HIV in New York City," *Journal of HIV/AIDS & Social Services* 7:3 (Oct. 12, 2008), pp. 229-240. <https://www.tandfonline.com/doi/abs/10.1080/15381500802307492>; David P. Wilson et al., "The cost-effectiveness of harm reduction," *International Journal of Drug Policy* 26:1 (Feb. 1, 2015), pp. S5-S11. <https://www.sciencedirect.com/science/article/pii/S0955395914003119#bib0360>.

14. *Review of Cost-Benefit and Cost-Effectiveness Literature for Methadone or Buprenorphine as a Treatment for Opiate Addiction*, Center for Health Program Development and Management, May 9, 2007. https://www.hilltopinstitute.org/wp-content/uploads/publications/Cost_benefit_Opiate_Addiction_August_29_2007.pdf; Amos Irwin et al., "A Cost-Benefit Analysis of a Potential Supervised Injection Facility in San Francisco, California, USA," *Journal of Drug Issues* 47:2 (Dec. 13, 2016), pp. 164-184. https://journals.sagepub.com/doi/full/10.1177/0022042616679829?casa_token=Ey5_zQJK9UMAAAAA%3AGOAllopfDXWkfmQGwZoR2XYGWXSqf5Phmxj_gJEqP977Nev3DagSI1VZNHm9UJWg6j4wktUKGY1g; Amos Irwin et al., "Mitigating the heroin crisis in Baltimore, MD, USA: a cost-benefit analysis of a hypothetical supervised injection facility," *Harm Reduction Journal* 14:29 (May 12, 2017). <https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-017-0153-2>.

15. Wilson et al. <https://www.sciencedirect.com/science/article/pii/S0955395914003119#bib0360>.

16. "Fentanyl Facts," Centers for Disease Control and Prevention, Feb. 23, 2022. <https://www.cdc.gov/stopoverdose/fentanyl>.

17. Marcelo H. Fernández-Viña et al., "State Laws Governing Syringe Services Programs and Participant Syringe Possession, 2014-2019," *Public Health Reports* 135:1 suppl (July/August 2020), pp. 128S-137S. <https://journals.sagepub.com/doi/pdf/10.1177/0033354920921817>; "Syringe Service Program Laws," The Policy Surveillance Program, Aug. 1, 2019. <https://lawatlas.org/datasets/syringe-services-programs-laws>.

18. "SSP Locations," North American Syringe Exchange Network, last accessed June 9, 2022. <https://www.nasen.org/map>; Des Jarlais, 2017. <https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-017-0178-6>.

harm reduction efforts.¹⁹ In addition, although little research has focused on the policies that harm reduction providers see as barriers to providing services, the studies that have investigated this issue suggest that successful implementation may be limited by outdated local, state and federal policy.²⁰

Because more research is needed to understand the policy factors at play, we undertook a study to explore the ways in which policy affects harm reduction organizations' ability to provide existing or desired services according to best practices. In this paper, we outline the methods and key findings of that study. We also provide policy recommendations that would allow SSPs to more successfully serve their communities.

Methods

For the purposes of this study, harm reduction organizations were defined as those that provided, at a minimum, distribution of needles, syringes and other safer-injection supplies. Although this was our minimum inclusion criteria, it is important to note that SSPs are among the longest-standing harm reduction programs in the United States and often serve as a connection point to other services, such as naloxone distribution, wound care and treatment referrals.²¹

With this research, we sought to explore the perspectives and experiences of organizations operating in a variety of policy landscapes and different state laws. We therefore reached out to 28 organizations purposively selected from the North American Syringe Access Network's database and additional internet research to represent a variety of legislative, political, geographic, metropolitan and operational circumstances.

Ten harm reduction organizations agreed to participate and be interviewed. The participating organizations operated in 10 states and in several distinct regions; served a mix of community types (urban, suburban and rural [of note, no organizations in the nation's largest cities participated]); and represented either independent community organizations or branches of state and local health departments (Table 1).

Table 1: Participating Harm Reduction Organization Descriptors

Organization	Region	Geographic Area	Community or Government
1	Northeast	Rural to small metropolitan	Community based
2	Midwest	Urban site; also serves rural and suburban participants	Public health department
3	Midwest	Urban site; also serves rural and suburban participants	Public health department
4	Mountain West	Rural, some small metropolitan	Community based
5	Southwest	Urban outskirts and rural	Community based
6	Pacific West	Rural	Community based
7	Northeast	Urban site, also serves rural and suburban participants	Community based
8	National	Urban, suburban, rural	Nonprofit; partners with community-based organizations and health departments
9	Southeast	Rural to small metropolitan	Public health department
10	Mountain West	Rural to small metropolitan	Community based



SSPs are among the longest-standing harm reduction programs in the United States and often serve as a connection point to other services, such as naloxone distribution, wound care and treatment referrals.

19. Singer and Heimowitz, 2022. <https://www.cato.org/policy-analysis/drug-paraphernalia-laws-undermine-harm-reduction-reduce-overdoses-disease-states#introduction>; Baker et al. <https://link.springer.com/article/10.1007/s10900-019-00732-8>; Davis, 2020. <https://www.networkforphl.org/news-insights/overdose-good-samaritan-laws-should-protect-not-punish/#:~:text=Overview,discourage%20people%20from%20seeking%20help.>

20. Sharp et al., p. 3. <https://journals.sagepub.com/doi/10.1177/0022042620932289>.

21. "Syringe Services Programs (SSPs) Fact Sheet." <https://www.cdc.gov/ssp/syringe-services-programs-factsheet.html#:~:text=SSPs%20are%20associated%20with%20an,in%20HIV%20and%20HCV%20incidence.&text=When%20combined%20with%20medications%20that,reduced%20by%20over%20two%20Dthirds.>

We conducted 15- to 45-minute semistructured interviews via video, phone or email (per organization preference) with participating organizations. Interviews covered services offered, populations served and policy barriers to services currently offered as well as to those the organization would like to offer. Audio and video interviews were recorded with permission, transcribed, deidentified and coded inductively. We then inserted key codes into a spreadsheet and identified patterns across multiple interviews.²²

Policy Barriers to Effective Harm Reduction

Because each of the 10 harm reduction organizations we interviewed operated in discrete policy environments and served unique populations, the details of their perceived policy challenges differed. Some faced a permissive state legislative landscape but tight or inconsistent regulation at the county or municipal level. Others struggled with state policies that prevented them from working in the ways that best met community needs. Importantly, though, all harm reduction organization providers interviewed for this study expressed concerns with overreach by local, state and federal government. This overreach took the form of regulations on how the organizations operated within communities as well as restrictions on how funding could be used.

Operational Overregulation

The top policy concern that harm reduction providers expressed as impeding their ability to provide optimal services was government overreach. This occurred when local, state and federal authorities sought to regulate programs in ways that ran counter to best practices or efforts to tailor services to community needs.

Providers most frequently discussed government overregulation in reference to the distribution of new, sterile injection supplies such as needles and syringes. One widely criticized policy that dictates how SSPs provide supplies is the “one-for-one” policy in which program participants must return a used syringe to receive a new one. Four states—Maine, Delaware, Florida and Hawaii—require one-for-one exchanges.²³ But providers from all over the country expressed concern that the policy does more harm than good, especially to the most vulnerable individuals who depend on SSPs as a resource that allows them to make safer choices. One provider who had worked under both one-for-one and needs-based policies explained,

The evidence shows us that the one-for-one produces quite a bit of harm. From an infectious disease perspective and from a wound-care perspective, if you’ve ever seen the difference between a needle used once and four times, it’s nasty. So, what happens is, a big chunk of our population is housing-insecure, couch surfing, unable to keep track of their used needles or keep them on their person. If you’re walking around with a backpack and looking for a place to sleep, if you’re looking to empty stuff out ... There’s a reasonable number of people who have partners who don’t know they use, or parents, and it’s much easier to discard the needles than to have them ... So, in order to get that target population new sterile equipment without them bringing something in return is impossible under a one-for-one rule.

The Centers for Disease Control and Prevention recognizes that needs-based syringe services—not one-for-one services—are the most effective way to reduce infectious-disease transmission and injection-related wounds among people who inject drugs.²⁴ But many communities worry about syringe litter ending up in parks, playgrounds or



All harm reduction organization providers interviewed for this study expressed concerns with overreach by local, state and federal government, which dictated how the organizations operated in the communities and spent their funding.

22. Alyona Medelyan, “Coding Qualitative Data: How to Code Qualitative Research,” Thematic, last accessed June 10, 2022. <https://getthematic.com/insights/coding-qualitative-data/#:~:text=What%20is%20Inductive%20Coding%3F,directly%20from%20the%20survey%20responses.>

23. “IDEA-Exchange,” Florida Health, Nov. 5, 2019. <https://www.floridahealth.gov/programs-and-services/idea/exchange.html>; “Needle Exchange Program,” Delaware.gov, last accessed June 10, 2022. <https://www.dhss.delaware.gov/dph/dpc/needleexchange.html>; “Syringe Service Programs (SSPs),” hawaii.gov, last accessed June 10, 2022. <https://health.hawaii.gov/harmreduction/syringe-service-programs>; Department of Human Services, “Chapter 252: Rules Governing the Implementation of Hypodermic Apparatus Exchange Programs,” Main Center for Disease Control and Prevention. <https://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/provider/documents/nep-rules.pdf>.

24. “Needs-Based Distribution at Syringe Services Programs,” Centers for Disease Control and Prevention, December 2020. <https://www.cdc.gov/ssp/docs/cdc-ssp-fact-sheet-508.pdf>.

other public places and view one-for-one as a way to mitigate these potential issues.²⁵ However, research demonstrates that needs-based SSPs do not necessarily present a greater improper disposal risk than one-for-one programs. Rather, needs-based SSPs can facilitate safe needle and syringe disposal by providing access to sharps containers and community drop-boxes (such as those found in many places for the disposal of insulin injection supplies); organizing community cleanups; and coordinating other locally driven strategies.²⁶

Harm reduction providers expressed additional overregulation concerns that extended beyond limits to the number of syringes they could distribute per person. These additional challenges consisted of policies that limit how and where harm reduction services can be provided. Several providers serving rural communities explained that—despite state permissions—local politics, as well as county and municipal laws, prevented them from operating mobile services that would increase access for remote populations.

One rural provider explained that local bans and a lack of political will among leadership prevented expansion into much-needed mobile services. Another provider—whose organization serves a rural county in which many program participants must drive an hour or more for services—discussed how local politics could affect their ability to establish new sites, “One community in the valley, a very small community, very frontier community ... they were very hostile, very clear that that was not going to be allowed in their community ... Then we have other communities that were not that way at all. So, you know, it just depends, I suppose, on who happens to be sitting on the town council at the time.”

Another provider, also from a predominately rural area, cited burdensome regulations—not a ban—that prevented the organization from launching a mobile unit: “I think mobile would help in some ways, but for me to have a mobile site, I have to have a nurse on site. I have to have a doctor on site. I have to be able to draw blood on site. So, no, mobile is very difficult.”

This is unfortunate, as studies consistently show that innovative, community-tailored approaches such as mobile units or vending machines are effective tools for serving hard-to-reach populations like those living in remote areas or those who are unhoused.²⁷ The specifics of how these units operate optimally differ according to community needs, pointing to the importance of building policy that prioritizes the voices not just of local politicians but also of local providers and the people they serve.²⁸

Additional areas of government overreach that the providers mentioned included federal bans on overdose prevention centers and on-site testing services; laws against the distribution of injection alternatives; and identification mandates. Harm reduction providers viewed all of these as policies that failed to acknowledge the on-the-ground realities of drug use and addiction and that unnecessarily prevented life-saving services or made them too difficult to access.



[Overreaching policies] failed to acknowledge the on-the-ground realities of drug use and addiction and ... unnecessarily prevented life-saving services or made them too difficult to access.

25. Erin Schumaker, “Needle exchanges are a proven tool to fight HIV, but officials still want to shut them down,” ABC News, June 30, 2021. <https://abcnews.go.com/Health/needle-exchanges-proven-tool-fight-hiv-officials-shut/story?id=78047242>.

26. Ricky N. Bluthenthal et al., “Higher syringe coverage is associated with lower odds of HIV risk and does not increase unsafe syringe disposal among syringe exchange program clients,” *Drug and Alcohol Dependence* 89:2-3 (July 10, 2007), pp. 214-222. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2562866>; Luc de Montigny et al., “Assessing a drop box programme: A spatial analysis of discarded needles,” *International Journal of Drug Policy* 21:3 (May 2010), pp. 208-214. <https://www.sciencedirect.com/science/article/pii/S0955395909001108>.

27. Md Mofizul Islam and Katherine M. Conigrave, “Assessing the role of syringe dispensing machines and mobile van outlets in reaching hard-to-reach and high-risk groups of injecting drug users (IDUs): a review,” *Harm Reduction Journal* 4:14 (Oct. 24, 2007). <https://harmreductionjournal.biomedcentral.com/track/pdf/10.1186/1477-7517-4-14.pdf>.

28. Carol Strike and Miroslav Miskovic, “Scoping out the literature on mobile needle and syringe programs—review of service delivery and client characteristics, operation, utilization, referrals, and impact,” *Harm Reduction Journal* 15:6 (2018). <https://harmreductionjournal.biomedcentral.com/track/pdf/10.1186/s12954-018-0212-3.pdf>.

Funding Restrictions

The second important policy challenge identified by harm reduction providers was related to funding. Several providers viewed restrictions on how they could use government funding as limiting their ability to tailor their work to meet community needs. As with other public health programs in the United States, harm reduction depends on tax dollars to operate.

The most common funding concern expressed was that although the federal government does fund harm reduction programs, it prohibits the use of federal dollars for the purchase of needles or syringes.²⁹ For both community-based and public health department agencies, this restriction required making difficult choices. Some organizations found themselves juggling money from various funding sources between permissible line items. As one provider explained,

When we come to a close on our fiscal year, we may be way over budget on one line item and under budget by a little bit on another line item. And so we kind of move money around within our contract to make sure our entire contract gets expended. And there have been times when we haven't been allowed to move naloxone (overdose reversal medication) money into syringe exchange because the money was federal.

Some providers said that, at times, these funding challenges have caused organizations to do more than move money around. They must weigh the choice to provide evidence-based services for a limited time or substandard services for a longer period of time to preserve their limited supply.

We're a needs-based program. So people know that when they come to us, they can get what they need. We're not going to say, 'You can only have this much,' or 'You can only have this much if you bring back this much.' We don't have those parameters because best practice is needs-based. So we're doing best practice. We want to continue to do best practice, but because we can't use federal funds for syringes and other injection equipment, we are now in this really horrible predicament.

Notably, this resistance to funding the purchase of needles and syringes is counterintuitive, as the federal government already pays for most of the downstream effects of sharing needles, such as HIV- and HCV-related health care costs. In 2019, the approximate lifetime cost to treat an individual living with HIV in the United States was \$420,285, and a 12-week course of HCV treatment could reach \$84,000.³⁰ Medicaid is the country's largest insurer of people living with HIV, and a large proportion of patients with HCV are insured by Medicaid or Medicare as well.³¹ Given the massive return on investment that SSPs provide—they have been referred to as one of the most cost-effective public health policies ever funded—the willingness of the federal government to support such programs makes sense.³² What is less logical is having policies in place that demonstrate a resistance to funding certain supplies, such as syringes, alongside a willingness to fund others, such as the overdose reversal medication naloxone.³³



What is less logical is having policies in place that demonstrate a resistance to funding certain supplies, such as syringes, alongside a willingness to fund others, such as the overdose reversal medication naloxone.

29. "Federal Funding for Syringe Services Programs," Centers for Disease Control and Prevention, May 23, 2019. <https://www.cdc.gov/ssp/ssp-funding.html#:~:text=The%20Consolidated%20Appropriations%20Act%20of,to%20purchase%20needles%20or%20syringes>.

30. Adrienna Bingham et al., "Estimated Lifetime HIV-Related Medical Costs in the United States," *Sexually Transmitted Diseases* 48:4 (April 1, 2021), pp. 299-304. <https://pubmed.ncbi.nlm.nih.gov/33492100>; Brandy Henry, "Drug Pricing & Challenges to Hepatitis C Treatment Access," *Journal of Health & Biomedical Law* 14 (September 2018), pp. 265-283. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6152913/#__ffn_sectitle.

31. "Medicaid and HIV," Kaiser Family Foundation, 2019. www.kff.org/hiv/aids/fact-sheet/medicaid-and-hiv/amp; Henry. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6152913/#__ffn_sectitle.

32. *The Global State of Harm Reduction: Towards an Integrated Response*, Harm Reduction International, 2012, p. 171. https://www.hri.global/files/2012/07/24/GlobalState2012_Web.pdf.

33. "Federal Funding for Syringe Services Programs." <https://www.cdc.gov/ssp/ssp-funding.html#:~:text=The%20Consolidated%20Appropriations%20Act%20of,to%20purchase%20needles%20or%20syringes>; "SAMHSA distributes \$11 million in grants to train first responders, community groups to prevent overdoses," Substance Abuse and Mental Health Administration, Aug. 13, 2021. <https://www.samhsa.gov/newsroom/press-announcements/202108131230>.

Importantly, the federal ban on funding syringes and needles was not the only problem organizations faced with regard to excessive restrictions on how they were able to spend government dollars. One provider expressed frustration about the siloed nature of funding structures. Despite the fact that many harm reduction organizations provide comprehensive services, they must apply to multiple distinct funding streams to fund different services.

Our funding doesn't really provide for an adequate amount of patient navigation or referrals to treatment or even testing. I mean, if the studies are right and 45-ish percent of the people coming to a syringe exchange are hep C positive and we've earned the trust and built the relationships with people, and they're not going to go over to the hospital and their local primary care provider to get tested. There are testing funds out there, but they're not intermingled well enough.

Policy Approaches to Support Evidence-Based, Community-Specific Harm Reduction

A 2017 study defined harm reduction's key principles as humanism, pragmatism, individualism, autonomy, incrementalism and accountability without termination.³⁴ It is telling that two of the six principles focus on the individual. After all, harm reduction has always been about giving people options to make healthier choices—regardless of where they start or where they are headed—rather than attempting to force abstinence. Thus, lawmakers who are proposing harm reduction policy related to SSPs should ensure that it embraces these principles and—based on our study findings—avoids the pitfalls of overreach, especially that of overregulation and restrictive funding.

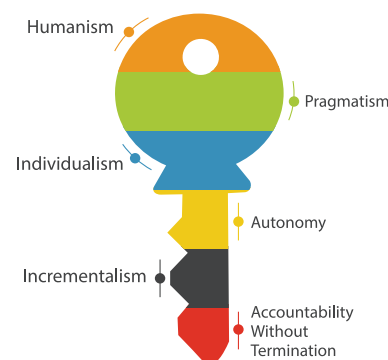
Our study suggests that all levels of government may be prone to overreach in ways that stifle the operation of evidence-based and community-centered harm reduction programs. Currently, harm reduction policy often imposes regulations via direct legislation or through funding restrictions, as states seek to manage what supplies are distributed, what services are provided and how these resources are disbursed.³⁵ But evidence suggests that when given the freedom to do so, harm reduction organizations actively work to strike a balance between providing services based on current science and prioritizing the voices of the participants and communities they serve.³⁶ This makes them considerably more qualified to develop and implement programs than lawmakers sitting in offices, far removed from the issues.

Such overreach runs contrary to the way the United States approaches other health-related policy. With regard to health care in general, the government has limited authority over how that care is carried out and supports patient choice and bodily autonomy. In fact, the most significant government health care regulations protect patient privacy and safety and promote equity of access.³⁷ Because harm reduction is a branch of public and community health, harm reduction policy should adopt a similar approach. Instead of micromanaging organizational operations, local, state and federal legislation should preserve the pragmatic, nonjudgmental principles of harm reduction and support best practices for meeting individuals where they are and protecting their right to make their own health decisions.³⁸

Adopting this approach requires that we acknowledge the decades of research supporting harm reduction and the expertise of harm reduction providers as well as the preferences

Harm Reduction Key Principles

Two of the six principles focus on the individual. Harm reduction has always been about giving people options to make healthier choices.



Beyond Policy

While less restrictive regulations are an important part of allowing harm reduction programs to meet the needs of the communities they serve, stigma and misunderstanding also present barriers to optimal operations. By working closely with health care and law enforcement organizations, harm reduction providers can help build more comprehensive community buy-in and support for their services.

34. Hawk et al. <https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-017-0196-4>.

35. Fernández-Viña et al. <https://journals.sagepub.com/doi/pdf/10.1177/0033354920921817>.

36. Carol Strike et al., "Guidelines for better harm reduction: Evaluating implementation of best practice recommendations for needle and syringe programs (NSPs)," *International Journal of Drug Policy* 22:1 (January 2011), pp. 34-40. https://www.sciencedirect.com/science/article/pii/S0955395910000617?casa_token=R1wiIB_MANKAAAA:OFf8V8vQMJU19CdUrpikaNo-EUzUy27nNZy4VJpGtxcoPv0lV5pjUWpdDk8d87UIESr0iB4SGiD.

37. "8 Important Regulations in United States Health Care," Regis College, last accessed June 14, 2022. <https://online.regiscollege.edu/blog/8-important-regulations-united-states-health-care>.

38. Mazen Saleh and Chelsea Boyd, "R Street Integrated Harm Reduction Principles and Priorities," The R Street Institute, December 2021. <https://www.rstreet.org/2021/12/14/r-street-integrated-harm-reduction-principles-and-priorities>.

of the recipients of those services. It also means writing policies that are flexible in their implementation to ensure that services are palatable and beneficial to the communities they are designed to serve.

With regard to funding, the restrictions on how government money can be used is challenging for most harm reduction organizations, but it is especially problematic for organizations in states with limited harm reduction budgets or general overregulation problems. Funding restrictions must therefore be removed, and control must be given to the organizations themselves to avoid piecemeal support and excessive control over program details. Doing so would empower organizations to build and implement the programs that would best serve the unique needs of their community, whether that means focusing on syringe distribution to reduce disease transmission, expanding treatment and referral services or passing out naloxone at community events to reduce stigma and improve community response.

Conclusion

As our research has demonstrated, although harm reduction has been implemented in many states in recent years, SSPs and other harm reduction organizations are struggling under the yoke of overreaching harm reduction policies. Often, these policies control how services can be provided and how funding can be used by overregulating operations and restricting funding. This type of overreach limits the effectiveness of harm reduction organizations and potentially harms their participants, especially in underserved areas.

Rather than regulating the details of harm reduction practice, we suggest that lawmakers support bills that provide organizational autonomy to deliver adaptable, evidence-based services tailored to meet specific community needs. Not only does this approach make sense within the harm reduction policy level itself, but it also allows harm reduction policy to fall in line with general health care policy, which has historically adopted an approach that limits state involvement, supports provider expertise and promotes bodily autonomy and patient choice.

If empowered in this way, harm reduction organizations would be able to better adapt to shifting needs and find creative solutions to the seemingly never-ending stream of new issues plaguing the communities they serve. Given that, since 1999, nearly 1 million individuals in the United States have died from a drug overdose, the importance of getting harm reduction policy right—right now—cannot be overstated.³⁹



one million

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39. "Death Rate Maps & Graphs," Centers for Disease Control and Prevention, June 2, 2022. <https://www.cdc.gov/drugoverdose/deaths/index.html>.

About the Author

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