THE NEEDLE AND THE DAMAGE DONE: INDIANA'S RESPONSE TO THE 2015 HIV EPIDEMIC AND THE NEED TO CHANGE STATE AND FEDERAL POLICIES REGARDING NEEDLE EXCHANGES AND INTRAVENOUS DRUG USERS

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I. INTRODUCTION

From an outsider's perspective, Austin, Indiana, resident Bobbie Jo Spencer's life is unenviable. Spencer and her disabled boyfriend survive off whatever various house and yard work she can find in this rural Indiana community.[1] In a good week Spencer earns $200, yet most of this meager income goes to support her addiction to the prescription painkiller Opana®.[2]

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[1] Chris Kenning, *In HIV-Riddled Town, Addiction the Lifestyle*, LOUISVILLE COURIER J. (July 2, 2015, 3:05 PM), http://www.courier-journal.com/story/news/local/2015/04/27/hiv-riddled-town-addiction-lifestyle/26482399/ [https://perma.cc/A3F2-UG6W].

[2] *Id.* Opana is the brand name for oxymorphone, a powerful opioid that addicts crush up and mix with water to achieve maximum effect.

However, Spencer is among the lucky addicts in Scott County. Despite previously sharing needles with multiple other addicts who have since been confirmed HIV-positive, tests returned a negative diagnosis for Spencer.[3] Unfortunately, at least 188 other addicts throughout Southeastern Indiana have been diagnosed with HIV since late 2014.[4] One such victim, a twenty-six year-old woman, who occasionally traded sex for drugs, was confirmed to be HIV-positive in late-June.[5] Despite being diagnosed with HIV, she still continues to feed her addiction and share needles with other addicts.[6] "Anything bad that can happen has already happened. So why stop now?"[7]

These personal accounts of the 2015 HIV epidemic in Southeastern Indiana provide a human face for the tragedy. Although Indiana state health officials declared that the outbreak peaked in July 2015,[8] experts fear that the disease's presence will last for decades to come.[9] In order to prevent a

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Because Opana commonly runs for only $130 a pill, it has become the drug of choice among drug abusers in Austin.

[3] *Id.*

[4] Alison Graham, *Complaint Filed Against Pence in Regards to HIV Outbreak in Scott County*, IND. DAILY STUDENT (Feb. 8, 2016, 8:01 PM), http://www.idsnews.com/article/2016/02/complaint-filed-against-pence-in-regards-to-hiv-outbreak-in-scott-county [https://perma.cc/6L2B-SVX3] (last updated Feb. 8, 2016, 11:47 PM). (State officials have confirmed 188 diagnoses as of February 1, 2016, though this number may continue to rise as other at-risk individuals are identified and tested.)

[5] Kenning, *supra* note 1. This woman wished to remain anonymous as a condition of talking to reporters. *Id.*

[6] *Id.*

[7] *Id.*

[8] Chris Kenning, *Indiana HIV Outbreak Has Peaked*, *Officials Say*, LOUISVILLE COURIER J. (July 23, 2015, 10:24 AM), http://www.courier-journal.com/story/news/local/indiana/2015/07/22/indiana-hiv-outbreak-peaked-officials-say/30513723/ [https://perma.cc/Z2VA-UVMS].

[9] Maureen Hayden, *HIV Numbers Slow but Decades of Worries Ahead*, NEWS AND TRIB. (June 18, 2015, 7:00 AM),

similar tragedy from reoccurring, both Indiana legislatures and the federal government must implement certain necessary policy changes to address the circumstances that led to this outbreak.

A. The Issue

Needle exchange programs serve a valuable role in preventing the spread of HIV and other diseases among abusers of intravenous drugs.[10] These programs offer crucial services such as supplying clean needles to addicts, disposing of contaminated needles, providing on-site medical care, and testing for HIV, hepatitis C, and various other diseases commonly spread through intravenous drug use.[11]

The importance of needle exchange programs cannot be understated as the use of heroin and other intravenous drugs continues to rise in the United States. The number of heroin users increased by 286% between 2002 and 2013[12] with 669,000 users of the drug identified in 2012.[13] Sharing

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http://www.newsandtribune.com/cnhi_network/hiv-numbers-slow-but-decades-of-worries-ahead/article_385ca44f-b58c-510b-9d6c-4ed3533ecda3.html [https://perma.cc/635J-LX96].

[10] *Federal Funding for Syringe Services Programs: Saving Money, Promoting Public Safety, and Improving Public Health* 1, THE AM. FOUND. FOR AIDS RES. (2013), http://www.amfar.org/uploadedFiles/_amfarorg/Articles/On_The_Hill/2013/issue-brief-federal-funding-for-syringe-service-programs.pdf [https://perma.cc/3JX8-SCQN].

[11] *Id.*

[12] Kimberly Leonard, *Heroin Use Skyrockets in U.S.*, U.S. NEWS & WORLD REP. (Jul. 7, 2015, 3:50 PM), http://www.usnews.com/news/blogs/data-mine/2015/07/07/heroin-use-skyrockets-in-us-cdc-says [https://perma.cc/7ST6-693H].

[13] Eliza Gray, *Heroin Gains Popularity as Cheap Doses Flood the U.S.*, TIME (Feb. 4, 2014), http://time.com/4505/heroin-gains-

contaminated needles and syringes for intravenous drug use, in turn, is one of the most efficient methods of transmitting HIV.[14] In 2013 alone, the use of injection drugs accounted for 3096, or 7%, of the estimated 47,352 new diagnoses of HIV in America.[15] As heroin and other addictive opioids continue to grow in popularity, it is crucial that addicts have access to clean needles so that future outbreaks of HIV and other diseases do not occur.

It is within this environment of growing intravenous drug use that in early 2015 Indiana found itself in the midst of the state's largest documented HIV epidemic.[16] Although state health workers were diagnosing up to twenty-two new cases a week at the height of the outbreak, the epidemic was largely contained by May 2015, with officials announcing the epidemic had peaked in July.[17] Various organizations, such as the Centers for Disease Control and Prevention ("CDC"), have praised the efforts of federal, state, and local officials in gaining control over the outbreak.[18]

Although every person and agency involved in curbing the spread of HIV should be commended for their efforts, the laws and policies that allowed the disease to thrive and spread deserve criticism. Austin, Indiana, has a number of

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popularity-as-cheap-doses-flood-the-u-s/ [https://perma.cc/F7UF-VRVU].

[14] THE AM. FOUND. FOR AIDS RES., *supra* note 10, at 1.

[15] *HIV and Injection Drug Use in the United States*, CTR. FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/hiv/riskbehaviors/idu.html [https://perma.cc/Q4RK-CE2T] (last updated Oct. 27, 2015).

[16] Kenning, *supra* note 8.

[17] *Id*.

[18] *The Anatomy of an HIV Outbreak Response in a Rural Community*, CTR. FOR DISEASE CONTROL AND PREVENTION PUB. HEALTH MATTERS BLOG (June 8, 2015), http://blogs.cdc.gov/publichealthmatters/2015/06/the-anatomy-of-an-hiv-outbreak-response-in-a-rural-community/ [https://perma.cc/N64B-PTAU].

socioeconomic factors that contributed to the disease's quick spread and allowed the outbreak to reach epidemic levels. In addition to ranking among the lowest counties in Indiana in life expectancy, Scott County also "has substantial unemployment (8.9%), a high proportion of adults who have not completed high school (21.3%), a substantial portion of the population living in poverty (19%), and limited access to health care."[19] Many of these indicators are not exclusively limited to Southeastern Indiana, as they are common throughout rural American communities.[20]

However, a number of warning signs pointing to a potential outbreak in the area went ignored.[21] Because this outbreak happened solely in Indiana, a portion of the blame must fall on local and state policies that prohibited simple preventive precautions from being implemented and allowed the disease to flourish.[22] Additionally, much criticism must be directed at the federal government's long-standing ban on using federal funds towards needle exchange programs.[23] Although Congress now allows federal funds to go toward the operation of needle exchanges, so long as this money is not used to purchase needles, there are still additional actions

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[19] Caitlin Conrad et al., *Community Outbreak of HIV Infection Linked to Injection Drug Use of Oxymorphone—Indiana, 2015*, 64.16 MORBIDITY AND MORTALITY WK. REP. 443, 443-444 (2015).

[20] *Id.*

[21] Steffanie A. Strathdee & Chris Beyrer, *Threading the Needle—How to Stop the HIV Outbreak in Rural Indiana*, 373 NEW ENG. J. MED. 397, 397 (2015). Warning signs included the rising number of heroin use, new diagnoses of hepatitis C among intravenous drug users, easy access to prescription drugs, and a lack of clean needles in the community. *Id.*

[22] These policies are discussed in depth in Section E of Part II of this note.

[23] *Id.* at 397-99.

the federal government must take to ensure that these programs function both effectively and efficiently.[24]

This Note will argue that Indiana's ban of needle sharing programs, prior to this recent HIV outbreak, is one of the primary policy failures that contributed to the spread of the disease. Although Indiana legislators have since passed legislation allowing needle sharing programs to operate under emergency circumstances, state law and policies still contain several major flaws that must be addressed to create an effective precautionary policy. Additionally, this Note will further posit that real change in preventing future outbreaks of HIV among intravenous drug users will not occur until the federal government substantially changes its policies towards needle exchanges and drug addiction. In the end, policy changes at both the state and federal level are required to prevent another HIV epidemic from occurring not only in Indiana, but across the entire United States.

B. Roadmap

This Note discusses the 2015 Indiana HIV outbreak. In order to explain the policies and laws that allowed the outbreak to spread into an epidemic, Section II outlines the arguments for and against needle exchanges, the history of the federal ban on funding for needle exchange programs, state approaches to needle exchanges, and relevant Indiana laws that facilitated the spread of HIV and mismanagement of the crisis. Section III examines the 2015 crisis, offering a timeline of events and noting critical moments where state policy failed to control the spread of HIV. Section IV first analyzes and argues for changes in Indiana policy that must

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[24] Leana Wen, *Repeal of Federal Ban on Needle Exchange: Necessary But Not Sufficient*, THE HUFFINGTON POST HEALTHY LIVING BLOG (Feb. 1, 2016, 1:49 PM), http://www.huffingtonpost.com/leana-wen-md/repeal-of-federal-ban-on-_b_9126368.html [https://perma.cc/9C4X-5AEL] (last updated Feb. 2, 2016).

be made to prevent future outbreaks before shifting focus towards the recently-lifted federal ban on funding for needle exchange programs. Finally, Section V concludes that changes must be made in policy across the United States towards needle exchange programs and intravenous drug users to ensure that this tragedy is never repeated.

II. BACKGROUND INFO

A. Arguments For and Against Needle Exchange Programs

Critics of needle exchanges argue that these programs conflict with U.S. zero-tolerance drug policy.[25] Many opponents of needle exchanges view drug abusers as criminals rather than as victims suffering from mental or physical illnesses.[26] Organizations and policy makers, against the funding of needle exchanges, believe that these programs are ineffective at combating drug abuse because they allow drug abusers to feed their addiction instead of combating the actual cause of the problem.[27]

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[25] *See* Rachel L. Hulkower & Leslie E. Wolf, *Federal Funds for Syringe Exchange Programs: A Necessary Component Toward Achieving an AIDS-Free Generation*, 22 ANNALS HEALTH L. 307, 319 (2013). Although critics of needle exchanges may come from any political background, conservative politicians made up the majority of opposition to these programs for years. *See* Maia Szalavitz, *Why Obama Isn't Funding Needle-Exchange Programs*, TIME (May 16, 2009), http://content.time.com/time/nation/article/0,8599,1898073,00.html [https://perma.cc/QA36-PHLR].

[26] Barbara Tempalski et al., *Social and Political Factors Predicting the Presence of Syringe Exchange Programs in 96 US Metropolitan Areas*, 97 AM. J. PUB. HEALTH 437, 437-38 (2007).

[27] Denise Paone et al., *Syringe Exchange: HIV Prevention, Key Findings, and Future Directions*, 30 INT'L J. ADDICTION 1647 (1995). Eric Voth, chair of the Institute of Global Drug Policy, has said, "My fundamental concern is that many of the needle exchanges aren't going

However, despite critics' concerns regarding the effectiveness of needle exchanges, studies, conducted by the CDC, the National Institutes of Health ("NIH"), the General Accounting Office ("GAO"), and the National Academy of Sciences ("NAS"), have all generally found that needle exchange programs effectively slow the spread of HIV without finding any link to increases in drug use among program participants.[28] Additionally, leading health agencies including the CDC, the American Foundation for AIDS Research, and the World Health Organization have all voiced support for needle exchanges after each group's independent study returned results indicating that needle exchanges curb the rate of new HIV infections among intravenous drug users.[29] Finally, numerous studies have also found that the cost of operating needle exchange programs is much less than the cumulative cost of treating a person diagnosed with HIV over their expected lifetime. Whereas the lifetime cost of treating one HIV-positive person is estimated to range between $385,200 and $618,900, the cost of a single clean hypodermic needle is estimated to be fifty cents.[30]

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after the core problem, which is drug abuse . . . I call them needle handouts." Laura Ungar, *Study: Needle Exchange Policy Prevented HIV*, USA TODAY (Sep. 3, 2015, 12:06 AM), http://www.usatoday.com/story/news/nation/2015/09/02/study-needle-exchange-policy-prevented-hiv/71568174/ [https://perma.cc/Q5BC-BB3Q].

[28] Katharine Q. Seelye, *A.M.A. Policy Group Backs Needle Exchanges*, N.Y. TIMES (June 27, 1997), http://www.nytimes.com/1997/06/27/us/ama-policy-group-backs-needle-exchanges.html?pagewanted=all&src=pm [https://perma.cc/T962-RE2K].

[29] Hulkower & Wolf, *supra* note 25, at 309.

[30] THE AM. FOUND. FOR AIDS RES. *supra* note 10, at 2; *see also* Ungar, *supra* note 27.

B. *Origins of the Federal Ban on Funding for Needle Exchange Programs*

As noted above, critics of needle exchanges argue that the programs go against the United States' longstanding drug policy.[31] The federal ban on funding for needle exchange programs traces its roots to the early 1970s with the beginning of President Nixon's War on Drugs.[32] The Controlled Substances Act of 1970 was the first major piece of legislation passed to promote the War on Drugs' efforts to combat drug use.[33] This law created classifications of controlled substances among drugs and delegated enforcement powers to the Attorney General.[34] In 1973, President Nixon established the Drug Enforcement Administration ("DEA"), commonly referred to as the DEA.[35] Following its establishment, the DEA consolidated all existing government organizations, combating the use of drugs, into a single federal agency as a way to better coordinate the efforts of the War on Drugs.[36] In turn, the DEA's 1979 Model Drug Paraphernalia Act was the federal government's first significant attempt to limit intravenous drug users' access to clean syringes and needles. The Act defined the scope of drug paraphernalia as including

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[31] *See* Hulkower & Wolf, *supra* note 25, at 308.

[32] *Id.* The War on Drugs refers to President Nixon's efforts to combat the growing drug epidemic of the 1970s and has been continued by subsequent presidential administrations. The War on Drugs uses a punitive model to implement stringent drug law primarily enforced on drug users rather than transporters and distributors. *Id.*

[33] Controlled Substances Act of 1970, Pub. L. No. 91-513, 84 Stat. 1242 (codified at 21 U.S.C. §§ 801-904 (2015)).

[34] 21 U.S.C. §§ 812, 871 (2015).

[35] *DEA History in Depth 1970-1975* 4, DRUG ENFORCEMENT ADMIN., http://www.dea.gov/about/history/1970-1975.pdf [https://perma.cc/36DU-JGEP].

[36] *Id.* at 5.

"[H]ypodermic syringes, needles and other objects used, intended for use, or designed for use in parenterally injected controlled substances into the human body."[37] Thus, the possession of needles or syringes was, in turn, criminalized and made punishable by both fines and prison sentences.[38]

The War on Drugs intensified in the 1980s following President Ronald Reagan assuming office in 1981.[39] During the Reagan administration, Congress passed numerous pieces of legislation that furthered the War on Drugs' punitive approach to combat drug use. The Anti-Drug Abuse Act of 1986, for example, created mandatory minimum sentencing guidelines for drug-related convictions,[40] and the Chemical Diversion and Trafficking Act of 1988 extended the DEA's jurisdiction to cover airplanes and boats.[41]

This era's punitive approach to drug abuse dealt a crippling blow to needle exchange programs in the late 1980s. In 1988, led by Republican Senator Jesse Helms of North Carolina, and with support of members of both the Republican and Democratic parties, Congress included a section in the Public Health and Welfare Act that prohibited the use of federal funds for needle exchange programs.[42] Codified in section 300e-5, the ban states:

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[37] Model Drug Paraphernalia Act (1979) (full text of Model Act is published in Appendix B of United States v. Main St. Distrib., Inc., 700 F.Supp 655, 671 (E.D.N.Y. 1988)).

[38] *Id.* at 672-73.

[39] Hulkower & Wolf, *supra* note 25, at 323-24 (describing the expansion of the War on Drugs during the Reagan Administration).

[40] Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, 100 Stat 3207 (1986).

[41] Chemical Diversion and Trafficking Act of 1988, Pub. L. No. 100-690, 102 Stat. 4312 (1988).

[42] Matt Fisher, *A History of the Ban on Federal Funding for Syringe Exchange Programs*, SMART GLOBAL HEALTH BLOG (Feb. 6, 2012, 10:25 AM), http://www.smartglobalhealth.org/blog/entry/a-history-of-the-ban-on-federal-funding-for-syringe-exchange-programs/ [https://perma.cc/K7J6-FPC3].

> None of the funds provided under this Act or an amendment made by this Act shall be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquired immune deficiency syndrome.[43]

This federal ban, enacted during the height of the United States' HIV/AIDS crisis of the 1980s, effectively left states, local governments, and private organizations to combat the spread of the disease on their own without much-needed support from the federal government.[44]

C. Federal Funding for Needle Exchanges under President Obama

The federal ban on funding for needle exchange programs remained in effect throughout the 1990s and much of the 2000s.[45] The ban remained despite numerous organizations, including U.S. Institute of Medicine, recommending as early as 1995, that the federal government lift the federal ban on spending for these programs, as its study found that needle exchange programs effectively reduced the number of HIV infections while not contributing

[43] 42 U.S.C. § 300ee-5 (1988).
[44] Hulkower & Wolf, *supra* note 25, at 324.
[45] Fisher, supra note 42.

to an increase in drug use.[46] However, in 2008, as part of his presidential campaign, then Democratic Senator Barack Obama promised to lift the ban.[47] President Obama made good on his promise during his first year in office through his signing of the Consolidated Appropriations Act of 2010 ("Act").[48] Although the Act did not fully repeal the ban, it provided a modification to the ban essentially allowing for federal funds to be used for needle exchange programs so long as local public health and law officials did not raise objections.[49] For the first time in twenty-one years, states could use federal funds for the operation of needle exchange programs so long as local authorities determined that the program's location was appropriate.[50]

The Department of Health and Human Services, in turn, published guidelines for existing state and privately run needle exchanges to follow in order to receive federal funding.[51] Requirements included that organizations receiving funds adhere to "state and local laws and the coordination of services for substance abuse and HIV prevention" and also provide documents confirming location

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[46] *Id*.

[47] Hulkower & Wolf, *supra* note 25, at 324-25.

[48] Consolidated Appropriations Act of 2010, Pub. L. No. 111-117, § 505, 123 Stat. 3034, 3279 (2009).

[49] *Id.*; *see also* Hulkower & Wolf, *supra* note 25, at 325. The pertinent section of the Act states that

> [n]one of the funds contained in this Act may be used to distribute any needle or syringe for the purpose of preventing the spread of blood borne pathogens in any location that has been determined by the local public health or local law enforcement authorities to be inappropriate for such distribution.

Consolidated Appropriations Act of 2010, Pub. L. No. 111-117, § 505, 123 Stat. 3034, 3279 (2009).

[50] Hulkower & Wolf, *supra* note 25, at 325.

[51] *Id.*

approval by local law enforcement and health officials.[52] Although these requirements indicated that the ban was not fully repealed,[53] the Act still showed progress by allowing needle exchange programs to finally receive much needed federal funding for the first time in twenty-one years.

Unfortunately, only three of the 203 recognized needle exchange programs, in existence before the passing of the Consolidated Appropriations Act in 2010, were able to receive federal funding before the ban was reinstated.[54] In late 2011, Congress passed the Consolidated Appropriations Act of 2012, which reinstated the ban as a casualty of budget negotiations with Republican leaders.[55] The Consolidated Appropriations Act of 2012 states that "no funds appropriated in the Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug."[56] Due to the passing of the Act, the legality of funding needle exchanges thus returned to the pre-2009 status quo.[57]

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[52] *Id.*

[53] *Id*.

[54] Traci C. Green et al., *Life After the Ban: An Assessment of US Syringe Exchange Programs' Attitudes About and Early Experiences with Federal Funding*, 5 AM. J. PUB. HEALTH, e9, e10-11 (2012).

[55] Azmat Khan, *Despite Show of Support, Federal Funding Ban on Needle Exchange Unlikely to Be Lifted Anytime Soon*, FRONTLINE (Aug. 7, 2012), http://www.pbs.org/wgbh/frontline/article/despite-show-of-support-federal-funding-ban-on-needle-exchange-unlikely-to-be-lifted-anytime-soon/ [https://perma.cc/CBE4-58DH].

[56] Consolidated Appropriations Act of 2012, Pub. L. No. 112-174, § 523, 125 Stat. 786, 807 (2011).

[57] Memorandum from Ronald O. Valdiserri, Deputy Assistant for the Sec'y of Health, Infectious Diseases, U.S. Dep't of Health and Human Serv., on Reinstatement of Federal Ban on Funding for Syringe Exchange Programs, to Colleagues (Mar. 29, 2012), https://www.nastad.org/sites/default/files/102846_OHAP_ECOPY_EXCHANGE_03282012-103554.CPY_.pdf [https://perma.cc/Y4E5-JK9V].

Despite this setback, the Obama Administration pledged to "continue to work with Congress and public health agencies to ensure that, to the extent possible, needle exchange programs are implemented in the context of comprehensive, recovery-oriented public health systems that also offer [intravenous drug users] treatment for addiction, other medical care, and testing for HIV. . . ."[58] However, the former administration's promise for help is not enough to combat the spread of HIV among intravenous drug users. As the recent outbreak in Scott County, Indiana showed, diseases do not wait idly by for policy changes to be implemented, and addictions do not magically disappear overnight. The one silver lining to the HIV epidemic continuing to ravage Scott County and other areas in rural Indiana is that the tragedy has reignited the debate over allocating federal funds for needle exchange programs.[59] This Note will later outline changes the federal government should make in its policy towards needle exchanges.[60] However, this Note will now detail various approaches to needle exchanges at the state level.

D. State Approaches to Needle Exchange Programs

States first began to regulate the sale and possession of hypodermic needles in the 1960s and 1970s as a way to

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[58] Office of Nat'l Drug Control Policy Staff, *Federal Funding Ban on Needle Exchange Programs*, WHITE HOUSE BLOG (Jan. 5, 2012, 4:02 PM), https://www.whitehouse.gov/blog/2012/01/05/federal-funding-ban-needle-exchange-programs, [https://perma.cc/WKB7-K4KT] (last updated Jan. 5, 2012, 6:10 PM).

[59] Carl Hulse, *Surge in Cases of H.I.V. Tests U.S. Policy on Needle Exchanges*, N.Y. TIMES, May 16, 2015, at A16, https://www.nytimes.com/2015/05/17/us/surge-in-cases-of-hiv-tests-us-policy-on-needle-exchanges.html?_r=0 [https://perma.cc/HM5U-J8E4].

[60] *See* discussion *infra* Section IV.

combat the rising use of heroin.[61] Similar to the federal government's approach on the War on Drugs, early state paraphernalia statutes focused on preventing individual possession rather than targeting the sources directly providing and facilitating the use of illegal drugs.[62]

However, by the late 1970s and early 1980s, states had shifted their focus to the "head-shop" industry and primarily targeted outlets that sold drug paraphernalia such as bongs and kits for freebasing cocaine.[63] These early laws were rooted in the "belief that the possession, sale, manufacture, delivery, and advertisement of drug paraphernalia encourage and glamorize the illegal use of controlled substances, as well as increase the public's acceptance of such use."[64] In total, thirty-seven states and Washington, D.C. adopted drug paraphernalia statutes based on the DEA's 1979 Model Drug Paraphernalia Act.[65]

Today, needle distribution laws vary between states. Twenty-eight states have either limited or removed previous barriers to needle distribution from various prescription and paraphernalia laws.[66] Additionally, "seventeen states explicitly authorize syringe exchange programs; this does not include states that have removed all legal barriers to

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[61] Michael D. Guinan, *The Constitutionality of Anti-Drug Paraphernalia Laws–The Smoke Clears*, 58 NOTRE DAME L. REV. 833, 835 (1983).

[62] *Id.* at 837.

[63] Scott Burris & Mitzi Ng, *Deregulation of Hypodermic Needles and Syringes As a Public Health Measure: A Report on Emerging Policy and Law in the United States*, 12 GEO. MASON U. CIV. RTS. L.J. 69, 86 (2001).

[64] High Gear & Toke Shop v. Beacom, 689 P.2d 624, 627 (Colo. 1984).

[65] Hulkower & Wolf, *supra* note 25, at 320.

[66] ROBERT WOOD JOHNSON FOUND., APRIL 2015 REPORT ON SYRINGE DISTRIBUTION LAWS (2015), http://lawatlas.org/files/upload/20150421_SyringeD_Report.pdf [https://perma.cc/8PG5-4A9J].

needle exchange."[67] Finally, "fourteen states have removed syringes from their definition of drug paraphernalia."[68] Thus, it is under this complicated web of various legal standards across the states that the estimated 220 needle exchange programs operating throughout America as of early September 2015 must work within.[69]

E. Relevant Indiana Laws and Policies

A closer examination of the various Indiana laws regarding needle exchange programs is necessary in order to understand Indiana's limited response to the HIV outbreak. Keeping with the federal government's punitive approach towards drug abusers, Indiana criminalizes the possession of hypodermic needles.[70] Indiana Code states: "a person who knowingly or intentionally possess an instrument, a device, or another object that the person intends to use for introducing into the person's body a controlled substance . . . commits a Class C misdemeanor."[71]

Indiana is one of twenty-five states that require a prescription in order to purchase syringes.[72] Furthermore, Indiana was previously one of twenty-five states to not explicitly authorize needle exchange programs.[73] However, in recognition of the ongoing HIV crisis in Scott County, Indiana passed Senate Bill 461, a piece of legislation tailored to combat the spread of the outbreak.[74] This law allows local communities, in the midst of an epidemic, to begin operating

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[67] *Id.*
[68] *Id.*
[69] Ungar, *supra* note 27.
[70] IND. CODE § 35-48-4-8.3 (2015).
[71] *Id.*
[72] Strathdee & Beyrer, *supra* note 21, at 398.
[73] *Id.*
[74] S.B. 461, 119th Gen. Assemb., Reg. Sess. (Ind. 2015).

needle exchange programs upon receiving approval from the state health commissioner.[75]

Despite this step in the right direction, certain limitations for establishing needle exchanges remain in place. Senate Bill 461 requires that local officials show an epidemic is spreading through intravenous drug use and that the exchange program is part of an appropriate response to meet the criteria required to gain approval from the state health commissioner.[76] Although Senate Bill 461 marks a step in the right direction, this Note will later show that there are more steps Indiana legislators must take to both prevent future outbreaks and provide support for any that do arise among intravenous drug users.[77]

Finally, sections of the Indiana Administrative Code, regarding reporting procedures for HIV, are also relevant analyzing the response to the HIV outbreak. State law requires that doctors, clinics, and hospitals report all confirmed and suspected cases of HIV "to the local health officer in whose jurisdiction the patient normally resides or . . . in whose jurisdiction the patient was examined at the time the diagnosis was made or suspected."[78] Additionally, "if the patient is the resident of a different jurisdiction, the local health jurisdiction receiving the report shall forward the report to the local health jurisdiction where the patient resides."[79] Furthermore, laboratories are required to report

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[75] Associated Press, *Indiana Lawmakers Pass Bill Allowing Needle-Exchange Programs to Combat HIV Outbreak*, FOXNEWS (Apr. 30, 2015), http://www.foxnews.com/politics/2015/04/30/indiana-lawmakers-pass-bill-allowing-needle-exchange-program-to-combat-hiv/ [http://perma.cc/XT6K-XTWP].

[76] *Id.*

[77] *See* discussion *infra* Section IV.

[78] 410 IND. ADMIN. CODE 1-2.3-47.

[79] *Id.*

HIV findings weekly to the state health department and may also choose to report findings to the local health officer.[80]

III. THE 2015 INDIANA HIV OUTBREAK

A. Initial Outbreak and Response

In December 2014, two new cases of HIV linked to intravenous drug use were reported in Scott County in Southeastern Indiana.[81] Because, on average, only five new cases of HIV are diagnosed in the area each year,[82] health officials initially did not fear that a potential outbreak was incubating among the community's addicts.[83] In retrospect, however, two new cases of HIV found in intravenous drug users should have served as warning signs of the impending epidemic. Dr. Shane Avery of Scott Memorial Hospital, the physician who treated both patients, stated that these HIV diagnoses were his first in almost a decade.[84] Avery noted on these first diagnoses that "[t]wo cases in two weeks, and you become concerned because that's unusual."[85]

However, it was not until mid-January of 2015, after Scott County doctors confirmed eight new cases of HIV, that officials began to worry about a potential epidemic.[86] It was

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[80] 410 IND. ADMIN. CODE 1-2.3-48.

[81] Barbara Brosher, *Timeline: Indiana's Response to the HIV Outbreak*, IND. PUB. MEDIA (Aug. 4, 2015), http://indianapublicmedia.org/news/timeline-indianas-response-hiv-outbreak-85766/ [https://perma.cc/YGJ4-RQMS].

[82] Strathdee & Beyrer, *supra* note 21, at 397.

[83] Bob Segall, *Inside Indiana's HIV Epidemic*, WTHR (May 18, 2015, 10:47 PM), http://www.wthr.com/story/29097510/inside-indianas-hiv-epidemic [https://perma.cc/9AUW-EBXN] (last updated May 21, 2015, 2:18 PM).

[84] *Id.*

[85] *Id.*

[86] *Id.*

at this point that the public should have been notified of the concerning number of new cases in the area. Beth Myerson, an HIV policy expert at the Indiana University School of Public Health and the co-director of the Rural Center for AIDS/STD Prevention, says that this sudden jump in HIV diagnoses "should have triggered a public warning."[87] Myerson takes issue with the public being kept in the dark about the outbreak, noting that "an abrupt increase of cases beyond the normally accepted scenario" demanded immediate action by state health officials.[88]

Although county and state officials did not alert the public during the early stages of the outbreak, behind the scenes, state health officials began to investigate the rapidly increasing number of HIV diagnoses.[89] Disease intervention specialists inspected every new case by interviewing victims confirmed to be infected, eventually determining that needle sharing was the leading cause of the outbreak.[90] On January 27, state health officials in Indianapolis finally met to discuss the next steps for monitoring the crisis in Scott County.[91]

Despite the state's early investigation into the crisis, Scott County officials remained in the dark until February 23 when state officials finally notified local officials of the growing crisis occurring within their own county.[92] Brittany Combs, Scott County Health Department's only public health nurse, noted that the announcement of the HIV crisis was a surprise for her and others that came "completely out of left field."[93] By this point in time, the Indiana State Department of Health ("ISDH") had known of the outbreak

[87] *Id.*
[88] *Id.*
[89] *Id.*
[90] *Id.*
[91] *Id.*
[92] *Id.*
[93] *Id.*

for five weeks and had been investigating and monitoring the county for four weeks.[94]

The effect of the Indiana State Health Department's failure to notify Scott County officials contributed to the rapid spread of HIV among intravenous drug users in the early weeks of 2015 will be impossible to determine. Local response from Scott County health officials would have been limited due to the county employing only five full time health officials at the time.[95] However, time is of the essence when trying to prevent the spread of HIV, as a person, who recently contracted the disease, is most infectious at the early stages due to a higher viral load in the blood.[96] Furthermore, intravenous drug use in Scott County is a communal activity that involves multiple generations of the same family and members of the community sharing contaminated needles.[97] Because addicts use and share up to ten needles a day to feed their addiction,[98] early notification of the public was an essential step to stopping HIV's spread that did not happen nearly soon enough in Scott County.

The Indiana State Health Department's failure to timely notify Scott County officials of the HIV outbreak not only cost lives, but also acts as an indictment towards Indiana's inefficient HIV reporting laws.[99] Indiana law at the time required that medical laboratories report new cases of HIV to either the health official in the county in which the patient is a resident of or the health officer in the jurisdiction in which the case is diagnosed.[100] However, because the

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[94] *Id.*

[95] *Id.*

[96] *Id.*

[97] CTR. FOR DISEASE CONTROL AND PREVENTION: PUB. HEALTH MATTERS BLOG, *supra* note 16.

[98] *Id.*

[99] Segall, *supra* note 83.

[100] 410 IND. ADMIN. CODE § 1-2.3-47 (2007).

majority of Scott County residents that contracted HIV were diagnosed in nearby Clark County, lab results were instead forwarded to Kevin Burke, the Clark County health officer and medical director of the Southeast Region of Indiana's HIV/STD Detection and Reporting Program.[101] When asked why his department did not alert Scott County officials of the rising number of HIV diagnoses, Burke commented that he felt it was the ISHD's decision to notify other counties.[102] Although Burke correctly followed set procedures, this loophole allowing Scott County health officials to go weeks without knowing of the growing cases of HIV in their jurisdiction highlights the lack of communication that marred the early stages of the crisis.

B. Indiana Alerts the Public to the Outbreak

Finally, on February 25, ISDH officials released a statement alerting the public of the outbreak.[103] The release noted twenty-six confirmed and four preliminary cases of HIV diagnosed since mid-December and suggested that a "large majority of cases are linked through injection drug abuse of the prescription drug, opana . . . a powerful opioid painkiller."[104]

On March 9, the ISDH filed a request with the CDC to send a disease intervention specialist team to investigate the outbreak and provide aid.[105] However, without the necessary local resources required for combating and treating the

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[101] Segall, *supra* note 83.

[102] *Id.*

[103] Brosher, *supra* note 81.

[104] *HIV Outbreak in Southeastern Indiana*, IND. STATE DEP'T HEALTH (Feb. 25, 2015), http://www.in.gov/isdh/files/February_25__Outbreak_in_Southeastern_Indiana.pdf [https://perma.cc/E4A2-LKUB].

[105] Segall, *supra* note 83 (*see* Interactive Timeline).

outbreak, new cases continued to rise in Scott County throughout March, with forty-five confirmed diagnoses by March 11.[106] This startling spread of HIV caused ISDH Deputy Commissioner Jennifer Walthall to remark on the crisis that the Department "[doesn't] have a record of an HIV outbreak like this in the state of Indiana--at least since the early 2000s."[107] Soon after the outbreak the CDC confirmed that the outbreak has reached epidemic status and arrived in Scott County on March 23, 2015, to help coordinate local efforts.[108]

C. Public Health Emergency Declared and First Needle Exchange Program Opens

On March 25, 2015, Indiana Governor Mike Pence met with Scott County officials regarding the crisis and stated during a press conference that he was considering all options to combat the spread of HIV, noting, however, that he still remained opposed to the operation of needle exchange programs in Indiana.[109] Following his meeting with Scott County officials on March 26, and with the number of confirmed HIV cases at seventy-nine,[110] Governor Pence issued Executive Order 15-05, which formally declared a public health emergency in Scott County.[111]

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[106] Brosher, *supra* note 81.

[107] *Id.* (*see* March 6, 2015 on Interactive Timeline).

[108] *Id.* CDC objectives included supporting the ISDH's investigation, helping the Department of Health conduct sample analysis, and coordinating HIV treatment and prevention and substance abuse programs. Segall, *supra* note 83.

[109] Brosher, *supra* note 81.

[110] *Id*.

[111] Ind. Exec. Order No. 15-05 (Mar. 26, 2015), http://www.in.gov/gov/files/Executive_Order_15-05.pdf [https://perma.cc/Z67S-45HJ].

Executive Order 15-05 allowed for Scott County to set up a limited needle exchange program to combat the epidemic, although certain restrictions remained in place.[112] First, Scott County officials were required to submit a formal request to the Indiana State Health Commissioner before receiving approval to begin the program.[113] Additionally, the Order prohibited any needle exchange programs' operations from extending beyond what is deemed "medically necessary" by the State Health Commissioner.[114] Finally, Executive Order 15-05 also dictated that any approved program may only run for the order's thirty-day duration.[115] These restrictions, reflect Governor Pence's hesitance at the time to overturn Indiana's longstanding ban on needle exchanges, despite the fact that studies for years had shown their effectiveness in combating the spread of disease through intravenous drug use.[116] Even after issuing Executive Order 15-05, Governor Pence continued to threaten to veto any bill proposing the legalization of needle exchanges statewide, telling the public "I don't believe that effective anti-drug policy involves handing out paraphernalia to drug users by government officials."[117]

Despite the numerous steps required before Scott County could open its needle exchange program, the first HIV

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[112] *Id.*

[113] *Id.*

[114] *Id.*

[115] *Id.*

[116] Seelye, *supra* note 28. Studies conducted in the 1990s by the CDC, the NIH, the GAO, and the NAS have all found that needle exchange programs effectively slow the spread of HIV. *Id.*

[117] Jake Harper, *Indiana's HIV Spike Prompts New Calls for Needle Exchanges Statewide*, NPR (Mar. 28, 2015, 7:38 AM), http://www.npr.org/sections/health-shots/2015/03/28/395821345/indianas-hiv-spike-prompts-new-calls-for-needle-exchanges-statewide [https://perma.cc/5N3X-M6KS].

testing center opened in Austin on March 31[118] This facility's functions included administering HIV tests, and providing information on the disease, addiction, the county's new needle exchange program, and other offered treatment options.[119] However, new cases of HIV continued to grow, and exceeded 120 cases by mid-April,[120] forcing Governor Pence to extend the emergency order on April 20 for another thirty days.[121]

D. Indiana State Legislature Passes Needle Exchange Bill

On April 29, Indiana state legislatures approved Senate Bill 461, thereby allowing any Indiana county to implement needle exchange programs upon meeting certain restrictive criteria.[122] Under this bill, counties may only begin operating an exchange program if they have an epidemic of HIV or hepatitis C, show the primary mode of transmission is through intravenous drug use, and show that a needle exchange is "medically appropriate" as part of the public health response.[123] Additionally, counties "must conduct a public hearing and receive approval from the state health commissioner before an exchange can take place."[124] State-provided money cannot be used to purchase needles, but can be used for related services, leaving cities, counties, and non-profits to purchase the actual syringes.[125] Governor Pence

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[118] Brosher, *supra* note 81.
[119] *Id.* (*see* March 31, 2015 on Interactive Timeline).
[120] Segall, *supra* note 83.
[121] Brosher, *supra* note 81.
[122] *Id.*
[123] *Id.*
[124] *Id.*
[125] Ungar, *supra* note 27.

signed the bill into law on May 5, despite these limitations.[126]

On May 20, following the enactment of the needle exchange program law and mere days before the executive order allowing for the temporary needle exchange program was set to expire, Scott County commissioners unanimously approved extending the existing needle program for at least one more year.[127] The following day, May 21, State Health Commissioner Jerome Adams approved Scott County's proposal, ruling that it fulfilled the new criteria required for establishing a needle exchange program.[128]

E. The Outbreak Is Contained and the Long Road to Recovery

In late July state officials announced that the epidemic had peaked with 175 victims infected with HIV.[129] New cases reported in July dropped to two or less per week from the previous rate of 22 diagnoses each week during the height of the outbreak.[130] By this point health officials had contacted about 85% of the 494 people identified as being at risk of HIV infection due to intravenous drug use or sexual transmission.[131] Unfortunately, according to late-June estimates, less than half of the victims who had contracted HIV had been prescribed anti-viral medication.[132]

Despite the HIV outbreak's peak and the dropping number of newly confirmed cases, the effects of the 2015 epidemic will be felt for years to come. Although the number

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[126] Brosher, *supra* note 81.
[127] *Id.*
[128] *Id.*
[129] Kenning, *supra* note 8.
[130] *Id.*
[131] *Id.*
[132] *Id.*

of HIV diagnoses reached 188 in early-February of 2016,[133] "cases of HIV in this community [Scott County] will remain there for the next 40 or 50 years," according to State Health Commissioner Jerome Adams.[134] Additionally, because HIV is a treatable disease now rather than the death sentence it was in previous decades, the ongoing costs of caring for those infected will heavily impact Indiana taxpayers for years to come.[135] Between the high cost of HIV treatment and the price of welfare and public assistance that many of these patients will have to rely on, health officials estimate that the public cost of treating the epidemic will range from $160 million to $250 million.[136]

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[133] Graham, *supra* note 4.

[134] Hayden, *supra* note 9.

[135] The average lifespan of someone infected with HIV is around 25 years. Bob Segall, *Inside an Epidemic: HIV Outbreak Brings Massive Cost*, WTHR (May 22, 2015, 10:02 A.M.), http://www.wthr.com/story/29130589/inside-an-epidemic-hiv-outbreak-brings-massive-cost, [https://perma.cc/ZJ2T-ZD33].

[136] *Id.*

IV. ANALYSIS/ARGUMENTS

A. What Indiana Can Learn From the Outbreak

Although some have praised Indiana's response to the outbreak,[137] there are still important changes to state policy that must be made in order to prevent a future outbreak from occurring. An effective prevention strategy for stopping the spread of disease through intravenous drug use requires a comprehensive approach that combines substance abuse treatment with access to sterile syringes and needles.[138] Indiana legislators passed important laws during the crisis that marked a step in the right direction, but sadly these laws contain numerous restrictions that must be corrected immediately. This section of this Note will therefore identify ongoing problems in current law and policy and suggest various changes to state law, with the goal being to change the public's perception of addicts, allow local Indiana communities to react faster and more effectively should another outbreak occur, and provide continuing treatment for those infected.

B. Addressing Problems in Indiana Law & Policy

1. Decriminalize Possession of Hypodermic Needles

Because state statutes and regulations pose a significant barrier for addicts to access clean syringes and needles,[139] a

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[137] Monica Ruiz, Assistant Research Professor at The George Washington University School of Public Health, told the USA Today that Indiana's response "was the fastest I've seen any government move" in addressing an HIV outbreak. Ungar, *supra* note 27.

[138] Hulkower & Wolf, *supra* note 25, 317.

[139] Don C. Des Jarlais et al., *Doing Harm Reduction Better: Syringe Exchange in the United States*, 104 ADDICTION 1441 (2009).

modification to these laws is an important first step in preventing future outbreaks of HIV among intravenous drug users. Notably, Indiana Code criminalizes the possession of drug paraphernalia, stating that "a person who knowingly or intentionally possesses an instrument, a device, or another object that the person intends to use for introducing into the person's body a controlled substance . . . commits a Class C misdemeanor."[140] The criminalization of the possession of needles serves only to demonize addicts and may in turn make members of this vulnerable class less likely to seek help for their addiction.[141]

Additionally, policies that criminalize an addict's behavior have been found to create tension between health care professionals who view a drug abuser's addiction as a disease and law enforcement officials who view drug abusers as criminals.[142] Characterizing drugs addicts as criminals rather than as ordinary people suffering from mental or physical illness in turn limits widespread societal support for needle exchange programs.[143] This stigma surrounding drug users may have hindered the effectiveness of Scott County's needle exchange, as by late June only 95 people had come forward to visit the center.[144] The program's requirement that drug users register with their initials and date of birth also may have scared off addicts who were unwilling to sacrifice their anonymity in exchange for clean needles.[145]

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[140] IND. CODE § 35-48-4-8.3 (2015).

[141] Lesley Simmonds & Ross Coomber, *Injecting Drug Users: A Stigmatized and Stigmatizing Population*, 20 INT'L J. DRUG POL'Y 121, 121 (2009).

[142] Tempalski et al., *supra* note 26, at 437.

[143] *Id.* at 438.

[144] Kenning, *supra* note 1.

[145] Strathdee & Beyrer, *supra* note 21, at 398.

Indiana Recovery Alliance, the only needle exchange operating in nearby Monroe County, has also had difficulty in reaching its community of drug abusers.[146] Only a "handful of people" have come to the program's offices since its opening in early February of 2016.[147] Although the program keeps all information private, Chris Abert, the Alliance's founder, cites the stigma surrounding drug abuse as the main deterrent in attracting at-risk individuals, noting that addicts are "very stigmatized. They're criminalized."[148] The Alliance provides every user with a card that authenticates their use of the program in an attempt to calm fears and attract new participants, and Erika Oliphant, the Monroe County deputy prosecuting attorney, promises that police will not arrest people with a card.[149] Only time will tell if these efforts will earn the trust of intravenous drug users.

These accounts of Indiana needle exchange programs' struggles in reaching intravenous drug users show that there is still much work needed to be done. Therefore, changing Indiana's drug paraphernalia laws to decriminalize the possession of hypodermic needles would be an important show of support towards drug addicts and encourage them to seek help before they contract HIV or any other dangerous disease through the use of contaminated needles.

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[146] Emily Beck, *Needle Exchange Fights Stigma Against Drug Users, HIV Outbreak*, IND. DAILY STUDENT (Feb. 24, 2016 at 11:01 PM), http://www.idsnews.com/article/2016/02/needle-exchange-fights-stigma-against-drug-users-hiv-outbreak [https://perma.cc/57EU-K658].

[147] *Id.*

[148] *Id.*

[149] *Id.*

2. Remove Remaining Restrictions for Establishing Needle Exchanges

In addition to modifying the state drug paraphernalia laws to show support towards addicts, changes must also be made regarding Indiana's policy towards setting up needle exchange programs. Prior to the 2015 HIV outbreak, Indiana law did not explicitly authorize needle exchange programs.[150] It was not until the HIV outbreak reached epidemic levels and Governor Pence issued a public health emergency in Scott County that needle exchanges were allowed to begin operation.[151] Senate Bill 461, passed as a response to the epidemic, legalizes needle exchanges so long as local officials can show the following: that a future outbreak is spreading through intravenous drug use; that the needle exchange program is part of an appropriate response to the crisis; and that the state health commissioner has approved the plan.[152]

Unfortunately, Indiana's current policy on needle exchanges as codified through Senate Bill 461 remains too restrictive to effectively prevent future outbreaks.[153] Senate Bill 461 only allows an approved needle exchange to operate for one-year before requiring renewal by the state health commissioner.[154] This limitation drastically underestimates HIV's long-term presence, which has been estimated by current Indiana State Health Commissioner Jerome Adams as being likely to persist in Scott County for the next 40 to 50 years.[155] Furthermore, although a needle exchange program may succeed in temporarily eliminating an

[150] Strathdee & Beyrer, *supra* note 21, at 398.
[151] *Id.*
[152] Ind. Code § 16-41-7.5-5.
[153] *See* Strathdee & Beyrer, *supra* note 21, at 397-99.
[154] Ind. Code § 16-41-7.5-5.
[155] Hayden, *supra* note 9.

epidemic within the one year restriction, this limitation ignores the fact that drug addictions are chronic diseases that will tempt addicts regardless of known health risks.[156] Additionally, the requirement that counties must show that there is an ongoing public health emergency before receiving permission to establish needle exchanges ensures that these programs can only be reactionary rather than preventative, thereby almost guaranteeing that a number of addicts will have transmitted the disease before clean needles can be distributed.[157]

Sadly, Indiana officials appear content to let the current flawed policies remain in place, as members of Indiana's public health, behavioral health and human services committee decided during its final meeting of the fall 2015 session that the state's current needle exchange policies are sufficient.[158] Members of the committee stated they were open to re-examining the program in the future if it becomes clear that the current approach is failing,[159] but as the Scott County outbreak showed, a preventive, rather than reactionary, approach is required to prevent a future epidemic.[160] If Indiana's public servants truly want to prevent a repeat of the 2015 tragedy, then a new aggressive public health strategy must be introduced.[161]

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[156] Strathdee & Beyrer, *supra* note 21, at 398.

[157] *Id.*

[158] Zach Osowski, *Health Committee Won't Change Needle Exchange*, EVANSVILLE COURIER & PRESS (Oct. 27, 2015), http://www.courierpress.com/news/state/health-committee-wont-change-needle-exchange-231678b9-7efb-0abf-e053-0100007fd105-337655211.html [https://perma.cc/8AMB-PK8C].

[159] *Id.*

[160] Strathdee & Beyrer, *supra* note 21, at 398.

[161] *Id.*

3. Introduce an Expansive Public Health Strategy

Ultimately, these restraints on establishing needle exchanges in Indiana shows that state legislators have a fundamental misunderstanding of how diseases spread among intravenous drug users. Only an aggressive, expansive public health strategy can prevent future outbreaks in Scott County and across the state.[162] As mentioned above, changes should be made to existing law such as decriminalizing the possession of drug paraphernalia and allowing needle exchanges to operate in perpetuity.

a. Monitor rural communities

Changes must be made in monitoring the warning signs of potential outbreaks.[163] Historically, HIV has been an urban disease, with most HIV attention and resources going towards inner cities.[164] Most HIV outbreaks in America have occurred in urban areas among black males older than 35.[165] The demographics in the Scott County outbreak were almost complete opposites of past American HIV epidemics, however. Whereas HIV outbreaks have typically affected urban black communities, the Scott County outbreak was mostly composed of young Caucasians in rural communities and was almost evenly distributed between men and women.[166] The Scott County HIV outbreak shares many of the same characteristics of the current heroin epidemic growing across America.[167] Therefore, when predicting

[162] *Id.*

[163] *Id.* at 397-98.

[164] Kenning, *supra* note 1 (statement of Garith Fulham) ("We've neglected rural America. . .")

[165] Strathdee & Beyrer, *supra* note 21, at 397.

[166] *Id.*

[167] *Id.*

where future outbreaks may occur, state health officials should specifically monitor areas afflicted with high rates of heroin addiction and hepatitis C, another strong indicator of potential HIV outbreaks.[168]

b. Focus on areas also suffering from hepatitis C outbreaks

In fact, hepatitis C may be the most indicative warning sign to look for when analyzing potential areas most at risk of HIV outbreaks.[169] Sumathi Ramachandan, of the CDC's Division of Viral Hepatitis, reported that hepatitis C had been present in Scott County for several years, allowing for multiple strains of the disease to be introduced over time.[170] A CDC study found 312 incidents of hepatitis C overlapping with the HIV cluster in Southeastern Indiana, with 25% of patients being co-infected with both diseases.[171] These findings were discovered by the CDC's computer toolkit GHOST (Global Hepatitis Outbreak and Surveillance Technology), which was first deployed for the Indiana outbreak.[172] The GHOST system's findings have led investigators to determine that hepatitis C had been present in Scott County for much longer than the HIV strain and that its presence in low-income rural communities should serve

[168] *Id.* (stating that in 2011 an outbreak of hepatitis C occurred in Southeastern Indiana affecting rural, white Hoosiers almost evenly between men and women. Hepatitis C has increased along with the rise of intravenous drug use in America, growing 75% between 2010 and 2012 alone).

[169] Michael Smith, *Drug-Fueled Indiana HIV Outbreak Was 'Preventable'*, MEDPAGE TODAY (Feb. 26, 2016), http://www.medpagetoday.com/MeetingCoverage/CROI/56416 [https://perma.cc/FN2U-74NV].

[170] *Id.*

[171] *Id.*

[172] *Id.*

as a warning sign for high rates of injection drug abuse.[173] The CDC's Division of HIV/AIDS Prevention insists that other communities with similar demographics to Scott County keep tabs on hepatitis C outbreaks, as knowing about the disease's growing presence "would allow local health officials to put treatment and prevention services in place."[174]

Luckily, it appears as if Indiana is taking the connection between hepatitis and HIV seriously. The four additional Indiana counties who have received approval to begin operating needle exchanges as of February 2016—Scott, Fayette, Madison, and Monroe County—all have high rates of hepatitis C.[175] Continuing to look for these warning signs is a vital component in preventing future outbreaks from occurring.

c. Provide additional funding for public health programs

State officials must also funnel additional funding for substance-abuse treatment in rural Indiana.[176] Scott County's health department has long been underfunded, and over the past decade "state and federal budget cuts [have] triggered the elimination of healthcare services for special needs children, shut down the county's home health care agency and well child care facility, and closed the county's only clinic that provided free, anonymous HIV and STD

[173] *Id.*

[174] *Id.*

[175] Paula French, *Indiana's HIV Outbreak: What Happened, and What Now?*, THE GAY WORD (Feb. 18, 2016), http://thegayword.com/indianas-hiv-outbreak-what-happened-and-what-now/ [https://perma.cc/L9MG-PZDE].

[176] Strathdee & Beyrer, *supra* note 21, at 398.

testing."[177] Although the spread of HIV in Scott County cannot be entirely blamed on the closing of this testing facility—a Planned Parenthood location—it highlights the damage caused by the recent decline in funding across the entirety of Indiana's health infrastructure.[178] Decreasing funding affects all Indiana communities, but the harm is most severely felt in less populated areas such as Scott County where vulnerable citizens have fewer options for seeking help.[179]

In addition to adding more testing facilities, Indiana must make sure that its poorer citizens most at risk of abusing intravenous drugs are provided health care to treat their addiction. 42% of drug addicts participating in a national poll cited lack of health care as the main reason they have been unable to receive treatment for their disease.[180] The recently passed Affordable Care Act, which requires insurance companies to provide treatment for drug addicts, is a step in the right direction for combating the disease and providing addicts with much needed medical help.[181] Allowing these poorer citizens access to essential HIV medication such as methadone and buprenorphine will not only improve these addicts quality of life, but can also lower the chances of contracting HIV if taken before injection.[182] Unfortunately, Indiana was slow in adopting Medicaid expansion, as it did not go into effect statewide until

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[177] Segall, *supra* note 83.

[178] Rae Paoletta, *A Severe HIV Outbreak in Southeastern Indiana Could Cost $58 Million in Treatment*, MTV NEWS (Dec. 28, 2015), http://www.mtv.com/news/2718201/indiana-hiv-outbreak-treatment-58-million-dollars, [http://perma.cc/UX28-WSLG].

[179] *Id.*

[180] Strathdee & Beyrer, *supra* note 21, at 398.

[181] *Id.*

[182] *Id.*

February 1, 2015.[183] The state's failure to provide affordable health care for poor rural communities in a timely manner allowed the Scott County outbreak to grow, indicating that allocating more funds towards health services is a necessary step in preventing future outbreaks.[184]

d. Renewed focus on the prescription drug epidemic

Changes must also be made regarding prescription drug abuse. Prescription drug abuse is a growing epidemic across all of America; an estimated 46 Americans die a day from prescription drug overdoses, and over 6 million Americans suffer from prescription drug abuse disorders.[185] Drug overdoses have increased five-fold in Indiana since 1999 and surpassed motor-vehicles as a leading cause of death in 2008.[186]

Prescription drug abuse first became a growing concern in the late 1990s.[187] The rise of prescription painkiller abuse was caused by doctors overprescribing these drugs, which in

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[183] *State Decisions on Health Insurance Marketplaces and the Medicaid Expansion*, HENRY J. KAISER FAM. FOUND. (Dec. 17, 2015), http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/#note-1 [https://perma.cc/HP2N-Z39Y].

[184] Strathdee & Beyrer, *supra* note 21, at 398.

[185] *Welcome*, BITTERPILL.IN.GOV, http://www.in.gov/bitterpill/, [http://perma.cc/5C7E-NC7T].

[186] IND. ST. DEP'T HEALTH, SPECIAL EMPHASIS REPORT: DRUG OVERDOSE DEATHS, 1999-2013 (2015), http://www.in.gov/isdh/files/2015_SER_Drug_Deaths_Indiana_Updated.pdf, [http://perma.cc/K8MN-V3H6].

[187] Daniel Raymond, *Injecting Opana: Indiana's HIV Outbreak and America's Opioid Epidemic*, HARM REDUCTION COALITION, http://harmreduction.org/blog/injecting-opana-indianas-hiv-outbreak-and-americas-opioid-epidemic/ (last visited Mar. 2, 2015) [http://perma.cc./UL5M-EGBS].

turn flooded the marketplace and allowed abusers and addicts to easily feed their addiction.[188] To combat the growing epidemic, federal and state policy have focused primarily on controlling the supply of prescription opioids by "shutting down pill mills, developing opioid prescribing guidelines, establishing prescription drug monitoring programs, setting up takeback days to dispose of unused prescription drugs, and other strategies."[189] These policies may have succeeded in limiting the number of opioid prescriptions, but they largely ignored those citizens who became addicted while supply was still high.[190] As the available reserves of prescription opioids dried up, many addicts turned to injecting heroin and whatever prescription opioids they could access.[191] In Scott County the drug Opana became the opioid of choice for injection among addicts due to its cheap cost and ready availability in the area.[192]

Policy makers should therefore place an added focus on treating existing opioid addicts to combat the spread of disease among intravenous drug users. In order to prevent recovering addicts from relapsing, drug treatment programs should provide addicts with FDA-approved medications such as methadone and buprenorphine to help ease them off opiates.[193] Additionally, providing addicts and their families with naloxone, a drug used to prevent fatal overdoses, would be a strong show of support for those most at risk.[194]

Placing more focus on treating prescription drug addicts does not mean that policies regulating prescription opioids should be dropped, although certain changes should be

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[188] *Id.*
[189] *Id.*
[190] *Id.*
[191] *Id.*
[192] Kenning, *supra* note 1.
[193] Raymond, *supra* note 187.
[194] Strathdee & Beyrer, *supra* note 21, at 398.

made. More training for health care providers regarding appropriate opioid prescribing practices would help ensure that these drugs go only to those who truly need access to them.[195] Screening patients for opioid dependency, treating those who show signs of addiction, and alerting other local doctors of these patients' addictions would also prevent giving addicts unfettered access to the source of their addiction.[196] These changes, in conjunction with a new added focus on treating those already addicted to opioids, would go a long way to preventing future HIV outbreaks in Indiana.

4. Look to Previous Successful Needle Exchanges for Inspiration

In addition to the policy changes recommended above, Indiana legislators should look at the success of other previous needle exchanges from both inside the United States and across the world for inspiration in creating its own comprehensive plan.[197] In 1984, Amsterdam became the first city to start a needle exchange program.[198] Although the program focused primarily on targeting the spread of hepatitis among intravenous drug users, a 2012 study released at the Washington AIDS Conference revealed that

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[195] *Id.* at 399.

[196] *Id.*

[197] Austin Coleman, *Needle Exchange Programs*, COUNCIL OF STATE GOVT'S KNOWLEDGE CTR. (June 25, 2015, 3:30 P.M.), http://knowledgecenter.csg.org/kc/content/needle-exchange-programs, [http://perma.cc/LM9V-LKFW].

[198] Tyler Curry, *Congress Moves to Lift Federal Ban on Clean Needle-Exchange Programs*, HIV PLUS MAG (Dec. 11, 2015, 5:45 P.M.), http://www.hivplusmag.com/prevention/2015/12/11/congress-moves-lift-federal-ban-needle-exchange-programs, [https://perma.cc/FP9S-CLJZ].

new HIV diagnoses from the city had fallen to nearly zero.[199] Other nations such as Canada have also succeeded in implementing successful needle exchange programs in recent years.[200]

Indiana legislators can also look towards the numerous successful domestic programs for inspiration. Rhode Island's needle exchange program ENCORE (Education, Needle Exchange, Counseling, Outreach, and Referral) has operated since 1994 with support from the Rhode Island Department of Health.[201] With three fixed locations and a mobile unit, ENCORE serves a valuable role as Rhode Island's only currently-operating needle exchange program.[202] Programs at the city-level have also proven successful in combating the spread of HIV, as New York City's various needle exchanges combined to limit new cases of HIV to 150 among its estimated 150,000 injection drug users in 2012.[203]

Indiana policy makers should focus on Washington, D.C.'s recently established needle exchange in particular to see the financial benefits these operations can provide. From 1998 through 2007, Congress banned Washington, D.C. from financing needle exchange programs within the city's

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[199] *Id.*

[200] An explosive HIV outbreak among injection-drug users in Vancouver, British Columbia, which resulted in an HIV incidence of 18.6 per 100 person-years in 1996, was controlled by expansion of needle-exchange programs and provision of opioid-agonist therapy free of charge through Canada's universal health care system. Strathdee & Beyrer, *supra* note 21, at 399.

[201] Rayland Joseph et al., *Hepatitis C Prevention and Needle Exchange Programs in Rhode Island: ENCORE*, 97.7 R.I. MED. J. 31, 33 (2014).

[202] *Id.* at 32-34.

[203] Curry, *supra* note 198.

limits.[204] In 1998 the Financial Services Appropriations Bill included language that made D.C. the only city in the US prohibited from using municipal revenue to support needle exchanges.[205] During this time private donations and grants from non-governmental charities were the only means of financial support for the city's only needle exchange in operation.[206] This ban lasted until December 2007 when President George W. Bush signed the 2008 Financial Services Bill, the first version in a decade that did not contain language prohibiting the use of locally generated revenue for funding needle exchanges.[207]

After lifting the ban in late 2007 the publicly-funded D.C. needle exchange program began offering free sterile syringes, HIV tests, condoms, and referrals to additional treatment.[208] A recent study on the effects of lifting the Washington, D.C. ban and the subsequent implementation of a city-funded needle exchange program supports the removal of bans across the country.[209] The study used a modeling system to determine that 296 new cases of HIV would have occurred within two years had the ban remained in place.[210] However, only 176 new cases of HIV actually occurred within the two-year span, indicating that lifting the ban prevented 120 new cases.[211]

In addition to saving lives, the study also concluded that removing the ban saved the city approximately 44.3 million

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[204] Monica S. Ruiz et al., *Impact Evaluation of a Policy Intervention for HIV Prevention in Washington, DC*, 20 AIDS AND BEHAVIOR 22, 23 (2016).

[205] *Id.*

[206] *Id.*

[207] *Id.*

[208] Ungar, *supra* note 27.

[209] *See generally* Ruiz et al., *supra* note 204.

[210] Ungar, *supra* note 27.

[211] *Id.*

dollars.[212] Financing the needle exchange cost the city $650,000 in its first two years of operation; in comparison, the lifetime costs associated with treating a single HIV case costs $380,000.[213] The money saved in implementing preventive rather than reactionary measures should appeal to Indiana legislatures in particular, as the recent HIV outbreak in Indiana is estimated to cost Hoosier taxpayers anywhere from $160 to $250 million.[214] The researchers behind this study concluded that their research "provides support for the adoption of a more comprehensive and integrated approach to HIV prevention that incorporates the influence of social, structural, and policy-level factors as possible drivers of individual- and community-level risk."[215]

Unfortunately, relying solely on state-operated programs such as ENCORE has often proven to be insufficient in combating the spread of disease through intravenous drug use.[216] Due to limited resources across state and local governments, additional federal support is required in order to truly combat the spread of HIV not only in Indiana, but across the entire country.[217]

5. The Need for Federal Support and Aid

Research from numerous national and global organizations has concluded over the past two decades that needle exchanges are successful components of strategies combating the spread of HIV among intravenous drug

[212] Ruiz et al., *supra* note 204, at 26.

[213] *Id.*

[214] Segall, *supra* note 135.

[215] Ruiz et al., *supra* note 204, at 27.

[216] *See* Coleman, *supra* note 188, at 2-3 (reporting that in Rhode Island from 2008 through 2009 only 28% of intravenous drug users searching for help with their addiction were able to access the ENCORE program).

[217] Hulkower & Wolf, *supra* note 25, at 339.

users.[218] But despite knowing of these benefits for years, the Federal Government continued to block funding for needle exchanges from 1988 through 2015.[219]

Fortunately, it appears as though Congress is finally acknowledging the benefits of needle exchange programs. On December 18, 2015, Congress approved an omnibus spending bill that contained provisions softening the freeze on federal funding for needle exchange programs.[220] This bill allows for federal funds to be used towards certain program expenses such as staff, vehicles, and supplies, with the sole exception being the cost of the actual needles.[221]

This easing of the federal ban will hopefully inspire states to change their approaches to needle exchanges. Lifting the federal ban should send a clear message to the states that the Federal Government is moving away from the punitive approach of the War on Drugs.[222] This in turn should encourage hesitant state governments to take further actions in stopping the spread of HIV, such as changing restrictive drug paraphernalia statutes and providing local funds for the operation of needle exchanges.[223]

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[218] National health organizations in support of needle exchange programs include "the American Medical Association, the American Public Health Association, the NAS, and the American Academy of Pediatrics;" global organizations include "the World Health Organization, the World Bank, and the International Red Cross-Red Crescent Society." Additionally, the American Bar Association strongly supports ending the ban. THE AM. FOUND. FOR AIDS RES., *supra* note 10.

[219] Curry, *supra* note 198.

[220] Phillip Smith, *Spending Bill Just Passed by Congress Includes Important Drug Reforms*, DRUG WAR CHRON. (Dec. 18, 2015, 3:31 P.M.), http://stopthedrugwar.org/chronicle/2015/dec/18/spending_bill_just_passed_congre, [http://perma.cc/9KYD-HN25].

[221] Wen, *supra* note 24.

[222] Hulkower & Wolf, *supra* note 25, 340–41.

[223] *Id.*

Perhaps changes in perception towards needle exchanges are already taking place. The inclusion of this provision into the omnibus spending bill was championed in both the House of Representatives and the Senate by Congressman Hal Rodgers and Senator Mitch McConnell, both Republican politicians from Kentucky.[224] Much like nearby Scott County in neighboring Indiana, Kentucky has been hit hard by the opioid epidemic, as the commonwealth suffers more than 1,000 overdose deaths a year.[225]

Despite Representative Rodgers being one of the biggest proponents of easing the ban, he remains opposed to allocating federal funds to the needles themselves.[226] Although needle exchange advocates have said that this limitation is not a deal breaker,[227] it highlights that there are still lingering problems that both the federal and state governments need to address. Only 17 states currently authorize needle exchange programs, thereby rendering this action ineffective in aiding states with bans on these programs such as Florida, Pennsylvania, and West Virginia.[228] Needles also remain classified as drug

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[224] Laura Ungar, *Funding Ban on Needle Exchanges Effectively Lifted*, USA TODAY (Jan. 7, 2016, 7:28 P.M.), http://www.usatoday.com/story/news/nation/2016/01/07/funding-ban-needle-exchanges-effectively-lifted/78420894/# [https://perma.cc/74JU-6AUX].

[225] *Id.*

[226] *Id.*

[227] Daniel Raymond, policy director for the Harm Reduction Coalition, told NPR that the restriction on using funds to purchase needles is "a compromise we can work with" and colleagues he has spoken to claim that it is not a deal breaker. *All Things Considered: Congress Ends Ban On Federal Funding For Needle Exchange Programs*, NPR (Jan. 11, 2016, 2:01 P.M.) (streaming at http://www.npr.org/2016/01/08/462412631/congress-ends-ban-on-federal-funding-for-needle-exchange-programs [https://perma.cc/DC3J-MMZQ]).

[228] Wen, *supra* note 24.

paraphernalia in 36 states, further reducing the positive effects of this change in federal policy.[229] Although lifting the ban will help fund existing programs, public health providers and advocates must continue to raise awareness and federal agencies must support their actions for this move to make positive inroads in curbing the spread of HIV.

Additionally, federal government policy makers still must change their approach towards addiction so that their actions tackle the source of the problem; possible methods towards combating addiction include providing medication treatment and psychosocial support for addicts.[230] One of the most important steps is to cut off the supply of opioids into local communities. In February 2016, local, state, and federal officers working together disbanded the drug ring thought to be behind the supply of Opana in Scott County.[231] U.S. attorney Josh Minkler, who helped organize the investigation, notes that cutting off a source of the drugs is only one step in combating the spread of HIV, however.[232] "A public health crisis will not be solved by simply arresting those who illegally sell drugs. It also requires a reduction in demand for illegal drugs," said Minkler.[233] Minkler also argues for the necessary role of cooperation among the various levels of government, stating that preventing future outbreaks "can only be accomplished by all of us—federal, state and local authorities along with public and private partnerships working together for prevention and

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[229] *Id.*

[230] *Id.*

[231] Ed Cara, *HIV Outbreak in Indiana: DEA Arrests 10 People Tied to Disease Spread, Warns Against Prescription Painkillers*, MED. DAILY (Feb. 7, 2016, 3:46 P.M.), http://www.medicaldaily.com/hiv-outbreak-indiana-prescription-painkillers-372554, [https://perma.cc/7BUK-6JWA].

[232] *Id.*

[233] *Id.*

treatment."[234] This response shows that government officials are aware that there are still many remaining steps to be taken to combat intravenous drug use, but health care officials are right to remain skeptical until further policies have actually been implemented.

Furthermore, because the CDC is in charge of identifying the at-risk areas that will receive federal funds, health care advocates are concerned that rural areas will not receive the support they need.[235] Although many rural areas in Indiana, Kentucky, and West Virginia have been the face of the current HIV and hepatitis outbreaks, some advocates are concerned that these areas will be overlooked for more densely populated urban areas.[236] Studies estimate that ten percent of all American doctors practice in rural areas, making it incredibly important that these areas receive funding that will allow for mobile clinics to reach the greatest number of at-risk individuals as possible.[237]

Only time will tell if the recent lifting of the federal ban on funding for needle exchanges will effectively combat the spread of HIV among intravenous drug users. There is a real concern that any programs established by federal funding will only be revoked in coming years with potential changes in policy caused by the 2016 elections.[238] The federal ban being lifted in late 2009 only to be reinstated in 2012 warns that this victory may be short lived. Despite these valid concerns, this change in policy should still be celebrated, so

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[234] *Id.*

[235] Stacey Burton-Alcocer, *Lifting the Federal Ban on Needle Exchanges: Is It Enough?*, NONPROFIT QUARTERLY (Jan. 11, 2016), https://nonprofitquarterly.org/2016/01/11/lifting-the-federal-ban-on-needle-exchanges-is-it-enough/, [https://perma.cc/LYN8-MJSU].

[236] *Id.*

[237] *Id.*

[238] *Id.*

long as policy makers remember that further actions are needed to prevent disease and save lives.[239]

V. CONCLUSION

Since the mid-1990s, numerous reports have shown that needle exchanges are effective,[240] cost-efficient programs.[241] Exchanges help combat the spread of HIV and other diseases among intravenous drug users and have garnered the support of numerous health agencies across the world.[242] Despite these benefits, needle exchanges have largely been unutilized because they are incompatible with the United States' policy in the War on Drugs.[243]

Indiana is one of many states that model their approach to intravenous drugs and those addicted to them after the federal government's War on Drugs.[244] The failure of various Indiana laws and policies regarding intravenous drugs contributed to the 2015 HIV outbreak in Southeastern Indiana that resulted in 188 confirmed HIV diagnoses in a little over a year.[245] Although the outbreak peaked in the summer of 2015, its affects will linger in the community for years to come.[246]

In order to prevent a future outbreak, Indiana must completely overhaul its stance on needle exchanges and intravenous drug use.[247] Although Indiana lawmakers loosened certain longstanding restrictions on needle exchange policies, there are still too many limitations in the

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[239] Wen, *supra* note 24.
[240] Seelye, *supra* note 28.
[241] THE AM. FOUND. FOR AIDS RES., *supra* note 10.
[242] Hulkower & Wolf, *supra* note 25, at 309.
[243] *Id.* at 339.
[244] *Id.*
[245] Graham, *supra* note 4.
[246] Hayden, *supra* note 9.
[247] Strathdee & Beyrer, *supra* note 21, at 397-99.

legislation that must be modified. In addition to loosening its restrictions on operating needle exchanges, Indiana must also adopt an aggressive public health strategy that focuses on preventing, rather than reacting to, potential future outbreaks.[248] Components of this strategy should include placing added emphasis on rural communities, focusing on areas suffering from high numbers of Hepatitis C diagnoses, taking inspiration from other successful needle exchange programs, and decriminalizing the possession of hypodermic needles. It is also vitally important to make drug addicts feel welcomed to search out treatment, as the current stigma around substance abusers makes it difficult for many addicts to search for the help they need. Finally, although the federal government recently loosened its ban on federal funding for needle exchanges, work still must be done across the board to ensure that these programs run both effectively and efficiently. Only by addressing the problem from both a state and federal level can another potential tragedy be avoided.

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[248] *Id.* at 398.