

FAQ

Q: Why don't your findings agree with the extensive public health literature?

A: For the most part, my findings don't differ. Most studies to date look at HIV rates exclusively; I find that HIV rates decrease after a SEP is introduced. So, SEPs achieve their intended goal.

Where my study departs from the existing literature:

1. A large, comprehensive dataset using administrative data on mortality and HIV cases (i.e. the study does not rely on ex-post survey data and is not just focusing on one clinic)
2. Causal inference versus correlations
3. Looking at SEPs in the most recent ten years. Most studies focus on the AIDS crisis of the 1990s. The opioid crisis has been different in many ways, including the reach and extent of the crisis, especially in rural areas.

Q: Are you saying that SEPs are bad?

A: Not at all. SEPs can have positive health effects- decreasing needle sharing and reducing HIV is a huge benefit. However, SEPs are not effective in reducing drug use. We need other policy interventions for reducing opioid misuse and addiction.

Q: Who is funding you and are you an advocate against SEPs?

A: My research is funded only by my university, and I am not receiving funding from any agency or think tank. This study has no political agenda. I am not working for or against SEPs, but rather trying to bring to light data and information to help public health officials make the most cost-effective and beneficial decisions when implementing policy.

Q: Correlation doesn't imply causation, so why are you just running a simple regression and assuming that you find a causal effect?

A: Great question! I certainly agree that correlation does not imply causation. Importantly, counties that build and open new SEPs may be doing so because the opioid crisis has hit particularly hard.

Throughout the study, I am careful to address alternative explanations and omitted variable bias and perform several robustness checks to functional form, define different control groups, and control for other state-level policies to rule out these possibilities.

To get at the causal effect, I ask the question, "What would a county's health outcomes have looked like in the absence of the clinic opening?" and compare these actual outcomes to what could have been predicted. Importantly, this method does not require the two counties to look alike on observables; it simply requires that the trends follow a similar trajectory before the intervention.

If the counties look similar on trends before the SEPs opening, controlling for observable differences, then any divergence in the trend at the time of opening can be attributed to the SEP. The estimates show a divergence in the post-period after an opening, suggesting causality.

Taken together, the evidence consistently points to the idea that SEPs are effective at reducing needle sharing and bloodborne illnesses. While SEPs offer drug counseling and referral services, providing a safe environment (harm reduction) is more the goal vs. curbing addiction.

However, additional resources like funding for substance abuse treatment facilities and legal access to promising drugs like Naltrexone may be more cost-effective avenues of reducing opioid misuse and overdose in the future.