NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

05-09

STATEMENT OF POLICY

Harm Reduction

Policy

The National Association of County and City Health Officials (NACCHO) supports a comprehensive, evidence-based approach to substance use that centers harm reduction and equity, to curb transmission of HIV, viral hepatitis, and other blood-borne diseases, prevent overdose, and ultimately, promote the health and well-being of people who use drugs (PWUD). NACCHO urges federal, state, and local policymakers to fund and support harm reduction strategies and address legal barriers related to their implementation, including:

- Provide robust funding for the implementation of harm reduction strategies including, but not limited to, syringe services programs; the distribution and disposal of smoking and other substance use equipment; naloxone distribution, training, and education; drug checking services; and overdose prevention sites;
- Provide robust, flexible funding to ensure access to health and social services that prevent or reduce the harms associated with substance use, including but not limited to HIV/STI and hepatitis services, substance use treatment and other mental and behavioral health services, and housing services;
- Provide robust, flexible funding to support a coordinated, comprehensive approach to the overdose epidemic, including by supporting health department infrastructure, partnership building, program planning and evaluation, and by supporting interventions to address stigma and discrimination;
- Ensure harm reduction policy—including federal, state, and local laws, regulations, and funding requirements—promotes implementation of harm reduction strategies in accordance with the peer-reviewed evidence base, best practices, and local health department and other expert recommendations;
    - Notably, Congress and federal funding agencies should remove barriers to the purchase of syringes and other harm reduction supplies;
- Revoke or amend policies that limit access to or implementation of harm reduction services or disincentivize healthy or life-saving strategies. This includes but is not limited to:
    - Decriminalize possession of personal amounts of illicit drugs;
    - Ensure syringes, fentanyl test strips, and other harm reduction equipment can be purchased over-the-counter;
    - Decriminalize possession of substance use paraphernalia;
    - Enact or amend Good Samaritan and Safer Reporting Laws to encourage people to access life-saving help in response to an overdose;
- Recognizing that decriminalization of substance use may not be feasible in many jurisdictions at this time, explore other policy solutions to limit the inequitable and harmful impact of the War on Drugs including by:

    - Identifying opportunities to implement deflection and diversion programs within the criminal justice system in accordance with evidence-based practices;
    - Revoking or advocating against drug induced homicide laws;
    - Where decriminalization of substance use possession or paraphernalia possession is not feasible, identifying opportunities to reduce associated criminal penalties (e.g., from a felony to a misdemeanor).

Local health departments are at the forefront 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 normalize a harm reduction approach by implementing or supporting harm reduction interventions. NACCHO encourages local health departments to:

- Ensure the implementation and accessibility of harm reduction services and strategies (i.e., those listed in the previous section);
- Ensure harm reduction strategies are implemented in accordance with best practices:
    - Notably, this includes distributing syringes based on clients' needs, not on a 1:1 model in which clients are required to return syringes to receive sterile ones; and maximizing access to sterile syringes in the community by supporting secondary exchange;
- Ensure the integration of healthcare, harm reduction, and social services to meet the comprehensive needs of PWUD (including but not limited to the services listed in the previous section);
- Educate stakeholders to:
    - Promote implementation of harm reduction strategies;
    - Promote access to harm reduction, health, and social services for PWUD;
    - Address stigma and discrimination and harmful myths and misconceptions about substance use and PWUD;
    - Support evidence-based policymaking, including the policies listed above;
- Coordinate a comprehensive, cross-sector, evidence-based approach to the overdose epidemic, including by:
    - Building partnerships and convening local stakeholders;
    - Leading or participating in meaningful program planning and evaluation for harm reduction;
- Engage and promote the leadership and employment of people with lived experience to enhance programming and advance equity.

Justification

Syringe service programs (SSPs) and other harm reduction strategies have played a critical role in the prevention of HIV and viral hepatitis and the reduction of other harms associated with substance use for more than 30 years.[1,2] As detailed by the Centers for Disease Control and Prevention (CDC) in *Summary of Information on The Safety and Effective 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).[3] 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.[4,5,6] Additionally, every dollar spent on syringe services

saves $6.38 to $7.58 in HIV treatment costs alone.[7] The public sector accounts for a significant portion of these savings; for example, the annual return on investment for syringe services is $243 million and $62 million in Philadelphia, PA, and Baltimore, MD, respectively.[8] In addition to syringe exchange, SSPs often connect clients to other healthcare and harm reduction services and promote public safety through syringe disposal and overdose prevention services.

In 2020, 9.5 million Americans misused opioids, including 9.3 million who misused prescription pain medicines and 902,000 who used heroin.[9] In 2019, 1.6 percent of high school students reported ever engaging in IDU.[10] In the United States, ten percent of HIV diagnoses occur among people who inject drugs (PWID), and the majority of HCV cases are attributable to IDU.[11,12] The opioid 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.[13,14] Since then, a number of jurisdictions have experienced HIV or HCV outbreaks among PWID, including at least 6 outbreaks of HIV among PWID that were identified between 2016 and 2019 alone.[15]

The United States is also experiencing unprecedented levels of overdose deaths, the majority of which involve opioids.[16] Fortunately, SSPs and other harm reduction strategies can reduce substance use, connect people to treatment and prevent overdoses. PWID who 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.[3] 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.[17] MOUD, including the use of methadone, buprenorphine, or naltrexone, is safe and effective for the treatment of opioid use disorder and is associated with reduced risk for HIV, HCV, and overdose mortality.[4,18,19] Naloxone is a medication that reverses overdoses, reducing opioid-related emergency room visits and overdose deaths.[20,21] Naloxone can be easily administered by people without medical training, including PWID themselves. naloxone distribution programs are also cost-effective.[22]

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.[23] A recent study revealed that nearly three-fourths of PWID would modify their behavior if they knew that their drugs contained fentanyl.[24] Consequently, an emerging harm reduction strategy involves offering drug checking services and tools such as fentanyl test strips, which provide clients with additional information about their drugs to help protect themselves from overdose. LHDs 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. In addition to drug checking, another behavior modification to reduce overdose is transitioning to smoking instead of injecting substances. Smoking instead of injecting may reduce the risk of overdose, as well as reduce vulnerability to HIV, HCV, abscesses, endocarditis, and other infections.[25]

Overdose prevention sites (OPSs) are venues where people can bring and use their drugs in the presence of staff, volunteers, or peers who 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.[26] 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."[27]

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.[28,29] SSPs also connect clients to MOUD, which has been associated with reduced crime..[30,31,32] 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.[33,34]

According to the North America Syringe Exchange Network (NASEN), there are nearly 400 SSPs across the country, many of which are operated or supported by LHDs.[35] However, many Americans face challenges in accessing SSPs. In the United States, more than 80 percent 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.[36] 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.[37,38] At least half of PWID live outside of major urban areas, which is associated with reduced access to SSPs.[39] Furthermore, SSPs often have limited operating hours, reducing the accessibility of their services.[40] These trends are particularly concerning, as PWID who report difficulties in accessing sterile needles are more likely to report sharing syringes.[41]

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.[42] 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.[43,44] 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.[45]

LHDs 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 LHDs to provide or support syringe services in their communities. Several federal agencies, including those that typically fund public health efforts, ban or are subject to bans on the use of federal funding to purchase syringes. Notably, CDC funding 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.[46]

These funding limitations and other policy barriers can make it challenging for LHDs to implement or support SSPs in accordance with best practices. Approximately one-fourth of 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.[35] However, this model is far less effective at meeting the needs of PWID compared to a needs-based distribution model.[47] 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.[48]

Thirty-two states criminalize syringe possession, as syringes are considered drug paraphernalia. This restriction may discourage utilization of SSPs and encourage improper syringe disposal. Ten states have enacted exemptions, for example for registered SSP clients, and only seven states completely exempt syringes from paraphernalia laws.[49] 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.[50] Decriminalization is an evidence-based strategy that eliminates criminal penalties for personal use, as well as the possession of drugs and related equipment. It may also remove penalties for low level drug sales. This non-carceral strategy would free up resources previously used to incarcerate PWUD that could instead be used to prevent, treat and reduce harms associated with substance use. In addition, decriminalization would also eliminate both barriers to harm reduction services as well as stigma associated with substance use, leading more people to seek treatment.[51]

Research shows that contrary to popular beliefs, incarceration is ineffective in improving public safety and has minimal, if any, impact on reducing crime. Diversion is a term that refers to “exit ramps” which move people away from the criminal legal system and offer alternatives to arrest and prosecution. Diversion programs target the underlying problems that lead to criminalized behavior, improving long-term safety, reducing crime, and saving money. Diversion programs are not one size fits all, and exist at many levels such as pre-arrest, pre-charge and pretrial. Furthermore, they are evidence-based: in a 2018 study in Harris County, Texas, researchers saw positive outcomes for diversion programs in criminal courts, with a substantial decrease in convictions and improved employment outcomes ten years after participation.[52]

Naloxone access, as well as both Good Samaritan and Safer Reporting Laws, can also promote harm reduction. Naloxone access laws increase public access to naloxone, while Good Samaritan and Safer Reporting Laws encourage people to call 911 in response to overdoses by establishing protections or immunity against civil liability, arrest, or criminal charges. These laws may protect a person experiencing or witnessing an overdose from civil liability and/or arrest related to the possession of illicit substances or paraphernalia. The scope of Good Samaritan Laws vary state to state, with some only ensuring protection against civil liability. Many states have either expanded protections to include protection against arrest and criminal charges or have separate Safer Reporting Laws which specify the scope of protection from arrest or criminal persecution for the person who experiences the overdose and/or the person who calls 911 and renders aid. [53]

States with naloxone access and Good Samaritan Laws have experienced 14% and 15% reductions in opioid overdose rates, respectively.[54] 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.[55,56]

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.

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Record of Action

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