PREEMPTION OF HARM REDUCTION PRACTICES DURING THE US OPIOID CRISIS

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ABSTRACT: Harm reduction programs such as syringe exchange programs and safe injection facilities are progressive ways to treat substance abuse disorder. Their implementation is continuously argued and grappled with amongst government institutions. State and local governments agree and disagree whether these programs are effective and should be implemented in their communities. Governments that find these programs ineffective may not consent to their implementation and can utilize tools at their disposal to impede their establishment. State governments can utilize their legislative power to obstruct the approval of harm reduction programs. Local governments, while not having the sovereign status of a state government, are nonetheless able to wield their own devices to impede harm reduction programs authorization. When these two government institutions disagree on whether to authorize harm reduction programs this intersection of opinions can produce intriguing results. The crossover of government differences of opinions can affect the overall outcomes of the programs. The difference of opinions on how to proceed with these substance use treatment programs creates an intersection of policy making and can lead to ineffective implementations. Exploring examples where government institutions disagree on this topic demonstrates how these programs can exist in spite of not being fully accepted, as well how differences of opinions affect the program's target audience, and impacts the positive outcomes produced by SEPs and SIFs.

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Introduction

The opioid crisis stems largely from the heavy over-prescription of opioid drugs in the United States starting in the early 2000s. Opioids are highly addictive drugs that bind to the opioid receptors in the brain and block one from feeling pain (Corbett, 2021). Around 1999, the pharmaceutical company Purdue Pharma created an opioid called OxyContin. The company was permitted to put a label on OxyContin which deemed it "less addictive" than other opioids, despite evidence proving otherwise (Vadivelu et al., 2018). Purdue started to push this new innovative "less-addictive" opioid, creating a tornado of over-prescription of a falsely advertised opioid (Vadivelu et al., 2018). This led to a wave of addiction that hit the United States over the next decades. Once it was discovered that Purdue Pharma was not being truthful to the public about OxyContin, the federal government stepped in to restrict how much/what could be prescribed. OxyContin flipped from being grossly overprescribed, to heavily monitored and restricted across the country (Vadivelu et al., 2018). This suddenly cut off the continuous supply that many people had become dependent upon, leading to the opioid crisis. The illegal market then stepped in to fill this gap of supply. Some of those dependent upon opioids turned to illicit supplies of OxyContin and then gradually started to use stronger drugs like heroin. The creation and push of the OxyContin drug directly produced a pipeline of people with opioid use disorder, some of whom turned into injection drug users.

Resulting from the opioid crisis, hundreds of thousands of people across the United States found themselves reliant on injection drugs, leaving them susceptible to diseases and overdose deaths. The act of consuming heroin or injection drugs leaves people who inject drugs (PWIDs) vulnerable to health and hygiene concerns. Injecting drugs requires clean needles and equipment in addition to disposal sites. When these needs are not met, PWIDs turn to sharing needles or using used needles to be able to consume. This can lead to an increased risk of contracting

infections and diseases like HIV, TB, Hepatitis B and C. Unsafe injection drug use, "accounts for the cause of one third of this country's cumulative AIDS cases" (Beletsky et al., 2008). Additionally, PWIDs are more vulnerable to overdose deaths. In 2010 to 2015 heroin overdose deaths tripled and between 2015-2016 drug overdose death rates rose amongst all age groups (Kreit, 2019). Overdose death is substantially impactful consequence of injection drug use that can happen to all PWIDs at any given moment. Recently, with the use of fentanyl, there has been an even larger increase of overdose deaths amongst PWID (Beletsky et al., 2008).

This is where harm reduction practices come into play. Harm reduction is a way of treating substance use disorder that focuses on reducing the harms associated with drug use (Corbett, 2021). These practices can decrease the negative health and hygiene effects created from consuming, specifically, injection drugs. Some of these practices include syringe exchange programs, safe injection facilities, and Narcan administration. Harm reduction is very controversial, leading to disagreements between state and local governments about if they should be implemented (Kreit, 2019). They create controversy because people do not agree on whether they are effective or if they are the correct way to treat addiction. Some government officials don't believe in harm reduction's effectiveness. Other officials still believe in the "war on drugs" and zero tolerance policies for treating addiction (Kreit, 2019). Most government interventions focus on zero-tolerance policies, so policymakers may be unsure when faced with harm reduction options (Burris et al., 2008). Opponents of harm reduction practices believe that these practices reward PWIDs and promote an increase in drug consumption (Burris et al., 1996). These differences in opinions about the effectiveness of harm reduction practices creates disagreements, including disagreements between state and local governments. These disagreements often lead to preemption.

Preemption occurs when a high authority of power overrides or overrules a lower authority's power. For example, if a state law conflicts with a federal law, the federal law supplants state law, making the state law invalid. There are two main types of preemption: explicit and implicit (Diller, 2007). A government body, when it does not agree with the policies of a subordinate government, can choose to enact laws that preempt the lower government bodies' laws.

This paper will explore the laws that preempt two different types of harm reduction practices. One of these practices are syringe exchange programs (SEPs), which focus on the exchange of needles amongst PWIDs. SEPs allow PWID to safely dispose of their used needles and pick up new sterile needles (Vallejo, 2018). Some SEPs also provide PWIDs with free HIV testing, safe injection practices, and drug treatment referrals. The federal laws that can preempt SEPs are possession laws, headshop laws, and drug paraphernalia laws. In terms of state laws, explicit drug paraphernalia laws that mimic the federal statutes also preempt SEPs.

Safe injection facilities (SIFs) are another type of harm reduction practice. It focuses on providing PWIDs a location to inject without fear of drug overdose (Martell-Crawford, 2017). PWIDs inject in the presence of healthcare professionals that are trained to step in and help if there is an overdose. This practice greatly decreases the amount of overdose deaths. The federal laws that can preempt this practice are the Controlled Substance Act and specifically the Crack House Statute. In terms of state laws, laws that mirror the federal Controlled Substance Act (CSA) can preempt SIFs.

In this paper, I will explore the relationship between preemption and these two harm reduction practices, focusing on how agreement/disagreement between state and local governments may impact the effectiveness of these practices. I will explain what harm reduction

practices are, specifically discussing syringe exchange programs and safe injection facilities. I will detail how they operate and in what ways they are effective. Next, I will explain what preemption is, and discuss the differences between express and implied preemption. I will investigate how preemption interacts differently between state and federal compared to state and local. I will detail how preemption interacts with and can affect SIF and SEPs. In order to understand how local communities reacted to state preemption, I will examine differences between localities that did and did not allow harm reduction practices in a state that has not allowed harm reduction policies and a state that has. I next discuss what happens when states and localities do and don't agree, and what might the future of SIFs and SEPs look like after an administration change. Finally, I will conclude by discussing recommendations that can be imposed to protect the further formation of SIFs and SEPs nationwide.

I. Harm Reduction Practices

Harm reduction practices rose to prominence to help combat the U.S. opioid epidemic. They are interventions that aim to improve health outcomes by minimizing risks and lessening adverse effects of drug use (Corbett, 2021). Harm reduction practices represent a different way to look at illicit drug use. Instead of criminalizing it, harm reduction methods help reduce the negative effects of illicit drug use. The basis of the idea of harm reduction is that drug consumption will continue, so it should be made safer for users. These programs also aim to create a comfortable enough environment for PWIDs to seek help if they want it. In this section, I will focus on two different types of harm reduction approaches: safe injection facilities and syringe exchange programs.

A. Syringe Exchange Programs

1. Definition

Syringe exchange programs are a type of harm reduction approach. The principle of the program is to provide a place for injection drug users – people who inject drugs through a vein, skin, or muscle – to go and receive clean needles (Corbett, 2021). They can also safely dispose of their used needles. This is an important program because, "lack of proper syringe disposal facilities and legal disincentives to safe disposal increases the risk that used syringes will be improperly discarded, creating public anxiety and risk of accidental disease transmission" (Beletsky et al., 2008). Having this access is incremental to reducing infections amongst PWID because 60% of them contract blood born infections (Vidourek et al., 2019) Syringe exchange programs give PWIDs a relatively safe space to dispose of and pick up new needles. This may seem inconsequential, but fear of prosecution and social rejection may force them to hide their usage, hence not allowing them to properly dispose of their needles (Beletsky et al., 2008). Some programs will even have people that speak to and show PWIDs safe ways to use their needles and dispose of them, teaching them safe injection practices. In addition to this, depending on the state laws, there will be access for PWIDs to seek treatment if they are open to it (Packham, 2021). Overall, syringe exchange programs' main goals are to keep used needles off the streets, teach safe injection practices to PWIDs, and reduce the prevalence of blood borne infections.

2. Evidence of Effectiveness

The effectiveness of SEPs in curbing drug usage is continuously called into question. The issue is that this is not the mission of SEPs; their mission is to decrease the prevalence of blood borne infections. SEPs have been proven by multiple studies to reduce the amount of HIV cases in the communities they find themselves in (Packham, 2021). A panel hosted by the National Institute of Health speaking on this issue reported that, "on average, seroprevalence of HIV antibodies increased by 5.9% per year in the 52 cities without SEPs and decreased by 5.8% per

year in the 29 cities with SEP" (Ferguson et al., 1998). With the rise of the opioid crisis and consequently injection drug uses the reported cases of Hepatitis C has doubled (Vidourek et al., 2019). SEPs have been found to be help prevent, curve, and combat these rising numbers. SEPs have also proved very effective in promoting and instilling safe injection practices in PWIDs. In one case study, after 6 months of going to an SEP 60% of the respondents reported quitting syringe sharing at their follow up interview (Bluthenthal et al., 2000). Additionally, PWIDs that attend SEPs are generally more likely to practice all around safer injection practices, showing that SEPs are successful in also educating PWIDs (Vidourek et al., 2019).

For SEPs to be able to assist in curbing drug usage, there needs to be an additional harm reduction program done in tandem with the SEP. In leu of this it has been determined that SEPs have been found to decrease HIV diagnosis but can also increase opioid related deaths (Pakham, 2021). This is because the introduction of an SEP in a community makes it cheaper to obtain drugs because the equipment needed to use them becomes free. Creating an increase of drug use in the area and as a result an increase in drug-related deaths, opioid deaths, and drug-related ER visits (Pakham, 2021). Nonetheless, SEPs are effective in achieving their goal which is to create a culture of safe injection drug use and decrease the prevalence of blood borne diseases.

3. Governing Syringe Exchange Programs

Syringe exchange programs face policy issues on federal, state, and sometimes local levels of the government. Most significantly, these programs may conflict with federal drug possession, head shop, and paraphernalia laws that stem from the Controlled Substances Act (CSA). Additionally, many states have adopted laws similar to the CSA. Drug possession laws prohibit the possession of an illegal substance (Burris, et al, 2002). The specifics of how much one must possess for it to be criminalized differs between the different states. Drug paraphernalia and head shop laws prohibit the sale or possession of any items intended to be used to consume

drugs, meaning they can regulate the possession of syringes (Burris, et al, 2008). These laws make it difficult for SEPs to operate since they must handle and hand out syringes which they know will be used for drug consumption. Additionally, possession laws make it difficult for PWIDs to agree to use SEPs. To be able to participate a SEP, PWIDs must be able to carry used syringes which often times contain trace amounts of illegal substances. This exposes them to potential arrest for possession. Although not all states have decided to closely follow the federal drug paraphernalia laws, as currently there are many states that allow for exceptions in their possession and drug paraphernalia laws to be made for SEPs when used to prevent a public health crisis (lawatlas).

The politics of the different states, which create the different make-ups of their respective state legislatures, all result in different approaches towards SEPs and the laws that prohibit them. Usually, more conservative state legislators will not allow for syringe exceptions even if their communities would greatly benefit from SEPs. One article argued that it was part of the Bible Belt's culture to reject the idea of SEPs and in turn these states do not allow for syringe exceptions (Blau, 2019). The states that allow for exceptions like California, Washington, Colorado, New York, Kentucky, have comparatively large amounts of SEPs. However, even in states where SEPs are allowed, local communities might not accept them. This was the case in Indiana when the state allowed for SEPs to try to mitigate their HIV crisis. Some of the local communities firmly decided against allowing SEPs and drove them out of their cities using local pushback (Corbett, 2021).

B. Safe Injection Facilities

1. Definition

Safe injection facilities (SIFs) provide a space for PWID to inject their drugs (Martell-Crawford, 2017). PWID bring with them to the facility the drugs they plan on using. The facility

in turn provides the user sterile needles and a clean space to inject. The program also provides attendees who monitor the PWID and make sure that they don't overdose. If they do, then the attendees intervene and try to prevent an overdose death. The mission of SIFs is to prevent overdose deaths, promote safe injection practices, and provide PWIDs a pathway to treatment when wanted (Martell-Crawford, 2017).

2. Evidence of Effectiveness

The effectiveness of safe injection facilities in the U.S. is still being studied, but there is some evidence they are effective in accomplishing their mission. Much of the empirical evidence pertaining to the effectiveness of SIFs is based on SIFs that exist outside the United States, such as in Canada, Australia, and Europe. Looking at data from European SIFs, the harm reduction program was found to create a link between PWIDs and healthcare workers that hadn't existed before (Martell-Crawford, 2017). This established a connection between these two communities that usually don't interact as much and if they do only after great harm has been done. This connection might have been the reason why the SIFs saw many PWID that attended the facility decide to enter rehab programs. As a result of this program, the amount of drugs used by PWIDs also decreased (Martell-Crawford, 2017). SIFs are very effective at reducing overdoes deaths. A study of the SIF in Canada revealed that the overdose deaths in the vicinity of the facility decreased by 35% after the SIF opened (Kreit, 2019). Other positive effects of SIFs are ones that closely mirror the positive effects of SEPs. The SIFs in both Canada and Australia were found to decrease needle sharing, decrease needle reuse, decrease public injections, and increase overall safer injection practices (Beletsky et al., 2008). Overall, the biggest positive impact that this harm reduction program creates is the link and line of communication between healthcare providers and PWIDs. This connection can create a domino effect of multiple different positive outcomes and reactions.

3. Governing Safe Injection Facilities

Safe injection facilities face very similar policy issues as syringe exchange programs: the SIFs immediately get struck down by the CSA. There are many parts of the act that risk making SIFs illegal including the drug paraphernalia laws. In addition to the paraphernalia and possession laws, the Crack House Statute of the CSA makes SIF operations illegal (Burris et al., 1996). The Crack House Statute prohibits managing, maintaining, or opening a place for the purpose of unlawfully manufacturing storing, distributing, or using a controlled substance (Burris et al., 1996) The day-to-day operation of an SIF is unlawful under the Crack House Statute. The CSA does include an exception for public health emergencies. In the United States vs. Safehouse, the defendants tried to take advantage of this by arguing that SIFs are a method of treating the opioid healthcare crises that the country currently faces (*United States v. Safehouse, 2021*). The largest issue working against SIFs is that multiple states are very wary of implementing them because of the multiple sections of the CSA that outright prohibit them. The mayors of New York and San Francisco were seriously considering SIFs but would not act on them until receiving approval from their state legislature because of their concern with federal law (Corbett, 2021). Nonetheless, state legislatures are also very shy about pulling the trigger on allowing an exception for SIFs because they are so controversial in the political landscape. This all creates disagreement between local cities, their state governments, and the federal government.

II. What Happens When Policymakers Disagree?

A. Sources of Policymaking Authority

Preemption occurs when two sources of law from different levels of government conflict with each other. It comes from the power of systems of authority to pass legislation (Diller, 2007). When a system of lower authority passes legislator that conflicts with legislation from a

system of higher authority. The system of higher authority will overrule the law from the system of lower authority. This government process follows the doctrine of preemption. It is applied to all laws surrounding all subjects and it concerns all government institutes. Ergo, preemption decides which laws, local, state, or federal, govern the legality of syringe exchange programs and safe injection facilities (Diller, 2007). As a result, there are preemption issues between federal and state laws and state and local laws. Preemption issues can be broken down into different types.

Preemption is separated into different categories that help explain the legal doctrine. There is first explicit and implied preemption. Explicit preemption is when the federal government has passed laws that explicitly state that they want to govern an issue (Diller, 2007). For example, Congress decides to intervene on an issue and states explicitly that state governments are not allowed to govern this issue. Then there is implied preemption which is when there is no explicit statement from the federal government about the governing of an issue (Diller, 2007). Implied preemption is split into two categories: conflict and field preemption. Conflict preemption is when a state law directly contradicts a federal law (Diller, 2007). Citizens cannot obey both state and federal laws simultaneously, so in this instance, the federal law wins. Field preemption, which is also referred to as occupation of the field, is when Congress means to completely occupy this field of law, leaving no room for state laws (Diller, 2007). Since field preemption is still implied preemption, systems of law must assume that the federal government meant to occupy the field without it having been explicitly said when inferring there is field preemption

B. Preemption also manages conflict between state and local governments

The practice of preemption between state and local governments is different from federal and state because the legal makeup of local governments differs from state governments. Under

the constitution, state governments are sovereign, which means that they are given the power, from the constitution, to enact and make laws. This is in contrast to local governments, which are not sovereign (Smith, 2016). With federal and state laws, in addition to both bodies being sovereign, there is the matter of the supremacy clause. The supremacy clause states that federal laws and the federal constitution take precedence over state laws and state constitutions (Diller, 2007). There is no such clause in intrastate preemption that explicitly decides which laws, state or local, take precedent. Due to local governments not being sovereign and not having a supremacy clause, their laws interact differently with state laws compared to, for example, what is seen between federal and state laws.

Intrastate preemption begins with the assumption that state laws take precedence over local laws, mirroring how federal and state laws interact even though there is no legal doctrine establishing this. Furthermore, local governments are not sovereign. Per Dillon's Rule, they only have powers expressly given to them by the state (Thompson, 2021). Some states passed "Home Rule Acts" that gave their local communities more power in light of Dillon's Rule. A Home Rule Act gives local governments the authority to pass legislation beyond the scope of what the Dillon Rule allows (Diller, 2007). It differs state by state; this statute can give local governments the express authority to enact legislation pertaining to certain issues that affect their community as extensions of the state government. So, conflicts between state and local laws depend on the sovereignty of states and whether that state has a Home Rule Act. If it does not, then the local government has little to no power against the state law. As opposed to state and federal conflicts where the supremacy clause clearly dictates how these conflicts go, i.e., usually in favor of the federal government. Fundamentally, conflicts between state and local laws are vastly different from conflicts between federal and state laws.

C. Preemption and Harm Reduction

In the context of harm reduction practices, federal, state, and local laws interact on different levels in terms of preemption surrounding this subject. Currently, there are over 25 states where syringe exchange programs (SEP) are legal under state laws (Opioid & Health Indicators Database"). Nonetheless, these programs are still illegal under federal laws. The CSA regulates drug paraphernalia and head shop laws. Drug paraphernalia and head shop laws give the legal authority for people that sell rolling papers, freebasing kits, and injection equipment to be prosecuted (Corbett, 2021). This could preempt any state laws allowing syringe exchange programs because these programs give injection equipment to injection drug users. One way states have been able to go around this explicit preemption is by referencing the savings clause. The CSA has a savings clause. A savings clause is when the federal government states they do not mean to occupy the field, meaning states can make their own legislation surrounding the issue relating to drug control/legislation (Diller, 2007). Furthermore, some states have found loopholes or exceptions to the CSA that allow for them to approve SEPs. In Illinois, the state government allowed for an SEP citing the research exception in the CSA; in New York, the state cited that the SEP was necessary for their defense against the opioid health crisis, and in Indiana, the state cited exemption under their own state Home Rule Act (Corbett 2021; Thompson 2021). The exceptions these state governments cited in addition to the CSA savings clause allowed the SEPs they approved of to have a slim margin of "immunity" from federal preemption.

In addition to federal preemption, there is also the issue of intrastate preemption when looking at the legality of SEPs. States have created certain exceptions to allow for the authorization of SEPs. Examples of these exceptions include governor executive orders, department of health authorizations, and state legislature (Burris et al., 2002; Corbett, 2021; Thompson, 2021). Throughout the years, because of the continuous opioid crisis, states have

tried to find ways around the federal and state laws that preempt SEPs, slowly allowing for exceptions to deregulate needles and injection supplies to allow for SEPs. By 2001, twelve states had passed legislature that allowed for the possession of syringes or exclusion of syringes from their paraphernalia laws (Burris et al., 2008). In Pennsylvania, drug paraphernalia laws prohibit SEPs; nonetheless, there are currently seven operating in the state (Ferguson et al., 1998) These are allowed, by prosecutorial discretion, to operate based on local approval. Local approval being if the county boards approve a SEP or the city mayors enact executive orders allowing for a SEP, the program is created. In contrast, in Indiana, while the state allowed for SEPs, the local governments fought against them. Using zoning laws and passing local ordinances, the county of Madison in Indiana pushed the SEP out of their community (Thompson, 2021). One Indiana county chose not to fund a SEP, effectively shutting it down, by having their local board vote not to approve/reapprove it (Corbett, 2021).

The issue of federal and intrastate preemption also comes up in terms of safe injection facilities. Head shop and drug paraphernalia laws can preempt safe injection facilities (SIF) in addition to the Crack House Statute in the Controlled Substances Act. The Crack House Statute makes it a crime to make a property available to others for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance (Kreit, 2019). It is the most significant hurdle that state governments face in order to establish SIFs without being legally challenged through federal preemption. One example of this fight is the United States vs. Safehouse case. Safehouse was a SIF that attempted to open in Philadelphia. Its legality was challenged in the federal courts based on the CSA. The defense argued that Safehouses' purpose is not to be a place for injection drug users to use but to provide public health care to PWIDs (*United States vs. Safehouse, 2021*). The Third Circuit Court of Appeals struck down this

defense, and the Supreme Court declined to review the case. One solution to federal preemption that Martell-Crawford argues is to elevate drug users to a protective class which would afford them certain protections that would allow for SIFs (Martell-Crawford, 2017). Currently, the justice department has hinted at taking a different stance regarding SIFs, which led to the opening of SIFs in New York City. The issue of federal preemption regarding SIFs is a continuously progressing issue.

D. Implications of Preemption for Implementation

When there is preemption, the impact localities experience varies depending on how the communities react and what harm reduction programs have been affected. Preemption can happen between federal laws and state or state laws and local laws. It can affect either syringe exchange programs or safe injection facilities. Preemption of state or local laws can cause these harm reduction programs to be outlawed and shut down. As a result of this, some localities will choose to protest the decision like in Indiana. While state law in Indiana allows for SEPs, they must gain the approval of the local county boards in order to be established. There are cases of two counties, Licking and Scott, where the boards voted against approving SEPs, and the people protested this decision (Kenning, 2021). They protested by voicing their disagreements at town halls and to local news reporters (WOSU 89.7 NPR News, 2020). The goal of such protest was to garner support and sway their local and state politicians to support the harm reduction program, which includes reinstating it or protecting it. Politicians can try to look for ways to protect these programs through mayoral executive orders or state police power. Whether or not these politicians will be swayed depends on the ongoing political climate and the views of the base that they represent.

In addition, there have been examples of litigation happening with one of these harm reduction programs. The state government of Pennsylvania sued the safe injection facility

Safehouse for being illegal under the Controlled Substance Act. Safehouse did not shy away from defending themselves in court and arguing for their right to exist outside the CSA parameters. This case, even if the decision was unfavorable for Safehouse, helped establish case law in terms of SEPs – a concept that did not exist prior. *Showing* principally, it established that in some cases there will be litigation as a result of preemption.

There has not been as much literature or case law on preemption of SIFs. This is because there have not been many instances where preemption can occur. The existence and establishment of SIFs is still a very new idea to the United States. Up until late last year, there were no officially sanctioned SIFs operating in the US. As a result, there hasn't been any notable instances, so far, of preemption happening in relation to SIFs, let alone details of the community's reactions.

The most interesting reaction to preemption of these programs is on the individual level. Individual activists and community organizers have spearheaded the implementation of SEPs and SIFs across the county. Without them these programs would not exist so their reactions to preemption can be extreme. Some individuals in the face of preemption or strict state and local laws decided to create underground harm reduction programs. Before their now widespread deregulation, "[i]n 1996, nearly a quarter of SEPs operating in the United States were illegal underground programs" (Burris et al., 2002). Emulating this there are unofficial "underground" safe injection sites. There is one in an undisclosed location that has been in operation from 2014-2019 (Kral et al., 2020). They allowed scholars to watch their operations and write about it for a journal article. In this article it details how this facility has had 33 opioid overdoses but 0 deaths (Kral et al., 2020). There have also been reports of SEPs, in order to get around strict state laws, allowing injection drug users to inject in their facility restrooms (Vallejo, 2018). In a way, these

SEPs are acting as an unofficial SIF. They are able to slightly skirt around state laws and the CSA because the operators of these SEPs can claim that they were unaware of what their bathrooms were being used for. These all are examples of the reaction of activists in this face of the opioid crisis that took over the US and the resulting government's hesitation towards implementing harm reduction practices like SEPs and SIFs.

E. Implications of Preemption for Outcomes

State policies directly impact the outcomes of harm reduction practices. If a state is against harm reduction policies, it will enforce specific laws and statutes that communicate this. In addition to this, the state's governor, attorney general, and/or representatives will vocally communicate to their constituents what their positions are regarding harm reduction (Burris et al., 2008). Clearly signifying to the local governments that the state will preempt local ordinances that conflict with their stance. The preemption of these harm reduction practices by the state creates multiple avenues of negative outcomes. The preemption of a local SEP and/or SIF further deters community activists from advocating for these programs. This is vastly harmful to these programs because activists are the main group leading the movement to establish SEPs and SIFs, they are the main reason why harm reduction programs exist in the United States today (Beletsky et al., 2008).

Additionally, after preemption some communities choose to establish "underground" illegal harm reduction programs. These programs are not beneficial to the communities they serve. Subsequently, because of their illegal status these programs cannot offer PWIDs referrals to treatment programs nor connections to health professionals (Kral et al., 2020). These illegal programs also expend a lot of energy and resources on keeping their operations concealed (Kral et al., 2020). By only serving PWIDs that have been referred by other PWIDs, being wary of

newcomers, and only assisting a very limited amount of PWIDs. With such limited funding and staff, the illegal statues of these underground harm reduction programs ultimately to do not benefit the community.

State governments that refuse to enforce the statutes that preempted SEP and /or SIFs, and are passive towards the topic, still negatively impact the outcomes of these programs. An example of this is in Pennsylvania, where the state has chosen to not enforce these state policies, but they also have refused to take a stance on the subject (Ferguson et al., 1998). While the state is not enforcing the policies it is wrecking the effectiveness of the SEP by not allowing federal or state funds to be used for its operation (Ferguson et al., 1998). Forcing the SEP to look for funds through private donations, makes operations more difficult.

Instead of focusing on the purpose of exchanging needles for PWIDs, a part of the program's efforts, the SEP will be continuously focused on funding. Putting the other focuses and goals of the SEP in limbo and causing SEP'S overall outcomes to be negative. Whether or not the state is outright enforcing the state policies, this is all still a negative stance towards harm reduction which affects the possible positive outcomes.

If the state is in support of harm reduction programs the state legislature will pass policies that support and allow for these programs **no matter** federal laws. An example of this is in Indiana's state statute ACT 461 which legalized SEPs in the state (Thompson, 2021). The statute allowed counties to establish SEPs without needing a state of emergency to be declared. This approval from the state government directly caused many counties in Indiana leading to a greater community of PWIDs that were being assisted in the state. Additionally, in New York City, the mayor announced his commitment to prosecutorial discretion in relation to the two safe injection facilities that were just established in the city (Mays and Newman, 2021). The federal

government is choosing, in regard to these two programs, to practice prosecutorial discretion. The support of the state and federal government of the SIFs led to overwhelming community acceptance. Having an acceptive community influences more PWIDs to visit the facilities and produce a greater number of positive results.

III. Case Studies

A. Case Studies Criteria and Background

The purpose of the case studies in this paper is to showcase how harm reduction practices interact with state and local laws that preempt them. I chose states and localities to analyze in these case studies looking for contract between local government that used strict laws or loose law to implement or impede harm reduction programs. The case studies compare two states, one with strict laws and the other with loose laws, against each other. One state has strict state laws surrounding harm reduction practices and the other state contains loose laws surrounding harm reduction practices. Amongst each state section in the case studies, is a comparison of two counties found in the state; one county that contains strict local laws and the other county contains loose local laws.

B. Indiana

State statute in Indiana prevented counties from taking preventative action against the joint opioid and HIV/AID epidemics that ran rapidly through the state's population. The opioid crisis in Indiana not only affected the community by creating a substance use issue but also negatively impacted the state's economy. The opioid crisis hit Indiana relatively hard compared to the rest of the country. From 2018-2019, Indiana's drug overdose rates had one of the highest increases in comparison to half the county ("Indiana Drug Overdose Dashboard"). Since 2013, Indiana's drug overdose death rates have been some of the highest in the country. It had the 19th

highest overdose death rate in the United States in 2019 and 74% of those overdose deaths were opioid involved (Thompson, 2021).

The opioid crisis has also affected Indiana's state economy. Indiana's economic damages during the year 2018 as a result of the opioid crisis exceeded $4 billion (Thompson, 2021). This includes all the services that are required with continuous overdoses and addiction issues. Those services encompass ambulances, emergency room visits, first responders, healthcare providers, drug courts, police officers, drug treatment services, etc. Since there is no comprehensive plan of treatment/prevention towards the opioid crisis, these services are being used repeatedly by potentially the same PWIDs. While the opioid crisis was decimating communities all over the country, Indiana was dealing with two pandemics simultaneously. In 2015, Indiana was dealing with an opioid crisis on top of an HIV/AIDS epidemic (Youngen, 2019). This all-in tandem pushed Indiana state officials to accept harm reduction programs, namely SEPs, when before they had been verbally against them.

Indiana has a state statute which mirrors the CSA drug paraphernalia law and classifies the use of needles for nonmedical purposes as a felony punishable by up to three years in prison (Youngen, 2019). The Indiana state statute outlaws the distribution, possession, and use of syringes for illegal substances. This state statute was one of the main reasons why, on top of state officials' own opinions, counties did not feel comfortable authorizing SEPs (Thompson, 2021). Even though they desperately needed some type of harm reduction program to help combat the simultaneous crises that they were going through. It's been reported that if Scott country had been able to implement an SEP from the beginning this would have helped prevent the large amounts of HIV diagnoses in the county (Thompson, 2021). The state also has possession laws

which are triggered by even trace amounts of illegal substances. The state legislature allowed for no exceptions for participants of SEPs (Burris et al., 2002).

Additionally, state officials were very outspoken about their negative views towards SEPs. Past AG Curtis Hill openly expressed his opinion that providing and distributing clean syringes would lead to more drug consumption and risk of overdoses (Thompson, 2021). Governor Mike Pence said that syringe exchange programs went against his personal views but that he would pray on the topic (Thompson, 2021). The state government's outspoken opinions in conjunction with the state statutes communicated to Indiana counties that harm reduction practices like SEPs and SIFs would not be supported by the state government. The counties would have had to authorize and establish these programs on their own, without any support. Not having the support from their government would have left these county-run programs too susceptible to federal preemption and the counties would have had to fund the programs all on their own.

Nevertheless, when the opioid and HIV/AIDS crisis caused a critical number of overdoses and of HIV/AIDS diagnosis in Scott County, Pence was swayed to authorizing SEPs. Governor Mike Pence declared a state of emergency which allowed him to suspend state law making syringes illegal. His statement surrounding the change of opinion was, "I do not support needle exchange as an anti-drug policy, but this is a public health emergency" (Youngen, 2019). This opened the door for counties to establish SEPs if and only if their Board of Supervisors approved them. Furthermore, the state of Indiana pushed the federal government to roll back on its ban of federal funded SEPs, something the state before its outbreaks feverishly approved of (Burris et al., 2008). The combined outbreaks put pressure on Indiana state lawmakers to allow for an exception around the state statute to authorize SEPs. Not only were state statutes passed

but state case law was established that helped with the authorization of SEPs in Indiana. Leatherman v State established that mere possession of a needle obtain through an SEP cannot be the basis for arrest or prosecution (Thompson, 2021). Although, a person can still be found guilty if there was evidence that they intended to use the syringe to use illegal substances.

After Gov. Mike Pence's announcement authorizing an exception for SEPs in counties where there was a grave public health emergency, not all county residents agreed with establishing an SEP in their towns. Even with the grave need there was still community pushback against SEPs. This was a result of negative personal beliefs and ideas about the outcomes of SEPs. In Madison County, the sentiments of the public towards SEPs were not positive. Madison County was also greatly impacted by both epidemics affecting the state of Indiana. After Pence's' authorization, the county voted to establish an SEP in 2015 (Gale JA et al., 2017). Nevertheless, in 2017 when the county was ready to approve its SEP it had to be rolled back because of public concerns (Youngen, 2019). For SEPs, to be allowed under the states' SEP authorization the counties must vote to approve them. After 2 years of being open the community was complaining about discarded and used needles found on the streets (Bull, 2017). The complaints reached such a level that the SEP was not reapproved even though it had support from community leaders. The Madison County Prosecutor Rodney Cummings soaks in support of reapproval and Madison County Sheriff Scott Mellinger said the number of people in the jail testing positive for Hepatitis C had decreased significantly because of the SEP (Bull, 2017). Opponents of shutting down the SEP have noted that blood borne infections and harmful injection practices will increase once the SEP closes (Bull, 2017). Negative sentiments from the public pushed the county officials to use the county council's appropriation power to vote to deny funds for the programs for supplies, equipment, and labor for operating it.

One of the main counties that led the push for the authorization of SEPs in the state of Indiana was Scott County. Scott County was one of the most vulnerable counties in the state during the crisis because of its dense population, poverty rate, and rural location (Youngen, 2019). It was the epicenter of the HIV outbreak which was directly linked to PWID, "of the 181 people newly diagnosed with HIV by November 1, 2015, 173 (95.6 percent) reported injecting…drugs" (Youngen, 2019). HIV/AIDS diagnoses in Scott County increased from only 4 in 2004-2013 to a cluster of 11 in January 2015 alone (Peters et al., 2016). In the next 6 months following January 2015, this cluster grew to 184 new cases of HIV and 280 new cases of HCV (Gale JA et al., 2017). There were multiple factors that came together which caused the outbreak in Scott country to be especially bad. One being the misinformation that the population in Scott County had about HIV/AIDs and injection drug use practices. Possibly as a result of its rural location and lower socioeconomic position, residents of Scott Country believed that HIV/AIDS was "gay disease" (Goodnough, 2015). PWIDs that were diagnosed with HIV/AIDs were shocked to find out about the diagnosis, "I thought it was a homosexual disease…I didn't ever think it would be in my town" (Goodnough, 2015). One of the programs that had to be instilled to ensure the success of SEPs in Scott Country was community outreach (Gale JA et al., 2017). The community had to be educated what unsafe injection drug use looked like, what its consequences could be, and **why** SEPs could help prevent this.

The establishment of an SEP in Scott County immediately had positive results and helped the community. Within 2 years of the implementation of an SEP in Scott County there were a lot less HIV/AIDs diagnoses (Youngen, 2019). Scott county, because of the success of their SEP, was not a state and national outlier in new HIV/AIDS diagnosis. This was accomplished even though there were many restrictions on the SEP that could have greatly hindered the positive

results. The Scott County SEP required IDUs to register with their initials and date of birth to obtain needles, limited operating hours, struggled with funding, and continued prosecuting unregistered IDUs carrying syringes (Strathdee and Beyrer, 2015).

The state of Indiana currently does not have any legally authorized safe injection facilities. Although one does not exist, there is the possibility of the state government establishing one using state law. The Indiana Home Rule Act of 1980 gives the local authorities "all…power necessary or desirable in the conduct of its affairs, even though not granted by statute" (Thompson, 2021). It gives local governments the legislature authority to act within its boundaries and pass legislature pertaining to local government organizations, zoning, natural resources, etc. The Indiana Supreme Court has listed which topics are permissible to legislate on under this act, but they have not ruled on how the Home Rule Act interacts with health care measures (Thompson, 2021). It creates a grey area in which local authorities can step in and pass ordinances, mayoral executive orders, etc. that authorize the establishment of SIFs. There is one exception to the Home Rule Act, which states that if the state government is regulating this topic, then the counties can't regulate it too (Thompson, 2021). Currently, the Indiana state government is regulating opioid use disorder treatment programs. An SIF does not dispense any medications, so it doesn't fall under the state definition of a treatment program (Thompson, 2021). For an SIF in Indiana to be established by local authorities it must be allowed under the Home Rule Act exception and must be labeled as a harm reduction program, not a treatment program.

Currently, the authorized circumstances of some SEPs in the state of Indiana have changed since the publication of a lot of the sources about Indiana SEPs. Since the publication of some of the articles that were used to site the information listed, the legal authorizations of SEPs in certain counties have changed. In Scott County, this past year the county commissioners voted

to end the counties' SEP. For the first time in 6 years, Scott County, which is credited with getting the state's 2015 HIV/AIDS crisis under control, the county will be without an SEP (Legan, 2021). The county leaders decided that the SEP served its purpose now that the state's HIV/AIDS crisis is under control. Additionally, Madison County and Marion County, which didn't before, currently do have SEPs which will have to pick of the slack and try to cater to the Scott County IUD community (Opioid & Health Indicators Database").

C. New York

The state of New York, like many others, declared the opioid epidemic a public health emergency. There was a drastic increase of Hepatitis C diagnosises, AID/HIV diagnosises, and overdose deaths beginning around the year 2000 (Cerdá et al., 2013). This was a result of the growing rates of opioid use and abuse which followed the increase in the medical use of opioids since 1990 creating an increase in injection drug use. Specifically, PWID of methadone and heroin in conjunction with unsafe injection drug practices led to an increase in diagnoses of blood borne diseases. New York City specifically saw overdose deaths caused by prescription opioids to increase from 3.9% to 15.6% and overdose deaths caused by methadone overdose to increase from 15.9% to 25.1% in 1990–2006 (Cerdá et al., 2013). Opioid overdose deaths in New York City alone, in 2006, at 2.7 per 100,000 persons, was almost seven times higher than the rate in 1990 (Cerdá et al., 2013).

The state of New York responded to this opioid crisis by passing statutes that would allow for the implementation of harm reduction practices statewide. New York state has passed, "statutes [that] authorize the state health commissioner to promulgate regulations exempting classes of persons from the needle prescription laws, a power the commissioner used to authorize syringe exchange programs" (Beletsky et al., 2008). SEPs are authorized by the Commissioner of Health exercising power granted in the paraphernalia law which allow state governments to

choose to waive its application. Additionally, governors have the authority to issue executive orders authorizing activities that do not conflict with existing law (Beletsky et al., 2008). They have been able to use this authority to authorize SIFs in their cities.

New York lawmakers argue that harm reduction practices are necessary for the local communities to have tools to combat the ongoing health crisis that is the opioid epidemic. In addition to state statutes the state government, "grants localities the power to pass laws to regulate persons and property for the purpose of securing the public health, safety, welfare, comfort, peace, and prosperity of the municipality and its inhabitants" (Martell-Crawford, 2017). Giving local governments the power to pass legislature which would allow for SEPs and SIFs. The state has also taken steps to start deregulating the sale or possession of 10 or less syringes. On top of allowing for SEPs collection sites, hospitals are legally allowed to perform syringe exchanges, pharmacies are authorized as syringe collections sites, and syringes can be purchased without a prescription in pharmacies (Burris et al, 2002.). Overall, the state government of New York has communicated with its local communities that they are supportive of harm reduction programs and have used different legal tools to try to protect SEPs and SIFs from federal preemption.

The ongoing state and local support of harm reduction practices like SEPs and SIFs have caused many cities in New York to implement these programs. There are currently 26 SEP running in different counties across the state of New York (Opioid & Health Indicators Database"). SEPs have had an overall positive effect on the communities of New York. In New York City, participants of SEPs were more likely to reduce risky injection drug practices and less likely to share drug paraphernalia like needles (Vidourek et al., 2019). Syringe exchange programs have also been found to reduce HIV costs by $325,000 per patient and deterred 4–7

HIV infections per 1,000 patients leading to additional savings (Vidourek et al., 2019). A New York City, NYC, SEP case study found that the SEP focused on saved the city around $1,000-$3,000 per client because of its prevention of HIV, which can lead to further costs associated with health and quality of life costs (Vidourek et al., 2019). This past year, the Mayor Bill de Blasio authorized the establishment of two SIFs which are currently located in the county of Manhattan (Mays and Newman, 2021). This was done after the federal government indicated their intention to implement protectional discretion in relation to any SIFs operating in the country (Peltz and Balsamo, 2022). This makes these two SIFs the first ever legally authorized SIFs in the country. Since the program was just implemented there isn't much data on its effectiveness. Although in their first few months of operation the two SIFs have already halted 150 overdoses during about 9,500 visits (Peltz, 2022).

While the majority of community responses have been positive, there have also been communities that have chosen to not implement any SEPs or SIFs despite the overwhelming state support. Rural counties of New York, where the opioid epidemic has hit harder, have chosen to not implement these effective programs. An example of this is Cortlan County, where in the year 2011 the county's health department reported 18 new HCV cases among people aged younger than 35 years (Zibbell et al., 2014). Compared to the previous year where the county only reported 1 new case in this age group, in a county of about 49,000 people this is an alarming increase of cases (Zibbell et al., 2014). Even though the county desperately needed an SEP to try to curb these infection rates, one was not approved of by the country board. Since 2011, the county will not have an SEP until 10 years after the fact. Recently, as of September 2021 the Cortlan County board approved of the establishment of a 1-year trial run SEP. This is a huge policy change from the position they had ten years ago. Cortland County resembles many other

rural counties in New York who experienced the negative effects of the opioid crisis but chose not to establish harm reduction programs to combat it. Hopefully, with efforts from advocacy groups to educate the public on the positive effects of harm reduction programs some of the +45 counties in New York that currently don't have any these programs will take proactive steps to establish them in their communities (Opioid & Health Indicators Database").

A good number of local communities in the state of New York have chosen to utilize the tools that the state government has provided for them in combating the opioid crisis. New York County – also known as Manhattan – has been the state leader in implementing harm reduction practices. The county has the most SEPs of any county in the state totaling at five and is the first county in the state to implement not one but two SIFs (Opioid & Health Indicators Database"). The population of the county such overwhelming proponents of harm reduction practices that when one of the county's representatives spoke out against the SIFs there was a protest organized in opposition of her statements (Peltz, 2022).

IV. Discussion

A. Does it matter when states and counties agree?

The establishment and authorization of SEPs and SIFs are substantially impacted by whether or not state and local county governments agree on their effectiveness. If a state government does not believe in an SEP or SIF, the state representatives will relate this position plainly to their constituents. State representatives either vocalize their criticism of these harm reduction programs or create legislation, both of which impedes their authorization. Additionally, state governments can occasionally elect to prosecute local governments that choose to oppose the state statutes. Either via prosecution or by cutting funding, state governments that do not agree with harm reduction programs have the means to cease or make it too difficult for harm reduction practices to be established. When local governments disagree with, the state's policy

on harm reduction programs, like SEPs and SIFs, local communities use their means to impede the establishment of these programs. Local governments have utilized zoning ordinances, funding bills, and public pressure such as protesting to thwart the implementation of and close SEPs and SIFs. It is insufficient for one exclusive government to agree on the implementation of harm reduction programs like SEPs and SIFs. In essence, state and local governments must be in agreement on their position in order to successfully implement effective harm reduction programs.

Harm reduction programs are ineffective when a singular government institution agrees on their implementation. If solely the state agrees on the implementation of SEPs and/or SIFs, but the local counties oppose, then these programs will not be implemented in those counties. While there could possibly be a singular county in the state that does agree on the implementation of a harm reduction program it would not be effective. If only a singular harm reduction program, like a SEP or SIF, was responsible for serving a sizable population of the entire state, then the program is likely to be ineffective. In this example, there's too many people demanding a service without enough ample supply and thus, the service is overall ineffective. This is due to the fact that the program is at overcapacity and unable to keep up with the wide-reaching population it serves, causing overall the ability to serve PWIDs and achieve their goals impossible. Vice versa, when a local government agrees on the implementation of SEPs and/or SIFs but the state government does not agree, programs are still rendered ineffective. If the local county is able to implement a harm reduction program like SEPs and SIFs in spite of state disapproval, it will still be ineffective. This is a result of the population they are trying to serve, PWIDs, being too scared to use the programs for fear of arrest/prosecution from state authorities. The most effective SEPs and SIFs are those that have both state and local government approval.

B. Do state and local policy making affect outcomes?

Policy making on the state and local level influences the outcomes of harm reduction programs such as SEPs and SIFs. When state policy criminalizes SEPs and/or SIFs, PWIDs feel uncomfortable or unwelcome to utilize these programs. The state policy functions as a barrier to effectiveness of the program. These kinds of state policies persuade local governments to not implement SEPs and/or SIFs which negatively affects outcomes. When state policy approves of and makes the establishment of these harm reduction programs effortless, this considerably positively impacts the outcomes of the programs. The target community, PWIDs, feel safe and comfortable utilizing these programs leading to a substantial population that will attend the SEPs and/or SIFs. Motivating local governments to implement the steps to authorize and approve of these harm reduction programs.

On the other hand, when local government enact policies that negatively impact harm reduction programs this decreases the positive outcomes of these programs. When local governments utilize zoning laws, executive orders, or funding bills to negatively affect and target SEPs and/or SIFs it signals to the public their disapproval of these programs. PWIDs internalize the negative attitude and feel uncomfortable utilizing or attending SEPs and/or SIFs. Meanwhile, if local governments pass ordinances that positively impact these harm reduction programs then this cultivates a positive effect on the outcomes. It signals their approval and support of harm reduction programs and incentivizes more PWIDs to attend the programs. Ultimately, this leads to more attendees at the SEPs and/or SIFs meaning a larger positive impact on the community as a whole.

C. Policy recommendations for presidential administration changes

The establishment and legal authorization of the two SIFs located in Manhattan County rests on the continued choice by the current administration to not prosecute. SIFs are illegal under the CSA; specifically the Crack House statutes, drug paraphernalia statutes, and possession statutes. The last presidential administration actively chose to prosecute the existence of a privately run SIF in Pennsylvania for breaking the statutes under the CSA (*United States v. Safehouse, 2021*). In general, tthe administration was very vocal in their disapproval of SIFs. The case, *United States v. Safehouse*, reached the Third Circuit Court prior to being denied certiorari. Following the election, the current presidential administration alluded to their commitment to enacting prosecutorial discretion in relation to SIFs. This assisted in the sanctioned establishment of two SIFs in Manhattan(Peltz and Balsamo, 2022). Establishing the precarious nature of the status of the authorizations SIFs. Attitudes towards these policies subject to change following each presidential administration change. In light of this view, state governments ought to prompt the enactment of policies that assist in protecting SIFs regardless the opinion/view of the current or future presidential administration. The safest method to protect the authorization of SIFs from changing following presidential administration is to pass state statutes proving and authorizing SIFs. These statutes can be passed through state ballot initiatives or through state legislators. The state's right to do this is appointed by the 10th Amendment police power which establishes states have a "duty to protect and preserve the welfare of their citizens and allows them to pass health laws" (Beletsky et al., 2008). The CSA would allow this because it allows for an exception for health facilities authorized under state law in addition to the fact that Congress has not made [a] clear statement of an intention to displace the state's regulation in relation to the CSA (Burris et al., 1996).

In addition to state policy, if local ordinances are passed this can similarly make SIFs an exception under the CSA Immunity Clause. The CSA Immunity Clause states, "no civil or criminal liability shall be imposed upon any duly authorized federal officer or political subdivision thereof who shall be lawfully engaged in the enforcement of any municipal ordinance relating to controlled substances" (Thompson, 2021). Conveying that if the local government passed a law declaring the opioid use disorder a public health emergency and provides an ordinance that authorizes SIFs to counter this emergency the SIF shall fall under immunity clause. These policy recommendations of passing state and local laws may assist protect SIFs from federal preemption as a result of power awarded to these governments by the state's policy power and the CSA's immunity clause.

V. Conclusion

Harm reduction programs can exist without full government support, but both state and local government approval are required in order to be effective in assisting PWIDs. SEPs and SIFs do not require state and local government authorization to be enacted and established in a community. They can be approved by only a state, or only a local county, or by neither when established illegally. There have been cases of either of these three instances occurring in counties. Communities that approve of SEPs or SIFs this way will have to surrender the positive effects on outcomes a fully approved harm reduction program produces. An SEP or SIF that only acquires approval from one government entity, or neither in the case of illegal programs, does not produce as effective positive outcomes as an SEP or SIF that's accepted by both state and local government. A harm reduction program approved by both the state and local governments is fully welcomed by the community it finds itself in. By approving the program on both levels of government the population is signaling to the program that it is wanted and accepted and

allows the program to operate in its full capacity in order to attract/treat as many PWIDs as it can.

State and local laws did not interact the way I believed they would after conducting my research. I believed that local laws would possess hardly any power against the potential preemption of state laws. Throughout my research I discovered that local laws acquire more power than originally thought. They wield the power of local public opinion in addition to zoning and funding laws. While these are not as imposing powers as state legislative power they still can impede, for example, harm reduction programs from being authorized. Local government power should not be overlooked or disregarded.

Ultimately, these findings were startling how occasionally after a state or local government authorizes a harm reduction program, the government will from time-to-time rescind this approval. For example, in Indiana - the state and local governments approved of establishing SEPs in order to treat the 2016 AIDS/HIV crisis and then rescinded approval of SEPs once they determined it was "handled". This happened in Scott County, which was the center of the epidemic in the state. Other state and local communities have followed a similar pattern. This indicates that these communities' harm reduction programs, like SEPs and SIFs, are not used as a progressive way to continuously treat substance use disorder, but rather as a temporary way to mitigate or avert further overdose deaths or blood borne disease increases. This philosophy ought to shift and regard SEPs and SIFs as a public health tool that must be provided as a preventative measure, not just as a reactive program against an all-out public health crisis.

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