Wild . . . But Not So Wonderful—Responding to Injection Drug Use in West Virginia

See also Allen et al., p. 445.

“One doesn’t have to operate with great malice to do great harm. The absence of empathy and understanding are sufficient.”
—Charles M. Blow

More than 70,000 people died of a drug overdose in the United States in 2017, and opioids were involved in two thirds of those overdose deaths.2 By every measure, West Virginia is at the heart of the “opioid epidemic.” Our state ranks first in fatal drug overdose rates; first in neonatal opioid withdrawal syndrome rates; and first and second, respectively, in rates of acute hepatitis B and C infection, which like HIV are transmitted through injection drug use (IDU).2–4

Although HIV prevalence in West Virginia is low, we have a higher proportion of counties categorized by the Centers for Disease Control and Prevention as “most vulnerable” to an injection-related HIV outbreak than any other state.5

STIGMA VS SCIENCE

Stigma surrounding illicit drug use and medication-assisted treatment undoubtedly informs related medical and public health responses in West Virginia. It was here in May 2017 that former Health and Human Services secretary Tom Price said, “If we’re just substituting one opioid for another [by prescribing medication-assisted treatment], we’re not moving the dial much.” The idea that opioid use disorder is not a medical condition that warrants clinical treatment but a moral failing best addressed outside the health care system is a common misconception in West Virginia and other rural communities. This attitude is the greatest obstacle to expanding evidence-based services that will bring the “opioid epidemic” under control.

The extent and power of this stigma was on full display in early 2018, when political and public opposition resulted in the closure of West Virginia’s largest harm-reduction program. These programs provide access to sterile syringes to prevent transmission of viral hepatitis and HIV; offer testing and linkage to care for these infections; distribute naloxone, the drug that reverses opioid overdoses; and provide referrals to drug treatment. There is 30 years of compelling, peer-reviewed science that demonstrates the effectiveness of these programs in reducing harms associated with IDU. In 2015, county health departments and one community-based organization, Milan Puskar Health Right, began offering these programs in West Virginia in an effort to reduce IDU-associated morbidity and mortality.

The Kanawha–Charleston Health Department (KCHD) ran one such program. It secured broad support from local stakeholders, including Charleston’s mayor and police chief, before opening in December 2015. The program was run by professional staff who adhered to protocols reflecting best practices for harm-reduction programs. It also met state guidelines for harm-reduction grantees and was certified by the West Virginia Department of Health and Human Resources. KCHD clients were offered 30 or fewer sterile syringes per visit (depending on how many used syringes they returned), testing for hepatitis and HIV, and referrals to drug treatment. Naloxone distribution and training were provided weekly, and primary care services were offered on-site through partnership with a federally qualified health center. Although comprehensive, the clinic operated only during a five-hour window on Wednesdays because of limited funding. An additional two hours on Thursdays were added in January 2018.

KCHD’s harm-reduction program grew quickly, serving 5039 clients in 2016 and 15,521 in 2017. Clients came from both within and outside Charleston. As it grew, the program was increasingly criticized by local policymakers. Charleston’s mayor publicly called it a “needle mill” and a “mini-mall for

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LIMITED TREATMENT OPTIONS

In the face of these grim statistics, one would expect a sense of urgency in scaling up evidence-based treatments for opioid use disorder. Medication-assisted treatment, including methadone and buprenorphine, are proven to reduce illicit opioid use, risky injection behaviors, and overdose mortality. Yet West Virginia has had a moratorium on new methadone programs since 2007, leaving only nine clinics operating in the state. West Virginia Medicaid does not cover methadone maintenance, presenting another barrier to treatment. Buprenorphine provides a more accessible route to medication-assisted treatment because it is covered by Medicaid and prescribed in primary care settings. However, state laws and regulations impose burdensome requirements, including mandatory professional therapy for patients, urine drug screens, and rules governing treatment termination for noncompliance that serve as both barriers and disincentives to prescribing. Currently, almost half of the state’s 55 counties do not have a single federally certified buprenorphine provider. The result is that, in most West Virginia communities, medication-assisted treatment is more difficult to obtain than are the illicit opioids it is designed to address.
junkies” and blamed it for producing a “crime wave” in the city (http://bit.ly/2TwwMsA). He asserted that the program had “blanketed [Charleston] with dirty hypodermic needles” and was adversely affecting the economic prosperity of a nearby mall and newly built convention center (http://bit.ly/2RghVGm). A mayoral candidate made opposing the program a centerpiece of his political campaign, blaming it for attracting “a criminal transient population” to Charleston (http://bit.ly/2TzadUj). After the police chief mandated that the program revise its protocols to include practices that directly contradicted effective and ethical harm-reduction practice (e.g., mandatory testing for blood-borne infections, dispensing re- tractable syringes) the KCHD program and its subsequent closure served as a strong disincentive to opening new programs. Currently, only 17 West Virginia counties have a harm-reduction program, leaving residents from the remaining 38 counties without access. Where programs exist, most operate only two hours per week (or less) because of insufficient funding, making access difficult even for eligible residents. All of this amounts to an extraordinary deficit in services for people who inject drugs in West Virginia at a time when overdose deaths are at record-high rates and the state is teetering on the precipice of a serious HIV outbreak.

It is in this context that Allen et al. (p. 445) offer their article in this issue of AJPH, which estimates the prevalence of IDU in Cabell County, West Virginia. Their estimate of 2.5% is astonishingly high, ranking Cabell County among such urban areas as Baltimore, Maryland, and San Francisco, California. Even more concerning is that almost half of respondents used a syringe in the past six months that had already been used by someone else, putting them at high risk for viral hepatitis and HIV infection. Another striking finding is that 71% recently used methamphetamine, confirming reports that meth is a serious concern in West Virginia and other rural states. Policymakers and providers must consider that a singular focus on opioids is inappropriate for what is clearly an increasingly complex drug landscape in rural America.

West Virginia, like many rural states across the United States, is in crisis. It is a crisis brought on not just by high rates of IDU but also by the refusal of policymakers to support and defend programs that are scientifically proven to reduce IDU-related morbidity and mortality. Stigma, whether rooted in lack of empathy or lack of understanding, is at the heart of this refusal. It is incumbent on all of us to challenge this stigma for the great harm it does. Our ability to do so will determine whether our communities—and our neighbors—survive the “opioid epidemic.”

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CONFLICTS OF INTEREST
The author has no conflicts of interest to declare.

REFERENCES