Assessing the Policy Attitudes of State Legislators Toward Overdose Prevention Centers (OPCs)

Understanding state legislator perspectives on harm reduction and OPCs may help inform policy advocacy efforts to prevent overdose, illness, and injury among people who use drugs.

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Abstract

Opioid overdose is the leading cause of death among Americans ages 18 to 45. Historically, New England states have been among the top states nationally for opioid-related overdose deaths. Overdose deaths from opioids like fentanyl are preventable with timely and effective intervention. Overdose prevention centers (OPCs) have been shown to be effective in preventing overdose and other use-related harms, including HIV and hepatitis C spread and underutilization of healthcare services by people who use drugs. However, federal and state laws that prohibit the operation of OPCs are critical barriers to preventing overdose in New England. This policy brief presents preliminary findings collected from New England state legislators (n=35) surveyed on their existing attitudes and beliefs about the overdose crisis and OPCs. Understanding state legislator perspectives on harm reduction and OPCs may help inform policy advocacy efforts to prevent OD, illness, and injury among people who use drugs.

In 2023, over 105,000 people died from a drug overdose (OD) in the United States.[1] Approximately 80,000 (76%) of these deaths involved opioids, a tenfold increase from the number of opioid-related overdoses in 1999.[2] Today, opioid overdose is the leading cause of death among Americans ages 18 to 45.[3] Historically, New England states have been among the top states nationally for opioid overdose deaths, and this is largely due to increases in accidental fentanyl poisoning.[4]

Overdose Prevention Centers (OPCs) are special places designed to prevent overdose deaths. They are safe settings for people to use pre-obtained drugs under the supervision of trained staff who provide immediate intervention in the event of an overdose or other health emergency. OPCs have also offered safer use equipment, drug checking resources, and linkages to healthcare services, including primary and mental health care, sexual health care, HIV and hepatitis C testing, and wound care.[5] Typically, they are run by nonprofit organizations that specialize in harm reduction and connecting people with health services.

OPCs are a matter of public policy because they exist at the intersection of public health and criminal law. Due to federal and state laws that classify providing a space for illegal drug use as a felony,[6] an organization cannot simply decide to open up and run an OPC on its own. It needs special permission from the state. As of early 2026, there are three recognized OPCs currently operating in the United States: two in New York City and one in Providence, Rhode Island.[7] However, policies such as drug paraphernalia laws and operational restrictions remain crucial barriers to OPC implementation across the country.[8] We sought an opportunity to explore how policymaker attitudes and beliefs relate to OPC lawmaking.

In Vermont, legislation has moved forward to support OPC implementation, whereas other New England states have not yet sanctioned them at the state level.[9] Despite these varying policy positions, New England is a region ripe for harm reduction policy development, and understanding the root of OPC hesitancy among New England legislators may help inform focused advocacy and research.

This exploratory study utilized a direct survey to identify commonly reported attitudes and beliefs about OPCs among New England state legislators. Three key preliminary findings from the study are explored in this brief report. Further findings will be shared in a subsequent publication.

#1. Community opposition was the most frequently reported barrier to establishing an OPC

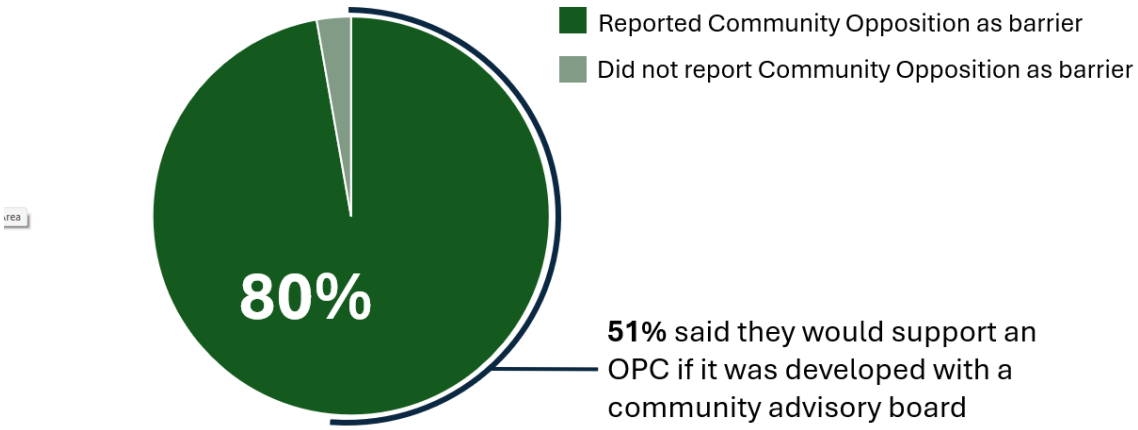
Community opposition is a known barrier to establishing harm reduction programs like OPCs around the country,[8,10] and one that is likely experienced to greater degrees by legislators who depend on community support for re-election and effective policy implementation.[11] With 80% of respondents reporting community opposition as a barrier to OPC implementation in their state, it was the most frequently reported across states and offices (Figure 1). Researchers and activists alike have attributed community opposition to harm reduction programs to stigma, or the set of negative beliefs and attitudes that some people hold about people who use drugs.[12–14] Community opposition and stigma are critical barriers to OPC implementation as policymakers often use public support data to inform policy action, and low rankings or opposing constituent opinions can halt implementation for many election cycles.[11] Key to understanding stigma as it relates to OPC implementation is the phenomenon of NIMBY-ism. NIMBY, standing for Not In My Backyard, encompasses neighborhood-level opposition to building new programs despite conceptual agreement that the services may be needed.[10] This form of stigma has been seen consistently across harm reduction program implementation, with community members verbalizing theoretical support while opposing the development of these programs in their area.[8,10,15]

Opposition to OPCs is often rooted in concerns that are reasonable but may be misinformed. Fears about increased public injection, crime, and homelessness are commonly cited reasons for resistance but

have not been shown to be significantly related with OPC operation.[16,17]

Notably, 51% of respondents indicated that one necessary condition for their support of OPC implementation is the center being developed with input from a community or client advisory board. Community Advisory Boards (CABs) are a cornerstone of harm reduction development and evaluation and are often composed of people with lived experience, healthcare workers and clinicians, business owners, and community members.[18] CABs are an evidence-based way of ensuring harm reduction programs meet the unique needs of the neighborhoods they serve, and may be a key method of dissolving community opposition. When community members are given the opportunity to provide input that shapes program implementation, they are more likely to support operation of novel programs and research efforts.[19] This is especially true when CABs are composed of different stakeholder groups, ranging from people who use drugs (PWUD) themselves to clinicians and researchers. Studies have shown that personal anecdotes and scientific research are both viable tools to garner support for harm reduction programs,[20] and CAB efforts are prime opportunities for those opposed to OPCs to interact with both. Importantly, CABs are also important vessels for translating novel programming into policy-oriented language. If CABs and program development teams are equipped with the tools to translate the program's progress into digestible findings, this data has the potential to be crucial drivers of community support, and thus, policy action.[11]

Figure 1. Community opposition was the most frequently reported barrier to establishing an OPC



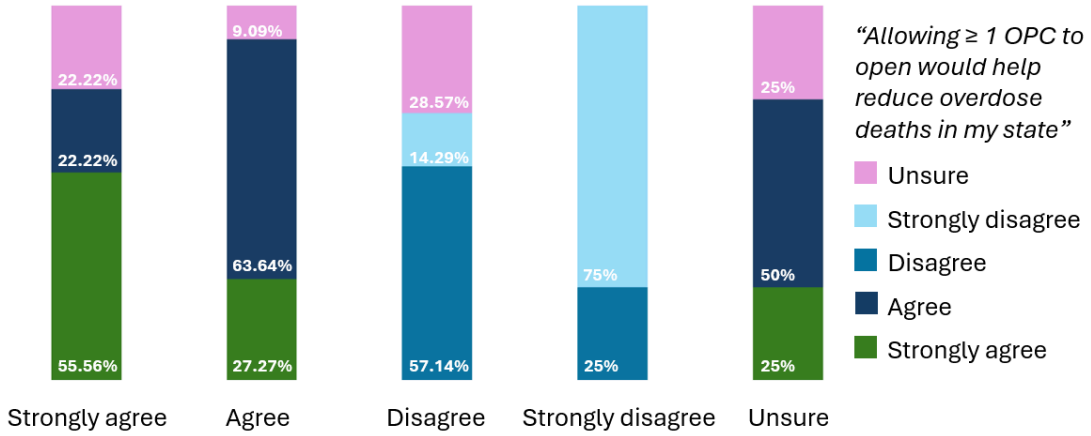
#2. Legislators who felt their state was not doing enough to prevent overdose were more likely to support OPCs

This exploratory finding addresses a classic public health question: does greater familiarity with an issue correlate with greater support for an intervention? Across harm reduction programming, studies have found that increased education and knowledge of the overdose crisis and evidence for overdose prevention initiatives are associated with improved attitudes towards harm reduction.[21,22] Similarly, multiple studies have found that increased understanding of the mechanisms by which harm reduction programming works (i.e., naloxone to reverse overdose and syringe exchange programs to prevent disease spread) was also associated with increased support for harm reduction after education.[23] Among this sample, legislators who felt that their state was not yet doing enough to prevent overdose were more likely to support OPC implementation in their state (Figure 2). Among legislators who disagreed, support for OPCs was nonexistent, and 75% of these respondents directly opposed OPC implementation.

While New England states have made significant progress in reducing overdose, there remain widespread and pervasive care gaps that sustain high mortality rates, especially among at-risk communities. Many involved in harm reduction initiatives located in this region would agree that, despite overall advances, the six New England states still struggle to overcome barriers to overdose prevention, including increasing access to reversal medicine, medication-assisted treatments, and drug testing equipment. Historically, parts of New England have been among the top states nationally for opioid overdose deaths, and New Hampshire and Massachusetts ranked the 1st and 3rd for the highest fatal fentanyl overdose rates in 2016.[4,24] It is difficult to parse whether responses from dissenting legislators (those who disagreed with the statement that their state was not doing enough) can be attributed to genuine knowledge gaps about the scope of the crisis or to a fundamental opposition to addressing it, but it highlights a potential area for focused messaging.

For those who are unfamiliar with overdose burden in their state, educational proposals that frame OPCs as tools in the greater fight against premature death and illness may be a successful approach among policymakers.[25] Overall, this finding supports previous research that urges harm reduction advocates to increase education about the burden of the overdose crisis and the gaps that OPCs may help fill, with special attention given to their care linkage services, infectious disease prevention, and poisoning response.[8,25]

Figure 2. Legislators who felt their state was not doing enough to prevent overdose were more likely to support OPCs



"Given the size of the crisis, my state is not yet doing enough to prevent overdose deaths"

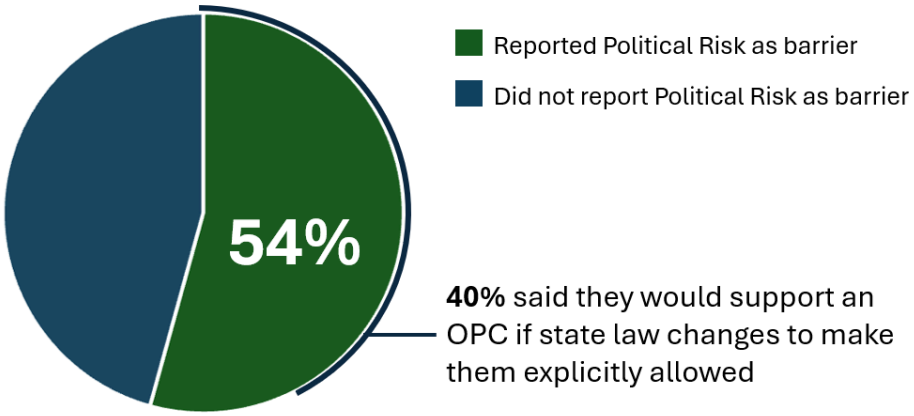
#3. Over half of respondents reported political risk or potential opposition as a barrier to establishing an OPC

Many harm reduction programs were not popular when first introduced. However, with evidence, time, and advocacy, initiatives like naloxone distribution and syringe exchange programs garnered political support at the state and federal levels. Research has endeavored to identify the motivators behind legislative decisions on novel or controversial policies and have consistently identified political risk (that is, becoming unpopular among voters) and political opposition as heavily weighted factors. Among this sample, 54% of respondents indicated political risk and opposition from colleagues as some of the biggest barriers to OPC implementation in their state. As has been noted in New England, when policies are predicted to be disliked, policymakers are less likely to advocate for them or are more likely to propose "watered-down" versions to increase appeal.[26] This is because the goal of policymakers is often to obtain popular support that facilitates cooperation and sustained, effective policy action.[11,27]

Research conducted on OPCs throughout global history (both observational and modeling studies) has established an association with reductions in overdose and the behaviors associated with infectious disease spread and increased linkages to healthcare.[7] In light of these successes, understanding its unpopularity with many American voters, and thus American legislators, requires deeper digging into the impact of stigma and language framing when discussing programming that does not center on abstinence.[28,29]

Historically, federal US policy approaches to addressing substance use and the overdose crisis have centered on abstinence and no-tolerance enforcement of laws like the Controlled Substances Act (CSA).[30] The CSA provides a legal framework for drug regulation and is mirrored in many state-level drug policies, sometimes with modifications.[6] Importantly, the CSA prohibits organization of any place for the purpose of acquiring and using controlled substances, a statute which many have interpreted to include OPCs.[7] However, state legislators have the power to sanction an OPC at the state-level under the Tenth Amendment, as has been done in Rhode Island and is in-process in Vermont through state authorization of OPC pilot programs.[7,31,32] 40% of respondents indicated that changes to state laws that make OPCs explicitly allowed would be a condition under which they would consider supporting its implementation (Figure 3). This relationship between state law changes, public support, and policymaker action occur in a complex cycle with many points of entry. These changes to state law would be more likely to occur if constituents voice support for OPCs and advocate for reformed CSA policy. However, public opinion polling has indicated that when state law changes first, public support follows; when OPCs are framed within state-regulated public health strategies, community support for them increases.[33] Thus, if state law is modified to allow for operation of OPCs, whether through explicit permission or loosening of federal law enforcement, popular support is projected to increase. In turn, this community support exerts pressure on all legislative officials to drive OPC-supportive policy, minimizing political risk from voters and colleagues.[33] This policy action cycle in harm reduction decision making warrants further study.

Figure 3. Over half of respondents reported political risk or potential opposition from colleagues as a barrier to establishing an OPC



Methods and Participants

This exploratory study surveyed New England legislators from New Hampshire (n=21), Maine (n=6), Connecticut (n=5), Massachusetts (n=2), and preferred not to say (n=1). Most respondents were state Representatives (n=31) and the remaining were state Senators (n=3) or unknown (n=1). Thirty-five complete responses were obtained between March and April 2026, with a response rate of about 3.5% from the 987 eligible legislators (or several percentage points higher if out-of-office replies are subtracted out of the denominator). This response rate is lower than previous research surveying state policymakers about healthcare generally,[34,35] but is comparable to similar studies exploring state legislators' attitudes about public health-focused policy via email-only survey.[36] The surveys were administered via Qualtrics and all participants were contacted via email three times using both Center for Modern Health and Dartmouth College email addresses. The complete questionnaire and a comprehensive response dataset will be made available following further analysis.

Conclusion

This exploratory study offers a preliminary look at New England legislators' attitudes toward overdose prevention centers, identifying community opposition, political risk, and perceptions of the overdose crisis as important factors shaping support. The findings suggest that community engagement, education, and attention to local legal and political barriers may help inform future policy efforts. Given the low response rate, further work is needed to explore ways of measuring legislator opinions outside the context of reviewing public votes and public statements, and more research is needed to determine whether these attitudes reported here reflect broader legislative perspectives.

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Declaration of Conflicting Interests

The authors have declared no potential conflicts of interest with respect to the research, authorship, or publication of this article.

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