

Harm Reduction: A Strategy to Reduce the Toll of Substance Use in Missouri

Harm reduction is a public health strategy that aims to reduce the negative consequences of substance use for individuals and minimize social harms. The primary goals of harm reduction techniques are reducing infectious disease transmission, improving public safety, providing supportive services and lifesaving medications, improving pathways to treatment, and ultimately reducing substance use disorder (SUD) and overdose rates. Research has shown that harm reduction approaches can result in reductions in morbidity and mortality associated with substance use if implemented comprehensively. Studies also show that some harm reduction approaches provide other benefits, such as improved community safety and protection for first responders. For states and localities combating the effects of substance use, harm reduction strategies are increasingly utilized to reduce SUD and associated public health and safety ramifications. With Missouri's recent investment in medication-assisted treatment, additional techniques, such as syringe services programs could be implemented to strengthen the overall harm reduction approach in the state.

Opioid Crisis in Missouri

Like many other states across the country, Missouri has experienced sharp increases in opioid use, overdose, and related deaths. Between 2010 and 2019, opioid overdose deaths in Missouri nearly doubled, from 590 to 1,094 deaths.¹ Additionally, there was a 538% increase in babies born with neonatal abstinence syndrome from 2006-2016, a condition that occurs when a fetus is exposed to opioids or other narcotics in the womb.² National and state data suggest an acceleration of overdose deaths during the COVID-19 pandemic. In the 12 months leading up to May 2020, overdose deaths were the highest on record of any year.³ In Missouri, opioid overdose deaths in the first nine months of 2020 were 30% higher than in 2019.⁴

One side effect of the increasing rate of opioid use is the growth of infectious diseases related to intravenous drug use, particularly the human immunodeficiency (HIV) and hepatitis C (HCV) viruses, which are spread through contaminated needles and unsanitary conditions. More than 12,000 Missourians are currently living with HIV, and Missouri has been identified by the Centers for Disease Control and Prevention (CDC) as a priority state for HIV transmission reduction in rural communities.^{5,6} Black Missourians are disproportionately impacted by these rising numbers, with 9.3 times more infections than their white counterparts.⁷ When it comes to HCV, over 4,500 cases were reported in Missouri in 2018.⁸ Approximately one-third of people who inject substances test positive for HCV within one year, and half test positive after five years, making substance use a primary risk factor for developing HCV.⁹

Harm Reduction Approaches

Two evidence-based approaches to reducing the individual and social harm caused by substance use include medication-assisted treatment and syringe services programs.

Medication-assisted treatment (MAT) is the combination of pharmacological intervention, counseling, and behavioral therapies to treat opioid use disorder (OUD). Administered by health care workers, MAT medicines are forms of opioid drugs that help "normalize the brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and normalize body functions without the negative effects of drug abuse."⁹ Studies show MAT is effective at treating OUD by helping to improve health outcomes and rates of recovery.¹⁰ Missouri policymakers have taken recent action to expand access to MAT. Between 2017 and 2019, legislative improvements for MAT included: expanding Medicaid coverage to low-income, postpartum women with SUD; mandating coverage for MAT pharmaceuticals for covered individuals with SUD; broadening scope-of-practice rules to include assistant physicians as prescribers of certain MAT therapies; and expanding access to MAT for justice-involved individuals with OUD.

Syringe services programs (SSPs) aim to decrease the individual and societal effects of intravenous drug use through access to sterile syringes and linkage to treatment and other services. SSPs reduce the risk of infectious diseases, with studies showing as much as a 50% reduction in HCV and HIV infections.¹¹ After Indiana legalized SSPs, the state saw a drop in new HIV cases from 175 in 2015 to 17 just three years later.¹² In addition to reducing infectious disease spread, SSPs link people to supportive services and treatment. In fact, individuals involved in SSPs are five times more likely to initiate treatment and three times more likely to stop using substances.¹³ The programs are also cost-effective; one study found that if \$10 million was invested in SSPs over a year, over \$75 million in lifetime treatment costs of HIV could be saved.¹⁴ Lastly, SSPs decrease unintentional needle sticks and overdose deaths without increasing substance use and crime rates.^{15,16}

Policy Considerations for Syringe Services Programs

In order to build on the success of harm reduction strategies in the state, Missouri could consider SSPs as an additional approach to reducing the impacts of SUD. Recommendations to effectively implement SSPs include:

- **Legalization and expansion of SSPs in Missouri.** Various legal strategies exist to allow for SSP operation. Two common approaches include the specific legalization of SSPs and the removal of legal barriers to SSP operation, including authorizing the sale of syringes or exempting syringes from drug paraphernalia definitions. Missouri law does not currently allow for the legal establishment of SSPs through either mechanism. Since 2014, the number of states authorizing SSPs has nearly doubled, with many southern, rural, and midwestern states changing laws due to HIV/HCV outbreaks. Thirty-one states and the District of Columbia have legalized SSPs, and seven additional states have legal conditions that allow or reduce legal barriers to operating SSPs.¹⁷ There are currently over 400 SSPs operating across the country.¹⁸
- **Establish protections for SSP participants from legal repercussions associated with safe syringe disposal.** Current Missouri statutes prohibit the use, sale, or distribution of drug paraphernalia including “syringes, needles, or objects used for injecting controlled substances.” State law also prohibits the distribution and possession of syringes or needles if intended for the use of controlled substances. Thirty-three other states, however, allow for the possession of objects used to inject drugs by SSP participants. Some states broadly remove or explicitly exclude objects used to inject substances from the definition of drug paraphernalia and others include legal exemptions for drug paraphernalia possession for SSP participants.¹⁹ Either approach ensures that SSP participants will not face legal ramifications for participating in safe syringe exchange and disposal activities.
- **Encourage SSPs to provide additional services, where feasible.** Providing comprehensive services at SSP sites that respond to participant needs is a recommended best practice that improves the success of SSPs. Some services that can be provided include referrals to SUD treatment, distribution of naloxone (a medication that reverses overdoses), vaccination, testing, and treatment for infectious diseases, and education on overdose prevention and safe injection practices. Requiring sites to provide all of these services, however, can be resource-intensive and unsustainable for leading organizations. Instead, sites should have flexibility to provide services that respond to participant needs and be allowed to refer participants to existing, off-site resources. Overall, most states that require SSPs to provide services allow the option to refer out rather than require them on site.¹⁹ This allows SSPs to be comprehensive while keeping their operations sustainable.
- **Disallow restrictions on direct and one-for-one needle exchange.** The effectiveness of SSP programs in reducing disease transmission is enhanced if restrictions on needle exchange are minimized. For example, some states require that participants only receive the same number of syringes that they return, and others specify that only participants can use the syringes provided by SSPs, prohibiting the distribution of clean syringes to non-participants. These types of restrictions limit the number of people who benefit from SSPs and discourage secondary distribution of clean syringes, which could lead to increased sharing and reuse of unsterile syringes.^{20,21}

Endnotes available upon request