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Ideological Anachronism Involving Needle and Syringe Exchange Programs:

Lessons From the Indiana HIV Outbreak

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On March 26, 2015, Governor Mike Pence of Indiana issued an executive order declaring a state of public health emergency in Scott County with an eye toward stemming the largest-ever HIV outbreak in the state. Evolving over 2 months, the HIV outbreak involved 153 confirmed cases and has been traced to extensive needle sharing by people who inject drugs.[1] Most of the confirmed HIV cases were associated with the intravenous use of a liquefied form of the opioid agonist oxymorphone (a Schedule II controlled substance) otherwise marketed as an extended-release tablet (Opana). Methamphetamine and heroin have been implicated as well. Concurrently, Governor Pence authorized a renewable short-term (30-day) needle and syringe exchange program (NSEP), the scope of which was to be delimited to Scott County. In so doing, Governor Pence temporarily overrode 3 drug paraphernalia state laws criminalizing the possession and distribution of sterile syringes. This Viewpoint describes federal and state syringe access policies, explores their attendant ideological backdrop, and points out their role in the eruption and amplification of avoidable HIV outbreaks.

The federal ban on the funding of NSEPs, sponsored by the late Senator Jesse Helms (R-NC), dates back to the Health Omnibus Programs Extension of 1988.[2] As written, the law precludes local authorities from using the Public Health Emergency Fund to provide "individuals with hypodermic needles or syringes so that such individuals may use illegal drugs."[2] Although the law was briefly repealed for fiscal years 2010 and 2011 by the Consolidated Appropriation Act of 2010, the federal funding ban was promptly reinstated in 2012 by the Consolidated Appropriation Act of 2012. A survey of state NSEP policies reveals that 23 states, including Indiana, criminalize the distribution or possession of

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syringes for illegal drug use through drug paraphernalia, syringe prescription, controlled substances, and pharmacy laws.[3] Moreover, only 16 states have resolved to explicitly authorize NSEPs.[3] Viewed broadly, these observations suggest that the federal underwriting of NSEPs has been banned for the better part of the last 30 years. These observations further reveal that about half of the states continue to have policies under which the implementation of NSEPs is deemed illegal.

The tug-of-war in and around NSEPs and syringe access laws is an ideological one. To some, NSEPs condone and encourage drug use, dissuade injection drug users from seeking help, signal governmental acceptance of illegal behavior, perpetuate the cycle of drug crime, contradict law enforcement efforts, and threaten public health and safety. According to Robert Martinez, director of the Office of National Drug Control Policy from March 1991 through January 1993, NSEPs "undercut the credibility of society's message that drug use is illegal and morally wrong."[4] Framed in this fashion, injection drug use represents a voluntary lifestyle choice by individuals free of behavioral disease. Viewed in this light, NSEPs undermine the "war on drugs" and its attendant drug-control policies. To others, NSEPs constitute patient-centered constructs designed to assist those whom the *International Classification of Diseases* defines as having "mental and behavioral disorders due to psychoactive substance use." These patients have a chronic relapsing disease that is amenable to intervention were they not stigmatized, incarcerated, deprived of employment, or kept at arm's length from medical care. They have been ostracized and marginalized for want of effective outreach. Nowhere was this clash of ideologies more plainly apparent than in Indiana where in Governor Pence, otherwise a staunch opponent of NSEPs, acknowledged their indispensability when stating, "In response to a public health emergency, I'm prepared to make an exception to my long-standing opposition to needle exchange programs."[5]

The scientific evidence has demonstrated the safety and efficacy of NSEPs as a lifesaving, harm-reducing public health intervention. Careful analysis of the evidence by Vlahov and Junge[6] documents that NSEPs "do not result in increased drug use among participants or the recruitment of first-time drug users." Moreover, NSEPs are not limited to the provision of sterile hypodermic needles to injection drug users and the safe disposal of used paraphernalia. Instead, NSEPs offer counseling, testing, and treatment for HIV as well as for hepatitis, tuberculosis, and sexually transmitted infections. In so doing, NSEPs reduce the risk of spread of HIV and related diseases, especially when coupled with safe sex measures. Equally important, NSEPs facilitate referral and entry of injection drug users into substance abuse treatment programs. NSEPs also provide the opportunity for overdose prevention (>10 000 documented overdose rescues in 2010 alone)[7] as well as referral to housing and employment services. What is more, NSEPs are credited with reducing the number of improperly discarded syringes and the likelihood of unintentional exposure by children as well as by sanitation, police, emergency, and firefighting personnel. NSEPs are as cost-effective given the affordability of syringes as compared with the substantial costs associated with therapy for HIV.

Injection-related transmission of HIV is well known. With injection drug users accounting for 8% of all new HIV infections in 2010 and 15% of those living with HIV in 2011, NSEPs

remain essential.[8] It is estimated that 186 728 individuals with injection-related HIV have died since the epidemic began, including an estimated 3514 in 2012.[9] Some of these HIV infections and their fatal outcome could have been prevented by functional NSEPs were it not for a perpetual federal funding ban and restrictive state statutes. Early state adopters Washington (1988) and New York (1992) have seen their rates of injection-related HIV decline, as did other states that proceeded to implement NSEPs. In this regard, what happened in Indiana was predictable and avoidable. Ranked 47th in health program funding and delayed in the expansion of its Medicaid program pursuant to the Affordable Care Act, Indiana has been hard pressed to extend basic health care services and reduce its uninsured rates. Scott County, the epicenter of the current epidemic, has recently been rated last in the state on health outcomes. Scott County has a long history of unemployment, poverty, and generational addiction. In addition, Scott County has been without an HIV testing center since early 2013 when the sole provider—a Planned Parenthood clinic—closed.

The way forward is clear. First, Indiana would do well to extend and expand its time-limited NSEP as well as to legalize the practice. Recent legislation to facilitate the time-limited implementation of NSEPs in other counties represents a constructive if insufficient step toward the containment of the outbreak. The need to prevent injection-related HIV transmission is all the more pressing given that the current national epidemic of prescription opioid dependence is rapidly transitioning to injected heroin. Second, Indiana should spare no effort to rapidly implement the expansion of its Medicaid program pursuant to its approval by the Centers for Medicare & Medicaid Services in January 2015. Third, Indiana needs to rebuild its public health and social services infrastructure with little time to spare. Fourth, serious consideration must be given at the national level to repealing the federal ban on the funding of NSEPs. What happened in rural Indiana can and will happen elsewhere.[9] Failure to act would constitute a tragic and costly opportunity missed.

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