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Syringe Distribution Programs Can Improve Public Health During the Opioid Overdose Crisis

Such initiatives can reduce overdose rates and infectious disease, increase use of treatment

Overview

Over the past decade, attempts to address the overdose crisis in the U.S. have resulted in more restrictive opioid prescribing policies—which, because they have reduced the overall availability of prescription opioids, have inadvertently led to a surge in the use of illicit drugs such as heroin.

Because these illicit opioids are often injected, they're associated with higher rates of overdose than prescription painkillers, and, when unsterile injection equipment is used or shared, people are at risk of getting a serious infection or transmitting disease.[1] As of March 2020, the Centers for Disease Control and Prevention determined that 44 states; Washington, D.C.; one tribal nation; and one territory were experiencing or at risk of an acute hepatitis C virus (HCV) or HIV outbreak due to injection drug use.[2] In 2017, people who inject drugs (PWID) accounted for nearly 1 in 10 new HIV diagnoses across the U.S., and in 2018, injection drug use was the key risk factor in 72 percent of newly diagnosed HCV cases.[3] In addition, PWID are also particularly vulnerable to housing insecurity, health problems, social challenges, and contact with the criminal legal system.[4]

To reduce the risks posed by the use or sharing of unsterile equipment (disease and infection), state governments should consider facilitating the use of syringe services programs (SSPs), which distribute free, new, sterile syringes to PWID. Such programs also often offer other services, such as vaccinations and education on preventing overdoses, and have also been shown to improve the odds that PWID will seek and engage with treatment.

Contrary to community concerns that SSPs encourage drug use or criminal activity, more than three decades of peer-reviewed research has instead shown them to reduce rates of HIV and HCV among PWID; increase proper disposal of used needles; ramp up participants' engagement with treatment; and not increase crime in areas surrounding the programs.[5] (For more on SSPs, see "What Is a Syringe Services Program?")

Recent evidence from Miami, for example, suggests that implementation of these programs also helps to reduce overdose-related hospital admissions, and that SSP costs are minor compared with the cost of treating HIV infections—which SSPs can help prevent.[6] Given the public health benefits of SSPs, the U.S. Department of Health and Human Services (HHS) and CDC support and fund implementation of the programs in jurisdictions that are either experiencing or at risk for increases in HIV or HCV cases.

However, local jurisdictions hoping to establish and operate SSPs face many state policy barriers. In addition, cost, stigma, and misconceptions about these programs and their participants have prevented some states from taking action to support the implementation of SSPs; consequently, there are not enough SSPs available to meet the needs of PWID in the United States.

State legislatures typically must authorize SSP operation in order to exempt programs from laws that criminalize drug paraphernalia, such as the syringes these programs distribute. While the opioid crisis has led to a near-doubling of such legislative authorizations between 2014 and 2019, 19 states—including 14 that are experiencing, or at risk for, an outbreak—still have not explicitly authorized syringe programs.[7] Furthermore, many states that permit SSP implementation do not provide the programs with any funding, and impose additional laws or regulations that require programs to deviate from best practices, hindering their effectiveness.[8]

State policymakers should consider addressing these legal, regulatory, and financial hurdles. The following steps would help to ensure the successful establishment and operation of SSPs:

- Permit SSPs to be established and operate according to best practices.
    - Pass legislation that authorizes SSP implementation.
    - Prevent local limits on syringe distribution by requiring unlimited need-based syringe exchange.
    - Minimize administrative burdens (e.g., data collection) that hinder program operation and jeopardize participant anonymity.
- Reduce participant interactions with law enforcement.
    - Exempt syringes and other safer-use materials (e.g., cookers and tourniquets) from drug paraphernalia statutes and regulations, and decriminalize their possession and distribution.
    - Train law enforcement on the efficacy and legal status of SSPs.
- Fund SSPs to cover materials and operations costs, including the purchase of syringes.
- Facilitate opioid use disorder (OUD) treatment by allocating state funds or federal grants so SSPs can provide buprenorphine, an FDA-approved drug for the treatment of OUD.

What Is a Syringe Services Program?

Syringe services programs (SSPs), also commonly referred to as syringe or needle exchange programs or harm reduction programs, were developed by and for people who use drugs to reduce the harms of injection drug use by providing access to and disposal of drug use equipment and other related services. These community-based programs can provide services from brick-and-mortar locations, through street outreach (e.g., mobile vans), or via delivery.[9]

Sterile supplies distributed for injection drug use include syringes, cookers, cotton, tourniquets, and clean water; some programs also distribute sterile mouthpieces, filters, and straws for people who use drugs through non-injection routes of administration, such as smoking or snorting, as non-injection drug use equipment also carries risk for infectious disease transmission.[10] Some SSPs also aim to reduce the risk of overdose by distributing naloxone, a life-saving medication that reverses the depressive respiratory effects of an opioid overdose, and drug-checking devices that identify contaminants in drugs.[11]

Additionally, SSPs may provide participants with health care services, such as vaccinations, screening and treatment for infectious diseases, wound care related to injection drug use, and referrals to substance use and mental health treatment and social services.[12] In addition to those referrals, some SSPs are beginning to provide buprenorphine, an FDA-approved medication for the treatment of opioid use disorder.[13]

Authorize SSPs in states

Although 31 states and the District of Columbia legally authorize SSPs, some have ambiguously worded laws that make implementation and expansion of SSPs difficult—and severely limit the number of people they can reach.[14] For instance, nine of the 32 also require local approval for SSP implementation, which is a challenge because SSPs often face community opposition due to stigma against PWID. This additional layer of approval means local jurisdictions can effectively prohibit new SSPs from opening through policy or zoning changes,[15] although courts may deem these local ordinances a violation of the federal Americans With Disabilities Act or Rehabilitation Act because ordinances discriminate against people with substance use disorder (SUD).[16] To avoid this friction between local officials and the courts, interested state policymakers should pass SSP-authorizing legislation that cannot be overriden at the local level; some states have already considered preemption clauses intended to inhibit local SSP bans.[17]

Some states limit syringe distribution due to concerns about their disposal, resulting in programs that fail to meet the needs of participants and therefore do not adequately mitigate public health risks.[18] Research from over a decade shows that SSP implementation facilitates access to the safe disposal of used needles and syringes, and that programs providing unlimited syringes to individual participants are more effective than programs that don't at reducing the number of people reusing syringes.[19] Limits on syringe distribution, such as one-for-one or "exact exchange" programs, discourage participants from giving sterile syringes to people who do not attend the program but would benefit from receiving new injection supplies. Fortunately, most SSPs do allow and encourage the redistribution of sterile syringes, known as secondary syringe exchange, which is considered a best practice.[20] Unlimited distribution of syringes also gives programs the flexibility to adjust services as necessary in times of emergency; for example, SSPs provided participants with more syringes than usual in a single visit during the COVID-19 pandemic when programs had to reduce or discontinue operating hours.[21]

Although most states do not stipulate the number of syringes that can be distributed—just four require one-for-one exchange—laws or regulations at the local level can limit SSPs' ability to provide unlimited distribution.[22] For example, in New Jersey, where state law authorizes SSPs but requires local approval to implement and operate a site,[23] the city of Paterson passed an ordinance that changed unlimited distribution syringe access to a one-for-one exchange—reducing the annual number of syringes distributed by about 80 percent and decreasing program participation.[24]

To maintain the supply of syringes and effectiveness of SSPs, state legislation should prevent localities from limiting syringes and focus on evidence-based approaches. North Carolina's law does just that, explicitly stating that sterile injection equipment be supplied "in quantities sufficient to ensure that [they] are not shared or reused," which effectively assures their unlimited distribution.[25]

Additionally, states should allow SSPs to be implemented, and to operate, without burdensome reporting requirements that interfere with program operations or the anonymity of participants.[26] Appropriate program-level reporting to the state or other funding entity could include the number of syringes distributed and received, other services provided (e.g., naloxone distribution), and the number of referrals to medical, mental health, or substance use treatment.[27]

Change drug paraphernalia laws

State drug paraphernalia laws, which typically prohibit possession of syringes for the purpose of illicit drug use, are often at odds with SSP objectives.

This tension can precipitate police encounters with SSP participants even when the programs are authorized by the state.[28] Evidence shows that real and perceived risk of brushes with law enforcement causes PWID to use SSPs less frequently than they otherwise would, and that the desire to avoid these encounters may cause increased syringe sharing and improper disposal of used syringes.[29] Thirty-three states allow SSP participants to possess syringes;[30] however, possession of non-SSP syringes can still be cause for arrest, forcing people to provide proof of their SSP participation to law enforcement.[31] In addition, many law enforcement officers are unaware of state laws decriminalizing possession of syringes from SSPs, so they continue to stop and arrest program participants—interactions that disproportionately occur with people of color.[32] Officers may also use syringe possession as probable cause to conduct a drug search, or as a basis for technical violations of probation or parole.

To reduce law enforcement encounters, states should consider decriminalizing all syringe possession and eliminate criminal penalties for SSP participants. For example, three states—Nevada, Oregon, and Wisconsin—explicitly exclude hypodermic needles and syringes from their definitions of drug paraphernalia.[33] And states should consider going further by following New Mexico's lead by permitting or decriminalizing other safer drug use materials (compared with unsterile equipment) in addition to syringes, such as sterile cookers and drug-checking devices such as fentanyl test strips. In 2019 lawmakers in Santa Fe made their state the first to remove criminal penalties attached to the possession of any drug paraphernalia, and District of Columbia councilmembers took this step as well in December 2020.[34]

Even when the law permits possession of paraphernalia, any drug residue left on it—for example, on syringes—can be a legal concern for SSP participants. Since this, too, could deter SSP participation, 10 states exempt such residue from the ban on controlled substances, and more states should ideally follow suit.[35]

To ensure that changes to law are implemented in the field, state government entities and civil society groups should work with local law enforcement to develop and deliver training on the value of SSPs, the state laws that

govern them, and drug paraphernalia. Evidence suggests that training should cover public health benefits of SSPs, how proper disposal of syringes through the programs can reduce the risk of needle stick injuries to police (accidental syringe pricks during an encounter), the legality of syringes and other drug paraphernalia, and the efficacy of medication treatment for OUD.[36] In Rhode Island, public health and law enforcement professionals jointly developed a training program including the above content, and pre- and post-survey results found that officers who completed the course improved their knowledge on occupational safety (i.e., risk of needle stick injuries) and the legal status of SSPs, while cultivating more positive attitudes about the role SSPs play in improving public health.[37]

Fund programs

To address the overdose crisis, state policymakers should allocate funding all along the continuum of care, with SSPs as a key component: The programs are a cost-effective method for preventing unnecessary hospital expenditures on infectious diseases, injection site wounds, and overdose, and often are the only place PWID might connect to medical care.

Yet SSP managers cite funding as a constant challenge.[38] Public funding is correlated with increased syringe distribution and other health services that lead to lowering or maintaining low HIV rates over time.[39] Without public funding, programs have to rely on a patchwork of temporary private grants that can each have their own requirements and restrictions, limiting the sustainability and scope of SSP operations. Conversely, programs that receive stable government funding report enhanced ability to expand services.[40]

States that authorize SSPs can support the programs' operating costs (but not the costs of needles or syringes) with federal HHS funds, through a determination of need with CDC showing that they have jurisdictions experiencing or at risk for increases in HIV or HCV cases.[41] HHS and CDC require that all federally funded SSPs offer sterile injection equipment, education on safer injection and overdose prevention, naloxone, and referrals to treatment to ensure comprehensive care.[42] Once states have been approved to use CDC funds, they are also eligible to use federal Substance Abuse and Mental Health Services Administration (SAMHSA) grants for syringe services.[43]

States should incorporate adequate SSP funding into their budgets to ensure that programs can provide all services necessary to be effective, including staffing and technical support, while taking into account the number of counties experiencing infectious disease outbreaks, the number of programs operating, and the number of program participants. Furthermore, states should permit SSPs to use state funds to purchase needles and syringes to reduce reliance on unstable private grant funding.[44]

A variety of innovative funding approaches have helped states support the operation of SSPs:

- New York was approved by the U.S. Centers for Medicare and Medicaid Services to allow SSPs to bill, as of July 1, 2018, for harm reduction services if they are enrolled as Medicaid providers.[45] As of July 1, 2018, Medicaid will reimburse programs for care planning, individual and group counseling, educational support groups, and counseling on treatment adherence, including medication management for OUD, HIV, HCV, and mental health conditions.[46] Patients must be referred by a licensed practitioner, but do not need prior authorization.[47]
- The California Budget Act of 2019 committed $15.2 million over four years to state SSPs, with the majority of the money earmarked to support staffing and a smaller amount going toward program administration.[48]
- In fiscal year 2020, the Massachusetts budget for the first time included a line item for harm reduction through syringe access for $5 million appropriated to the state Department of Public Health.[49] This new line of funding remains in the governor's proposed fiscal year 2021 budget.[50]

Facilitate engagement with treatment

Although SSPs primarily seek to reduce the harms of injection drug use, evidence suggests that people who participate in SSPs are more likely than those who don't to enter treatment for substance use disorders—serving as an important bridge to treatment, perhaps because SSP staff build relationships with participants over time.[51]

The health care system often has a harder time reaching PWID because injection drug use can be associated with other problems such as homelessness. For that reason, it's important to connect SSP participants to care as soon as they are interested in treatment.[52] Although some SSPs may not have the capacity to provide OUD treatment long term, the programs can initiate participants on buprenorphine treatment and then transfer them to a health clinic to maintain their care. Surveys of program participants—particularly those who reported barriers related to payment, transportation, and stigma—show that they would rather initiate buprenorphine treatment onsite at an SSP, and not at a different health care facility.[53] And these programs have equally positive outcomes, with research showing that SSP retention rates are comparable to those of traditional treatment settings.[54]

States should allocate federal grants or state funds to facilitate the provision of buprenorphine on demand to SSP participants with OUD, whether the medication is given onsite or through a referral network. Some states have had success with this approach.

- In 2017, Washington used funds from the SAMHSA State Targeted Response to the Opioid Crisis grant to include SSPs as "spokes" in its hub-and-spoke system—specialized substance use disorder treatment centers are hubs, and multiple ancillary facilities, or spokes, provide office-based services.[55] Four of the 11 hub-and-spoke networks in Washington state currently incorporate SSPs as referral partners.[56]

  The state also has plans to expand the role of SSPs as "hubs" in these networks using SAMHSA State Opioid Response (SOR) funding to develop "opioid treatment networks" intended to reach rural areas where there are fewer providers available to act as hubs.[57] Instead, each SSP hub would have a local medication treatment provider as a spoke.
- The New Jersey Department of Human Services allocated $355,000 per year for fiscal 2019 and 2020 in SAMHSA SOR grant funds to pilot a low-threshold buprenorphine initiation program at an SSP. The money paid for a mobile advanced practice nurse and case manager to provide buprenorphine treatment services to SSP participants, particularly those who are uninsured.[58]
- The New York State Department of Health funds 12 statewide SSPs to operate Drug User Health Hubs,[59] established in 2016 to reach people at risk for overdose who were not engaged in treatment or other health services. The hubs provide access to medications for OUD treatment and do not require that participants cease using illicit drugs.[60] In 2018, there were more than 1,800 intakes at the hubs, primarily the result of referrals from SSPs and other community-based programs.[61]

Conclusion

SSPs play an important role in reducing the harms of injection drug use and engaging participants in treatment and other services. Nevertheless, barriers remain to effectively implement these programs and reach individuals who would benefit from them. States have taken steps to address state and local tensions over authorization, resolve law enforcement concerns, and facilitate connections to lifesaving OUD treatment, and state policymakers should look to these examples as a guide for lawmaking and budgeting. Expanding the resources and reach of SSPs could equip states to better address the opioid overdose crisis and improve the health of PWID.

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