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ISSUE BRIEF: Recent Federal and State Policy Developments Important to Syringe Service Programs and What May Be Next

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Background

Syringe service programs (SSPs), also sometimes referred to as syringe exchange programs or needle exchange programs, are community-based programs providing access to sterile needles and syringes, as well as safe disposal of used syringes. Often these programs also provide access or referrals to health care services, resources, testing for HIV and STIs, and mental health (MH) and substance use disorder (SUD) diagnosis and treatment services. Other services commonly provided include wound care, naloxone distribution, and education on safe injection and preventing overdose.[i]

The United States is in the midst of an overdose crisis. In 2021, more than 107,000 people in this country died from a drug overdose,[ii] and from 1999 to 2020, the number of overdose deaths increased by more than 500%.[iii] Studies suggest that an increasingly toxic and unpredictable illicit drug supply is worsening the overdose crisis[iv] and is likely "disproportionately harming racial and ethnic minoritized communities, with deep-seated inequalities in living conditions (including stable housing and employment, policing and arrests, preventive care, harm reduction, telehealth, medications for opioid use disorder, and naloxone access) likely playing a role."[v] This is borne out by the data: each year since 2012, Black people "have experienced higher annual percentage increases in overdose deaths" when compared to white individuals; and in 2020, Native people (including Native American and Alaska Native) "experienced the highest rate of overdose mortality" of any studied racial group while Latino people experienced a 40.1 percent increase in drug overdose rates.[vi]

The evidence demonstrating the efficacy and cost-effectiveness of SSPs is clear and has been cited by public health authorities including the National Institutes of Health, the Centers for Disease Control and Prevention, and the American Medical Association.[vii] Decades of research has shown that SSPs are effective in preventing HIV, HCV (hepatitis C virus), and other blood-borne infections.[viii] SSPs are also a critical source of overdose prevention information for people who inject drugs and serve as an important bridge to SUD treatment services and medications.[ix] Data shows that people who participate in SSPs are more likely to reduce their injection drug use and/or to engage with SUD treatment services and medications.[x] SSPs also benefit the communities in which they're located: contrary to misguided beliefs, research has demonstrated

that SSPs do not increase drug use or crime, but do reduce the presence of needles through safe needle disposals.[xi]

Despite challenges to the expansion of SSPs nationally, including bans on using federal dollars to pay for syringes[xii] and clean smoking kits,[xiii] and the promulgation of state and local policies that restrict SSP access (which has resulted in program closures in certain parts of the country), there are also reasons for optimism. Recent federal policy reforms and funding decisions can be leveraged to build additional local and state support for SSPs. Over the past five years, several states have passed laws aimed at improving access to SSPs. Likewise, many states and localities have embraced innovative practices that can be adopted more broadly to strengthen drug user health and prevent infectious disease.

Updates on Funding for SSPs

Increasing Federal Discretionary Dollars

A substantial barrier that SSPs face is lack of funding: historically, most SSPs have relied on private funding through foundation-generated grants and/or individual and corporate donations with little to no government funding (from federal, state, or local governments). Limited funding leads to SSPs often being understaffed and unable to keep up with community demand and government reporting requirements.[xiv] These issues can be particularly pronounced in rural settings due to the limited health structures already in place there (many SSPs are affiliated with established local health services).[xv]

Fortunately, though there continues to be resistance in many states and Congress to funding the actual injection or preparation tools, policymakers are often willing to fund SSP infrastructure, training, program development, and other means of expansion. Historically, SSPs have been able to access funding through many federal agencies and funding streams because of the broad range of services they offer. For example, SSPs can access funds dedicated to: preventing HIV or supporting those with HIV; SUD and MH services; substance use prevention; chronic disease care; and harm reduction programs.[xvi] Specifically, the CDC provides SSP-eligible funding through the Comprehensive HIV Prevention Programs for Health Departments, Hepatitis Prevention and Surveillance, and Integrated HIV Surveillance and Prevention Funding for Health Departments.[xvii] The Health Resources and Services Administration can distribute funds to SSPs through the Rural Communities Opioid Response Program, Ryan White HIV/AIDS Program, and Bureau of Primary Health Care–Health Center Program Funding.[xviii] Lastly, the Substance Abuse and Mental Health Services Administration (SAMHSA) provides federal funding to SSPs through the Substance Abuse Prevention and Treatment Block Grants and Minority AIDS Initiative–Continuum of Care.[xix]

In recent years, more federal funds are available to SSPs because Congress increased funding for CDC infectious disease activities and expanded the types of funds that can be used for harm reduction interventions.

CDC Funding: Funding for activities covered by the CDC's "Infectious Diseases and the Opioid Epidemic" portfolio has increased slightly through the annual appropriations process and through COVID-19 response legislation. Most recently, Congress approved $5 million increases to this budget line in FY 2022[xx] and again in the FY 2023 omnibus funding package (the funding currently sits at $23 million).[xxi] In the CDC's FY 2023 Congressional Justification, the agency identified the Infectious Diseases and the Opioid Epidemic activities it plans to prioritize in the coming year, which highlights the agency's work to support SSPs:

> CDC will expand support for syringe services programs and strengthen national capacity to share information and expand access to harm reduction services. CDC will continue to leverage existing partnerships in syringe services programs and other high-impact settings such as correctional facilities, emergency departments, and in non-emergency healthcare encounters for drug use-related infections to improve the health of people who use drugs.[xxii]

SAMHSA Funding: The American Rescue Plan, federal COVID-19 recovery legislation that became law in December 2021, included a $30 million budget for harm reduction-specific funding at SAMHSA. After a notice of funding opportunity and application process, in May 2022, SAMHSA announced its first set of grantees. Funds up to a maximum of $400,000 per year for up to three years were awarded through 25 grants.[xxiii] SAMHSA's guidance to help implement this grant program notes that it was authorized under Section 2706 of the American Rescue Plan Act of 2021, which is not subject to the standing ban precluding federal funds from being used to pay for syringes. The guidance further states that "[s]yringes to prevent and control the spread of infectious diseases are allowed for purchase with these grant funds," and grantees that use funds for those purposes will need to explain how harm reduction supplies, like syringes, "contribute to preventing and controlling the spread of infectious disease in the Harm Reduction grant application."[xxiv]

SAMHSA's State Opioid Response (SOR) grant program received nearly $1.6 billion in the FY 2023 omnibus funding package, a $50 million increase over FY 2022. SOR funds can be used for several purposes, including overdose prevention and related outreach and coordination with partners including harm reduction programs. Since the program was established, many states have used SOR dollars for a host of harm reduction activities.[xxv]

National Institutes of Health (NIH) Funding: The NIH has also recently launched a research network that will test harm reduction strategies in communities across the country that have experienced high numbers of overdose deaths.[xxvi]

Additional Dollars to Leverage

In the fall of 2021, HHS released its Overdose Prevention Strategy that includes "harm reduction" as one of the four primary ways to prevent overdose.[xxvii] The Strategy further identifies "Expand(ing) sustainable funding strategies for harm reduction services" as a key means of preventing drug overdose.[xxviii]

In addition to an increase in both the type and amount of federal discretionary dollars that can support services provided by SSPs, other funding streams—including Medicaid and forthcoming opioid settlement dollars—can be leveraged to expand access to SSPs.

Medicaid: CMS has indicated that it supports states using Medicaid funds to finance harm reduction services and best practices to promote harm reduction work. Because states administer and manage Medicaid, they can amend plans to cover certain harm reduction services as part of the Medicaid benefits offered in their state. For example, in 2018, New York amended its Medicaid plan to include harm reduction services such as care plans, medication management, support groups, etc., even when these services are provided at SSPs.[xxix]

Additionally, Medicaid is willing and able to fund peer-based support and community-centered care models, which are an important part of harm reduction work. In December 2021, CMS issued guidance to all state health officials, titled "Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services."[xxx] In the guidance, CMS encourages state mobile crisis teams to "consider including representatives from recovery community centers and harm reduction initiatives in their composition or establishing formal relationships with such programs when they are locally available." The guidance also notes that, under the SUPPORT Act, which authorized Medicaid's state mobile crisis opportunity, "qualifying community-based mobile crisis intervention services must be delivered by a multi-disciplinary team," whose members are all trained in harm reduction, trauma-informed care, and de-escalation strategies. CMS further urges these teams to carry fentanyl test strips, suboxone, and naloxone (and to train staff to administer it in the event of an overdose). [xxxi] Many states, including Massachusetts and California, have SSPs that operate as mobile programs. Those states should consider how SSPs that are Medicaid providers (or may become Medicaid providers) could be reimbursed by Medicaid for certain eligible health services.

Opioid settlement dollars: A number of states, including New York,[xxxii] Rhode Island,[xxxiii] and Pennsylvania[xxxiv] have expressed their intent to utilize some of the forthcoming $26 billion in opioid settlement funds[xxxv] for harm reduction services, including those provided through SSPs. This funding represents a significant opportunity to strengthen the state and community infrastructure of SSPs nationally.

Updates on Recent State Policy Reforms

Strengthening Support for, and Removing Barriers to, SSPs

Although SSPs exist in most states, these programs do not exist in every county of every state, and the demand for their services continues to grow as awareness increases. Even in counties that do have SSPs, often government regulations limit access for those who would be eligible or benefit from utilizing SSPs. Examples of the most common restrictions or requirements that hinder access include: requiring one-for-one (1:1) exchanges (participants only receive one new needle for each needle returned); mandating the person using the supplies be the one picking

them up; requiring proof of residency in the county of the SSP; limiting individuals' frequency of visits to the SSP; requiring, to be established, that the SSP obtain special approval by local government or law enforcement;[xxxvi] requiring the facility provide certain other services (such as health care or referrals) to operate; and imposing excessive data collection on SSP staff. Additionally, many local law enforcement where SSPs exist still maintain and enforce criminal laws prohibiting the possession of syringes.[xxxvii] Unfortunately, this happens even in jurisdictions where syringe possession is legal, as discovering SSP items on a person may allow an officer to find sufficient probable cause to conduct a search for illegal substances.[xxxviii] Conversely, some states that still prohibit the possession of needles and syringes rely on unofficial agreements between harm reduction programs and local police, which tacitly means officers will not arrest individuals found in possession of needles and syringes,[xxxix] but this is entirely dependent on the officer and is not a sustainable solution.

Fortunately, in recent years, a number of states have approved laws to increase access and reduce barriers to SSPs. As of 2019, 39 states (including D.C.) had laws that explicitly authorized SSPs, limited regulations of SSPs, or removed other impediments faced by SSPs.[xl] This represents an increase from 25 states in 2014.[xli] Between 2014 and 2019, the largest growth in SSP-supportive policy was found in rural, southern, and midwestern states, including Arizona, Florida, Georgia, Idaho, and Illinois.[xlii]

Over the past five years, state legislation expanding access to SSPs has done so by removing needles and syringes from the definition of "drug paraphernalia" in criminal and civil statutes. Georgia's 2019 law, for example, allows employees and agents of SSPs to possess and distribute syringes and needles without fear of prosecution or liability.[xliii] Tennessee's 2017 law authorizing SSPs exempts SSP participants and employees from criminal prosecution for possession of injection supplies.[xliv] In 2016, Maryland passed a law preventing any SSP program participant, staff, or volunteer from being arrested, charged, or prosecuted for possessing or distributing any drug paraphernalia if the items are related to the SSP.[xlv] Once states cross this hurdle, they often move to expand the "drug paraphernalia" exemption to cover "cookers," and later to cover any residual substances found within these items. For example, in 2021, New York passed a law removing all objects used for injecting controlled substances from the definition of drug paraphernalia, as well as decriminalizing the possession of residual controlled substances in a syringe/needle and the possession of any controlled substance when discovered as the result of seeking immediate care.[xlvi] The next step in the process of legalizing SSPs and this type of harm reduction appears to be the legalization of overdose prevention centers (OPCs), as there has been a growing number of proposals introduced to pilot OPCs at preexisting SSPs.

In the past 3 years, several states have also removed barriers that limited the establishment or operation of SSPs. For example, Massachusetts no longer requires Department of Public Health approval to start SSPs.[xlvii] In 2021, Arizona passed a law that specifically authorized any city, town, or county government as well as nongovernmental organizations to establish and operate overdose and disease prevention programs, including SSPs.[xlviii] In 2020, Colorado amended its state SSP law to allow nonprofit organizations and state health facilities to operate SSPs without prior approval from the board of health or other entities.[xlix]

When it comes to funding, several states have opened the door to support SSPs with state dollars but have conditioned funding on programs' willingness to register and coordinate with the state public health department. For example, Idaho, which passed a state law in 2019 to authorize SSPs, does not require programs to register with the Department of Health and Welfare, but registration ensures compliance with state and federal laws and allows the program to receive funding from the department.[l] In 2017, Ohio statute as amended to allow the Board of Health to establish Bloodborne Infectious Disease Prevention Programs (SSPs), which enables the Board to provide funding for the services.[li] To receive funding from Virginia's Department of Health, an SSP must offer a full range of comprehensive harm reduction services, including the exchange of injection supplies, wound care, safe sex supplies, risk reduction counseling, overdose prevention and naloxone, testing (hepatitis, HIV, STDs, TB), PrEP and nPEP, and referrals (for medical care, insurance, mental health, SUD treatment, and other community services).[lii] While it is helpful for SSPs to gain access to additional sources of funding, this often comes with additional hurdles.

Several state public health departments provide other forms of support to local SSPs. The California Department of Public Health identifies to the state's SSPs potential funding sources and best practices, and also plays an important public education role by maintaining on its website a directory of the state's SSPs.[liii] There is also a Syringe Exchange Certificate Program to streamline the processing of applications for SSPs in the state, which has approximately 105 SSPs in 31 counties.[liv] In Idaho, all SSP websites direct visitors to the Idaho Health & Welfare Department page, which hosts a map of all SSPs in the state. Additionally, the Department webpage includes guidance and resources for community entities hoping to start SSPs.[lv] States have demonstrated that there are several ways to provide support to SSPs and to promote better community access to the essential services they provide.

Policy Recommendations to Strengthen Access to SSP Services

Additional policy reforms at the federal level, and in states and localities, are critical to expanding support for SSPs and strengthening the health outcomes of the people they serve.

Federal policy recommendations to expand support for SSPs:

- Congress should fully eliminate the current federal funding restrictions on syringes/needles and safer smoking supplies.
- HHS, including CMS, SAMHSA, CDC, and HRSA, should work to improve equitable access to culturally and linguistically effective harm reduction services, including those provided by SSPs; this should involve an examination of barriers that community-based SSPs may face in applying for federal funds (including reporting requirements that incorporate personal identifiable information about the people they serve) and adoption of policies that minimize those barriers.
- Congress should increase annual federal discretionary funding at the CDC, SAMHSA, and other HHS agencies for harm reduction interventions, including those provided by SSPs.

- CMS's Center for Medicaid and CHIP Services (CMCS) should issue guidance to states, making clear that harm reduction services are effective, evidence-based health services, and identifying specific ways for states to utilize federal Medicaid dollars to support harm reduction services.
- The Biden-Harris administration should support and fund public education on overdose prevention, recognition, and response, and ensure that tools that are effective in preventing overdose death (including standing orders for naloxone) are widely available.
- DOJ should withdraw its lawsuit challenging the Safehouse overdose prevention center.[lvi]
- HHS should issue guidance and use incentives to ensure that directly impacted people are meaningfully included and consulted throughout the development and implementation of policies and programming governing access to harm reduction services, and that they continue to be included and consulted as systems develop individual- and population-based outcome measures across race, ethnicity, sexual orientation, gender identity, primary language, age, and socioeconomic status, as well as at the intersections of these identities.
- The Biden-Harris administration should examine the impact, particularly on BIPOC communities, of policies that require coordination between harm reduction services (including those provided through SSPs) and law enforcement entities.

State policy recommendations to expand support for SSPs:

- Amend state laws to explicitly authorize SSPs and provide legal protections for syringe possession.
- Remove needles, syringes, cookers, and other injection supplies procured or distributed by SSPs, as well as any residual substances found within those items from the definition of "drug paraphernalia" in criminal and civil statutes.
- Limit state and local regulation of SSPs and program participants, so that programs can effectively meet the public health needs of every community.
    - SSPs should not be required to go through or seek approval from state departments of health or any local boards of health to be established.
    - States and localities should limit reporting requirements of SSPs.
- In states without explicit legal protections for SSPs, direct local law enforcement authorities not to arrest or charge SSP workers or program participants for the possession of SSP-procured or distributed injection supplies.
- Reform laws and policies that unduly restrict SSPs from being located in metro areas due to unavoidable proximity to schools and parks.
- Remove barriers to and provide state and local funding for SSPs.
- Eliminate one-for-one syringe exchange policies and allow unlimited sterile syringe access.
- Eliminate policies that limit the establishment or operation of SSPs.
- Remove barriers to innovative approaches such as public health vending machines and mail-order services to distribute SSP supplies and ensure that the full range of effective supplies are included (such as syringes and naloxone).
- Address concerns about environmental impact by establishing and funding hotlines to ensure collection/disposal of used syringes and protect programs from related legal challenges by exempting SSPs from review under state environmental laws.
- Allow pilot overdose prevention centers (OPCs) at preexisting SSPs.

Across the country, community support for SSPs has grown, and funding streams have become more accessible. Notably, many states that began their SSPs as "pilots" and provided "temporary" funding quickly realized the positive effects of SSPs and moved to make the programs and funding permanent.

Still, while most states now have SSPs, a lot of work remains. These critical programs have yet to be established in every county of every state – meanwhile, the demand for SSP services continues to increase as knowledge and awareness of their myriad benefits spreads. Despite much of the health care community's broad acceptance of harm reduction programs like SSPs, best practices are not always used, and barriers to starting and maintaining effective SSPs persist. Research shows that SSPs are a critical part of the continuum of effective harm reduction interventions that can improve individual health outcomes and the health of communities at large: as such, additional federal, state, and local funding for SSPs should be provided, and policy changes should be implemented at all levels to remove barriers and strengthen access nationwide.

Acknowledgments

This issue brief was supported in part by Arnold Ventures philanthropy.

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[vi] *Id.*
[vii] *Syringe Service Programs*, NAT'L INST. ON DRUG ABUSE, https://nida.nih.gov/research-topics/syringe-services-programs#how-do-syringe (last visited Feb. 6, 2023); *Syringe Services Programs (SSPs)*, *supra* note 1 ("Nearly thirty years of research shows that comprehensive SSPs are safe, effective, and cost-saving, do not increase illegal drug use or crime, and play an important role in reducing the transmission of viral hepatitis, HIV and other infections."); *Needle & Syringe Exchanges*, AM. MED. ASS'N, https://www.ama-assn.org/topics/needle-syringe-exchanges (last visited Feb. 6, 2023) ("The American Medical Association strongly supports needle and syringe exchange programs as part of a wider harm reduction approach to treating substance abuse and addiction.").
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[ix] *Id.*
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[xi] *Id.*
[xii] Language included in recent annual federal appropriations legislation (including the recently approved "Consolidated Appropriations Act of 2023") is as follows: "None of the Federal funds contained in this Act may be used to distribute any needle or syringe for the purpose of preventing the spread of blood borne pathogens in any location that has been determined by the local public health or local law enforcement authorities to be inappropriate for such distribution." Consolidated Appropriations Act of 2023, Pub. L. No. 117-328, § 807, https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf.

[xiii] "Notwithstanding any provision of this title and the amendments made by this title, no funds made available to carry out this title or any amendment made by this title shall be used to purchase, procure, or distribute pipes or cylindrical objects intended to be used to smoke or inhale illegal scheduled substances." Consolidated Appropriations Act of 2023, Pub. L. No. 117-328, § 526, https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf.
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[xxii] CDC Justification of Estimates for Appropriation Committees, DEP'T OF HEALTH & HUM. SERVS., at 19 (2022), https://www.cdc.gov/budget/documents/fy2023/FY-2023-CDC-congressional-justification.pdf (for FY 2023).
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[liii] *Syringe Exchange Programs in California*, CAL. DEP'T OF PUB. HEALTH: OFF. AIDS, https://www.cdph.ca.gov/programs/CID/DOA/Pages/OA_prev_sep.aspx (last visited Feb. 18, 2022).
[liv] *Directory of Syringe Services Programs in California*, CAL. DEP'T OF PUB. HEALTH: OFF. AIDS, https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_prev_sepdirectory.aspx (last visited Feb. 18, 2022).
[lv] *Safer Syringe Programs for Providers*, *supra* note 46.
[lvi] *United States v. Safehouse*, SAFEHOUSE, https://www.safehousephilly.org/us-v-safehouse (last visited Feb. 8, 2023).