HIV Outbreak Triggers Substance Abuse Policy Changes

By Shawntaye Hopkins

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On the front page of the March 25 edition of Indiana’s *Floyd County News and Tribune*, a syringe lying in dirt and grass is pictured underneath two, bold words: An Outbreak.

Austin, Ind., a city of about 4,200 people in Scott County, Ind., off Interstate 65, has been the epicenter of an HIV outbreak, said Maureen Hayden, statehouse bureau chief for CNHI Indiana Newspapers. HIV has spread among intravenous drug users and more than 170 cases have now been reported.

“For it to occur in a small community—a small, poor, rural community—among IV drug users ... was startling and helps explain, in part, why I think many people were unprepared for how fast this erupted and how to respond,” Hayden said.

Hayden, a reporter who continues to cover the outbreak in southeast Indiana, was one of three presenters who discussed Indiana’s situation and substance abuse treatment options during a recent CSG eCademy webcast, “Harm Reduction: Needle-Borne Disease and Substance Abuse.”

Indiana Gov. Mike Pence declared a public health emergency as the crisis escalated.

“It triggered a lot of resources being devoted to Austin and to Scott County,” Hayden said of the declaration. “It just opened the door for many, many resources to go rushing down into this community.”

Many individuals in the area lacked health coverage, Hayden said, and the state started to sign them up for Indiana’s expanded Medicaid program. The state also lifted a ban on needle-exchange programs on a county-by-county basis.

Indiana state Rep. Ed Clere said the HIV outbreak highlighted a number of things, including an opioid problem—particularly with the prescription drug Opana—in the state that is also being experienced throughout the country.

“The Scott County situation involved the injected use of Opana, and there was a lot of focus on that, but it just as easily could have been heroin or another injected drug,” said Clere, who is also chairman of the House’s Public Health Committee and chairman of CSG’s national Health Public Policy Committee.

Clere said the needle-exchange bill would not have passed without the crisis although some legislators remained reluctant to support it.
“A year earlier, we couldn’t even pass a bill allowing for the study of needle exchange,” he said. “And a year later we’re actually doing syringe exchange, so it was quite a transformation.”

Clere said needle-exchange programs must be initiated locally and then approved by the state. The county health officer has to find that there is an epidemic of HIV or hepatitis C, that the primary mode of transmission is intravenous drug use and that syringe exchange is medically appropriate as part of a comprehensive response to the epidemic.

“Opioid dependence has reached a critical level in the United States,” said Courtney Cunningham, program director of the New England Comparative Effectiveness Public Advisory Council. “The epidemic has been largely driven by overprescribing and diversion of opioid painkillers as well as the low cost and increased potency of heroin.”

The options for treating opioid addiction are very different from the options for treating other addictions, Cunningham said.

“There are currently no FDA-approved medications to treat addiction to cannabis, cocaine or methamphetamine, but there are options for treating opioid addiction,” she said.

Medications for treating opioid addiction include methadone, buprenorphine, naltrexone (Revia and Vivitrol), and a combination of buprenorphine and naloxone (Suboxone). Studies have shown that programs that treat opioid addiction using a medication are superior to short-term detox. The council has recommended policy changes that improve access to medications such as methadone.

“As many of you know, opioid addiction is powerful and without boundaries,” Cunningham said. “It’s our hope that through robust research and informed dialogue and thoughtful policy changes, we may be able to alter the trajectory of this harrowing epidemic.”

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