

# BIG IDEAS

ADVANCING SOLUTIONS TO MOVE CLOSER TO ELIMINATING HEPATITIS C  
IN THE UNITED STATES

## COMMUNITY EXPERIENCE OFFERS LESSONS FOR EXPANDING ACCESS TO SYRINGE SERVICES PROGRAMS (SSPs)

**THE UNITED STATES IS GRAPPLING** with the public health crisis of substance use disorder (SUD), largely fueled by a dramatic increase in persons who inject opioid drugs such as prescription pain killers, heroin, and fentanyl, or other drugs such as cocaine and methamphetamine.<sup>1</sup> In 2017, 70,237 overdose deaths occurred in the U.S., a 9.6% increase from 2016. Sixty-eight percent of these deaths involved opioids.<sup>2</sup> Hepatitis C (HCV) cases have increased three-and-a-half times from 2010-2016 and cases among pregnant women have doubled, primarily due to the increase in injection drug use.<sup>3,4</sup> For decades, stigma and discrimination towards people who use drugs has inhibited the ability of communities, elected officials, and medical providers to respond compassionately and appropriately to the people in our communities in need of health and other services to address the consequences of SUD.

Momentum is slowly building to support harm reduction efforts aimed at minimizing the consequences of drug use, such as preventing the spread of infectious disease. One of the most important and effective interventions to stop the spread of infectious diseases and other health consequences of drug use is the provision of sterile syringes to persons who inject drugs (PWID), along with other harm reduction services. Frequently, concerns have been raised that syringe services programs (SSPs) could increase drug use...a claim long refuted by research data. Moreover, elected officials at the federal and state levels increasingly recognize SSPs as an evidence-based intervention that play an important role in the response to the opioid crisis.<sup>5</sup> With a general public conditioned to fear and shun PWID, it can be hard to share new information and quickly change popular opinion. This brief highlights lessons from states on how to maintain support for SSPs.

### WHAT ARE SSPs?

SSPs—sometimes called syringe or needle exchange programs (a term often viewed as too narrow to describe the range of services provided)—are an evidence-based approach to reduce the transmission of HCV and HIV among PWID.<sup>6</sup> SSPs are part of a larger reduction health model to provide a safe, consistent, and non-judgemental space for persons with substance use disorder to access services and resources to improve their quality of life and

### SSPs CAN IMPROVE DRUG USER HEALTH AND CREATE A PATHWAY TO TREATMENT

A consensus among national leaders, backed by strong evidence, supports the availability of syringe services programs (SSPs) as a path to reduce HCV and HIV transmission, improve the health of persons who inject drugs (PWID), and create opportunities for people to access substance use disorder treatment. Experience in places that have implemented these programs can offer lessons for achieving greater access to SSPs nationwide. Key lessons include:

- **Community knowledge and support must be built and maintained**
- **Political and community leadership is critical**
- **Responsiveness and innovation are needed for long-term success of SSPs**

## COMMON SERVICES OFFERED BY SSPs

- Sterile syringe and needle distribution
- Naloxone and overdose prevention strategies
- Wound care
- Medication-Assisted Treatment (MAT) for substance use disorder
- Infectious disease screenings
- Condoms and lubricants
- Outreach and peer education
- Referral to substance use disorder (SUD) treatment or to social services (e.g. housing)

protect their health. As of 2018, there are 320 SSPs operating in the U.S., and half of PWID have access to an SSP.<sup>7</sup> The use of sterile needles, syringes, and other equipment (or ‘works’) to inject drugs can significantly reduce the risk of transmitting or acquiring infection. SSPs also provide an opportunity to engage PWID in health care and social services. These programs, which often utilize peer navigators who themselves may be in recovery or managing a SUD, offer a sense of relatability, understanding, and trust that is seldom experienced by people with SUD in traditional settings. Feeling welcomed is vital to giving people with SUD the resources and self-efficacy they need to protect their health and well-being, and motivate entry into and maintain adherence to treatment.

Even in urban areas where SSPs are well-established, the travel time to a program and the lack of affordable transportation options can limit access. Moreover, not all programs are open daily, and limited operating hours mean that people cannot always access them at times that work for their schedules. Many SSPs operate as mobile vans in order to reach more places with high need and offer greater flexibility for reaching clients. All of these challenges are exacerbated as the opioid crisis and other drug use trends have spread to suburban and rural areas, both because travel times and resource limitations tend to be greater, and more conservative social attitudes may increase the stigma associated with drug use and seeking services.

Research has shown that SSPs are effective at both improving health outcomes and reducing costs. Utilization of SSPs can decrease risk of acquiring HCV by as much as 80%.<sup>8</sup> A \$1 syringe can prevent an HCV infection that could cost over \$205,000 in lifetime health care costs.<sup>9</sup> Recent changes in federal law have grown more supportive of SSPs. Jurisdictions must first apply to the Centers for Disease Control and Prevention (CDC) for a determination of need to establish an SSP in the area. Once approved, current

law permits the use of federal funds (largely funds provided by the CDC and Prevention or the Substance Abuse and Mental Health Services Administration for domestic HIV prevention or through U.S. global HIV programs) to support costs associated with the operation of SSPs including staff time, except for the direct purchase of syringes.<sup>10,11</sup> With the change in appropriations language, greater attention shifts to facilitators and barriers to SSPs at the state and local levels. Further, community opposition and laws that prohibit the operation of SSPs or that make it a crime to possess syringes without a prescription may be hurdles to be overcome. Compared to other health interventions, SSPs are both low-cost and generally operate on limited budgets. While the cost of purchasing syringes is modest compared to other costs, state, local, or charitable funds must be secured to purchase syringes for SSPs. Sustainability of funding may be an on-going challenge.

## LEARNING FROM THE FIELD

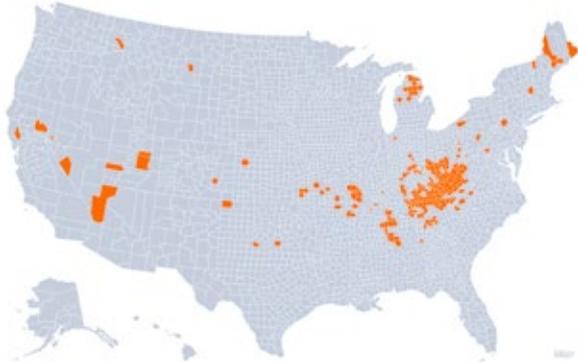
Policy change in states and local communities involves a mix of sharing scientific knowledge, respecting community values, and navigating different understandings of the role of the respective levels of government (i.e. federal, state and local) and differing levels of financial and other resources. Understandably, differences from place to place will generate differing responses, and this is certainly true when considering how to respond to PWID and the consequences of injection drug use. Nonetheless, states and communities share many common challenges and efforts around the country can offer helpful guidance. Lessons for expanding SSPs include three simple ideas:

### Community knowledge and support must be built and maintained

Some states have changed laws to facilitate SSPs, yet SSPs have opened in some places only to close because of community opposition. West Virginia has 28 of the 220 counties identified by the CDC as most vulnerable for HIV and HCV outbreaks. The state’s incidence of acute HCV infection is nine times and drug overdose deaths are two-and-a-half times the national average.<sup>12,13</sup> Only nine of the state’s most vulnerable counties have operating SSPs.<sup>14</sup> In 2018, a popular SSP closed that provided a range of wraparound services for PWID and served over 400 clients a week. The closing significantly changed the public health landscape of the area by removing critical access to infectious disease and overdose prevention for PWID, and increased frequency of PWID engaging in high risk practices such as sharing syringes.<sup>15</sup> This highlights the fact that popular support depends on a variety of critical stakeholders. More work is needed to build new acceptance from other community leaders, including law enforcement, faith leaders, county officials, educators, and parent-teacher groups.

## SSP ACCESS: A MISMATCH BETWEEN NEED AND SERVICES

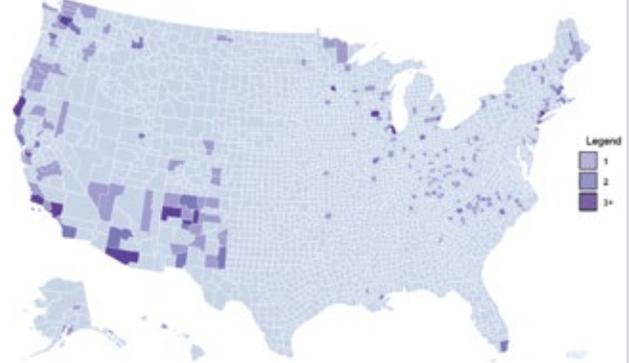
### VULNERABLE COUNTY RANK (2016)



COUNTIES ASSESSED BY CDC TO BE VULNERABLE TO AN HIV OR HCV OUTBREAK AMONG PEOPLE WHO INJECT DRUGS.

SOURCE: Centers for Disease Control and Prevention

### SYRINGE EXCHANGE PROGRAMS (2018)



TOTAL NUMBER OF SYRINGE EXCHANGE PROGRAMS.

SOURCE: Data Source: North American Syringe Exchange Network.

For more information, see the amfAR Opioid & Health indicators Database - <https://opioid.amfar.org>

### STATE LEADERSHIP IN ACTION: NORTH CAROLINA

Facing strong resistance from the legislature, advocates worked to generate support from law enforcement to change public sentiment and political will to support harm reduction legislation. Collaboration between advocates and law enforcement spurred lawmakers to legalize SSPs and pass laws that provided standing order distribution of naloxone (for overdose prevention), and removed criminal liability for individuals who experience or witness (and seek help for) an overdose. North Carolina established 26 SSPs and distributed over 1.1 million syringes in the first 18 months following legalization. Since January 2019, the North Carolina Harm Reduction Coalition has dispensed over 101,000 free naloxone overdose reversal kits, and reports 13,394 confirmed overdose reversals since the first naloxone laws passed in 2013.<sup>16</sup>

### Political and community leadership are critical

Leadership comes in many forms. Following the Scott County, Indiana HIV outbreak, the local sheriff and lead state public health official were instrumental in changing the governor's position on allowing a SSP in that area.<sup>17</sup> Law enforcement often play an outsize role in shaping public opinion on these programs, and members of the clergy also have unique levels of trust that can help build support for new approaches to responding to drug use. Since many jurisdictions require local approval for SSPs to be established, political leadership at both the state and local levels, however, can be especially important for swaying the

public or for impeding the establishment of programs when they oppose them.

### STATE LEADERSHIP IN ACTION: KENTUCKY

With 54 of the 220 most vulnerable counties, Kentucky undertook a statewide effort to implement harm reduction syringe exchange programs (HRSEPs) accessible to its most at-risk communities. The state's governor led efforts to create cross-agency partnerships to gain the required local approval to establish HRSEPs, and maintain ongoing support for syringe programs as a critical component of harm reduction efforts to combat the opioid crisis. Today, the state has 62 SSPs operating throughout the state.<sup>18</sup>

### Responsiveness and innovation are needed for long-term success

Drug use has consequences not only for individuals, but also for communities. Community members often voice concern about the public nuisance factor of a proposed SSP. For example, community members may be concerned that they will witness more people publicly injecting, more litter on the streets, or in playgrounds and public parks. Successful SSPs form the strongest partnerships with other community stakeholders before problems arise and address concerns as soon as they are raised. In some cases, they ask schools and churches and others to report instances of used syringes being found, both so that they can safely collect them, but also to identify locations where services are needed. Community needs—including the needs of persons who use drugs—also change and evolve, and many successful

SSPs have proven to be innovative problem solvers that make their communities safer.

### STATE LEADERSHIP IN ACTION: HAWAII

Hawaii has several initiatives to improve drug user health outcomes. Hawaii Health and Harm Reduction Center (HHHRC) implemented mobile SSPs that follow set schedules to serve clients in urban and rural areas on the state's islands. A survey of SSP clients revealed that nearly 50% sought treatment at an emergency department (ED) for wound care. HHHRC saw this as an opportunity for outreach, and started a street-based wound care clinic in collaboration with the Hawaii Department of Health. Clients receive treatment for wounds and skin infections, and other services such as sterile injection equipment and STI prevention. Clients meet on-site with the Hep Free Hawaii HCV care coordinator to receive HCV testing and full coordination of the services they need to access follow up care and treatment, as well as referral resources for other health care services, including transportation to appointments. The program spends only 5 cents to every dollar spent on wound care in an ED.<sup>19</sup>

## THE TIME IS NOW

Untreated opioid addiction and injection drug use are the primary causes of high rates of HCV in the U.S.. To create a path to HCV elimination, it is critical that more jurisdictions support and implement SSPs and other interventions that address the health and social services needs of PWID. States and communities have critical knowledge to help show us the way.

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