

Introduction

Syringe services programs (SSPs), also known as needle exchange or syringe access programs, are an integral component of a substance use disorder prevention and control strategy. SSPs provide people who inject drugs (PWID) with sterile, hypodermic needles and associated materials to reduce the sharing of contaminated equipment. SSPs have been shown to reduce the transmission of blood borne pathogens such as HIV and viral hepatitis¹; the CDC and the U.S. Department of Health and Human Services describe SSPs as effective, evidence-based blood borne pathogen risk reduction interventions^{2,3}. SSPs are also a pathway for PWID to access treatment services. In addition to improving public health, SSPs are a good financial investment; they save money due to treatment costs avoided from prevented infections⁴.

The severity of the opioid epidemic suggests revisiting the legal environment in Missouri to enable the implementation of this proven public health solution. Randall Williams, Director of Health and Senior Services, recently signaled support for passing legislation to legalize SSPs, noting their public health benefits and success in other states⁵. This brief outlines suggestions for implementing SSPs in St. Louis County should Missouri legalize them. The possibilities presented are based on best practices from SSPs across the country and U.S. Department of Health and Human Services implementation guidance^{6,7}.

Local Legislative Approval and Program Certification

1. It is recommended that the County Council enact an ordinance granting Saint Louis County Department of Public Health the authority to certify organizations to operate SSPs and operate an SSP that adheres to the same certification standards.
 2. The Saint Louis County Department of Public Health shall certify SSPs contingent upon the prospective implementer completing a needs assessment and complying with guidelines to be developed in consultation with organizations currently serving PWID and prospective SSP participants. The guidelines will include the objectives, core services, and safety measures enumerated below.
 3. It is recommended that each SSP assemble an advisory board to give technical guidance and identify and help resolve any issues that may arise. It may include community members, program participants, representatives of community-based organizations, and professionals in the fields of substance use, syringe exchange, harm reduction, law, medicine, and other relevant disciplines.
 4. The Saint Louis County Department of Public Health will perform an initial inspection and subsequent annual inspections to ensure compliance with operating guidelines. SSPs will receive a permit after passing the initial inspection and will receive a renewed permit after each annual inspection.
 5. SSPs are a clinical service comparable to any hospital or outpatient clinic and should be treated as such with regards to any zoning and permitting codes and ordinances. SSPs shall not be discriminated against during any zoning or permitting processes.
 6. All ordinances pertaining to these facilities should include a meaningful process of public consultation.
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Program Standards

OBJECTIVES

SSPs should develop standard operating procedures, reviewed by the advisory board, that promote progress towards the following objectives:

1. Reduce the transmission of HIV, viral hepatitis, and other blood borne diseases.
2. Increase safe disposal of used needles and syringes.
3. Increase referral of people who inject drugs to evidence-based substance use disorder treatment.

CORE SERVICES

Programs should provide the following services to work towards the specified objectives:

1. Collect used needles and syringes and dispose of them safely.
2. Distribute needles and syringes in the quantities and sizes requested by clients **without requiring an equivalent exchange for used needles**. This best practice allows those with no needles on their person or those without places to store used needles (such as the homeless) to have access to clean needles⁸, attracts PWID, and increases the likelihood that clean equipment is used at each injection.
3. Conduct testing for HIV, hepatitis, and other blood borne infections or refer to appropriate facilities if testing is not available.
4. Educate and provide materials to participants on syringe disposal, prevention of infectious disease transmission, and overdose prevention.
5. Stock naloxone to administer in the case of an overdose onsite, distribute naloxone if budget allows, and refer participants to sources of free naloxone if not available for distribution onsite.
6. Screen, refer, and link participants to substance use disorder treatment services as requested.

Each SSP may decide to offer additional services such as access to social workers or counselors, lists of community resources, or provision of additional health screenings to cater to the needs of its participants.

PROGRAM SAFETY AND WASTE MANAGEMENT

1. SSPs must ensure reasonable and adequate security of program sites, equipment, and personnel. A security plan must be submitted as part of the application for certification, and SSP administrators are encouraged to notify local law enforcement agencies before opening a program.
2. SSPs must institute protocols to ensure proper sanitation and waste management. All injection equipment and other medical waste must be disposed of safely, and programs must adhere to waste management codes at all times.
3. All SSP workers should be encouraged get tested for blood borne infections and get vaccinated for hepatitis A and hepatitis B. All workers should be educated about what to do in the case of an accidental needle stick or other exposure to blood borne pathogens.

SERVICE DELIVERY MODELS

As long as an SSP remains in compliance with program guidelines, it may choose to operate using any single evidence-based model of service delivery or combination of models. Program administrators should select the most appropriate model(s) to meet the needs of their participants based on insights gained from the needs assessment and input from those who use the program⁸. Examples include:

1. Fixed sites
2. Satellite outreach sites (community agencies that already provide other services in the community and also perform SSP functions on behalf of a parent SSP)
3. Mobile outreach
4. Peer-based services

MONITORING AND EVALUATION

1. Organizations certified to operate an SSP must keep records detailing the total number of individuals served, the number of participants receiving each core service, expense patterns, proof of proper medical waste disposal, and any substantial changes made to the model of service delivery.
2. DPH can provide technical assistance and tools to support SSP operators to conduct a needs assessment, monitor program implementation, and evaluate the effectiveness of the program.

Relationship with Law Enforcement

1. Protocols for education on the basic principles of SSPs should be developed and implemented for all law enforcement officers in the surrounding jurisdictions. Protocols should be designed with input from public health practitioners and be updated regularly to reflect any new harm reduction services in the community.
2. People who inject drugs must be able to participate in SSPs without fear of intimidation or arrest. If legislation allowing the possession of syringes and needles is contingent upon participation in an SSP, SSPs should issue cards identifying clients as participants in these programs. Police departments should ensure that individuals are not arrested, harassed, searched, detained, or otherwise punished based on their possession of sterile syringes obtained from legal SSPs. Participants must be able to keep used syringes in their possession for the purpose of returning them to syringe exchange sites. Law enforcement should refrain from arresting people for possession of controlled substances based on trace amounts of drugs contained in a used syringe.
3. A protocol for safely handling and disposing of syringes found during searches should be designed and implemented.
4. Law enforcement adherence to the protocols should be monitored, and police officers who do not comply with them should be appropriately disciplined.

Fiscal Impact

Budgetary requirements for operating an SSP are contingent upon factors such as the number of participants, the service delivery model chosen, and the range of ancillary services offered. Organizations should budget for personnel (administrators, outreach workers, counselors, etc.), supplies (syringes and injection materials, pregnancy tests, condoms, HIV tests, naloxone kits, educational materials, ID cards), capital investments (storefront or van for mobile outreach), and other expenses such as training. The cost to the county to certify programs initiated by nongovernmental organizations would be negligible, and operational costs would be borne by those organizations that decide to open SSPs.

Analyses suggest that increasing access to SSPs would be highly cost-saving. The average lifetime cost of treating one person with HIV is about \$400,000 and the average cost of treating one person with hepatitis C can range from \$26,400 for acute infection to \$300,000 for chronic infection⁴. In terms of savings on HIV treatment alone, studies suggest returns on investment of between \$3.50 and \$7.00 per dollar invested in syringe access^{4,9}. There are likely about 10 new cases of HIV due to injection drug use per year in St. Louis County given the 2016 incidence rate of 10.8/100,000 and assuming that around 9% of new cases are linked to injection drug use, per CDC estimates¹⁰. Preventing these cases would entail treatment savings of about \$4 million, with about \$1.2 million redounding to the payers of uncompensated care (nonprofit providers and local and federal government programs) and \$1.6 to Medicaid*.

Savings from preventing hepatitis C could potentially be even more significant; postulating 100 newly reported cases of hepatitis C per year linked to injection drug use, treatment costs averted through prevention could total between \$2.6 million and \$8 million for medication alone[†]. Preventing even a few infections would have a significant fiscal impact, even before accounting for the costs averted from treating some participants' underlying substance use disorders.

Organizations have multiple options for funding SSPs. As of 2016, state and local health departments may use federal funding for SSPs after receiving a determination of need from the CDC; funding from CDC, SAMHSA, HRSA, or other federal agencies may not be used for the sterile needles or syringes themselves, but can be used for other expenses including but not limited to personnel, HIV and HCV testing kits, syringe disposal, naloxone, condoms, educational materials, and planning and evaluation activities⁶. Local and state governments may also choose to contribute funds. Studies show that public funding for SSPs is correlated with reducing HIV incidence and maintaining low HIV incidence¹². Funding may also be sought from nonprofit funders. Potential funders include the Drug Policy Alliance, AIDS United, MAC AIDS Fund, the Tides Foundation, and the North American Syringe Exchange Network.

* About 40% of people with HIV are covered by Medicaid and about 30% are uninsured¹¹.

† The number 100 is a hypothetical. 944 new cases were reported in 2015 (21 acute, 923 chronic). 17 acute cases (81%) were linked to injection drug use but the portion of remaining cases attributable to drug injecting is uncertain. Medications cost between \$26,400 and \$80,000.

Conclusion

SSPs are a key component of a comprehensive strategy to address the opioid epidemic and the public health risks of injection drug use. SSPs have been demonstrated to interrupt the transmission of blood borne diseases and connect people who inject drugs to vital health and social services, all while saving money in infection treatment costs averted.

A wide evidence base exists not only to support the overall effectiveness of SSPs, but also to inform successful program implementation. Based on lessons learned from programs across the country and implementation guidance from the Department of Health and Human Services, Saint Louis County Department of Public Health is well positioned to certify effective SSPs. Using these resources, the St. Louis region has the opportunity to improve population health and ultimately save lives.

Suggested Citation

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