

05-09

## STATEMENT OF POLICY

### Syringe Services Programs & Other Harm Reduction Strategies

#### Policy

The National Association of County and City Health Officials (NACCHO) supports a comprehensive, evidence-based approach to syringe services programs, also known as syringe or needle exchange programs, in order to support the health of people who inject drugs and to curb transmission of HIV, viral hepatitis, and other blood-borne diseases. NACCHO urges state and local policymakers to do the following:

1. Support syringe services program development and operation in accordance with the peer-reviewed evidence base, best practices, and local health department and other expert recommendations to assure access to evidence-based, low-threshold services;
2. Remove legal barriers to accessing and safely disposing of sterile needles, syringes, and other injecting equipment;
3. Modify state and local statutes to permit over-the-counter sales and purchase of syringes at pharmacies and other locations;
4. Revise paraphernalia laws to decriminalize syringe possession;
5. Enact or amend Good Samaritan Laws that protect against arrest or prosecution at the scene of an overdose to encourage people to call 911 and ensure that law enforcement, first responders, people who inject drugs, and the broader community are aware of these laws;
6. Increase the availability of drug treatment and overdose prevention, including Medications for Opioid Use Disorder (MOUD) and naloxone training and distribution;
7. Address stigma and discrimination against people who use drugs among law enforcement, criminal justice personnel, healthcare and public health professionals, and the public;
8. Assure adequate resources to support health department surveillance, program planning, and program evaluation capacity to assess disease and risk behavior trends and the impact of syringe services programs, as well as other disease prevention and health promotion interventions for people who inject drugs, on local health outcomes; and
9. Support linkages to substance use treatment and referrals to social services, legal services, housing opportunities, and community-based recovery supports.



Local health departments are on the frontlines of the overdose epidemic and are local leaders in HIV and viral hepatitis prevention and care. Their strong community partnerships and public health expertise position them to implement or support syringe services programs and other harm reduction strategies. NACCHO encourages local health departments to:

1. Support the implementation of syringe services programs;
2. Support the implementation of other harm reduction strategies in response to local trends and needs, including but not limited to naloxone training and distribution, drug checking services, and overdose prevention sites;
3. Establish or strengthen linkages between healthcare, harm reduction, and substance use treatment services to promote the health of people who use drugs and increase opportunities for initiation of substance use treatment;
4. Engage and promote the leadership and employment of people who currently or previously used drugs, including to enhance service design and delivery and provide peer education and recovery support; and
5. Support evidence-based policymaking and practice at the state and local levels by educating policymakers, law enforcement, criminal justice personnel, health department staff, healthcare providers, pharmacists, and other relevant professional and community partners regarding the benefit of syringe services programs, as well as other harm reduction strategies, and relevant laws, policies, and processes.

NACCHO urges Congress to remove the ban on the use of federal funds to purchase needles or syringes and provide adequate funding to scale up syringe services programs and other harm reduction strategies.

Furthermore, NACCHO encourages federal agencies, including the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration, to support the implementation of syringe services programs and other harm reduction strategies and ensure funding for HIV, sexually transmitted infections, viral hepatitis, and substance use prevention is flexible enough to enable state and local health departments to address these syndemics and respond to local needs and trends.

### **Justification**

Syringe service programs (SSPs) have played a critical role in the prevention of HIV and viral hepatitis for more than 30 years through the distribution of sterile syringes and other injection equipment.<sup>1,2</sup> As detailed by the CDC in *Summary of Information on The Safety and Effectiveness of Syringe Services Programs*, SSPs are an effective, safe, and cost-saving strategy to prevent the spread of infectious diseases through injection drug use (IDU), including HIV and viral hepatitis (specifically hepatitis B (HBV) and C (HCV) viruses).<sup>3</sup> SSPs reduce HIV and HCV incidence by 50% and have been identified as critical components of public health efforts to end the HIV epidemic and eliminate viral hepatitis.<sup>4,5,6</sup> Additionally, SSPs are cost-saving; every dollar spent on syringe services saves \$6.38 to \$7.58 in HIV treatment costs alone.<sup>7</sup> The public sector

accounts for a significant portion of these savings: the annual return on investment for syringe services is \$243 million and \$62 million in Philadelphia, PA, and Baltimore, MD, respectively.<sup>8</sup> In addition to syringe exchange, SSPs often connect patients to other healthcare and harm reduction services and promote public safety through syringe disposal and overdose prevention services.

In 2018, 10.3 million Americans misused opioids, including 9.9 million who misused prescription pain medicines and 808,000 who used heroin.<sup>9</sup> In 2017, 1.5 percent of high school students reported ever engaging in IDU.<sup>10</sup> In the United States, 10% of HIV diagnoses occur among people who inject drugs (PWID), and the majority of HCV cases are attributable to IDU.<sup>11,12</sup> The opioid misuse epidemic, and the associated increase in IDU, has catalyzed the spread of HIV and viral hepatitis. Between 2010 and 2016, HCV cases tripled in the United States, and CDC has identified 220 counties in the United States that are at risk for HIV or HCV outbreaks among PWID.<sup>13,14</sup> Two jurisdictions have already experienced HIV clusters associated with IDU, including Scott County, IN, which experienced 181 cases between 2014 and 2015, and Cabell County, WV, which experienced 74 cases as of December 2019.<sup>15,16</sup>

The United States is also experiencing unprecedented levels of overdose deaths, the majority of which involve opioids.<sup>17</sup> Fortunately, SSPs and other harm reduction strategies can reduce substance use, connect people to treatment, and prevent overdoses. PWID that regularly use an SSP are five times as likely to access substance use treatment and three times as likely to reduce or stop IDU than PWID who have never used an SSP.<sup>3</sup> SSPs often link clients to healthcare, substance use, and harm reduction services, including vaccination, testing, and treatment for HIV and viral hepatitis; Medications for Opioid Use Disorder (MOUD); and overdose prevention services.<sup>18</sup> MOUD, including the use of methadone, buprenorphine, or naltrexone, is safe and effective for the treatment of opioid use disorder, and consequently is associated with reduced risk for HIV, HCV, and overdose mortality.<sup>4,19,20</sup> Naloxone is a medication that reverses overdoses, reducing opioid-related emergency room visits and overdose deaths.<sup>21,22</sup> Naloxone can be easily administered by people without medical training, including PWID themselves, and naloxone distribution programs are cost-effective.<sup>23</sup> The emergence of fentanyl, an extremely powerful opioid, in the illicit drug supply is now a major driver of opioid overdoses in the United States.<sup>24</sup> A recent study revealed that nearly three-fourths of PWID would modify their behavior if they knew that their drugs contained fentanyl.<sup>25</sup> Consequently, an emerging harm reduction strategy involves offering drug checking services, such as fentanyl test strips, which provide clients with additional information about their drugs to help protect themselves from overdose. Local health departments play an important role in distributing naloxone and fentanyl test strips and providing training and education to ensure community members know how to use these lifesaving tools. Naloxone distribution and drug checking services are often integrated with syringe services, however, they can also be adapted to a variety of settings, such as pharmacies, healthcare facilities, or schools.

Overdose prevention sites (OPSs) are venues where people can bring and use their drugs in the presence of staff, volunteers, or peers that are trained to respond to overdoses. Though OPSs are distinct from SSPs, they usually provide syringe services and other sterile injection equipment and may offer healthcare services or referrals and education and counseling on safe consumption

practices. There are nearly 100 OPSs in more than ten countries across the world, and a growing body of evidence indicates that OPSs are a cost-effective, and potentially even cost-saving, strategy to reduce HIV, HCV, and overdose deaths.<sup>26</sup> The legality of OPSs in the U.S. is currently being debated in the court system: In 2019, a federal judge ruled that a proposed OPS in Philadelphia does *not* violate federal laws, but the Department of Justice indicated their intent to “pursue further judicial review” and noted that similar efforts undertaken by other jurisdictions would “be met with immediate action by the Department.”<sup>27</sup>

In addition to preventing the spread of HIV and viral hepatitis, reducing overdose deaths, and connecting clients to other healthcare, substance use, and harm reduction services, SSPs promote public safety by reducing substance use, crime, and needlestick injuries. Several studies have examined the relationship between SSPs and crime and have consistently found that SSPs do not increase crime.<sup>28,29</sup> SSPs may also reduce crime by connecting clients to MOUD, which has been associated with reduced crime.<sup>30,31,32</sup> Several studies have also evaluated the relationship between SSPs and syringe disposal. Cities or neighborhoods with SSPs have fewer improperly disposed syringes, protecting police officers, first responders, and the public from needlestick injury.<sup>33,34</sup>

According to the North America Syringe Exchange Network, there are nearly 400 SSPs across the country, many of which are operated or supported by local health departments.<sup>35</sup> However, many Americans face challenges in accessing SSPs. In the United States, more than 80% of adolescents and young adults live more than ten miles away from an SSP—with a median distance of 37 miles—a trend that is exacerbated in the South and Midwest.<sup>36</sup> These regions also have high levels of opioid misuse and the South is disproportionately impacted by HIV, where half of new HIV infections in the U.S. occur.<sup>37,38</sup> At least half of PWID live outside of major urban areas, which is associated with reduced access to SSPs.<sup>39</sup> Furthermore, SSPs often have limited operating hours, reducing the accessibility of their services.<sup>40</sup> These trends are particularly concerning as PWID who report difficulties in accessing sterile needles are more likely to report sharing syringes.<sup>41</sup>

Stigma and legal barriers also reduce access to SSPs. PWID report high levels of stigma and discrimination in healthcare, which leads to delayed healthcare use, seeking care elsewhere, and not disclosing substance use to healthcare providers.<sup>42</sup> Not only does this limit access to healthcare and linkage to substance use and harm reduction services, but internalized stigma also impacts utilization of SSPs.<sup>43,44</sup> However, PWID report high levels of trust in SSPs and their staff, which demonstrates the importance of SSPs as a source and connection to care for PWID.<sup>45</sup>

Local health departments play an important role in the provision and assurance of harm reduction services in their communities. However, federal, state, or local policies can limit the ability of local health departments to provide or support syringe services in their communities. The federal government bans the use of federal funding to purchase syringes, although it can be used for all other SSP-related purposes if CDC determines the jurisdiction is at risk for an increase in HIV and HCV as a result of IDU (as of December 2019, the majority of states have received this determination of need). Additionally, some states prohibit the use of state funding to support SSPs.<sup>46</sup>

These funding limitations and other policy barriers can make it challenging for local health departments to implement or support SSPs in accordance with best practices. Nearly 100, or approximately one-fourth, of the SSPs operating in the U.S. follow a 1:1 model, in which clients are required to return a syringe before obtaining a new one.<sup>35</sup> However, this model is far less effective at meeting the needs of PWID compared to a needs-based distribution model.<sup>47</sup> Furthermore, unlimited and/or needs-based distribution models enable secondary syringe exchange, in which clients can distribute sterile syringes to other people who use drugs, amplifying the reach of SSPs. Other best practices for SSPs include offering safe syringe disposal, naloxone training and distribution, and engaging and hiring people with lived experience to enhance service delivery.<sup>48</sup>

Most states criminalize syringe possession, as they are considered drug paraphernalia, which may discourage utilization of SSPs and encourage improper syringe disposal. Thirty-two states criminalize syringe possession, although 10 of those states have enacted exemptions, for example for registered SSP clients. Only seven states completely exempt syringes from paraphernalia laws.<sup>49</sup> Not only is the criminalization of syringe possession detrimental to public health and harm reduction strategies, but the United States pays a high cost to incarcerate people for syringe possession.<sup>50</sup>

Naloxone access and Good Samaritan Laws can also promote harm reduction. Naloxone access laws increase public access to naloxone, thereby reducing overdose deaths, while Good Samaritan Laws encourage people to call 911 in response to overdoses by establishing protections against law enforcement action. For example, these laws may protect a person experiencing or witnessing an overdose from arrest related to the possession of illicit substances or paraphernalia. States with naloxone access and Good Samaritan Laws have experienced 14% and 15% reductions in opioid overdose rates, respectively.<sup>51</sup> However, a lack of awareness of these laws has been documented among PWID, police officers, and first responders, demonstrating the importance of not just policy enactment but implementation and enforcement.<sup>52,53</sup>

SSPs and other harm reduction strategies are critical components of the response to the opioid epidemic, preventing the spread of HIV and viral hepatitis and reducing overdose mortality. Decades of research has demonstrated that SSPs are safe, effective, and cost-saving, and they often offer or connect people to healthcare, substance use, and other harm reduction services. However, inadequate funding, stigma, and legal barriers have left many Americans without access to SSPs and addressing these barriers and supporting or implementing SSPs in line with evidence-based practices should be central to local public health efforts to respond to the opioid epidemic and associated infectious diseases.

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## **Record of Action**

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