

Syringe Services Programs

FEBRUARY 2022

INTRODUCTION

Syringe services programs (SSPs), initially limited to the exchange of hypodermic needles and syringes and often still called needle or syringe exchange programs, have been present in the United States in some form since the early 1980s.¹ Often illegal due to drug paraphernalia laws – an issue that still exists in 2022 – only seven U.S. cities had programs by the end of 1991.² According to the Centers for Disease Control and Prevention (CDC), in November 2007, there were 185 SSPs in 36 states, the District of Columbia, and Puerto Rico.³ As of February 2022, that number has increased to 414 operational SSPs in all 50 states, the District of Columbia, and Puerto Rico, although only 38 states, the District of Columbia, and Puerto Rico either explicitly or implicitly authorize SSPs through statute or regulation.⁴

This fact sheet provides readers with an overview of SSPs, including the components that make up a comprehensive SSP and the obstacles encountered by programs and their participants.

SCOPE OF THE PROBLEM

An estimated one million people in the United States inject illicit drugs⁵ including heroin, amphetamines, buprenorphine, benzodiazepines, barbiturates, cocaine, and methamphetamine.⁶ Every year, the number of people in the United States who suffer a fatal overdose increases, with 70,630 drug overdose deaths in 2019⁷ and, between April 2020 and April 2021, more than 100,000 deaths.⁸ According to the European Monitoring Centre for Drugs and Drug Addiction, “overdose is the leading cause of avoidable death among people who inject drugs ... [and] accounts for nearly half of all deaths

among people who inject heroin, exceeding HIV and other disease-related deaths.”⁹

In addition to overdose, people who inject drugs (PWID) are at risk of contracting HIV, viral hepatitis, and tuberculosis, as well as developing skin and heart infections such as cellulitis and myocarditis.¹⁰ From 2010 to 2016, reports of hepatitis C virus (HCV) cases rose 3.5-fold, with the majority of such cases attributed to injection drug use.¹¹ Further, PWID account for more than 2,500 new HIV cases each year.¹² As of March 26, 2020, the CDC determined that 44 states, the District of Columbia, Puerto Rico, and the Cherokee Nation faced the risk of “significant increases in hepatitis infection or an HIV outbreak due to injection drug use.”¹³ The increase in injection drug use also significantly increases economic costs to the United States. Per the CDC, “Hospitalization in the US due to substance-use related infections alone costs over \$700 million annually.”¹⁴ The transmission of bloodborne diseases such as HIV, HCV, viral hepatitis, and bacterial and fungal infections through injection drug use is primarily caused by “using and sharing contaminated injection drug equipment, unsanitary conditions and low vaccination rates among at-risk populations.”¹⁵

WHAT ARE SYRINGE SERVICES PROGRAMS (SSPs)?

SSPs are harm reduction programs that provide a wide range of services including, but not typically limited to, the provision of new, unused hypodermic needles and syringes and other injection drug use supplies, such as cookers, tourniquets, alcohol wipes, and sharps waste disposal containers, to PWID. Comprehensive SSPs also either directly provide, or offer linkage or referrals to entities that provide: substance use disorder treatment, including medication for addiction

treatment; vaccination for viral hepatitis; screening for viral hepatitis, HIV, sexually transmitted infections, tuberculosis, and other infectious diseases; provision of pre- and post-exposure prophylaxis for HIV; naloxone and other overdose prevention tools; peer support services; educational materials and training in areas related to injection drug use; and referral and linkage to other services, including medical care, mental health services, and other support services.¹⁶

OBSTACLES TO SSP OPERATION

Despite the evidence that SSPs are instrumental in helping to maintain public health and safety, both for PWID and the communities in which SSPs are located, SSPs are often subjected to misinformation among legislators, law enforcement, and members of the community. For example, despite decades of research to the contrary, the belief persists that having an SSP in a community increases drug use, crime, and the presence of used hypodermic needles and syringes in the streets and other public areas.¹⁷ As a result of this misinformation, many communities will not allow SSPs to operate in their area or lobby to close currently operational SSPs.

As mentioned in the introduction, one of the biggest obstacles to operating an SSP is that hypodermic needles and syringes are often considered drug paraphernalia under state laws which potentially subject SSP employees, volunteers, and participants to criminal sanctions. Only 11 states and Puerto Rico do not include hypodermic needles and syringes in the definition of “drug paraphernalia.”¹⁸ However, other states have tried to address the issue by including exceptions or exemptions for hypodermic needles and syringes to the state criminal penalties. Eight states (New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, and Tennessee) include exceptions for possession, while two states (Georgia and Indiana) include exceptions to the criminal penalties for furnishing and/or distributing hypodermic needles and syringes. An additional 15 states (California, Washington, Montana, Colorado, New Mexico, Louisiana, Illinois, Michigan, Kentucky, Florida, Virginia, Maryland, Delaware, Vermont, and Maine) and the District of Columbia include exceptions to their criminal penalties for

both possession and furnishing/distributing hypodermic needles and syringes. The difficulties arise when these exceptions are only applicable to SSP employees or volunteers and not to participants, or when employees, volunteers, and participants are required to furnish proof of their association with an SSP for the exemption to apply.

Finally, SSPs might encounter other obstacles in the form of state laws that place onerous requirements on SSPs such as: 1) a state licensure requirement; 2) requiring employees, volunteers, and participants to carry SSP-specific identification; 3) requiring SSPs to somehow mark the hypodermic needles and syringes so that they are identified with the SSP that furnished the supplies; 4) requiring local law enforcement approval or requiring that the SSP provides every law enforcement agency with jurisdiction over the area where the SSP is or will be located with certain information; and 5) allowing the county or municipality where the SSP is or will be located to terminate the program without cause.

BENEFITS OF SSPs

Research shows that SSPs are associated with multiple benefits to both participants and the communities in which SSPs are located. Participation in an SSP can result in a discontinuation of injection drug use, entry into a treatment program, and retention in treatment. Further, SSP participation results in a reduction in the rates of both HIV and HCV and other bloodborne diseases that can be transmitted by sharing needles. Finally, the presence of an SSP in a community results in less sharps waste in public places. “Nearly 30 years of research has shown that comprehensive SSPs are safe, effective, and cost-saving, do not increase illegal drug use or crime, and play an important role in reducing the transmission of viral hepatitis, HIV and other infections.”¹⁹

New participants in SSPs “are five times more likely to enter drug treatment and about three times more likely to stop using drugs than those who don’t use the programs.”²⁰ Use of SSPs is also linked to a self-reported reduction in, or discontinuance of, injection drug use.²¹ Furthermore, “studies show that SSPs protect first responders and the public by providing safe needle disposal and reducing community presence of needles.”²² A study published in *Drug and Alcohol Dependence* found that syringes were eight times more

likely to be improperly discarded in cities without an SSP than in communities with an SSP.²³ Additionally, the CDC's 2015 National HIV Behavioral Surveillance system showed that "the more syringes distributed at SSPs per people who inject drugs in a geographic region, the more likely people who inject drugs in that region were to report safe disposal of used syringes."²⁴

As mentioned above, SSPs are associated with a reduction in the rates of both HIV and HCV.²⁵ A 2018 special report published by the CDC found that, among people aged 18 to 39 who inject drugs, 39 to 48 percent of those individuals reported sharing syringes, with younger individuals more likely to share syringes than older individuals.²⁶ Sharing syringes and other injection-related equipment, such as cookers, cotton swabs, and tourniquets, is associated with an increased risk of contracting HIV and viral hepatitis. That same CDC report found that SSPs are effective at reducing syringe sharing. Unfortunately, only 53 percent of PWID reported participating in an SSP.²⁷ The lack

of SSP usage is likely due to the inability of communities to establish effective SSPs because of "legal and regulatory issues, insufficient funding, and misunderstandings about the effectiveness and safety of SSPs."²⁸

When program participants receive medications for addiction treatment, "HIV and HCV transmission is reduced by more than two-thirds."²⁹ Further, a 2016 evaluation of an SSP in the District of Columbia showed a 70 percent decrease in new HIV cases among people who inject drugs, "and a total of 120 HIV cases averted in two years."³⁰

CONCLUSION

Although SSPs face many obstacles to their operation, comprehensive programs can provide enormous benefits to both their participants and the communities in which they are located.

¹ McLean, Katherine. The Biopolitics of Needle Exchange in the United States. *Crit Public Health*, 2011 Mar 1; 21(1): 71-79. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3291106/>

² Id.

³ Id.

⁴ *Opioid & Health Indicators Database*, amfAR (accessed Feb. 14, 2022) https://opioid.amfar.org/indicator/num_SSPs.

⁵ Amy Lansky et al., *Estimating the Number of Persons Who Inject Drugs in the United States by Meta-analysis to Calculate National Rates of HIV and Hepatitis C Virus Infections*, PLOS ONE (2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4026524/>.

⁶ Gloria J. Baciewicz, M.D., *Injection Drug Use*, MEDSCAPE (Aug. 19, 2021), <https://emedicine.medscape.com/article/286976-overview>.

⁷ Holly Hedegaard, M.D., Arialdi M. Minino, M.P.H., & Margaret Warner, Ph.D., *Drug Overdose Deaths in the United States, 1999-2019*, U.S. DEP'T OF HEALTH AND HUMAN SVC. 1 (Dec. 2020), <https://www.cdc.gov/nchs/data/databriefs/db394-H.pdf> and F.B. Ahmed, L.M. Rossen, and P. Sutton, *Provisional Drug Overdose Death Counts*, CTR. FOR DISEASE CONTROL AND PREVENTION, NAT'L CTR. FOR HEALTH STAT. (reviewed Jan. 12, 2022), <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

⁸ *Provisional Drug Overdose Death Counts*, CTR. FOR DISEASE CONTROL AND PREVENTION (last reviewed Aug. 11, 2021), <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

⁹ *Prevention of Drug-related Deaths*, EUR. MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, https://www.emecdda.europa.eu/publications/topic-overviews/prevention-drug-related-deaths_en.

¹⁰ *HIV and Injection Drug Use*, CTR. FOR DISEASE CONTROL AND PREVENTION (last reviewed April 21, 2021), https://www.cdc.gov/hiv/basics/hiv-transmission/injection-drug-use.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhiv%2Ffrisk%2Ffidu.html.

¹¹ *Syringe Services Programs (SSPs) Fact Sheet*, CTR. FOR DISEASE CONTROL AND PREVENTION (last reviewed May 23, 2019), <https://www.cdc.gov/ssp/syringe-services-programs-factsheet.html>.

¹² Id.

¹³ *Determination of Need for Syringe Services Programs*, CTR. FOR DISEASE CONTROL AND PREVENTION (last reviewed Feb. 7, 2020), <https://www.cdc.gov/ssp/determination-of-need-for-ssp.html>.

¹⁴ *Summary of Information on the Safety and Effectiveness of Syringe Services Programs (SSPs)*, CTR. FOR DISEASE CONTROL AND PREVENTION (last reviewed May 23, 2019), <https://www.cdc.gov/ssp/syringe-services-programs-summary.html>, citing Matthew V. Ronan & Shoshana J. Herzig, *Hospitalizations Related to Opioid Abuse/Dependence and Associated Serious Infections Increased Sharply, 2002-12*, HEALTH AFFAIRS 35:5, May 2016, at 832-837, [Hospitalizations Related To Opioid Abuse/Dependence And Associated Serious Infections Increased Sharply, 2002-12 | Health Affairs](https://doi.org/10.1371/journal.pone.0151111).

¹⁵ *Persons Who Inject Drugs (PWID)*, CTR. FOR DISEASE CONTROL AND PREVENTION (last reviewed July 19, 2018), <https://www.cdc.gov/pwid/index.html>.

- ¹⁶ See *Syringe Services Programs (SSPs)*, CTR. FOR DISEASE CONTROL AND PREVENTION (last reviewed May 23, 2019), <https://www.cdc.gov/ssp/index.html> and *Summary of Information on the Safety and Effectiveness of Syringe Services Programs (SSPs)*, CTR. FOR DISEASE CONTROL AND PREVENTION (last reviewed May 23, 2019), <https://www.cdc.gov/ssp/syringe-services-programs-summary.html>.
- ¹⁷ “Nearly 30 years of research has shown that comprehensive SSPs are safe, effective, and cost-saving, do not increase illegal drug use or crime, and play an important role in reducing the transmission of viral hepatitis, HIV and other infections.” CENTERS FOR DISEASE CONTROL AND PREVENTION, *Summary of Information*, *supra* note 10.
- ¹⁸ Alaska, Nevada, Oregon, Wisconsin, South Carolina, New Jersey, Connecticut, Rhode Island, Massachusetts, New Hampshire, and Maine.
- ¹⁹ CENTERS FOR DISEASE CONTROL AND PREVENTION, *Summary of Information*, *supra* note 10.
- ²⁰ *Id.*
- ²¹ *Id.*
- ²² *Id.*
- ²³ Hansel E. Tookes et al., *A Comparison of Syringe Disposal Practices Among Injection Drug Users in a City With Versus a City Without Needle and Syringe Programs*, DRUG AND ALCOHOL DEPENDENCE 123(1-3), June 2012, at 255-259, <https://www.sciencedirect.com/science/article/abs/pii/S0376871611005229?via%3Dihub>.
- ²⁴ *HIV Surveillance Reports*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed Aug. 5, 2021), <https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>.
- ²⁵ *Access to Clean Syringes*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed Aug. 5, 2016), [Access to clean syringes | Health Impact in 5 Years | Health System Transformation | AD for Policy | CDC](#).
- ²⁶ *HIV and People Who Inject Drugs*, CTR. FOR DISEASE CONTROL AND PREVENTION (last reviewed Aug. 6, 2021), <https://www.cdc.gov/hiv/group/hiv-idu.html>, citing *HIV Infection Risk, Prevention, and Testing Behaviors Among Persons Who Inject Drugs – National HIV Behavioral Surveillance: Injection Drug Use, 23 U.S. Cities, 2018*, CTR. FOR DISEASE CONTROL AND PREVENTION (Feb. 2020), <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-24.pdf>. Specifically, the percent who reported sharing syringes were 48 percent of persons aged 18-24, 44 percent of persons aged 25-29, and 39 percent of persons aged 30-39.
- ²⁷ *HIV and People Who Inject Drugs*, CTR. FOR DISEASE CONTROL AND PREVENTION (last reviewed Aug. 6, 2021), <https://www.cdc.gov/hiv/group/hiv-idu.html>.
- ²⁸ *Id.*
- ²⁹ CENTERS FOR DISEASE CONTROL AND PREVENTION, *Summary of Information*, *supra* note 10.
- ³⁰ *Id.*

ABOUT LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

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