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THE GENESIS OF SYRINGE PRESCRIPTION TO PREVENT HIV IN RHODE ISLAND

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INTRODUCTION

ACCESS TO STERILE SYRINGES is critical to lower the risk of transmission of HIV and other blood-borne pathogens among injection drug users (IDUs). Several strategies to increase access to sterile syringes among injection drug users have been tried, including needle exchange programs (NEPs), which have been replicated throughout the world.¹ In the United States, health officials have recommended that state and local laws be modified to allow the legal purchase and possession of syringes.² This has been done successfully in Connecticut, Min-

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¹ See Donald C. Des Jarlais & Samuel R. Friedman, *Research, in DIMENSIONS OF HIV PREVENTION: NEEDLE EXCHANGE* 63, 64 (Jeff Stryker & Mark D. Smith eds., 1993) (testing the possible positive and negative effects of needle exchange programs as a means of preventing the further spread of AIDS among IDUs).

² Organizations supporting syringe access include: the American Medical Association (AMA), the American Pharmaceutical Association (APhA), the Associa-

nesota, and Maine.³ An additional strategy is to have physicians prescribe syringes to injection drug users to decrease the risk of transmission of HIV and other blood-borne pathogens.⁴ To the best of our knowledge, only a few physicians, in rare situations, have tried this method of increasing access to sterile syringes. This strategy has the added advantage of bringing injection drug users into medical care, developing a physician-patient relationship, and increasing the potential for the provision of medical care to a population at high risk for disease. It can also facilitate access to social services, mental health services, and substance abuse treatment. This article will describe the genesis of physician syringe prescription in Rhode Island and some of the lessons learned to date.

BACKGROUND

Access to sterile syringes varies tremendously by state and is controlled by laws and regulations that are enforced, to varying degrees, in different regions.⁵ Rhode Island has had, perhaps, the strictest syringe control laws in the United States. Until recently, it was a felony offense to possess even a single syringe, punishable by up to five years in prison. This law was vigorously enforced, costing the state over \$1,000,000 per year

tion of State and Territorial Health Officials (ASTHO), and the National Alliance of State and Territorial AIDS Directors (NASTAD).

³ See CONN. GEN. STAT. ANN. § 21a-65 (West Supp. 2000) (permitting legal possession of ten or fewer syringes); ME. REV. STAT. ANN. tit. 17-A, § 1111 (West Supp. 1999) (defining "illegal possession" to include persons who intentionally or knowingly furnish or possess 11 or more syringes) and ME. REV. STAT. ANN. tit. 22, § 2383-B(2)(F) (West Supp. 1999) (exempting syringe exchange program (SEP) operators from prosecution); MINN. STAT. ANN. § 151.40(2) (West 1998) (permitting registered or licensed pharmacists to legally sell unused hypodermic needles and syringes in quantities of 10 or less); see also Linda A. Valleroy et al., *Impact of Increased Legal Access to Needles and Syringes on Community Pharmacies' Needle and Syringe Sales - Connecticut, 1992-1993*, 10 J. ACQUIR. IMMUNE DEFIC. SYNDR. & HUM. RETROVIROLOGY 73, 74 (1995) (permitting pharmacists and other health professionals to sell up to 10 syringes and individuals without medical purposes to possess up to 10 syringes).

⁴ See Josiah D. Rich et al., *Physician Syringe Prescription: A Pilot Intervention to Prevent HIV and Hepatitis*, (unpublished paper presented at the XIII International AIDS Conference, Durban, South Africa) (July 2000).

⁵ See Lawrence O. Gostin, *The Legal Environment Impeding Access to Sterile Syringes and Needles: The Conflict Between Law Enforcement and Public Health*, 18 J. ACQUIR. IMMUNE DEFIC. SYNDR. & HUM. RETROVIROLOGY S60, S61-S63 (Supp. I 1998) (examining the legal impediments to the sale and distribution of syringes in various states).

for incarceration costs alone.⁶ As a consequence, injection drug users in Rhode Island have had the highest reported syringe reuse rate (an average of 24 times per syringe) in the United States which correlated with syringe sharing.⁷ In addition, street prices for syringes are among the highest in the nation (\$5 per syringe).⁸

In fact, Rhode Island has had among the highest proportion of AIDS cases related to injection drug use; it is one of four states with over 50% of the AIDS cases associated with injection drug use.⁹ Injection drug use has been the leading risk factor associated with AIDS in Rhode Island since 1992. The high proportion of AIDS cases related to injection drug use is a direct consequence of syringe sharing due, in large part, to the strict legal control of the purchase and possession of syringes in Rhode Island.¹⁰

LEGAL ACCESS TO SYRINGES IN RHODE ISLAND

In response to a notification of the availability of funds from the American Foundation for AIDS Research (amfAR) to implement legal needle exchange programs, ACT-UP of Rhode Island and other activists introduced a bill, successfully passed by the Rhode Island legislature, allowing a legal pilot needle exchange program in 1994. This pilot program, by design, was

⁶ See Josiah D. Rich et al., *The Economic Cost of Strict Syringe Control*, 81 MED. & HEALTH/R. I. 207, 207 (1998) (noting that from 1994 to 1996, Rhode Island spent \$4,156,251 to incarcerate individuals violating syringe possession laws).

⁷ See Josiah D. Rich et al., *Strict Syringe Laws in Rhode Island Are Associated With High Rates of Reusing Syringes and HIV Risks Among Injection Drug Users*, 18 J. ACQUIR. IMMUNE DEFIC. SYNDR. & HUM. RETROVIROLOGY S140 (Supp. I 1998) (reporting that a syringe was reused on average 24 times).

⁸ See Josiah D. Rich et al., *High Street Prices of Syringes Correlate with Strict Syringe Possession Laws*, 26 AM. J. DRUG & ALCOHOL ABUSE 481, 483 (2000) (finding that street syringe prices were higher in regions where syringe possession laws were in place and higher still where laws were perceived as strictly enforced).

⁹ See Centers for Disease Control and Prevention, *AIDS Associated with Injecting-Drug Use - United States, 1995*, 45 MORBIDITY & MORTALITY WKLY. REP. 392 (1996) (indicating that IDU-associated AIDS accounted for more than 50% of cases reported from Delaware, Connecticut, Maryland, and Rhode Island).

¹⁰ See Gostin, *supra* note 5, at S61-S63 (arguing that legal restrictions regarding access to sterile syringes presents tough obstacles to HIV/AIDS prevention). See generally Lawrence O. Gostin et al., *Prevention of HIV/AIDS and Other Blood-Borne Diseases Among Injection Drug Users: A National Survey on the Regulation of Syringes and Needles*, 227 JAMA 53 (1997).

administered by the State Department of Health. By the time the legislation was passed, the amfAR funding had been utilized in other states. Even without this funding, the Rhode Island needle exchange program began in 1995 and was run entirely by volunteers on a "shoestring" budget in donated space.¹¹ Enrollment has steadily increased to over 1,700 participants. This is approximately 15% of the estimated 10,000 injection drug users in the state. The few hours of operation and locations (initially only four hours per week and in only a single location, currently 12 hours per week in two locations) have limited enrollment and ongoing participation, especially among minorities.¹² However, the program continues to expand, and for the first time, received substantial funding from the Rhode Island Department of Health in 1999.¹³

Additional efforts to increase injection drug users' access to sterile syringes to prevent the transmission of HIV and other blood-borne diseases has led to an effort to change the laws regulating syringe possession in Rhode Island. In 1996, the Rhode Island Medical Society's board unanimously voted to support a policy of syringe decriminalization. This action led to the Rhode Island Medical Society-sponsored legislation to remove legal penalties for syringe possession, which was defeated by one vote in the state legislature in 1997. In 1998, a compromise bill was passed that reduced the penalty for syringe possession from a felony to a misdemeanor without jail time. This has led to a dramatic decrease in arrests for the possession of syringes. A survey of public places known to be high drug use areas has shown no increase in discarded syringes in the year since the law was changed.

However, syringe re-use among injection drug users has only slightly decreased and still remains higher than most other states (an average re-use of 14 times). In addition, there has

¹¹ See Peter Lurie & Ernest Drucker, *An Opportunity Lost: HIV Infections Associated with Lack of a National Needle-Exchange Programme in the USA*, 349 LANCET 604 (1997) (examining the correlation between the absence of a national needle-exchange program and preventable HIV infections); see also David Vlahov & Benjamin Junge, *The Role of Needle Exchange Programs in HIV Prevention*, 113 PUB. HEALTH REP. 75 (Supp. I 1998).

¹² See Josiah D. Rich et al., *Obstacles to Needle Exchange Participation in Rhode Island*, 21 J. ACQUIR. IMMUNE DEFIC. SYNDR. 396, 397-99 (1999).

¹³ See Josiah D. Rich et al., *Strategies to Optimize the Impact of Needle Exchange Programs*, 10 AIDS READER 421 (2000).

been no change in the street price of syringes since the change in the law. Anecdotal reports suggest that many injection drug users are still reluctant to carry their syringes and, despite the decrease in the penalty for possession, it is still illegal to purchase or sell a syringe without a prescription. Legislation to allow the legal purchase and possession of syringes, without a prescription, has just been passed by the state legislature and became law in September 2000.

PHYSICIAN SYRINGE PRESCRIPTION IN RHODE ISLAND

In 1997, Lawrence O. Gostin, J.D. and Zita Lazzarini, J.D., M.P.H., conducted a nationwide review of the state laws regulating syringe possession.¹⁴ Lazzarini pointed out that syringes could technically be prescribed in Rhode Island, at the discretion of the Director of the State Department of Health.¹⁵ The Director of the Rhode Island Department of Health was initially concerned about the potential for the abuse of syringe prescription by unscrupulous physicians.

However, with the support of the Rhode Island Medical Society, the Rhode Island Pharmacists' Association, the Rhode Island Board of Medical Licensure and Discipline, and the Rhode Island State Board of Pharmacy, the current Director of the Department of Health, Dr. Patricia Nolan, sent a memo describing the "Rhode Island Blood Borne Pathogen Harm Reduction Program" to all licensed physicians in the state in the spring of 1999.¹⁶ This memo states that it is clearly legal to prescribe syringes with the support of the Department of Health:

The Department of Health is inviting interested physicians to participate in a clinical program to offer syringes by prescription to injecting drug users in order to prevent acquiring bloodborne pathogens and/or transmitting them . . . To participate, a physician will need to agree to the following:

¹⁴ Lawrence O. Gostin & Zita Lazzarini, *Prevention of HIV/AIDS Among Injection Drug Users: The Theory and Science of Public Health and Criminal Justice Approaches to Disease Prevention*, 46 EMORY L.J. 587 (1997).

¹⁵ Personal communication by author with Zita Lazzarini, 1997.

¹⁶ Memorandum from Dr. Patricia Nolan, Director of Health, on the Rhode Island Bloodborne Harm Reduction Program (Feb. 25, 1999) (on file with author).

- Agree to document this care in medical record, including the assessment of risk of disease transmission and on-going substance abuse management.
- Make syringe prescription a part of the patient's on-going medical care;
- Include other harm reduction strategies in the patient's care;
- Assist patients in disposing of used syringes safely, and
- Notify the pharmacy at the time of initial prescription.¹⁷

It took a considerable amount of time and effort to establish this degree of local support for physician syringe prescription to prevent HIV and other diseases.

RHODE ISLAND PHYSICIAN SURVEY

In the spring of 1999, concurrent with the above-noted memo, we performed a survey of all infectious disease and addiction medicine physicians in Rhode Island.¹⁸ Eighty percent of the 49 eligible physicians responded. The results are shown in Table 1. The selected sample of physicians had extensive experience with injection drug users and patients with HIV or AIDS. A majority of the physicians were also currently providing care for injection drug users and patients with HIV infection.

The results of the survey appear to indicate that most of the physicians believed that syringe prescription would be a useful and necessary tool in reducing the transmission of blood-borne pathogens. Furthermore, almost all of the physicians indicated that they would prescribe syringes if it were clearly legal. Several physicians had been asked by IDU patients for syringes, and many suspected that diabetic patients were using their sy-

¹⁷ *Id.*

¹⁸ See Josiah D. Rich et al., *Prescribing Syringes to Prevent HIV: A Survey of Infectious Disease and Addiction Medicine Physicians in Rhode Island*, 35 SUBSTANCE USE & MISUSE (forthcoming 2000).

ringes for purposes other than insulin injection. Despite their understanding of the issue and willingness, none of the physicians had ever prescribed a syringe for the express intent of preventing disease among injection drug users.

One of the major obstacles impeding syringe prescription is the perception surrounding its legality. A number of physicians completed and returned the survey before receiving the memo from the Rhode Island Department of Health affirming the legality of providing syringes in the state. However, this does not account for the incorrect understanding that the majority of the physicians had about the law. Indeed, many physicians expressed concern or uncertainty about losing their medical licenses and/or getting sued if they prescribed syringes. If syringe prescription is to be a viable public health strategy, physicians will need to be educated and reassured about the related laws.

In summary, among a selected group of physicians with extensive experience treating injection drug users, there is, at least, a willingness to consider syringe prescription to prevent HIV transmission. It is unclear how these findings may be generalized to other physicians in other specialties and/or in other states.

WHICH INJECTION DRUG USERS SHOULD BE ELIGIBLE FOR SYRINGE PRESCRIPTION?

In the 1995 report of the National Research Council and the Institute of Medicine, it was stated that "for injection drug users who cannot or will not stop injecting drugs, the once-only use of sterile needles and syringes remains the safest, most effective approach for limiting HIV transmission."¹⁹ Therefore, any active injector could potentially benefit from, and should be eligible for, the legal provision of syringes by prescription. The provision of syringes to an active injection drug user to help him or her move towards the goal of "once-only use of sterile syringes" is an adequate goal in itself. This is especially true in a state where syringe access is strictly controlled and IDUs report high rates of syringe re-use. Equally important is the goal of

¹⁹ PANEL ON NEEDLE EXCH. & BLEACH DISTRIB. PROGRAMS, NAT'L RESEARCH COUNCIL & INST. OF MED., PREVENTING HIV TRANSMISSION: THE ROLE OF STERILE NEEDLES AND BLEACH 2 (Jacques Normand et al. eds., 1995).

reducing syringe sharing which should dramatically decrease the transmission of blood-borne diseases.

A major concern about the provision of syringes to injectors is the potential for syringes to act as a "trigger" or a stimulant for an injection drug user to inject. This is more important when a person is in remission from his or her addiction or trying to abstain. The best way to minimize the effect of syringes acting as a "trigger" is to educate the client about this possibility. However, syringes are certainly not the only "trigger" and it is always possible to get a syringe, but not always possible to find a sterile one. This is not a reason to not prescribe syringes, but an issue that should ideally be discussed with each patient, so that this effect may be minimized.

MEDICAL PROBLEMS OF INJECTION DRUG USERS

The provision of syringes, although adequate in itself to justify prescribing, is only a part of the potential benefit. By definition, the prescription of syringes involves a physician-patient relationship (or perhaps a health care provider/patient relationship in the case of physician assistants or nurse practitioners) for a group that is at high risk for many diseases, and who often do not access health care.

Even prior to the HIV epidemic, injection drug users were known to be at much higher risk for mortality than the general population. In New York City between 1965 and 1972, the death rate of adult heroin users aged 24 to 54 years was estimated to be five times greater than that among age-matched non-heroin-addicted adults (28.2 per 1000 vs. 5.6 per 1000).²⁰ Violence (including murder and suicide), narcotic overdose, and infections have accounted for many preventable deaths among injection drug users.²¹ Infections associated with injection drug use include hepatitis, cellulitis, endocarditis, abscesses, pneumonia, sexually transmitted diseases, and tuberculosis. Characteristics of injection drug use which contribute to the transmission of viral, bacterial, and parasitic microorganisms are un-

²⁰ See Gerald H. Friedland & Peter A. Selwyn, *Infections (Excluding AIDS) in Injection Drug Users*, in HARRISON'S PRINCIPLES OF INTERNAL MEDICINE 831 (Anthony S. Fauci et al. eds., 14th ed. 1998).

²¹ See Frederick P. Rivara et al., *Alcohol and Illicit Drug Abuse and the Risk of Violent Death in the Home*, 278 JAMA 569, 573-74 (1997).

sterile injection technique, contaminated water used to dissolve drugs or rinse equipment afterward, and shared injection equipment.²²

In our experience, the primary causes of death for HIV infected addicts with CD4 counts above 200 (generally prior to the development of AIDS) are related to injection drug use. In a recent study of HIV-positive women who died at our center, 18 out of 100 died before developing AIDS.²³ Seventeen of the 18 were injection drug users. Ten died of an overdose, one of endocarditis, one of alcohol-related cirrhosis, one of alcohol-related pancreatitis, and one of homicide related to narcotics.

It is estimated that 29% of hepatitis-related deaths are IDU-associated. There were more than two million drug-related cases of hepatitis in 1995. Estimates range between 70% to 90% of injection drug users that have positive tests for hepatitis C. Up to 85% of people with hepatitis C will develop chronic hepatitis. Liver failure due to chronic hepatitis C is the leading cause of liver transplants in the United States.²⁴

Access to medical care can help to identify, treat, and prevent many of these diseases. This includes sexually transmitted disease screening and treatment, HIV and hepatitis B and C screening, hepatitis B vaccination, tuberculosis screening, pap smear testing, and general primary care, ideally with "one-stop-shopping."

BARRIERS TO MEDICAL CARE AMONG INJECTION DRUG USERS

Injection drug users also have substantial barriers to receiving medical care. The subculture created to sustain the illegal activities of injection drug users also makes them a "hidden" population with limited access to primary health care. Care is hindered by availability as well as by the fear of moral judg-

²² See Friedland & Selwyn, *supra* note 20, at 831-35.

²³ See E. Mylonakis et al., *Substance Abuse is Responsible for Most Pre-AIDS Deaths Among Women with HIV Infection in Providence, Rhode Island, USA*, 12 AIDS 958, 959 (1998).

²⁴ See J. Michael McGinnis & William H. Foege, *Mortality and Morbidity Attributable to Use of Addictive Substances in the United States*, 111 PROC. ASS'N AM. PHYSICIANS 109, 114-15 (1999); see also Lorna E. Thorpe et al., *Hepatitis C Virus Infection: Prevalence, Risk Factors, and Prevention Opportunities Among Young Injection Drug Users in Chicago, 1997-1999*, 182 J. INFECTIOUS DISEASES 1588 (2000).

ment or even legal reprisal when injection drug users access traditional health care services. There exists a tremendous amount of fear and mistrust about the medical establishment, in part because of the response injection drug users get when their injection practices are revealed. In addition, injection drug users (as is true of other chemically dependent individuals) often lead unstable, chaotic lives which make it less likely that they will have the perseverance to make and keep an appointment for a medical visit several weeks in advance. This tendency not to keep scheduled appointments is one reason that injection drug users may be viewed as undesirable patients in the medical provider community. They may be less likely to comply with prescribed treatments, keep appointments, and tolerate delays in obtaining an appointment for treatment.²⁵ These characteristics do not blend well with high threshold facilities nor with practitioners who are not accustomed to an addicted patient population.

Economic and social barriers also prevent injection drug users from accessing existing services. These barriers include a higher incidence of unemployment, poverty, and homelessness with a concomitant lack of medical insurance and transportation. There are a myriad of systematic and individual barriers to medical care that result in low levels of health care for a population at high risk for disease. Providing low threshold access to primary care is possible in a variety of ways—these include

²⁵ See David Bangsberg et al., *Protease Inhibitors in the Homeless*, 278 JAMA 63, 63 (1997) (stating that problems of treatment adherence in the homeless population are demonstrated in tuberculosis studies and therefore raise similar concerns for drug users and antiretroviral therapy); see also David D. Celentano et al., *Self-Reported Antiretroviral Therapy in Injection Drug Users*, 280 JAMA 544, 545 (1998) (commenting that unstable living conditions of intravenous drug users affect antiretroviral therapies prescribed by healthcare providers); Patrick G. O'Connor et al., *Medical Care for Injection-Drug Users with Human Immunodeficiency Virus Infection*, 331 NEW ENG. J. MED. 450, 455 (1994) (arguing that the lack of primary care among HIV-infected injection drug users causes delays in treatment and prolonged hospitalization); Mark Senak, *Predicting Antiviral Compliance: Physicians' Responsibilities vs. Patients' Rights*, J. INT'L ASS'N PHYSICIANS IN AIDS CARE, June 1997, at 45 (noting that a holistic approach may be needed to attain compliance with drug regimens); Deborah Sontag & Lynda Richardson, *Doctors Withhold H.I.V. Pill Regimen from Some: Failure to Follow Rigid Schedule Could Hurt Others, They Fear*, N.Y. TIMES, March 2, 1997, at A1; Steffanie A. Strathdee et al., *Barriers to Use of Free Antiretroviral Therapy in Injection Drug Users*, 280 JAMA 547 (1998).

storefront clinics in low-income neighborhoods,²⁶ mobile health clinics (vans), clinics associated with drug treatment facilities,²⁷ and clinics created in conjunction with NEPs and other community services. Providing services in a manner that is cognizant and respectful of patients, such as drop-in hours, appointment flexibility, and nonjudgmental interactions helps overcome barriers to access. Language competency, provision of child care, provision of bus or cab tokens, and diversity of staff are all examples of gender, racial, and cultural sensitivity which expand access to care for marginalized populations. Finally, since a major obstacle is the lack of insurance, the availability of free or sliding scale services is essential to providing care to injection drug users as well as other substance abusers.

BARRIERS TO SUBSTANCE ABUSE TREATMENT AMONG INJECTION DRUG USERS

There exist substantial barriers to substance abuse treatment as well. Though substance abuse treatment has repeatedly been demonstrated to be effective in reducing drug use and its harmful sequelae, most injection drug users are not engaged in treatment. It is estimated that only one of six injection drug users is in treatment at any given time.²⁸ Given the chronic, relapsing nature of addiction, it is common for injection drug users to enter treatment in a "revolving door" fashion. They tend to have an unstable and sporadic involvement in treatment over time.²⁹ In 1998, 40% of the 2,425 in-patient admissions for medical detoxification services in Rhode Island left prior to

²⁶ See Nathaniel Gunn et al., *Primary Care as Harm Reduction for Injection Drug Users*, 280 JAMA 1191 (1998) (noting that a primary care clinic targeting the IDU population benefitted both drug users and student physician knowledge).

²⁷ See Patrick G. O'Connor et al., *Human Immunodeficiency Virus Infection in Intravenous Drug Users: A Model for Primary Care*, 93 AM. J. MED. 382 (1992) (providing primary care in conjunction with treatment facilitated compliance among HIV-infected intravenous drug users).

²⁸ See Robert E. Booth et al., *Facilitating Treatment Entry Among Out-of-Treatment Injection Drug Users*, 113 PUB. HEALTH REP. 116, 118 (Supp. I 1998) (reporting on the effectiveness of intervention strategies targeting out-of-treatment IDUs).

²⁹ See David S. Metzger et al., *Drug Abuse Treatment as AIDS Prevention*, 113 PUB. HEALTH REP. 97, 98 (Supp. I 1998).

program completion.³⁰ These gaps in treatment place individuals at renewed and increased risk for HIV infection.³¹

Barriers to treatment are described in a National Institute on Drug Abuse (NIDA) funded ethnographic study of 70 out-of-treatment heroin addicts.³² These barriers included high-threshold programs such as those with long waiting lists and few available subsidized treatment slots. Many participants lived on public assistance and supplemented their incomes with illicit activities. Payment of private fees for methadone maintenance was often out of the question. Without relying on involvement in illegal activities, they are unable to pay private fees since welfare income barely finances basic needs. Treatment intake procedures were time-consuming, complicated, and demanding. Examples of wait-listing included daily call-backs to prove their motivation or being put on a wait-list to call back in a month or several months. This process was made all the more difficult as many participants were without phones or permanent residences.

Certainly not all barriers to substance abuse are institutional. Both the physical and psychological addictions of heroin or cocaine are powerful motivators for continuing to inject. Drug use in general is often a coping mechanism for dealing with past or current traumas. Addressing those traumas without the benefit of drugs may be overwhelming for many individuals. Additionally, "getting clean" may entail giving up social networks that have been an important, if not healthy, part of the injector's life. There is no doubt that many substance users perceive benefits to continued injection drug use and the act of entering treatment to be fraught with indecision. It is precisely this indecision which can be influenced by a trusting physician-patient relationship.

Physician syringe prescription can act as a tool for outreach to a high risk, and often out-of-treatment population of drug users. It is a way to tap into drug-using networks and bring those

³⁰ See Rhode Island Dep't of Health, *Health by Numbers* (Apr. 1998).

³¹ See Diana M. Hartel & Ellie E. Schoenbaum, *Methadone Treatment Protects Against HIV Infection: Two Decades of Experience in the Bronx, New York City*, 113 PUB. HEALTH REP. 107, 112 (Supp. I 1998) (finding that longer time in treatment is associated with a lower probability of HIV infection).

³² See Lynn D. Wenger & Marsha Rosenbaum, *Drug Treatment on Demand—Not*, 26 J. PSYCHOACTIVE DRUGS 1, 2-4 (1994) (analyzing the effect of the lack of on-demand drug treatment).

populations into a care system. Moreover, syringe prescription is appropriate at whatever stage an injector is in—initial use, prolonged use, relapse, and possibly even recovery. At each step, interest in and access to substance abuse treatment should be addressed.

PHYSICIAN SYRINGE PRESCRIPTION STUDY

In order to evaluate the feasibility, acceptability, and outcome of physician syringe prescription, we have begun a pilot program in Providence, Rhode Island. This program, and its evaluation, began with funding from the Open Society Institute and the American Foundation for AIDS Research. Additional funding from the Center for Substance Abuse Treatment (CSAT) to evaluate the physician-patient motivational intervention has been recently awarded. The program is situated at two locations, an academic teaching hospital and an inner city community clinic. We began enrolling clients in the spring/summer of 1999. We have an active recruitment program, which includes flyers, word-of-mouth, and business cards, with a toll-free telephone number. We have approached injection drug users in medical care, especially HIV infected individuals. We have also worked closely with prison discharge planners, drug treatment, and detoxification programs, including methadone maintenance programs and street outreach in high drug use areas.

Participants undergo a five-minute telephone screening to determine eligibility, and if they qualify, they are scheduled for an evaluation that involves a 30-40 minute administered questionnaire. The medical visits are then arranged, and often occur on the same day as the baseline evaluation. Participants are reimbursed for the baseline evaluation (\$10), a three-month evaluation (\$20), a six-month evaluation (\$25), and a 12-month evaluation (\$30). Medical visits are scheduled as often as needed. The staff currently includes four physicians, one substance abuse referral specialist, one nurse, two interviewers, and one administrator. To date (December 15, 2000), we have had 413 phone screens, of whom 338 have been successfully enrolled and 295 have been seen by a physician.

Syringes are prescribed, usually 100 at a time, and additional syringes are prescribed by the physician as often as necessary to prevent the reuse and sharing of syringes. Syringes are provided for free to the clients with private funding. Patients are

instructed on safe injection and safe disposal and encouraged to either return syringes or dispose of them appropriately, in accordance with the Rhode Island Department of Health recommendations. Biohazard containers are provided for free. Pharmacists are notified at the time of the first prescription and only two designated pharmacies have been utilized, thus far. Other clients have been the most common source of referrals.

PRELIMINARY IMPRESSIONS AND ISSUES

When the physician-patient relationship begins with the acknowledgement of injecting behaviors, there is an enhanced element of trust and confidence. Anecdotally, patients seem to be comfortable in accepting help and advice, and being more open and honest. This facilitates the provision of medical care and increases the possibility of participating in other services, including psychiatric care and substance abuse treatment services.

(1) Initial recruitment was slower than anticipated. We thought that with a street price of syringes at five dollars, some individuals might participate in the study in order to sell syringes. This does not seem to be happening to any great extent. Clients are not selling syringes at a high rate and they are not refilling syringe prescriptions more than they seem to use them. They have anecdotally reported providing syringes to others in need. Almost all have reported decreased syringe sharing or syringe reuse. Two individuals, after an initial interview with a physician, when offered the option, chose to go immediately into drug treatment. After this decision was made, they both were again offered free sterile syringes, in case they needed them. They both decided not to receive the syringes. Several others have specifically requested less than a hundred syringes. More recently enrollment has dramatically increased through word-of-mouth.

(2) The participants seem to be open and honest about their drug use and understand that physicians are trying to help them in a non-judgmental way, and they are quite appreciative of the physician's efforts. Participants are extremely willing to participate in healthcare including hepatitis B vaccination, HIV, hepatitis C, sexually transmitted disease, and tuberculosis testing and follow-up.

(3) The physician-patient interaction based on the acknowledgement of injecting behaviors seems to open the door for discussing a whole host of injecting related activities including prostitution, participation in the underground economy, violence, and abuse. As a physician, one has an opportunity to see how chaotic the lives of some of these individuals are, and how many of them are at extremely high risk for transmission of infectious diseases, as well as other medical illnesses, psychiatric and psychological disorders, and violence.

(4) Most participants generally report appropriate disposal of syringes. However, despite the provision of free biohazard containers, and encouragement to return used syringes to the clinic, few do so. Most are concerned that contaminated syringes will be used by others and therefore report breaking the tips off prior to disposing them in puncture-proof containers. However, there is a reluctance among many to carry a large number of syringes back to the program. As nearly half are homeless, many prefer not to even have the biohazard containers.

(5) Some clients report being reluctant to use a single syringe only once ("it seems like a waste"), which is not surprising given that once-only use is very different from what most drug injectors in Rhode Island are used to. It may take time and a consistent supply of syringes to change some injecting practices, such as syringe reuse.

CONSIDERATIONS FOR OTHERS WHO WOULD CONSIDER PRESCRIBING SYRINGES TO INJECTION DRUG USERS IN OTHER LOCATIONS

(1) Know the law. It is important to clarify, or at least know, the local legal status of prescribing syringes. As we were the first to prescribe on a large scale, we believed that it was important to be certain that what we were doing was legal.

(2) Document in the medical record the need for and rationale for prescribing syringes, and that attempts at alternative options were tried (such as referral to substance abuse treatment).

(3) Seek local support. We received considerable local support. Again, being that we were the first, this level of support may not be a necessary prerequisite, but the more support the better.

(4) Evaluate outcomes if possible. As with any new and unproven strategy, it is helpful to have data to evaluate this strategy and convince others to support it.

(5) It is critically important to create linkages to other programs that can assist this population, especially substance abuse treatment programs.

CONCLUSIONS

Physician syringe prescription for injection drug users is feasible. There have been no major problems, and the physician-patient and the pharmacist-patient interactions have gone well. It is too early to tell the long-term effects of this intervention on ongoing risk behavior, drug use, or participation in medical, social, and substance abuse treatment services, but these are current areas of study. Physician syringe prescription can be extremely rewarding from the physician's standpoint, and other physicians may be encouraged to begin prescribing syringes to injection drug users. In addition to the benefit of providing legal access to sterile syringes for injection drug users, syringe prescription creates an opportunity to provide medical, social, psychiatric, and substance abuse treatment to a population in desperate need.

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Table 1: Physicians' Opinions

Statement	Agree	Disagree	Unsure
I would prescribe syringes to prevent disease in an IDU if it were clearly legal to do so.	72%	5%	23%
It is currently legal to prescribe syringes in Rhode Island to prevent disease in IDUs.	26%	56%	18%
There is a legitimate medical reason for injection drug users to obtain sterile syringes.	95%	0%	5%
It is not the role of physicians to provide IDU patients with syringes to inject illegal drugs.	8%	79%	13%
I am opposed to prescribing syringes to injection drug users on moral/ethical grounds.	3%	95%	3%
Syringe prescription should involve referrals for addiction treatment.	87%	8%	5%
Syringe prescriptions should be strictly monitored with a heavy emphasis on entering drug treatment.	69%	18%	13%
My medical license might be in jeopardy if I prescribe syringes to IDUs.	28%	38%	31%
I might get sued if I prescribe syringes to IDUs.	28%	33%	36%
Injection drug users would make my office less comfortable for other patients.	26%	59%	8%

