

A microscopic image of plant tissue, likely a cross-section of a stem or leaf, showing various cell structures and vascular bundles. The image is in shades of blue and purple, with some cells appearing more densely stained than others.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

When Are “Paraphernalia” Critical Medical Supplies?

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Abstract

Evidence of harm reduction interventions’ morbidity and mortality benefits is abundant and of high quality, so there are good reasons for regional and national groups to advocate for more widespread distribution of legally regulated “drug paraphernalia,” including needles, syringes, and fentanyl test strips. But lack of consistency among states’ laws means that patients’ interstate travel can subject them to being charged with possession of illegal items. This commentary on a case offers guidance to clinicians looking to help patients understand legal risks of interstate travel with supplies that are prescribed or recommended to reduce harms of their drug use and explores the ethical responsibilities of physicians in jurisdictions that legally prohibit these harm reduction interventions.

Case

GG has opioid use disorder (OUD) with a history of multiple incidental overdoses. Part of GG’s OUD treatment plan, managed by a local clinic team, requires GG’s use of clean syringes and fentanyl test strips, a supply of which GG brings when visiting family. GG is pulled over by a state trooper just after crossing an interstate border. A search of the vehicle finds no illegal drugs, but GG’s syringes and test strips are confiscated. GG tries to explain, “Those are medical supplies I get from my clinic. I need those,” but GG is arrested and jailed for drug paraphernalia possession.

Commentary

We considered this case as physicians in Texas, which has an opioid crisis and laws that hinder distribution of harm reduction supplies, identified in state and federal law as “drug paraphernalia.”^{1,2} Texas state law and federal law define drug paraphernalia as “any equipment, product or material . . . primarily intended or designed for . . . processing, preparing, injecting, ingesting, inhaling . . . into the human body a controlled substance,”^{1,2} and Texas law also includes in its definition “testing equipment used or intended for use in identifying or in analyzing the strength, effectiveness, or purity of a controlled substance.”¹ In the last decade, Texas has experienced a steady increase in opioid-related deaths,³ with a sharp increase beginning in 2019, similar to national trends.⁴ Because in Texas and other states with similar laws patients’ interstate travel

can subject them to being charged with possession of illegal items, this commentary offers guidance to clinicians looking to help patients understand legal risks of interstate travel with supplies that are prescribed or recommended to reduce harms of drug use and explores the ethical responsibilities of physicians in jurisdictions that legally prohibit these harm reduction interventions.

Paraphernalia and Harm Reduction

Harm reduction strategies are important in limiting the morbidity and mortality associated with opioid and other substance use disorders (SUDs). Cities with syringe service programs (SSPs; previously described as **needle exchange programs**), where people who inject drugs obtain sterile needles and syringes for injection use, are associated with a decrease in HIV seroprevalence compared to an increase in HIV seroprevalences in cities without these programs.⁵ Meta-analyses confirm that SSPs are associated with decreases in HIV transmission.^{6,7} Similarly, fentanyl test strips, which allow for identification of drugs containing fentanyl, are a form of paraphernalia that serve as a preventive medical supply, given the association of fentanyl with overdose deaths.⁴ People who inject drugs identify fentanyl testing as protective against overdose and will alter their use behavior if a sample contains fentanyl.^{8,9,10} Indeed, fentanyl test strips are in high demand among people who inject opioids.¹¹ Expert consensus supports broad availability of fentanyl test strips as a component of **comprehensive harm reduction**.^{12,13,14} Thus, this evidence suggests that fentanyl test strips and sterile needles and syringes serve as medical supplies that decrease mortality and morbidity associated with injection drug use despite their regulation as drug paraphernalia in certain jurisdictions.

Legality of Service Programs

SSPs operate legally in 38 states, the District of Columbia, and Puerto Rico; they are present in an additional 6 states through unregulated or unauthorized programs.¹⁵ The Centers for Disease Control and Prevention recommends that SSPs “ensure low-threshold access to services.”¹⁶ The White House Office of National Drug Control Policy in 2021 helped to create a model SSP state policy to enhance consistency in program regulations across state lines.¹⁷ This model act outlines components of a high-quality SSP, including access to SUD treatment, testing and treatment for HIV and hepatitis, access to general and mental health care, data collection and reporting requirements, immunity from criminal charges and prosecution for SSP operators and patients, education and training materials for the community, and funding.¹⁷ Drafters of the model act took into account existing state laws that pose barriers to implementation of SSPs in attempting to draft model legislation that would reduce barriers to both program implementation and access to high-quality services and related referrals by not requiring “a potentially burdensome application process.”¹⁷ Nevertheless, states’ adoption of the model act has been slow, and laws imposing tight restrictions and limitations on care remain common.^{15,18} For example, states can require registration of participants and employees of the programs or methods of identification for the needles and syringes supplied by the SSPs or implement a one-to-one exchange model in which participants receive one clean hypodermic needle and syringe for every used one returned.¹⁵ These requirements likely limit engagement with SSPs, but, in Texas, SSPs and fentanyl test strip distribution to patients remain legally prohibited.^{15,19} The Texas Medical Association has unsuccessfully advocated for legal reform in these areas.^{20,21,22} The American Medical Association (AMA) also has policy supporting access to fentanyl testing strips and SSPs, including modification of paraphernalia laws to protect SSP patients and employees.²³

Harmonization of laws across state lines is critical, as differences between the states can delay care. For example, requirements in some states for identifiable needles and syringes and one-to-one exchange could lead to legal consequences for SSP patients crossing state lines who are not familiar with the laws in their new state or have not yet registered in an SSP.

Steps for Clinicians

Adopt the medical perspective. The ethics of SSPs is straightforward from a narrow utilitarian perspective in that the primary harm of opioid use is death; this harm provides a low bar for ethical analyses that frame the issues in terms of benefits counterbalancing the potential harm of death.^{24,25} However, in the public sphere, attitudes toward and perspectives on harm reduction strategies are more complicated. Arguments against harm reduction typically take the form of opposition to “enabling” and using tax or health care dollars to support illicit drug use.²⁶ This polarization around harm reduction can be understood through differences between medical and religious/legal/criminal justice understandings of illicit drug use. Physicians identify SUD as an illness resulting from multicausal, multilevel biopsychosocial vectors that requires evidence-based treatment, including harm reduction. For physicians, allowing individuals to die due to their behaviors **violates fundamental nonmaleficence** and beneficence principles. The legal and criminal justice systems understand drug use as wrongful but responsible, freely chosen behavior by individuals subject to punishment under the US retributive justice model, which is underpinned by the metaphysical assumption that punishment and allowing death by overdose are just deserts of illicit use and that harm reduction interventions serve to delay these just-desert consequences. Further analyses of this culture clash can be found in several recent publications.^{25,27,28} Clinicians should adopt the medical viewpoint, as this standpoint is lifesaving, more humane, and beneficent, and they are called to advocate for this approach under principle III of the AMA Principles of Medical Ethics: “A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.”²⁹

Provide disclosure and consent for patients traveling across jurisdictions. Conscientious care involves anticipating and preventing harms that patients might encounter and counseling them about legal risks posed by items such as syringes and test strips. Counseling should include informing patients that travel with their treatment materials might place them at risk of arrest when traveling to jurisdictions that either do not recognize or explicitly prohibit these harm reduction strategies.

Provide adequate support materials for traveling outside the home jurisdiction. Emerging guidance about traveling recommends that patients carry their materials in their suitcase using the original containers, including prescription information on the original container and a letter on official letterhead from the treating physician or treatment program that indicates that they are treatment materials^{30,31,32} and not paraphernalia. Syringes and needles are common suitcase objects for a variety of medical conditions and do not commonly elicit TSA queries in airport security screening.³² Nevertheless, patients should be counseled on being aware of differing laws across jurisdictions and carefully considering the risks and benefits of out-of-state travel with harm reduction supplies. The potential persists for criminal consequences of possession of these materials in jurisdictions that do not recognize them as legitimate medical equipment.

Be aware of personal risk in providing harm reduction materials to patients in unfriendly jurisdictions. The situation in which a conscientious physician in a forbidding jurisdiction seeks to provide harm reduction materials is the most ethically fraught situation under consideration. Our review of available information did not identify legal or professional regulatory consequences for conscientious, evidence-based practice in unfriendly jurisdictions. Physicians can mitigate legal or regulatory risk by seeking information assistance from state medical societies, as well as by using online state Department of Health or Department of Health and Human Services legal databases, such as those for Texas.^{33,34}

A professional obligation to care for one's patient in the face of some degree of risk to oneself is a personal decision for the doctor and patient. Two relevant principles from the AMA Principles of Medical Ethics illustrate this dilemma. Principle III states: "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient."²⁹ Principle IX states: "A physician shall support access to medical care for all people."²⁹ The case dilemma here involves a situation in which respecting the law involves denying access to medical care for a group of people. Advocating for change in this lamentable situation is recommended and might be considered an **ethical obligation**.

Conclusion

From a clinical perspective, harm reduction equipment being called "drug paraphernalia" is misleading and can compromise the care and safety of patients and place patients and physicians at legal risk. Sorting out the nomenclature of medical harm reduction strategies and equipment is a task to be addressed at the level of state regulation, assisted by organized medicine's advocacy. At present, important differences among states persist despite advocacy and policy guidance for standardization across state lines. These inconsistencies increase both health and legal risks experienced by people who inject drugs.

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Editor's Note

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Authors disclosed no conflicts of interest.

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