

Surgeon General's Warning

Jerome M. Adams, MD, MPH, is an anesthesiologist, a vice admiral in the U.S. Public Health Service Commissioned Corps, and currently the 20th Surgeon General of the United States. Prior to becoming surgeon general, he served as the Indiana State Health Commissioner from 2014 to 2017. In January he spoke at a Cato policy forum moderated by Cato Senior Fellow Jeffrey A. Singer, MD, on the benefits of a harm reduction approach to opioid addiction.

I'm thrilled to be here to discuss the important role of syringe service programs, and I very much want to thank Cato for hosting this great conversation. Today in America, over two million people struggle with an opioid use disorder.

But the fact is, our fervor to address the root causes of addiction means that many people have transitioned from prescription opioids to heroin and to fentanyl. Consequently, we've seen a significant increase in intravenous drug use and related morbidity and mortality, including an explosion of infectious diseases linked to injection drug use. This new and unfortunate reality has impacted families, not only across the country, but likely right here in this very audience. As some of you know, my own baby brother Philip is currently serving a 10-year prison sentence for crimes he committed to support his addiction. Phillip suffered from untreated anxiety and depression, and he turned to drugs to self-medicate. I share his story and my family's struggle to show that Americans across the political spectrum suffer from addiction, and that addiction can happen to anyone.

We'd like to think that addiction happens to people who come from bad families. Well, my family managed to raise the surgeon general of the United States. I'd like to think that there are a lot of families out there who'd be proud to say that about their child. My family also raised a son who is about an hour away from here right now in prison. And I share my story because I

hope to give others the courage to share their stories so that together we can fight stigma. I truly believe that stigma is one of our biggest killers. Unless our loved ones and their families and friends feel comfortable seeking help, we'll never reach those who need it the most. Often people who misuse drugs are in a state of poor mental and physical health, and they're hesitant to seek treatment due to the stigma of addiction. I didn't know that my brother was using injection drugs until he was incarcerated, but there's a proven biological component to addiction.

It is not a matter of simply having the willpower to just say "no." I'll put it another way. There is no one in America who woke up this morning and said, "Today, I'm going to become addicted to drugs." Opioid addiction can occur very quickly, often after just a few uses. Individuals who stop can experience extremely uncomfortable withdrawal symptoms. It's important for us to understand today, in the context of the conversation we're having, that instead of using to get high, most chronic IV drug users are seeking to alleviate the sickness that comes with extreme withdrawal. Opioid addiction can be extremely difficult to defeat, as I can attest to from witnessing my own brother's challenges. But the fact is that recovery is possible with the right support and resources. And at its core, that's what our discussion today is all about: recognizing that addiction is a disease; that it can afflict and affect any person, any family, any community; and that as with other

diseases, we have evidence-based treatments that can help people recover.

But due to stigma, many of our most effective treatments are being underutilized. I want to talk about syringe service programs, because they're one of those underutilized treatments. Syringe service programs are scientifically proven to improve and to save lives, whether it's in urban Washington, DC, or rural Scott County, Indiana. Opioid addiction is so powerful. People who use drugs will often inject wherever they can and with whatever needles they can. As part of my experience in Scott County, we actually sat down with many people who inject drugs, and I've spoken to IV drug injectors who report using the same needle over and over again until it literally breaks off in their vein.

Think about that. Think about a needle breaking off in your arm while you're injecting. By facilitating sterile syringe access and disposal, syringe service programs (SSPs) not only reduce costly and potentially deadly medical complications, such as skin abscesses and endocarditis, but importantly, they connect people who inject drugs with mental health and addiction treatment services, such as medication-assisted treatment or MAT, so they can break a vicious cycle.

We have a lot of science behind the fact that the needle exchange component is important for preventing the spread of infectious diseases, but there's also an array of other services that are provided. Participants in comprehensive syringe service programs are five times more likely to enter drug treatment and three and a half times more likely to cease injecting compared to those who don't use syringe service programs. Decades of research show that syringe service programs do not increase crime or drug consumption and are, in fact, cost-saving. The lifetime cost for a single

HIV case is estimated to be in the hundreds of thousands of dollars. Hepatitis cases can also easily be well into the hundreds of thousands of dollars if you get someone who ends up with cirrhosis and needs a liver transplant.

Providing that 10-cent needle and that connection to other services has been proven time and time again to be cost-saving. SSPs also, as I mentioned, play a critical role in reducing infectious disease outbreaks that are often associated with the opioid epidemic, such as HIV and hepatitis. From 2010 to 2016, there's been a three-and-a-half-fold increase in reported cases of hepatitis C, coincident with the spread of the opioid epidemic. And the majority of those new cases have been linked to injection drug use. SSPs are associated with a 50 percent decline in the risk of HIV and hepatitis C transmission; and when linked to substance use treatment, they prevent even more infections.

Nearly 1 in 10 HIV infections in the United States is linked to injection drug use. That's why syringe service programs are a strategic part of HHS's Ending the HIV Epidemic initiative, the nation's 10-year plan to reduce HIV infections in the United States by 75 percent in five years and by 90 percent by 2030.

One of the more tragic consequences of the opioid epidemic has been the meteoric rise in opioid overdoses and deaths. There's currently a person dying of an opioid overdose every 11 minutes in this country, and I have to tell you, there's not a day that I don't think about that statistic. It really breaks my heart to have to go and visit my brother while he's incarcerated. The one blessing is that he's still alive, and that's not the case for far too many families out there. And that's why I'm underscoring the importance of syringe service programs as distribution points for Naloxone.

Naloxone, or in other forms known as Narcan or Evzio, is an opioid overdose reversal agent proven to save lives. It can res-

cue someone from a potentially fatal overdose by restoring a person's ability to breathe, a process which may slow and eventually stop when a person overdoses on opioids. In an effort to reduce opioid overdose mortality, my office is focused on putting Naloxone in the hands of all first responders and as many people in the community as possible.



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In April of 2018, I issued the first Surgeon General's Advisory in more than 10 years, highlighting the importance of Naloxone access as a way to curb opioid morbidity and mortality. We know that over 50 percent of the overdoses that occur in this country aren't occurring on a street or in a back alley. They're occurring at home or outside of a medical setting. And just as with CPR, we have a very limited time to respond. The fact is Naloxone can be easily injected or nasally sprayed. What I have here is Evzio, the take home, intra-nasal version of Naloxone. If you see someone who's non-

responsive, who you suspect is having an opioid overdose, you simply put it in their nostril and press. That's how easy it is to save a life.

Any one of you can save a life if you have Naloxone on hand and know how to use it, and that's critically important to understand. We taught all of America about CPR. The truth is, it's more likely when you walk out of the Cato Institute today that someone's going to walk up to you and say, “We need you to respond to an opioid overdose,” than “We need you to respond to someone who's having a cardiac arrest.”

Syringe service programs are a proven way to get Naloxone in the hands of those most likely to witness an opioid overdose. In addition to the benefits already mentioned, SSPs can also provide vaccinations, serve as touchpoints for testing and treatment of STDs, and connect people to primary care treatment, because—guess what?—people who are injecting drugs, that's not their only problem. In my opinion, the biggest benefit of syringe service programs lies in building trust with those who have a substance use disorder. And again, remember, I started by talking about stigma, because that divide keeps people from getting the services that they need. Syringe service programs are a platform for building trust. I observed these benefits and more during my tenure as state health commissioner of Indiana when I oversaw the response to the nation's largest-ever outbreak of HIV related to injection drug use. The small town of Austin, Indiana, about 4,000 people, had 3 total HIV cases in the previous decade, and then in a little over a year and a half had over 200 cases of HIV related to injection drug use.

The fact is, public health professionals, myself included, often lecture others about what they should be doing without actually taking the time to ask people about their priorities and their concerns. But just as the opioid epidemic is occurring at the community level, so too must solutions have local

buy-in and be locally led. I am a big, big proponent of the adage that people need to know that you care before they care what you know. And that's why in Indiana, I didn't try to solve the HIV outbreak from behind a podium in Indianapolis. I drove two hours to rural Scott County and learned that the local sheriff was worried about needles being found in public areas and his officers getting pricked by hidden syringes when searching subjects.

If you're a sheriff, those are truly legitimate concerns. I shared with the sheriff how syringe service programs have actually been proven to decrease needles found in public areas, been proven to reduce needle stick injuries to officers by 60 percent. But if I had said that from behind a podium in Indianapolis, it wouldn't have mattered. Sitting down across from the sheriff and having a sandwich with him and hearing out his concerns and validating them opened up the door for me to be able to share the science with him. I learned that local faith leaders were worried about enabling drug use, so I explained that SSPs would provide connections to treatment and pathways to recovery. And the fact is, the local faith leaders didn't really care about how many needles we handed out, but they greatly cared about how many people we were able to connect to addiction and recovery treatment services, how many people we were able to help provide a home that evening, how many people we were actually able to feed.

Those were the metrics that they cared about, and we had to speak in a language that resonated with them. So what were the results? Well, we did not see more drug use as evidenced by the demand for syringes. The average number of syringes needed by clients each day by quarter initially went up as we developed trust, then leveled off, and then started to come down. So no, syringe service programs do not drive up drug use. But we did see HIV diagnoses go down. And most importantly, more people entered treatment. By listening to and involving the

community, we were able to implement an evidence-based approach to address their concerns and to overcome the outbreak.

I'm proud of the tremendous progress made in expanding SSPs, syringe service programs, over the last several years. In 2016, federal law was changed to permit use of federal funds to support syringe service programs, largely based on the Indiana HIV outbreak and our response. CDC Core Prevention Funding can now be used for SSPs. The CDC conducted a national vulnerability analysis to identify

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areas at risk for outbreaks among people who inject drugs. And CDC now funds individual states to conduct local vulnerability assessments. We have made tremendous progress in expanding SSPs.

As I wrap up, I want to leave you with a few items. First, I ask you to help me fight stigma. I truly believe stigma is our biggest killer. Stigma kills more people than opioid overdoses. Stigma kills more people than cigarettes, because it keeps people, no matter your disease or your risk factor, from admitting you have a problem, from asking for help. It keeps people from giving you help. There are doctors, there are nurses, there are health professionals out there who question whether they should resuscitate someone with Naloxone. No one says we shouldn't provide you smoking cessation services because you continue to smoke cigarettes. No one says you shouldn't treat my asthma that I have, because I didn't pay attention to the triggers that make it become worse. We don't judge anyone else in any other way and then say we're not going to treat you.

Choose to use de-stigmatizing language. For instance, say, “person who was addicted to drugs” rather than “addict.” That's a term I hear used often in the media, but “addict” is a very stigmatizing term. Say, “using or not using drugs,” versus saying, “clean or dirty.” People are not defined by their addiction. Second, go to cdc.gov/SSP to learn more about syringe service programs. Share it on your social media channels. Help other people become more educated about syringe service programs. Get involved in your community. Consider volunteering at or at least visiting an SSP. I'll tell you, I talked about SSPs a lot before I visited one. Then I visited one and saw it in action, and you really do see people connected to care, connected to services. You see that trust that is built between the people who work there. There is no substitute for seeing it in person.

Join me in raising awareness about Naloxone. You could save a life, whether you're at work or at home or in the parking lot or walking down the street. Educate your friends, family members, and colleagues about the steps we can all take to combat the opioid crisis.

And finally, I call on you to lead with what I call bold compassion. Continue moving your communities, our communities, from a solely criminal justice-based approach to a more public health-oriented and partnership-based approach. Be proactive in encouraging dialogue. Ask the tough questions. Encourage others to share their stories in an effort to educate and to eradicate stigma, because the stronger the foundation of trust in our communities, the better equipped we will all be to solve this crisis and to face or, better yet, prevent the next one. Again, thank you to the Cato Institute. Thank you, Dr. Singer, and thank you to all of you for joining me today. Let's keep this conversation going. I hope you will all join me in spreading the benefits of syringe service programs and lowering stigma. ■