A Guide to Establishing Syringe Services Programs in Rural, At-Risk Areas

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I. INTRODUCTION

Key points:

- Increasing rates of injection drug use have led to increased rates of infectious disease in rural areas.
- Rural areas have fewer syringe services programs than urban areas.
- Syringe services programs reduce blood borne disease.
- Syringe services programs do not increase drug use.
- Syringe services programs are cost effective.
- Syringe services programs are typically the only location lay people can easily obtain naloxone.
- Syringe services programs provide clients with access to services such as health care, treatment, and other essential supports and services.

In 2015, Scott County, Indiana (population 24,000) saw unprecedented rates of Hepatitis C virus (HCV) and human immunodeficiency virus (HIV). These increased rates were driven by increasing rates of intravenous drug use in rural southern Indiana's Scott County. The small town of Austin, Indiana (population 4,200) in Scott County became the center of this outbreak. In March 2015, the Indiana State Department of Health reported nearly 80 new cases of HIV. CDC public health experts stated that some residents/persons were injecting a liquefied form of the prescription opioid Opana, up to 15 times a day. At the time, Indiana banned syringe services programs in the state. However, due to the outbreak of blood borne diseases such as HIV and hepatitis C virus (HCV) infections in the county, then Governor Pence declared an emergency. The declaring the emergency allowed the Scott County Board of Health to establish a "short term" syringe services program to provide new, sterile needles to community members who inject drugs. Following the issuance of the Executive Order, the Indiana state legislature passed SEA 461 in May 2015 to allow syringe services programs to be established in the state upon meeting very specific conditions. The legislation allowing syringe services programs in Indiana is set to expire in 2019.However; a bill was signed into law in 2017 that gives more authority to local governments to establish syringe services programs and extends the authorization period for syringe services programs until 2021.

Opioid misuse and overdose death rates have been at unprecedented levels in almost every state in the United States, however, rates are particularly high in rural counties. Lack of access to treatment, high rates of opioid prescribing, and scarcity of health services has exacerbated the opioid epidemic in many rural states. Health care providers, who can prescribe medication

assisted treatment using one of the three FDA approved medications for opioid use disorders, are scarce in rural areas. According to a 2012 study, only 3% of family physicians, the most common specialty in rural areas, were certified to provide buprenorphine to treat opioid use disorders.

In 2016, the Centers for Disease Control and Prevention (CDC) released a report published in Morbidity and Mortality Weekly Report (MMWR) that provided an overview of the risk for blood borne infections (human immunodeficiency virus (HIV) and hepatitis C (HCV) and hepatitis B virus infections) among people who inject drugs. While overall rates of injection drug use are decreasing, according to the CDC, white people who inject drugs accounted for more than 50% of the new initiates of people injecting drugs in 2015. The CDC warns in the 2016 MMWR that lack of access to syringe services programs in rural areas could lead the way to future increases in blood borne diseases. Of course, as resources to treat opioid use disorders are expanded, attention must be paid to making certain that facilities and health care resources are available in all at-risk communities, regardless of race or other demographic background.

After the outbreak in Indiana, the CDC identified 220 other counties vulnerable to a similar outbreak of HIV/HCV In its analysis, CDC examined indicators such as the number of drug overdose deaths, access to prescription opioids, access to buprenorphine, and sociodemographic characteristics such as per capita income, race, and unemployment rates. The CDC identified 26 states with more than 1 at-risk county. States with the most at-risk counties included West Virginia, Kentucky, Tennessee, Maine, Vermont, Pennsylvania, Indiana, Missouri, and Ohio. These states also have large rural populations and many of these states, until recently, had legal barriers to establishing syringe service programs. In addition, surveillance data from four predominantly rural states (KY, TN, VA, and WV) indicate a 364% increase in the number of acute HCV infections from 2006 to 2012.At the same time, there were few syringe services programs available in any of these states. A survey of syringe services conducted in 2013 found that 20% of syringe services programs were in a rural location.

While syringe services programs provide sterile syringes, they also provide other needed services such as screening for infectious disease, wound care, contraceptive access, treatment for substance use disorders or referral services, and other health care. Syringe services programs can also provide an important route for naloxone distribution to an at-risk population. Naloxone is an opioid antidote that reverses an opioid involved overdose, whether a prescription opioid, heroin, or fentanyl. Distributing naloxone widely and educating a community about overdose prevention has been shown to reduce overdose deaths.

Further, a 2017 study found that naloxone distribution at syringe services programs is cost-effective and yields health benefits. The study also found the greatest health benefits in syringe services programs that combined naloxone with linkages to addiction treatment and pre-

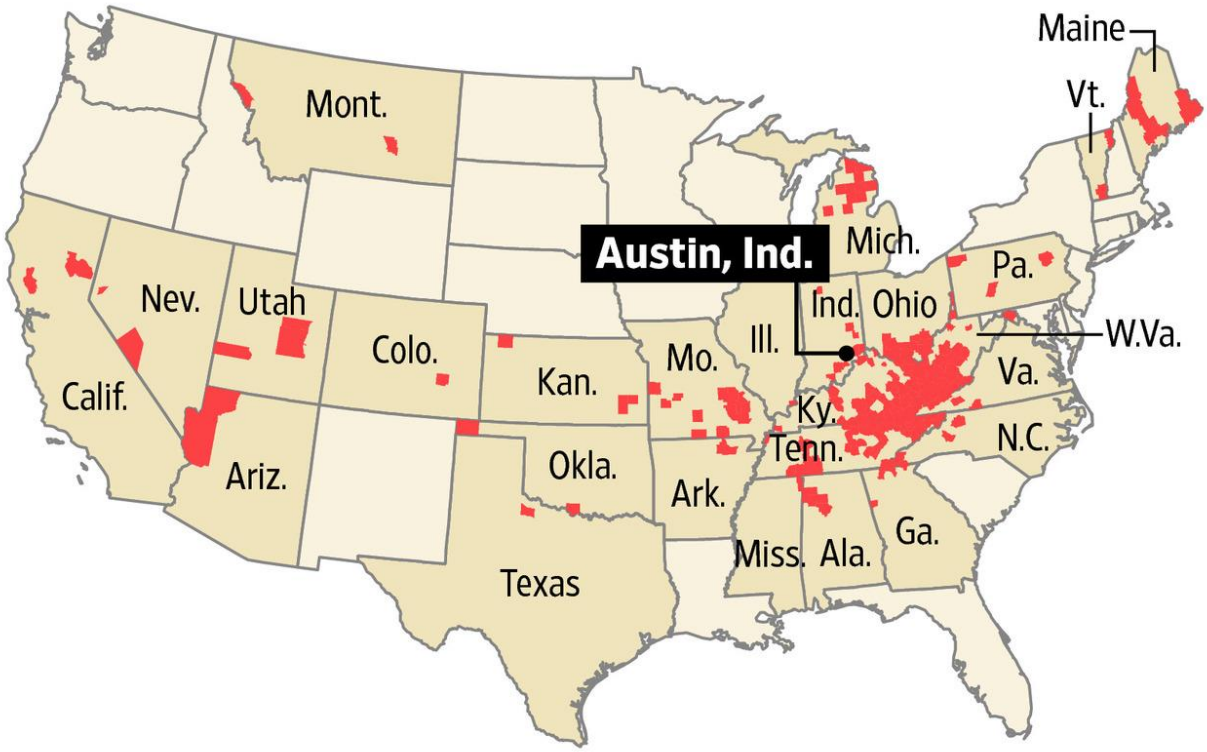
exposure prophylaxis or PREP. PREP is an anti-HIV medication that keeps HIV negative people from becoming infected.

Naloxone is a prescription drug and can be made available for distribution via a standing order if allowed under state law. A survey of syringe services programs conducted in 2013 found that 61% of urban syringe services program offered naloxone, while just 37% of programs in rural areas did. However, naloxone is increasingly being made available in most syringe services programs. Overdose reversal kits are available at syringe services programs in North Carolina to high-risk individuals. In West Virginia and Kentucky, naloxone is available through community clinics that host syringe services programs, as well as through local community groups such as the Kentucky Harm Reduction Coalition. The Network for Public Health Law provides an overview of all state laws on naloxone distribution and Good Samaritan Laws for calling 911 in case of an overdose.

Where Disease Eruption Is a Threat

A CDC report identified 220 counties where factors such as unemployment rates, overdose deaths and sales of prescription painkillers contribute to a high vulnerability for outbreaks of HIV and hepatitis C among injection drug users.

Counties vulnerable to outbreaks of HIV and hepatitis C



Source: Centers for Disease Control and Prevention THE WALL STREET JOURNAL.

It is well-established that syringe services programs are effective at decreasing blood borne diseases, as well as reducing the risk of needle stick for first responders, access to treatment and other health services. However, since they began in the 1980s, they have been the source of controversy and some contend, wrongly, that they perpetuate a permissive attitude toward drug use. There is no evidence to support the contention that syringe services programs increase drug use, crime, or the presence of discarded syringes.

Unfortunately, the call to establish syringe services programs[i] usually is preceded by a crisis in a community – increasing rates of opioid misuse, whether prescription drug or heroin, along with a lack of access to treatment -may presage an increase in HIV and HCV. The crisis exists and then the community must respond to the crisis.

The purpose of this guidebook is to provide information about the important role syringe services programs can play in the opioid epidemic. It can also be used for community members seeking to establish syringe service programs, ideally before an outbreak of HIV, HCV, or overdose deaths. This is not a technical guide to developing syringe services programs. Other guides exist to aid those who wish to develop these programs. However, this guidebook provides more recent data considering today's opioid epidemic and is intended to introduce community members to the basics of syringe services programs, identify the need for them in certain at-risk communities, and provide guidance on what to should consider when establishing these programs.

The term "syringe services program" is used throughout this guide although other terms are commonly used for such programs, including needle exchange programs (NEP), syringe access programs (SAP), and other terms. The term syringe services program is used because it more accurately reflects the array of services, including the distribution of sterile syringes, offered at such programs.

II. SYRINGE SERVICES PROGRAMS OVERVIEW

- Syringe services programs vary from mobile units to fixed or some sites have both a mobile presence and a fixed site.
- Syringe services programs vary in the types of services provided.
- Local communities should determine what types of services can be provided, and who should provide them (via consultations with people who inject drugs in the local community).

Syringe services programs began in Europe in the 1980s as part of an effort to reduce rates of blood borne diseases such as Hepatitis B virus (HBV) infection, HIV and HCV among people who inject drugs. Urban areas in the United States followed suit and initiated such programs. Boston, Massachusetts and Tacoma, Washington were the locations of some of the earliest syringes services programs in the United States. A 1989 article in The New York Times tells the story of the Tacoma site's development by a local activist, with the support of the local police chief. Amsterdam had early success in decreasing the rate of HIV infection among people who inject drugs by instituting syringe services programs. Syringe services programs have been controversial since their inception because of their association with intravenous drug use and disenfranchised populations. Thus government instituted a ban on federal funds to be used for syringe exchange programs in 1988. This ban was lifted briefly in 2009 and reinstated in 2011. However, in 2016, language was included in the federal appropriations bill that allows federal

funding for syringe exchange programs, except for paying for syringes. Costs associated with a syringe services program vary but the cost of the syringe itself is minor, estimated by the CDC in 2005 to be less than $1.00. Guidance has been issued by the Centers for Disease Control and Prevention that details how to request federal funding. When applying for federal funding, information must be provided that establishes a compelling need for a syringe services program. However, complying with the determination of need requirements is not overly complicated and the request should be made early when planning to establish a syringe services program.

Syringe service programs vary from mobile to fixed sites, the number of syringes that can be provided, and the types of services offered. At programs requiring a "one for one" exchange of syringes, an individual can only receive a needle if s/he turns one in. In others, individuals can receive as many syringes as s/he thinks are needed between visits to the program. A 2001 California study of syringe services programs found that clients were less likely to reuse syringes at programs where they were provided syringes on an as-needed basis, rather than one-for-one. Limiting the availability of syringes has been shown to be a risk factor for sharing needles. The Joint United Nations Programme on HIV/Acquired Immunodeficiency Syndrome (AIDS) (UNAIDS) recommends providing 200 sterile syringes per person who injects drugs every year for a high level of coverage.

Syringe service programs can be fixed sites, or can combine a fixed site with a mobile unit or other outreach. Outreach can include peer delivery, especially significant in rural areas where people in need of sterile syringes may live in remote areas. Other programs are co-located in community clinics that provide or refer people to various health services, such as substance use disorder treatment, HIV and HCV treatment or other health care for the consequences of injection drug use. Syringe services programs provide a safe method of disposing of used needles to prevent reuse of a needle, as well as inadvertent needle stick injuries. While the rates of reported needle stick injuries are low, first responders such as law enforcement and fire fighters are more likely to be at risk of injury due to the nature of their jobs. Some jurisdictions such as Kentucky and North Carolina incentivize people who inject drugs to disclose this information to a first responder before being searched to avoid possible needle stick injury. If this information is disclosed, they will not be charged with possession of drug paraphernalia.

Research on the efficacy of syringe services programs has demonstrated that they effectively reduce blood borne diseases such as HCV and HIV. It has also been shown that syringe services programs can increase entry into treatment. A study found that new users of syringe services programs were five times more likely to enter treatment than those who did not. The most common opposition to syringe services programs is the assertion that they encourage drug use. Some believe that providing new, sterile needles to someone who injects drugs encourages them to continue using. There is no evidence to support this contention however. Given that a substance use disorder is a brain disease and a chronic, relapsing condition, simply denying an individual the means to use drugs will not keep the person from continuing to use. There is wide

consensus among public health experts that meeting the drug user where s/he is and providing the person who injects drugs with services, to include drug treatment, is the most humane and effective means of addressing the issue. Providing needed services to people who inject drugs also helps the greater community by improving the community's public health and saving taxpayer dollars.

The services provided at syringe services programs vary. The 2013 survey of syringe services programs found that referrals to treatment, as well as counseling and testing for HIV and for HCV are available in the vast majority of syringe services programs. However, according to responses from the 2013 survey, fewer rural syringe services programs provide naloxone (37%) than did urban (61%) or suburban (57%) syringe services programs, Syringe services programs that provide mobile distribution go to where people who inject drugs are located. Mobile units are useful for distributing syringes in remote areas or in areas where siting a fixed location is difficult due to community opposition or cost. Mobile units can also operate as part of a fixed facility to facilitate use by remote populations. Outreach workers operate in any of these facilities but can also go into communities of people who inject drugs to provide them with needles and other health related information. Also consider increasing the reach of the syringe services program by considering secondary exchange. Unfortunately, far too few people who inject drugs have ready access to sterile syringes; therefore, it is important to identify multiple methods to distribute sterile syringes.

III. CONSIDERATIONS FOR RURAL AREAS

- **Syringe services programs are new to rural areas**
- **Draw on the strengths inherent in a rural area to build support for a program**
- **Understand local regulations**
- **Engage people who will use the program in program design**

Syringe services programs are relatively new in rural America. Of the 204 syringe services programs in operation in 2013, just 20% were in rural parts of the US. Injection drug use is seen in some quarters as a problem that doesn't affect rural areas. But rural areas are not immune to injection drug use. And unfortunately, because of the lack of treatment and syringe services programs, rural areas are more at risk than other parts of the country for outbreaks of HCV and HIV as seen in Scott County, Indiana in 2015.

Rural America has many different definitions depending upon which government agency is defining the term. For example, the US Census Bureau defines it differently than the Office of Management and Budget or the Federal Office of Rural Health Policy. However, if you live in a rural area, you usually define it by how far the drive is to a town center or facilities such as a health clinic or hospital. Commute time to a more densely populated area can require an hour or more drive with little to no public transit available. This poses unique challenges for syringe services programs in rural communities. Below is a list of items to consider before establishing syringe services programs in rural areas.

- Identify a central location. The first rule of syringe services programs is that you must meet people where they are to build trust and encourage participants to return. Locations that are inconvenient (both in time and location) will create a disincentive to participate in the syringe services program. Keep in mind that people who inject drugs may have difficulty finding transportation to an established syringe services program and public transportation is scarce in many rural areas. Engage the community first to find a location where most people in need of services congregate and consider what their mode of transportation is. Outreach workers can help get this type of information from people who inject drugs. In addition, find out if bus services are available in the area and whether the potential location for the syringe services program is on a bus line.

- Communicate Early and Often. If there is a concentration of community services in a specific area, there might be local opposition to siting the facility. Be aware that the community may already feel burdened and not want another social service. Be sensitive to their concerns and seek to engage them in a constructive dialogue about how to mitigate these issues – before – identifying a location. Include representatives from all aspects of your community in this effort. Community members should, include law enforcement, elected officials, business leaders, public health, medical community, people who inject drugs, individuals in recovery, the faith community, and families and friends of individuals with substance use disorders. In addition, some communities have found success in seeking out individual leaders in these communities first, to gain their support so they can be a trusted advocate for you with the rest of the community. The may be a useful resource for communities facing opposition to siting syringe services programs.

- Location, location, location. Find a location where people will feel comfortable going. A community clinic in one at-risk county is in a prime location, however, since it is near a police station, there is a concern that people who inject drugs may not feel comfortable going to that facility. Again, talking to individuals who inject drugs or who are in recovery

will help identify potential issues. People in rural areas may be particularly concerned about anonymity. Be cognizant of the facility's entry point, is there a more discreet entrance where people can feel some privacy when they enter or exit. Alternatively, work with existing facilities so that people who use the main entrance can be directed to the appropriate location to receive syringe services. Sometimes, co-locating can provide access to a wider range of services while also ensuring anonymity. Explore assorted such as mobile vans, co-locating with another facility, providing needles through individual outreach workers, or secondary exchange.

- Identify Potential Siting Challenges. Before siting a facility, understand your local zoning ordinances, or consult with a local land use attorney. Some ordinances may preclude the siting of a syringe services program. For example, is the proposed location in an area that results in a limitation on the number of such facilities in an area? If you are seeking to establish a mobile unit, find out if the van can go to the same location every week at a set time. Build this into your budget as the van will have to be staffed, maintained, and a location identified. Knowing the answers to siting questions can help keep concerns from growing into full-blown opposition. Building support with local faith communities and law enforcement may help overcome concerns about syringe services programs. In fact, they may be your strongest allies. In addition, information about the public benefit of syringe services, to include a reduction in needle stick injuries, infectious diseases, and overdose deaths has been used in some communities facing zoning restrictions.

- Identify Other Community Services. Syringe services program refer people to services such as drug treatment, birth control, enrollment in health care, housing referrals and other health care services. Before deciding on a location, determine whether these services exist in the area. To find local treatment availability, see SAMHSA 's treatment locator .

- Data tracking: Some state laws establishing syringe services programs require extensive record keeping to track the number of syringes that are distributed, the number of clients in the programs, etc. State law may also require that reports to be provided to local governments or to the community. Determine up front how these data will be tracked, whether they will be shared and how to ensure confidentiality for participants.

Funding: Syringe services programs rely upon a combination of private, foundation, and government funding, with the majority of syringe services programs reporting that they rely primarily on state and local funding. The mean rural syringe services program budget in 2013

was $26,023, significantly less than urban or suburban syringe services programs. To obtain funding from the Federal government, demonstrated need must be established. The CDC has issued guidelines for health departments who wish to apply for these funds. Funds should be requested early in the planning stages for syringe services programs. If seeking state funding, check with your state public health department first to make certain that state funds may be spent on syringe services programs.

IV. Determining the Need for a Syringe Services Program in Your Area

- **Conduct a community needs assessment**
- **Identify community resources that can be connected to the program**

Conducting a community needs assessment first, can help dispel concerns about a syringe services program and build a case for why such a program is needed. The Harm Reduction Coalition has useful information for conducting such an assessment. Local public health clinic leadership can also help or contact your state's harm reduction coalition. First, however, review your state's law on syringe services programs before doing anything as state law may mandate the specific items to include in a community needs assessment.

Questions to ask in a community needs assessment may include:

1. What are the rates of injection drug use in my community? Contact your state or county health department. Although this information may be difficult to obtain so examine other data such as injection drug use related arrests, overdose deaths, or treatment admissions. In addition, other indicators may include increasing cases of endocarditis or abscesses.
2. What is the rate of HIV and Viral Hepatitis in my area? Contact your state or county health department. In addition, if the state has made a request for federal syringe service program funding to the CDC, they will have information on injection drug use and HIV/HCV in your community. Also check with your county to see if it is on the CDC's list of vulnerable counties for HIV/HCV outbreaks. Another potential source of information is checking with researchers in public health departments in your state university.
3. Where do injection drug users congregate? Reach out to homeless shelters, substance use disorder treatment centers, individuals in recovery, or other harm reduction advocates.
4. What zoning restrictions exist in my community that could limit siting of a needle exchange? Check your local zoning ordinances to see if they limit the number or location of syringe exchange programs. This has been an ongoing issue with siting of methadone

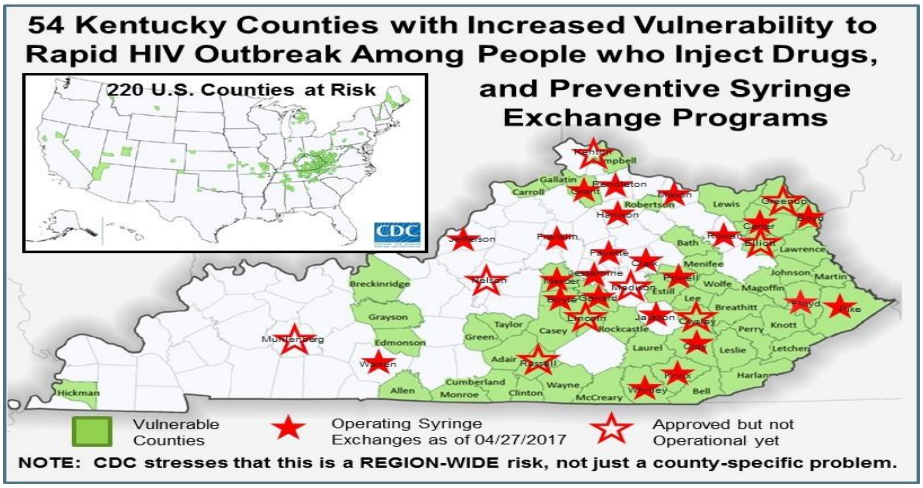
clinics in urban areas. Working with an existing public health clinic can help mitigate objections to a new facility. Objections to siting a needle exchange may include the concern that a needle exchange will increase crime; however there is no evidence to support this.

5. Are health care resources available in the area to treat both substance use disorders and infectious disease? SAMHSA has a physician locator for doctors eligible to prescribe buprenorphine. SAMHSA also has a broader treatment locator to help identify mental health and substance use disorder treatment availability in an area.

V. Examples of Rural Syringe Exchange Programs and Overview of State Laws

Kentucky

The Kentucky Harm Reduction Coalition maintains a list of syringe services programs located in Kentucky. They are located within county health departments and provide screening for infectious disease, the opioid overdose antidote naloxone, and other services for people who inject drugs. As the map below shows, of the 220 counties identified by CDC to be at-risk for increased HIV rates, 54 are in Kentucky. The Commonwealth has moved quickly to make certain that syringe services programs are available in many of the at-risk counties, with more planned.



West Virginia

In Morgantown WV, a free clinic offering syringe services opened in 2015. Others have also been established across the state and are affiliated with county health clinics. The syringe services programs are usually limited to half a day one day a week at the community health clinics. Screening for infectious disease and referrals to treatment are provided at all the clinics. The Kanawha County Clinic partners with local recovery organizations to answer questions and provide treatment referrals and support for individuals coming to the syringe services program. More on the Kanawha County program is here. The Cabell-Huntington Health Department also runs a syringe services program in Huntington WV. While in a more populated area, the Huntington location is also used by individuals in surrounding communities. More information on this syringe services program, along with other efforts to address the opioid epidemic in Huntington can be found here.

State Laws: While syringe services programs have existed in the United States since the 1980s, several states did not have laws in place until recently that allowed for the establishment of syringe services programs. In addition, states that did allow them, such as Maryland and Massachusetts, limited the number of syringe programs or limited the location of the programs. Below is an overview of a few states with new laws allowing for these programs. The impetus behind the new laws in these states has been the opioid overdose epidemic, as well as increasing rates of injection drug use and HCV and HIV in areas that previously had low prevalence of both injection drug use and HCV and HIV.

Indiana

As stated previously, authority to establish syringe services programs in Indiana was established through an emergency declaration by then Indiana Governor Pence. In 2017, a new law was passed and signed into law by the current governor giving more authority to local governments to establish syringe services programs upon declaration of a local public health emergency, where an epidemic of HCV or HIV already exists. County health departments in Indiana can then contract with community based organizations to provide syringe services. For example, the Indiana Recovery Alliance is coordinating such programs in Indiana, including a mobile delivery model. Partnering with local community based organizations can help extend the reach of resource strapped county health departments.

Kentucky

In 2015, the Kentucky legislature passed a comprehensive law addressing burgeoning rates of heroin use and overdose death. This legislation allowed county health departments to establish Harm Reduction and Syringe Exchange Programs. The legislation took effect under an emergency provision in May 2015 and requires local approval under a three-step process for an exchange program to be operated. There must first be a local needs assessment, then community

collaboration and lastly a determination of how best to reach individuals in need of the program. Other states should consider the severity of their situation and whether requiring such a process will prevent the swift establishment of syringe services programs in their community. The Kentucky Public Health Department guidelines also list other issues to consider such as how the syringes will be delivered and what outcome measures will be gathered. In the 2016 Kentucky legislature, the law was revised to require that needle exchange programs provide one for one exchange. Meaning that one needle must be handed in for a clean needle to be provided. Kentucky code is here.

North Carolina

Syringe service programs became legal in 2016 with the signing of HB972. Passage of the bill allows governments and non-governmental entities to establish syringe services programs. It also allows for limited immunity to those using or working in the programs. The Act states that the purpose of such programs is to "Reduce the spread of HIV, AIDS, viral hepatitis, and other blood borne diseases in this State. (2) Reduce needle stick injuries to law enforcement officers and other emergency personnel. (3) Encourage individuals who inject drugs to enroll in evidence-based treatment." It also allows for limited immunity for possession or a needle or residual controlled substance in the needle or other device if the individual has documentation that the needle was provided to the individual from an exchange program developed pursuant to the law. The North Carolina Harm Reduction Coalition has an overview of the law and how it is applied in North Carolina. The National Harm Reduction Coalition lists syringe exchange programs in North Carolina on its site. Syringe exchange programs in North Carolina vary from fixed sites to mobile. Link to the North Carolina General Assembly website is here. In addition, the state of North Carolina maintains a website with extensive information on syringe services programs.

West Virginia

Morgantown, West Virginia established a syringe services program in 2015. Others have also been established, including locations in Huntington and Charleston WV., The West Virginia Department of Health and Human Resources partnered with the city of Huntington and the Cabell Huntington Health Department to initiate their syringe services program. The Huntington and Charleston syringe services programs both partner with a local recovery to provide peer support to clients. Read more about Huntington's strategic plan to address the opioid crisis here. Find West Virginia's code here.

Additional State Laws

In 2017, Tennessee passed and the Governor signed legislation revising current law on syringe services programs. Find a link to the Tennessee state legislative code here.

In 2017, Virginia also passed legislation allowing syringe services programs. The law allows Virginia's Commissioner of Health to establish and operate harm reduction programs that include sterile syringe distribution, during a public health emergency. A public health emergency was declared in Virginia in 2016.

For a state by state look at laws relating to syringe access, Law Atlas updated as of May 2016.

VI. Frequently Asked Questions About Syringe Services Programs

1. Don't they promote drug use?

There is no evidence that providing people with clean syringes and with resources such as treatment referrals and other health care for the consequences of injection drug use, encourages drug use. In fact, syringe services programs can help facilitate entry into treatment.

2. Why are they necessary?

Individuals who inject drugs are at heightened risk of contracting HIV and HCV because of risky injection drug use practices such as sharing used syringes due to lack of access to sterile supplies and a stigma that is attached to accessing these supplies. According to the CDC,**1 in 10** HIV diagnoses are among people who inject drugs (PWID).In addition, if current rates continue, the CDC believes that **1 in 23 women who inject drugs and 1 in 36 men who inject drugs will be diagnosed with HIV in their lifetime.** More than **half** of people who inject drugs used a syringe services program in 2015. In addition, the CDC also reports that new injection drug users tend to be younger and white, these cohorts are more likely to share needles.

3. How do they work?

Syringe services programs vary by the types of services they provide. But the basic premise of all syringe services programs is that they provide new, sterile needles in exchange for used ones. They also provide other services such as treatment for infectious diseases, referral to treatment for substance use disorders, naloxone distribution, enrollment in health care, and other health related services such as wound care or contraceptives.

4. Why does my community need it?

Increased rates of injection drug use have led to increased risk for blood borne diseases such as HIV and HCV. While overall, the rates of HIV have decreased nationally, we are seeing increases in areas that previously had low rates of both HIV and HCV. The chance of an HIV negative individual contracting HIV by sharing a used needle is 1 in 160 per the CDC. Implementing a syringe services program in your community can save money, save lives, and help people with chronic substance use disorders get into treatment. One 2014 study found that $10 to $50 million in funding for syringe services programs throughout the United States would avert 194-816 HIV

infections and generate a net savings of $65.8 to $269.1 million dollars in averted HIV treatment costs.

5. **Won't they lead to more needles on the street?**

At least one study has shown that there was less visible evidence of needles on a street with an operational exchange than in a city without an exchange. In addition, many syringe services programs track the number of needles returned and in many cases, they come close to or exceed the number that are distributed, implying that it is unlikely used needles would litter public streets. In a one for one exchange, where you must provide one syringe for every new, sterile syringe needed, there is an incentive to find discarded needles on the street. However, establishing needs based exchanges are still the optimal type of exchange to decrease infections due to sharing needles.

6. **Do they help get people into treatment?**

A survey of syringe services programs in 2013 found that the vast majority (82%) of syringe services programs provided referrals to treatment for people with substance use disorders. And some syringe services programs, such as in West Virginia, partner with local recovery programs to help clients with referrals to treatment. One study found that new users of syringe services programs were five times more likely to enter treatment than those who did not use a syringe services program.

7. **Do they help decrease HIV infection rates?**

The short answer is yes, according to several research studies.[ii] One such study in Washington, DC found that once a ban on DC funding for syringe exchange programs was lifted, 120 injection drug use related HIV cases were averted over a 24 month period, resulting in $45.6 million in cost savings. Additional information is available here.

8. **How can we pay for syringe services programs?**

Syringe services programs are paid for in a variety of ways and depend upon state and federal laws. Some states do not allow using government funds for syringe services programs. Therefore, programs are usually paid for with a variety of grant, state, local and federal funds. Information on applying for federal funds can be found here.

9. **How much do they cost?**

Costs for syringe services programs vary by location and the services provided. However, if they are implemented in areas before injection drug use and blood borne diseases begin to increase, they can save state and local governments considerable healthcare costs. The Indiana outbreak is estimated to cost $48million in lifetime treatment based on 135 HIV cases in Scott County. The

median income in Scott County, Indiana, according to the US Census Bureau is just $44,442. A study in Australia found that every $1 invested in syringe exchange accounted for $1.3 to $5.5 in averted health care spending.

10. Don't syringe services programs increase crime?

No, research has shown that syringe services programs do not increase crime. A research study on crime in Baltimore MD showed that there was no significant increase in crimes near the area of the syringe services program than in the non-syringe services program.

11. Do they prevent needle stick injuries?

Discarded needles can create a risk for injury for members of a community, including law enforcement and fire fighters who may encounter them. Law enforcement report concern about needle stick injuries, and because they may encounter people who inject drugs, they are among the most at risk members of a community for needle stick injuries. A study in Connecticut found significant decreases in self-reported needle stick injuries among law enforcement personnel after passage of laws increasing access to clean needles.

RESOURCES:

Non-Profit Organizations:

AIDS Education and Training Center - Trains healthcare providers and disseminates information about HIV/AIDS.

AIDS United – Advocacy organization with information on syringe services programs

amfAR.org **–** Has extensive resources on syringe services programs, including fact sheets, research and other materials concerning syringe services programs and harm reduction**.**

AVERT **–** International HIV/AIDS information and education.

Comer Family Foundation– Chicago based foundation.

National Association of County and City Health Officials – Resources for county health officials on syringe services programs.

North American Syringe Exchange Network **–** Syringe services program directory and Buyers Club, providing a bulk discount on syringe service supplies

North Carolina Harm Reduction Coalition **–** Extensive information on syringe services programs and fact sheets, including myth busters and information on law enforcement partnerships.

The Harm Reduction Coalition **–** National organization with extensive information and resources on syringe services programs and other harm reduction strategies. Also includes list of grant funding programs for syringe services programs.

Rural Center for AIDS/STD Prevention at Indiana University – Provides information on establishing syringe services programs in Indiana.

The Henry J. Kaiser Family Foundation – Information on syringe services programs and health issues.

Washington Heights CORNER Project–Templates and tools for start-up syringe services programs.

Federal Government Agencies:

The Centers for Disease Control and Prevention – Federal agency providing surveillance information, infographics, studies, and guidelines for requesting federal funding for syringe services programs

HIV.gov – Department of Health and Human Services website with resources on syringe services programs and HIV.

General Information on the Opioid Epidemic from HHS

National Institute on Drug Abuse– HHS agency within the National Institutes of Health

Surveillance:

The National Survey on Drug Use and Health

https://www.cdc.gov/hepatitis/statistics/index.htm

https://www.cdc.gov/hiv/statistics/index.html

Syringe Services Program Guides:

Kentucky Public Health: Establishing a Harm Reduction and Syringe Exchange Program in Kentucky

Guide to Starting and Managing Needle and Syringe Programmes.

State of North Carolina technical assistance guide

Naloxone:

Law Enforcement Naloxone Toolkit

Guide to Using Naloxone

Human Rights Watch: A Second Chance**:** Video and recommendations for Overdose Prevention, Naloxone, and Human Rights in the United States.

[i] Throughout this document, the term "syringe services program" is used. Other terms for syringe services program include needle exchange, syringe access or syringe exchange programs. The term syringe services program is used throughout this document (and by the Department of Health and Human Services) because most programs where individuals can receive sterile needles also provide services such as medical treatment, screening for infectious disease, and other services.

[ii] Wodak A, Cooney A. Do needle syringe programs reduce HIV infection among injecting drug users: a comprehensive review of the international evidence. 2006;41:777–816.