Northwest (HHS Region 10)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Northwest ATTC presents:

Harm Reduction in Rural Alaska

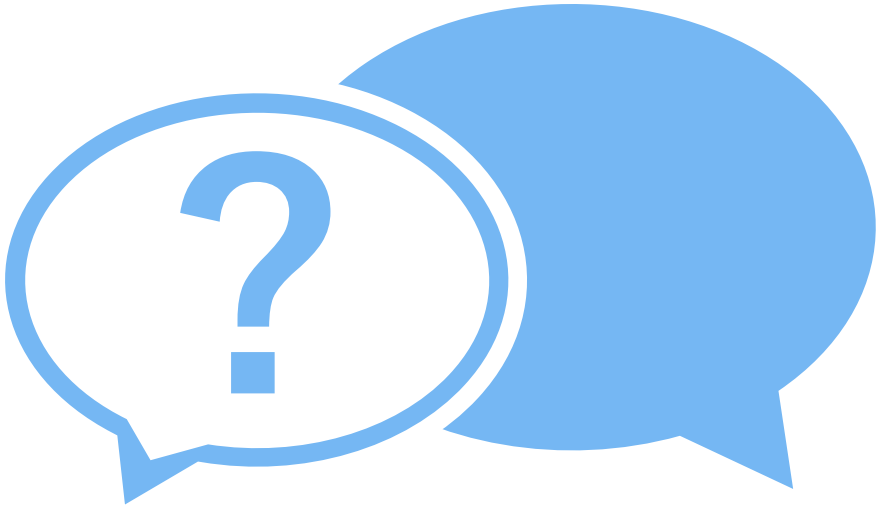
Thank you for joining us! The webinar will begin shortly.

- **Participants are automatically muted during this presentation**
- **Got questions?** Type them into the chat box at any time and they will be answered at the end of the presentation.
- An ADA-compliant recording of this presentation will be made available on our website at: http://attcnetwork.org/northwest

SAMHSA
Substance Abuse and Mental Health Services Administration

Q&A

Questions? Please type them in the chat box!



Surveys

Look for our surveys in your inbox!

We greatly appreciate your feedback!

Every survey we receive helps us improve and continue offering our programs.

It only takes **1 minute** to complete!

Certificates

Certificates of Attendance are available for live viewers!

Viewing Groups:
Please send each individual's **name** and **email address** to **northwest@attcnetwork.org** within 1 business day.

Your certificate will be emailed within a week to the address you registered with.

HARM REDUCTION IN RURAL ALASKA

Sarah Spencer DO, FASAM

April 2022

Tribal Land Acknowledgement

In applying a lens of cultural humility to issues of diversity, equity, and inclusion, Northwest ATTC offers this land acknowledgement for today's event.

Our work intends to reach the addiction workforce in HHS Region 10: Alaska, Idaho, Oregon, and Washington. This area rests on traditional territories of many indigenous nations, including tribal groups with whom the United States signed treaties prior to the granting of statehoods.

Please join us in support of efforts to affirm tribal sovereignty and in displaying respect and gratitude for our indigenous neighbors.

FINANCIAL DISCLOSURES

I have no financial conflicts of interest to disclose

I am currently employed by the Ninilchik Traditional Council as an addiction and family medicine physician

I work as an addiction treatment consultant for the Opioid Response Network in Alaska and for other non-profit agencies such as ANTHC.

LEARNING OBJECTIVES

1. Review the barriers to accessing harm reduction services in rural areas

2. Explore the strengths and opportunities that rural communities have to offer to in the development of harm reduction services

3. Discuss the process and importance of community involvement in the creation of new harm reduction programs in rural areas

4. Understand how medications and rural medical clinics can play a critical role in reducing morbidity and mortality for PWUD

What is harm reduction?

Refers to an approach designed to reduce the harmful consequences associated with high risk activities.

We do not try to 'save' or 'rescue' anyone, we support them wherever they are without judgement or assumption

Is Harm Reduction Enabling

No

- People are already engaging in high-risk behaviors such as: sex without condoms, driving fast, using drugs.

Yes

- Keep themselves safer while they engage in behaviors that can be harmful
- Reduce HIV & hepatitis C transmission
- Be honest about their drug use or behavior
- See their own strengths and what they can do… and be successful

Slides courtesy of Annette Hubbard

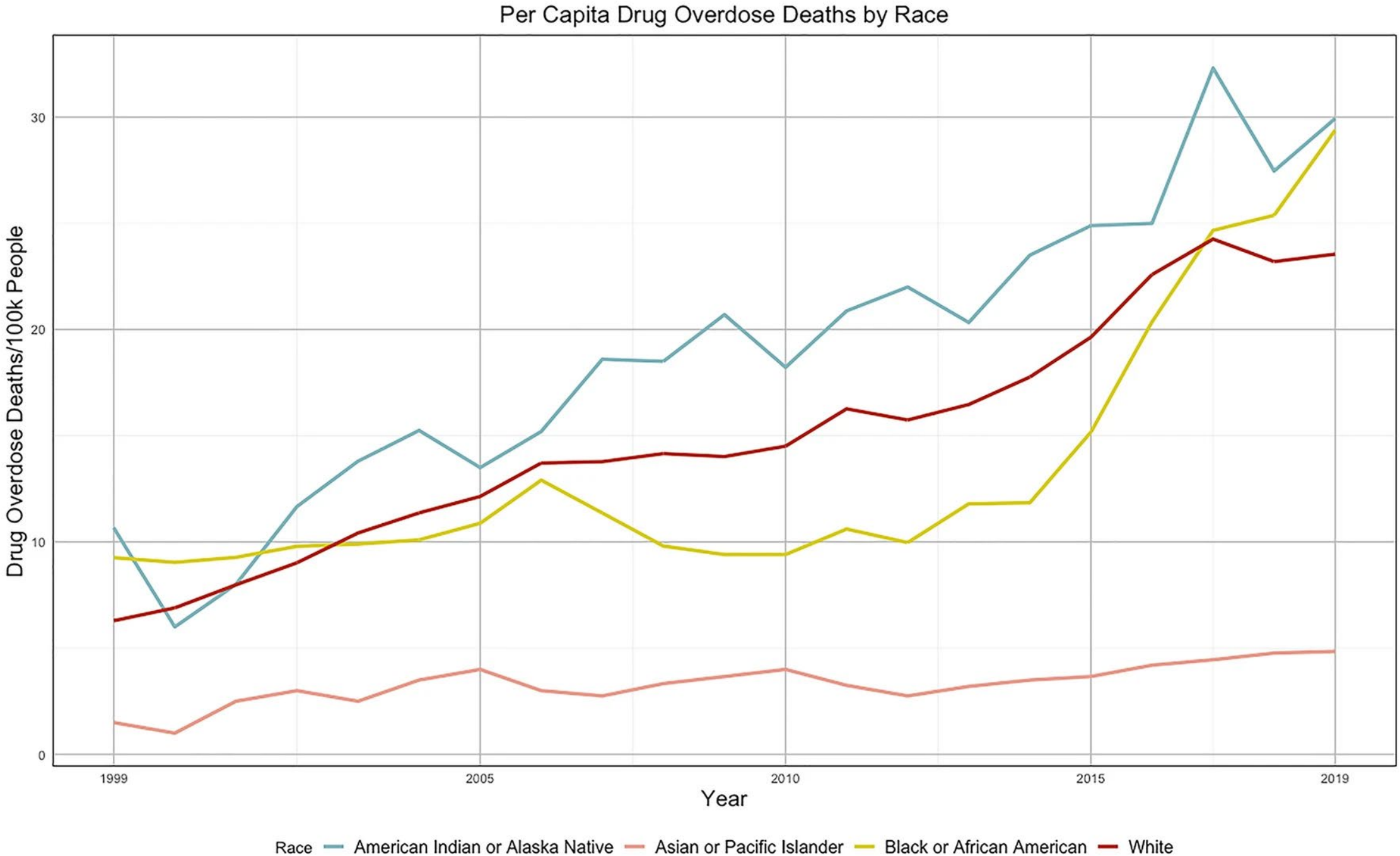
Over 200 Alaska Native villages spread over 660,000 mi2

Most off the road system

550 Community Health Aides/Practitioners CHAPs in 170 tribal clinics

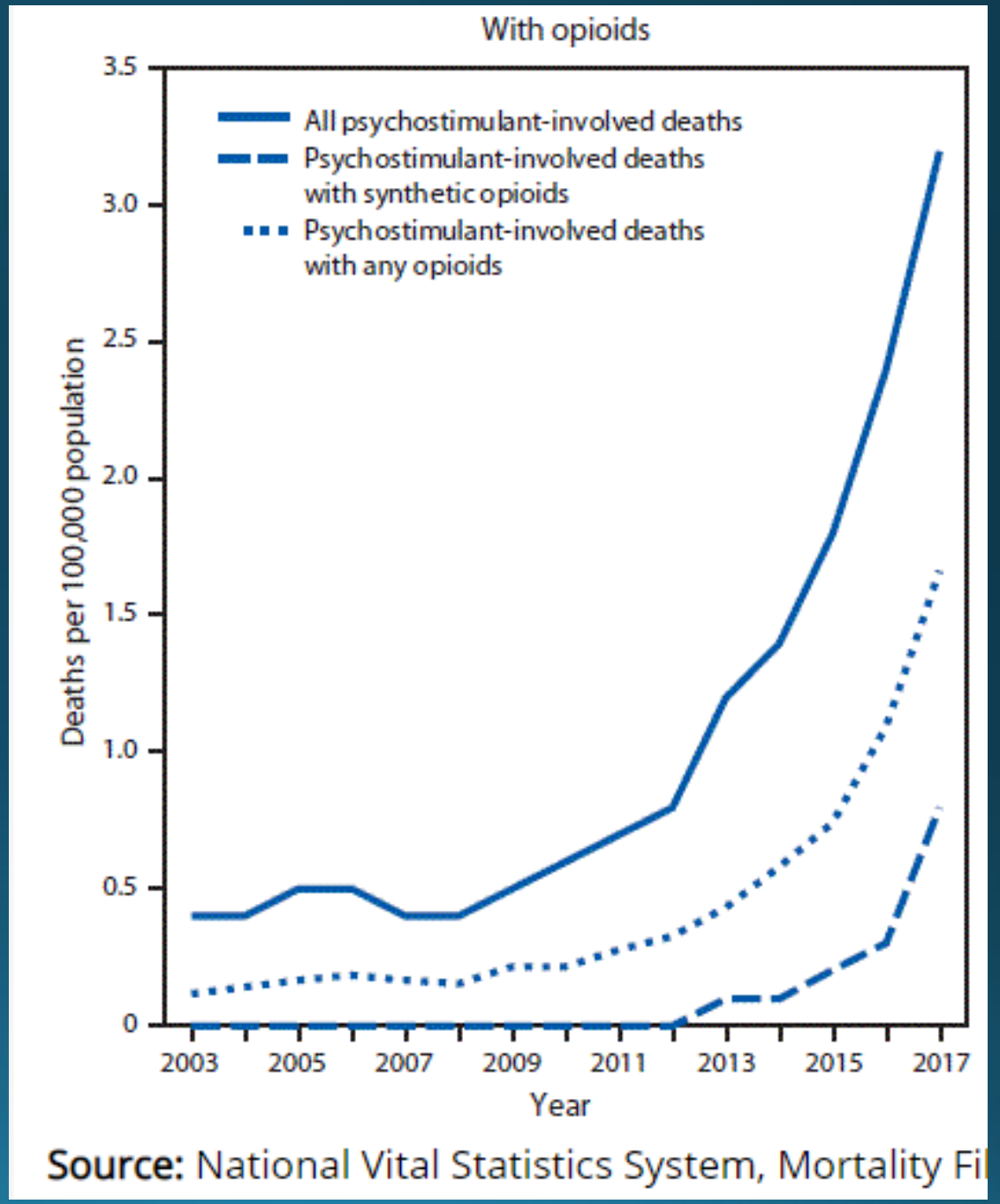
Currently Medications for OUD offered by less than half of the regional healthcare hubs

Low Threshold access to MOUD as a strategy to reduce overdose and disease

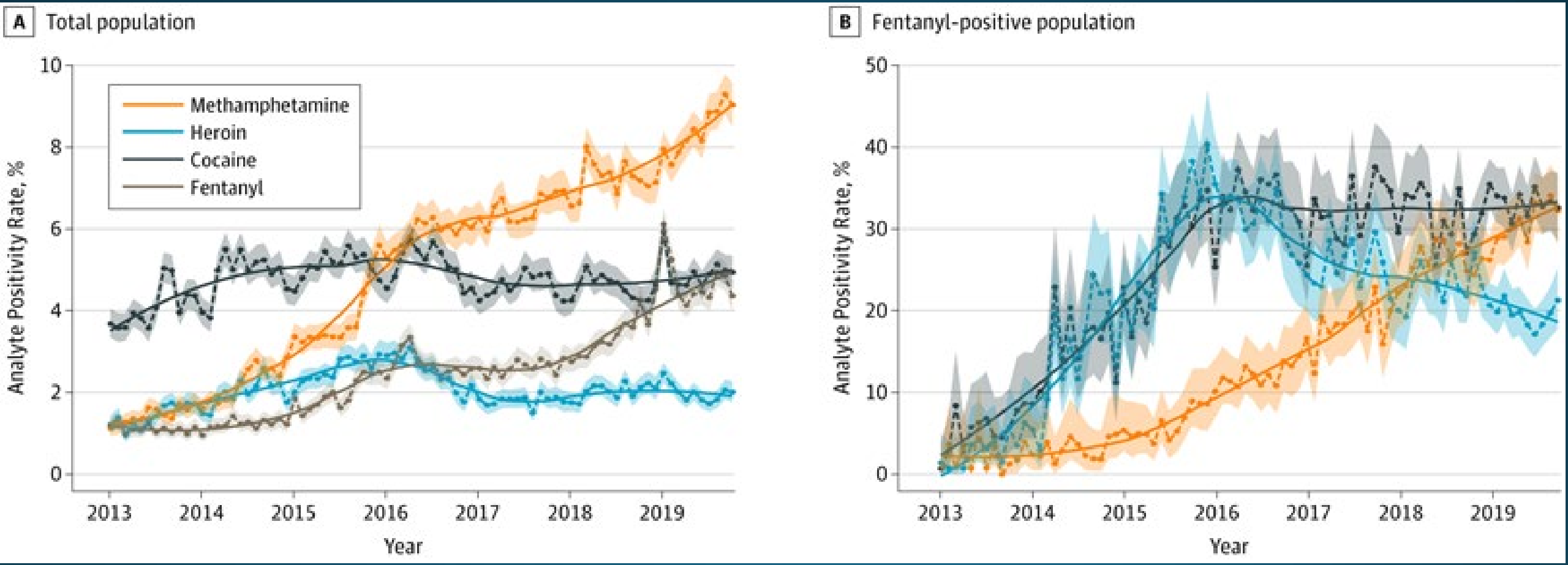

Per Capita Drug Overdose Deaths by Race
Drug Overdose Deaths/100k People
30
20
10
0
1999
2005
2010
2015
2019
Year
Race
American Indian or Alaska Native
Asian or Pacific Islander
Black or African American
White

Roughly ½ of methamphetamine overdoses involve opioids

Injecting meth with heroin "goofballing"is 3X more likely to result in overdose than injecting heroin alone



Dramatic increases in fentanyl contamination of stimulants



Twillman, JAMA, Jan 2020

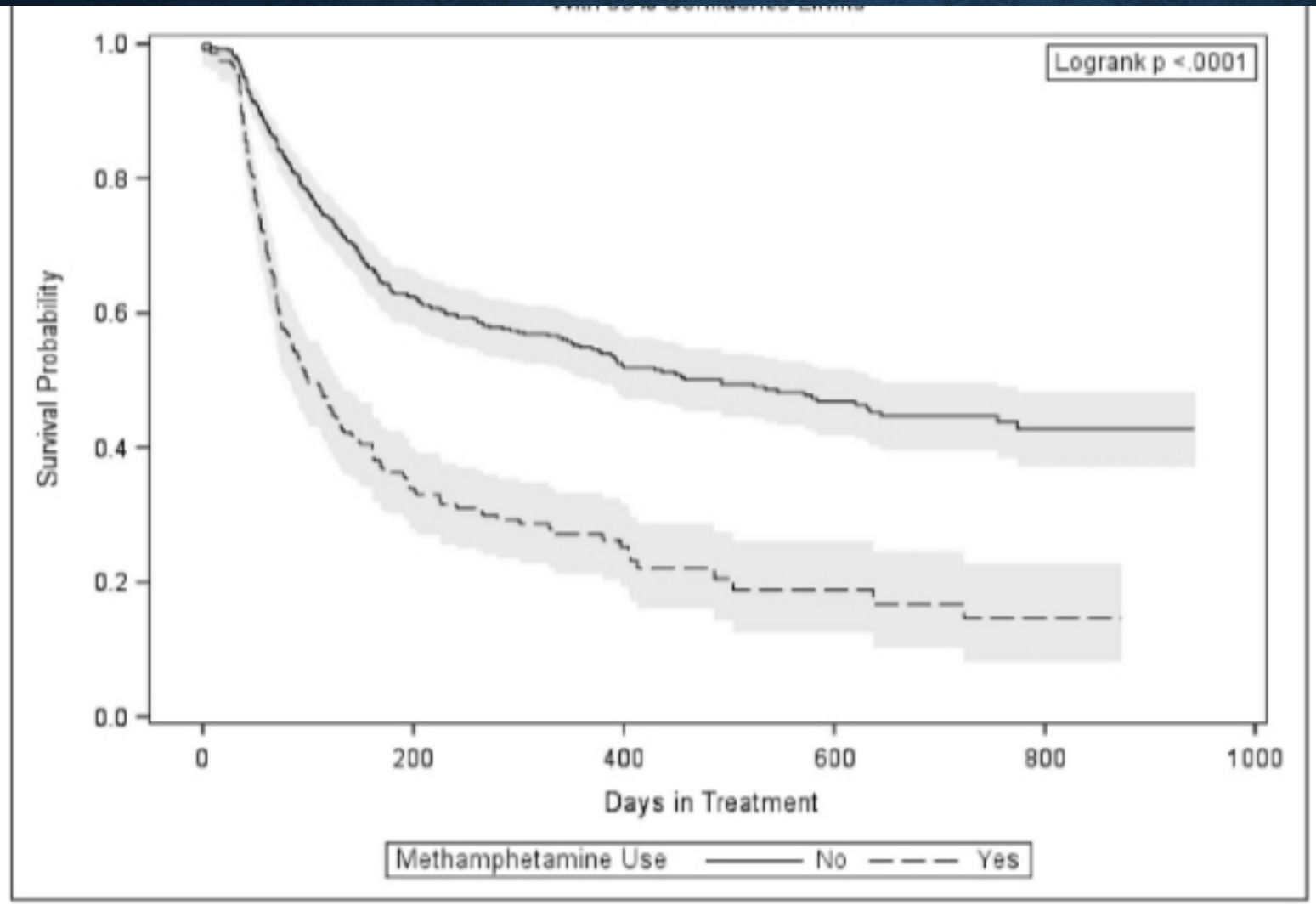


Fig. 1. Kaplan-Meier survival curves for methamphetamine users and non-users with 95% confidence bands ($n = 770$).

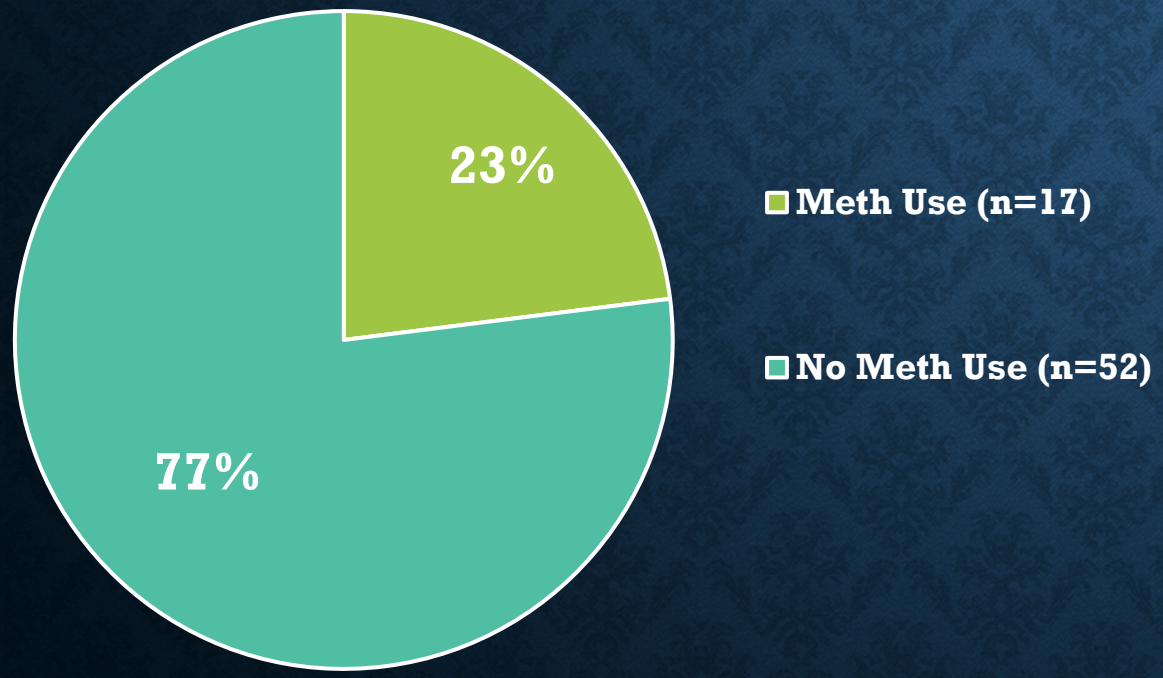
Meth users have poorer retention in MAT programs for OUD

But those who stay in treatment reduce their meth use

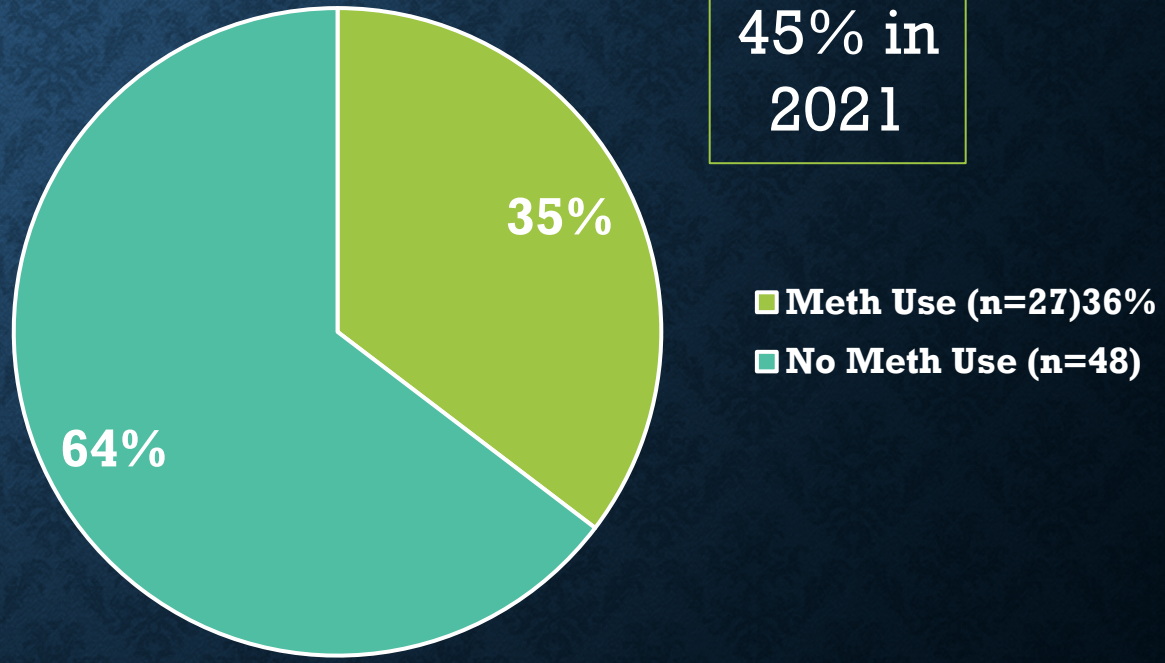
https://www.journalofsubstanceabusetreatment.com/article/S0740-5472(19)30250-8/fulltext

Percentage of Rural Alaskan OBOT patients using Methamphetamine

2016-2018 OBOT patients (n=74)



2018-2020 OBOT patients (n=74)



45% in 2021

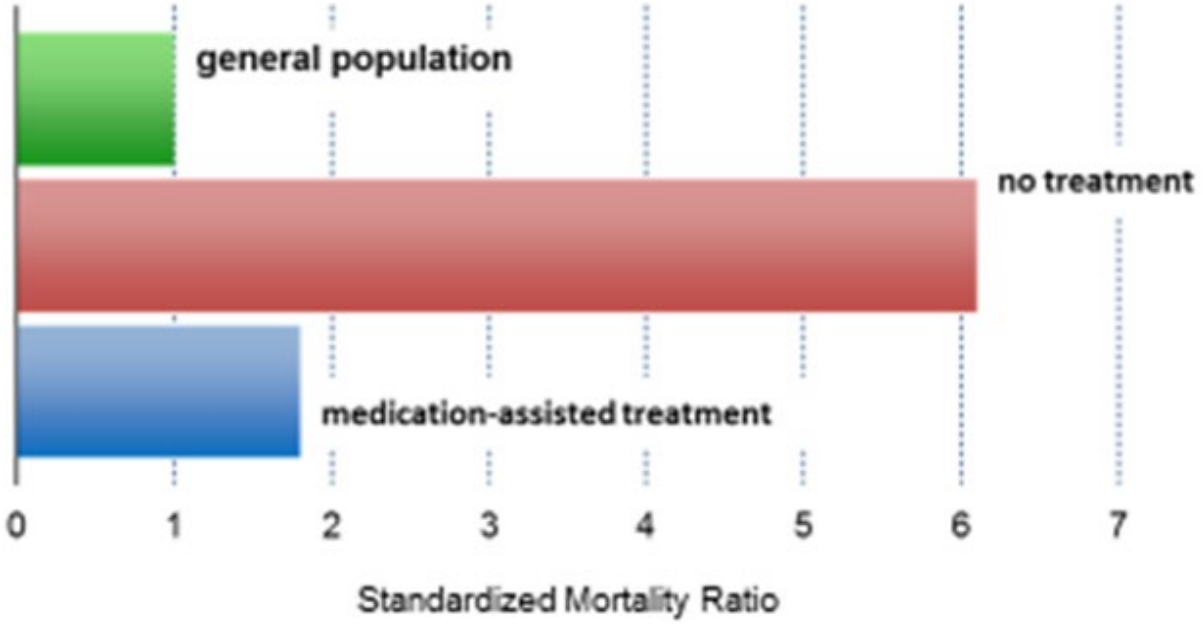
The percentage of patients in out OBOT who use methamphetamine has increased from 23% in 2016-2018 to 36% in 2018-2020 group

Ninilchik Community Clinic MAT program – ASAM 2021 poster/AMERSA 2021 Abstract Presentation

Benefits of MAT: Decreased Mortality

Overdose risk the first 2 weeks after leaving treatment is 10-30 times higher

Death rates:



MOUD can reduce death rates by 80%

Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017

PCSS Providers Clinical Support System

PEW

TOPICS PROJECTS FEATURES ABOUT GET INVOLVED S

State Policy Changes Could Increase Access to Opioid Treatment via Telehealth

Removing restrictions and providing proper reimbursement would benefit underserved populations

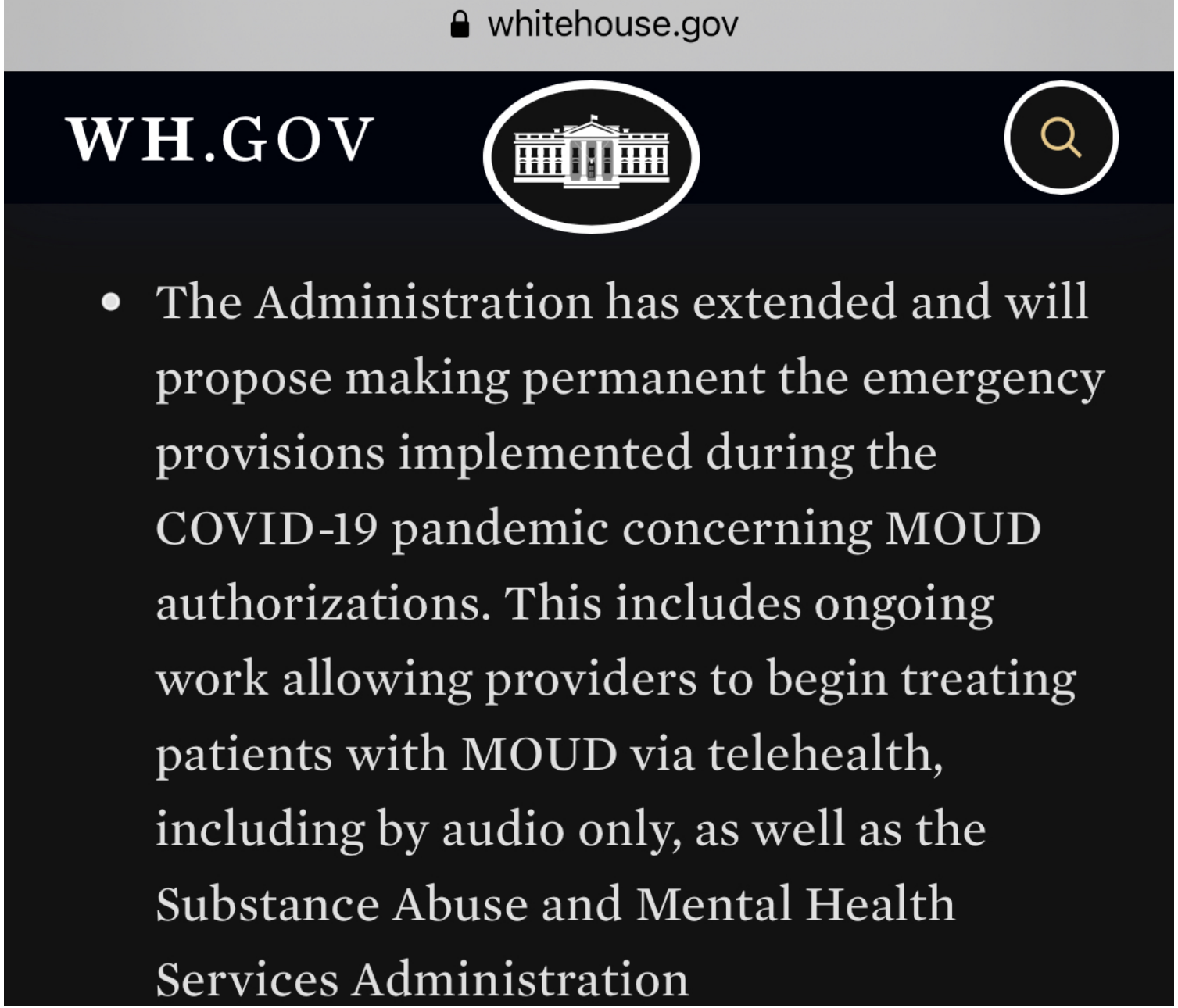
ISSUE BRIEF | December 14, 2021 | Read time

Projects: Substance Use Prevention and Treatment

New policy measures are now needed to ensure that patients can continue to benefit from telehealth treatment for OUD after the pandemic. To accomplish this goal, state Medicaid agencies and lawmakers can take several measures, such as:

- Requiring public and private insurers to reimburse OUD treatment providers for all services delivered via telehealth.
- Setting public and private reimbursement rates for telehealth-based OUD services on a par with in-person treatment.
- Expanding locations where patients can receive OUD treatment services via telehealth, including their homes.
- Allowing patients with Medicaid to access OUD treatment services by telephone.
- Enabling correctional institutions to use telehealth for OUD treatment services.

https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/12/state-policy-changes-could-increase-access-to-opioid-treatment-via-telehealth



https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-addressing-addiction-and-the-overdose-epidemic/?utm_campaign=sotu2022&emci=2b6c0bda-f79b-ec11-a22a-281878b85110&emdi=a2c995a7-fe9b-ec11-a22a-281878b85110&ceid=9316349

Internet Eligible Controlled Substance Provider Exception

IHS Announces a New Policy to Expand Access to Medication Assisted Treatment in Remote Locations

The Internet Eligible Controlled Substance Provider exception to the Ryan Haight Act allows IHS-designated providers to prescribe Medication Assisted Treatment (buprenorphine) over telemedicine when the patient is not in the presence of a DEA-registered practitioner and regardless of DEA facility registration status. This exception will expand access to the full spectrum of treatment options for opioid use disorder to individuals in rural and remote areas. Expanding Medication Assisted Treatment locations will reduce the time for patients to start their recovery journey, potentially lower the risk for return to drug use, and may reduce the potential of death from overdose. An example where this policy exception could be used is in a remote Alaska village clinic that is staffed only by a community health aide.

https://www.ihs.gov/newsroom/ihs-blog/november2018/ihs-announces-a-new-policy-to-expand-access-to-medication-assisted-treatment-in-remote-locations/

MONTHLY INJECTABLE XR BUPRENORPHINE

A LOW THRESHOLD MOUD OPTION

- Monthly injections administered in a medical clinic
- No risk of diversion
- Highest dose of buprenorphine for excellent opioid blockade
- Opioid blockade lasts for months once stable
- Flexible dosing every 4-6 weeks
- Covered by Medicaid

Advantages of Monthly Injectable Buprenorphine In Remote Native Alaskan Villages

No concern for diversion

Diversion concerns and stigma around sublingual buprenorphine can be a huge barrier to patient access as providers/clinic administrators are hesitant to offer this treatment

Monitoring medication compliance can be very difficult in remote locations

Not easy to access facilities for random medication counts and urinalysis

Reduces risk of withdrawal and relapse related to Rx interruption

Mail delivery in the bush can be frequently interrupted due to weather holds and other logistical concerns (reduced flights during COVID) that can result in Rx refills not arriving on time, leading to acute withdrawal which can trigger relapse and overdose

Flexible dosing q4-6 weeks, slow reduction in levels reduces withdrawal sxs

Excellent and long-lasting opioid blockade

Provides protection from overdose, even for patients with extended lack of clinic access such as those in fishing industry or who may become incarcerated, reducing risk of overdose in this remote population

Monthly Injectable Buprenorphine XR : Patient Selection

- Useful for patients who benefit from buprenorphine but have trouble with medication compliance, who have fallen out of care multiple times
- Patients who do better on high dose buprenorphine (still struggle with cravings at 24mg/day)
- Patients who don't tolerate SL therapy due to nausea
- Patients who cannot reliably attend scheduled and random monitoring appointments or have difficulty filling frequent prescriptions due to transportation (no vehicle or license), location (lives off road system) or employment barriers (slope workers, commercial fishermen), at risk for med interruption (incarceration)
- Patients who continue injecting drugs (high overdose risk)
- Patients who are at high diversion risk

  -Patients actively using other illicit substances (stimulants)

  -Homeless patients who have difficulty storing their meds

  -Patients who have sold their buprenorphine in the past

REAL PATIENT TESTIMONIALS REGARDING MONTHLY XR BUPRENORPHINE

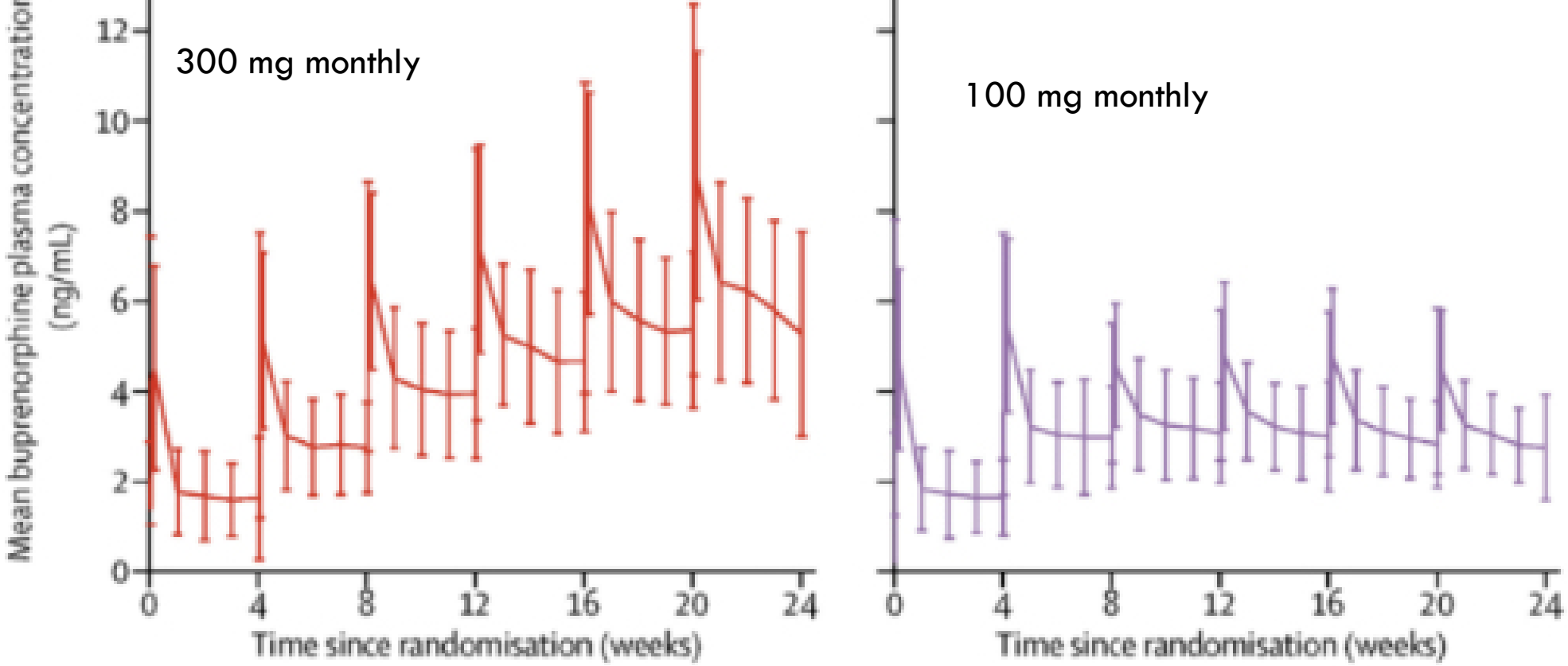
"It works great! Anyone that says that it doesn't is full of s#!t!"

"I love that I just feel normal every day when I wake up."

"I was glad that I didn't feel any withdrawal symptoms when I went to jail."

"I don't even think about heroin anymore."

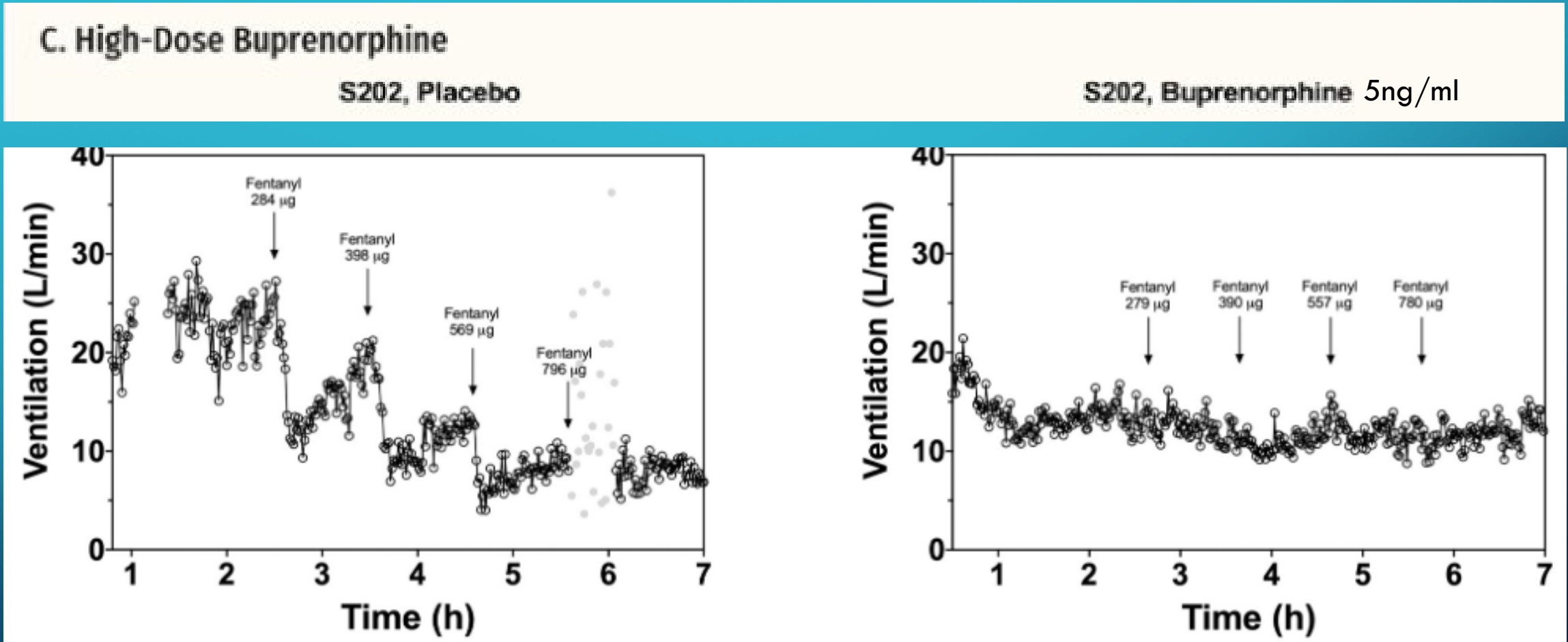
"I tried using heroin and it [my opioid receptors] was totally blocked."



BUP-XR provides sustained plasma levels > 2–3 ng/mL, which are needed to block opioid agonist effects thus having an advantage over transmucosal BUP, which might provide this level of blockade only part of the day

Haight et al., Lancet 2019

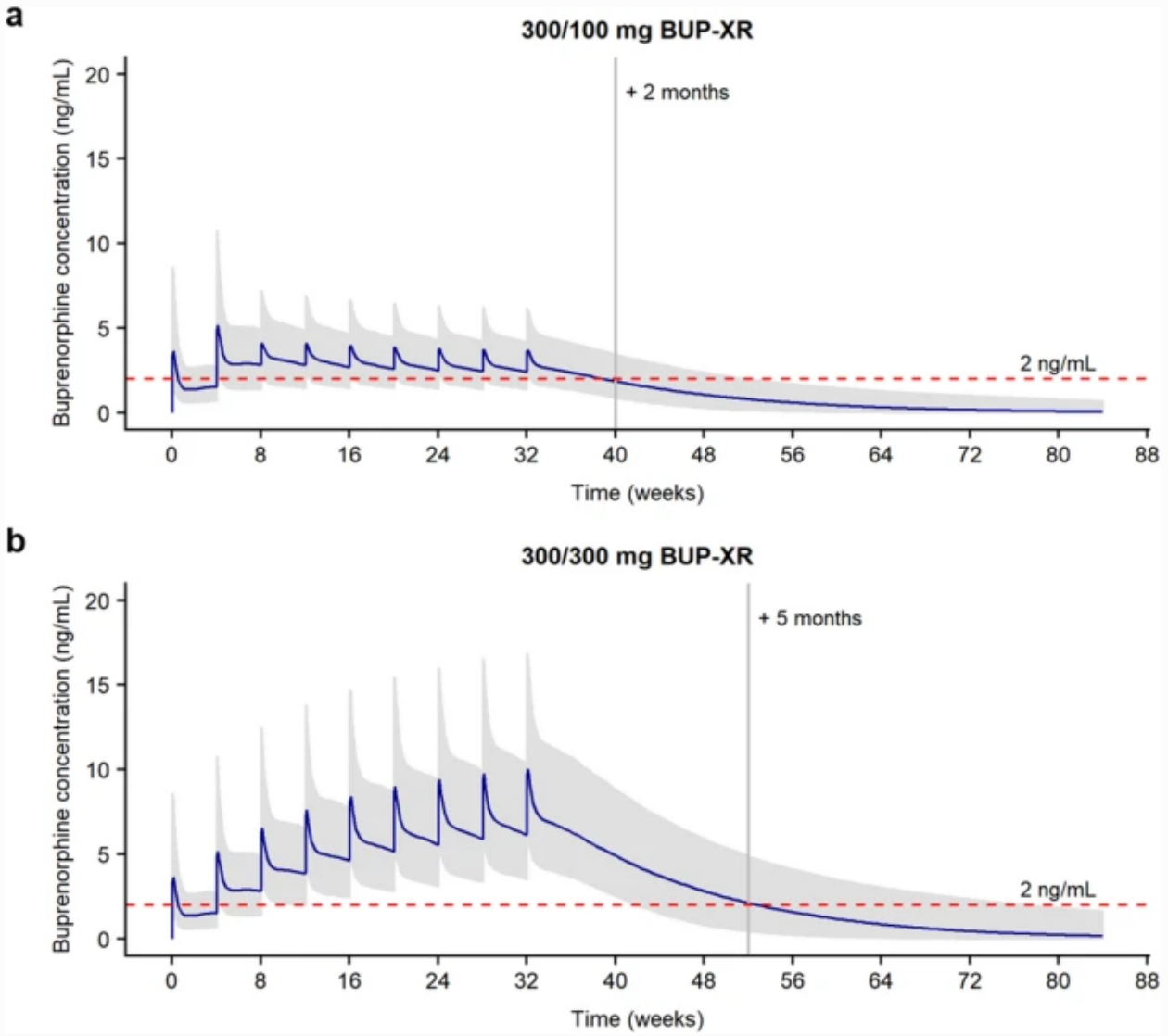
High Dose XR Buprenorphine blocks fentanyl induced respiratory depression



Blockade was lost under 2 ng/ml

https://journals.plos.org/plosone/article/figure?id=10.1371/journal.pone.0256752.g004

Fig. 6



Predicted decrease in buprenorphine plasma concentrations for BUP-XR dosing regimens following treatment interruption. **a** 300/100-mg dosing regimen 2; **b** 300/300-mg dosing regimen. Blue solid lines: median of the simulated data; gray shaded areas: 90% prediction intervals of simulated data. A total of nine subcutaneous injections were simulated in 5000 subjects. The horizontal red dashed line indicates the 2-ng/mL minimum concentration required for opioid blockade, as established from

Patients stable on 100 mg will have blockade for 2 months (1 missed shot)

Patients stable on 300 mg will have blockade for 5 months (4 missed shots)

https://link.springer.com/article/10.1007/s40262-020-00957-0

Patients may always get their Sublocade injection regardless of UDS results, as long as their UDS is positive for buprenorphine before first injection

XR-BUP may be started **sooner than 7-day stabilization period**, may be **empirically kept at 300mg monthly**, and may require **supplemental SL BUP** during early treatment months

Real-world outcomes with extended-release buprenorphine (XR-BUP) in a low threshold Bridge clinic

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The authors have no relevant conflicts of interest or financial disclosures.

MGH 1811
MASSACHUSETTS GENERAL HOSPITAL

AMERICAN SOCIETY OF ADDICTION MEDICINE
FOUNDED 1954
ASAM

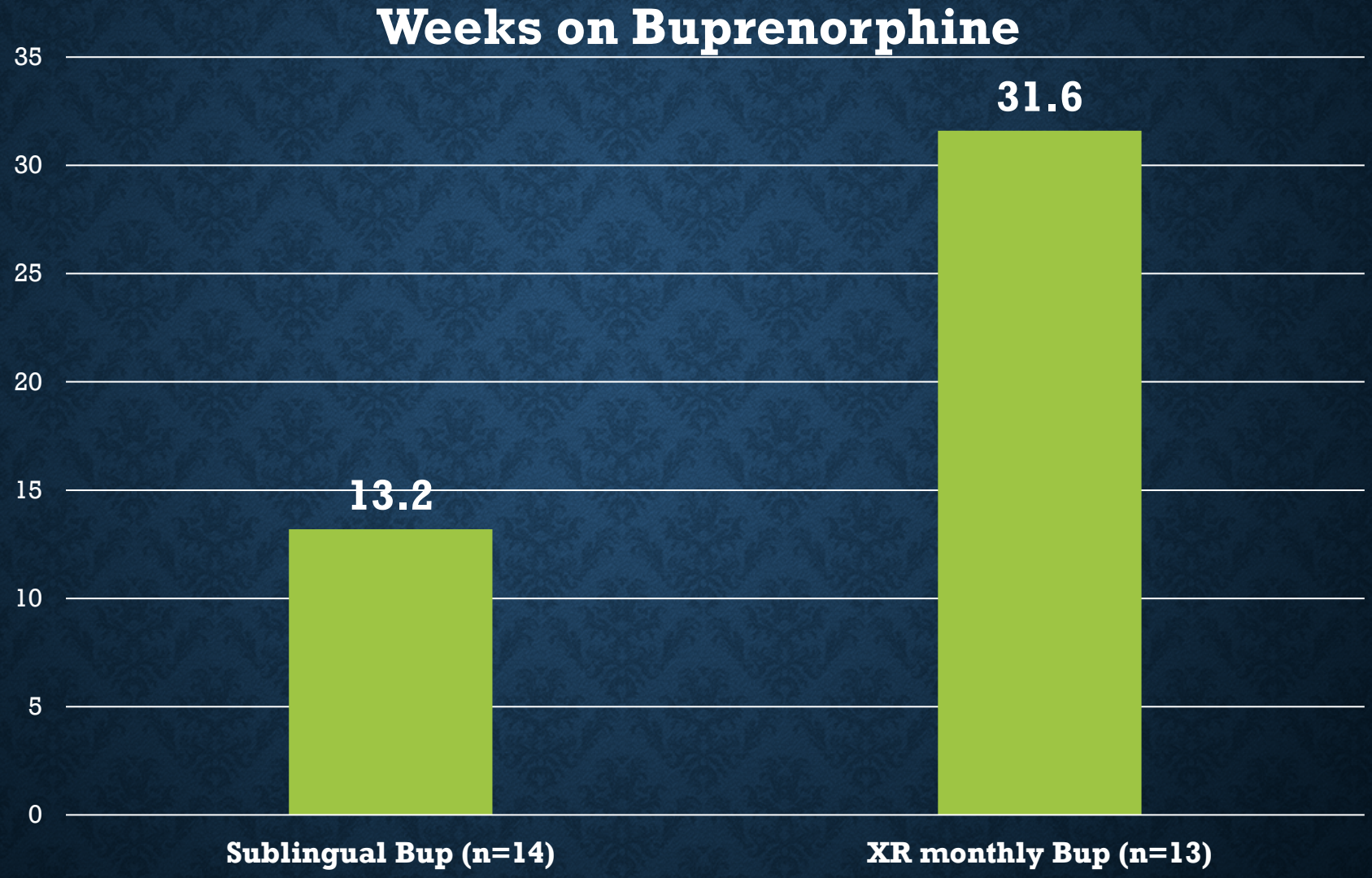
Harm Reduction Based Low Threshold Care

- Don’t discharge patients for ongoing drug use
- Create patient centered care plans based on patient goals
- Flexible walk-in/same day appointments
- Co-located/telemed behavioral health
- Motivational interviewing during appointments
- Peer support

Harm Reduction Based Low Threshold Care (continued)

- Assistance with transportation
- Assistance with filling out applications for treatment or social services
- Short prescriptions with frequent appointments
- Monthly injectable medications
- Contingency management/ Motivational incentives
- Hep C treatment/ PREP
- Narcan kits
- Clean injection supplies

SL vs XR Buprenorphine



Patients who use meth stayed in treatment on average 2.4 times longer (18 weeks longer) on XR Bup vs SL Bup

NTC Community Clinic "Retention of patients with OUD who use methamphetamines in a rural Alaska OBOT", ASAM 2021 poster/AMERSA 2021 oral abstract presentation

2015 Syringe Access Locations
Only Urban
ANC, Fairbanks, Juneau

2022 Syringe New Access Locations
Homer (volunteer/grassroots SAP)
Bethel (Tribal clinic SAP, remote/bush)
ANTHC (mail order for Alaskan Natives)

HOMER, ALASKA

-The “Cosmic Hamlet by the Sea”

-The “Halibut Capital of the world”

-The “End of the Road”

-220 road miles from Anchorage

- (nearest exchange)

-Population 5,000

-Critical Access hospital Service area serves about 10,000

-Economy based on Fishing (commercial and sport) and tourism

HOW CAN SUCH A SMALL TOWN NEED AN SAP?

-In 2014/2015 local medical providers began reporting increasing rates of injection related infections. Their patients reported having difficulty finding new needles.

-Family Planning noticed more cases of patients with injection related Hep C

- Infection rates up over 400% in some Alaskan communities

-Patients in my addiction clinic reported to me that it was very difficult to obtain new needles in town.

- One local pharmacy began to refuse to sell
- Second continued to sell but collected a log of names/signatures of patients and limited amount

A handful of social service, health care providers and interested community members were discussing the need for a syringe access program…

But, none of us knew anything about how they worked…

Is it really worth it to have a syringe access program in a small town?

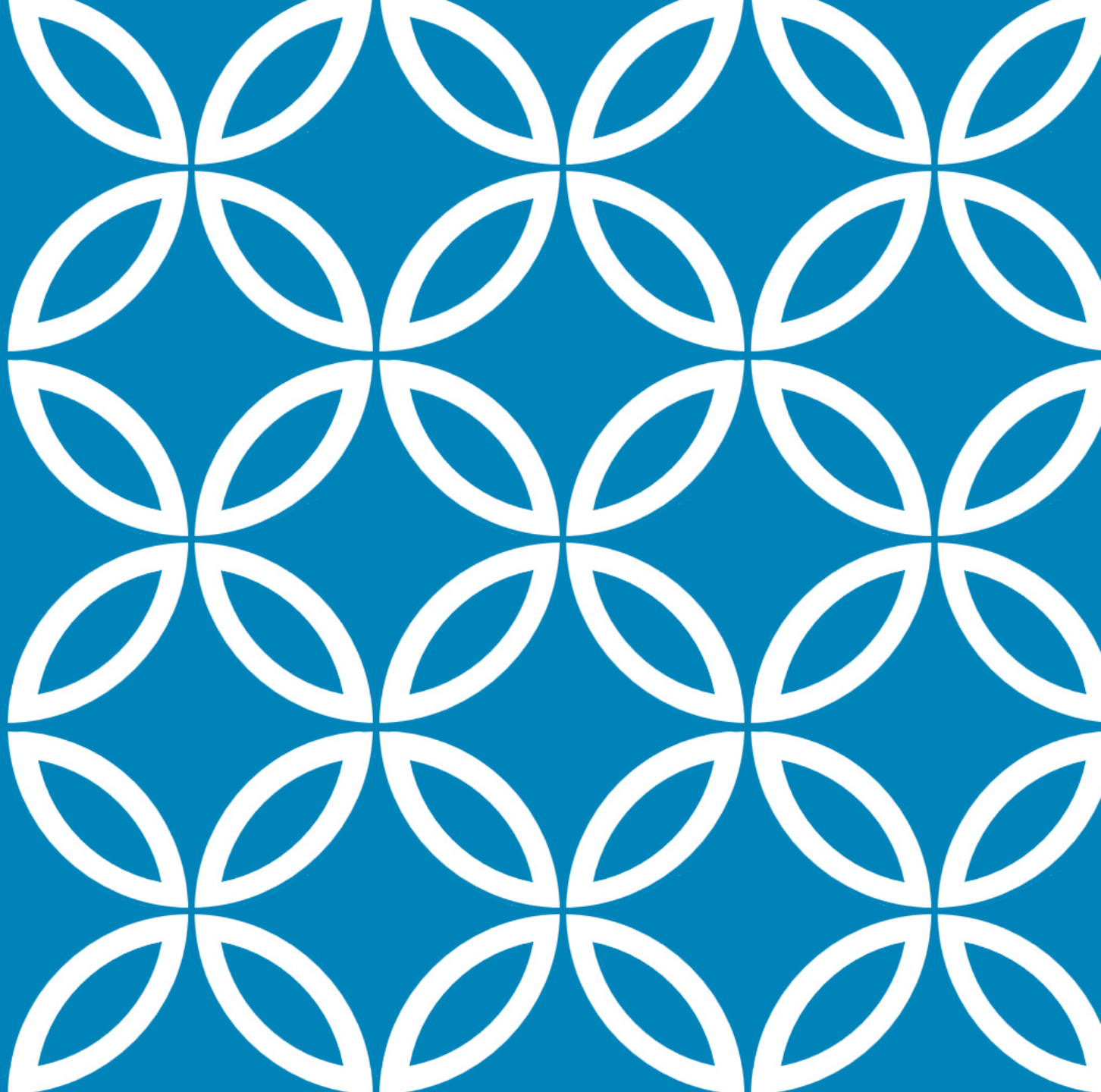
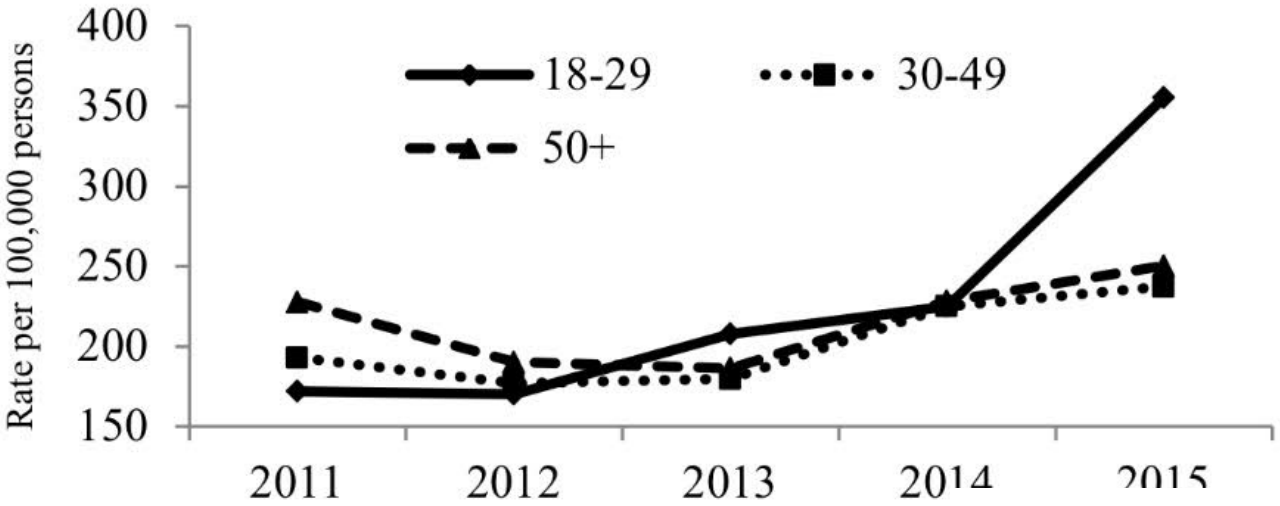


Figure. Rates of Reported HCV Cases, by Age Group (in Years) and Year — Alaska, 2011–2015



Rates of Hep C up 400% in young Alaskans who inject drugs

Rates by region were highest for the Gulf Coast
190 and 187 cases per 100,000 persons, respe
Over the 5-year time period, the largest inc
cases occurred in the Southeast region.

Table 2. Annual Rates by Region — Alaska, 2011–2015

Region	Overall Rate*	Rate* in 18–29 Year-Olds	% Change in Rate among 18–29 Year-Olds from 2011–2015
Anchorage	161	221	100% increase
Mat-Su	188	377	140% increase
Gulf Coast	190	330	45% increase
Interior	104	103	75% increase
Northern	71	83	267% increase
Southeast	187	247	490% increase
Southwest	97	413	270% increase

**Rate per 100,000 persons, based on Alaska's 2013 population.*

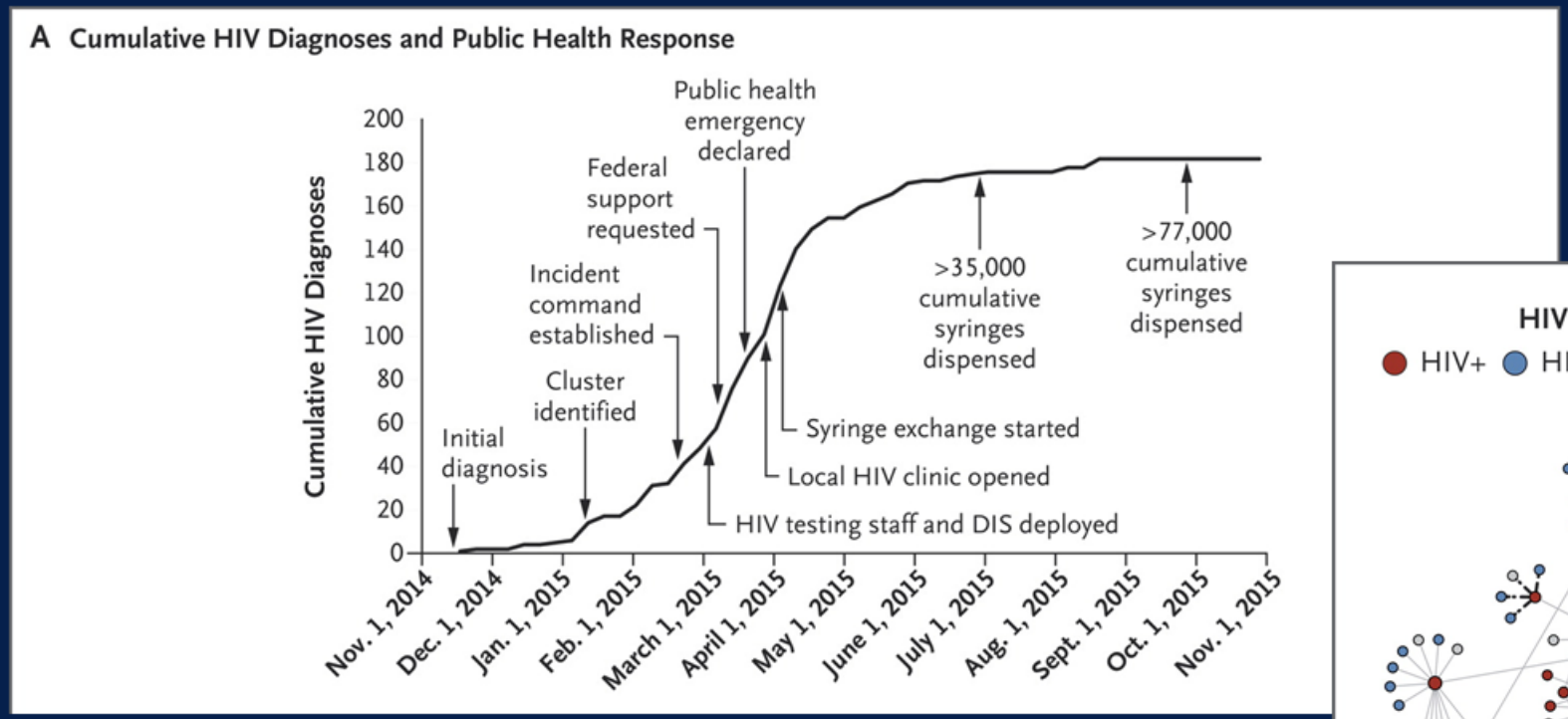
This outbreak started in a community smaller than Homer, AK

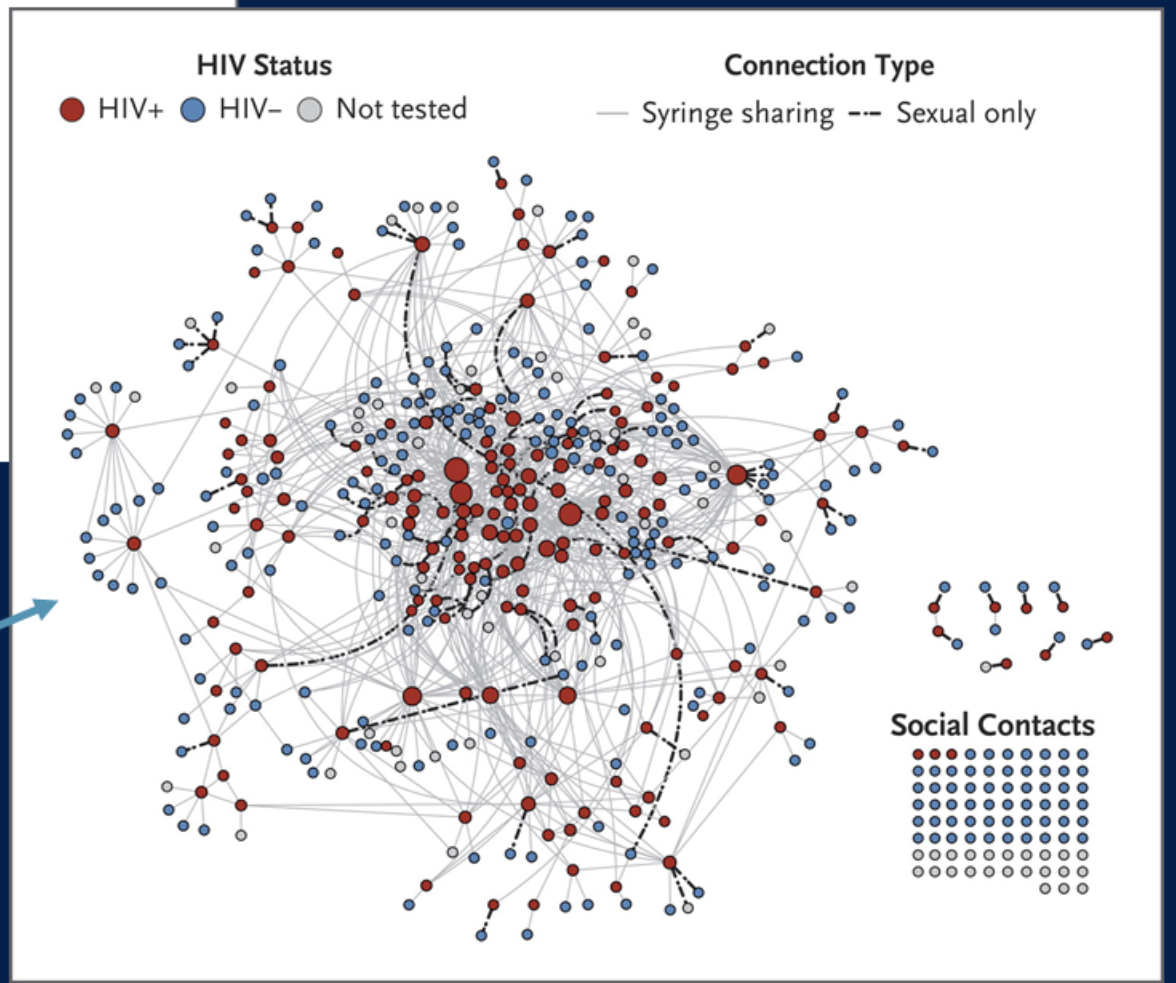
10. Medical Disorders of Addiction: HIV and Opana

- Peters PJ et al., NEJM 2016:

  "HIV Infection Linked to Injection Use of Oxymorphone in Indiana, 2014–2015"

- 181 outbreak-related HIV case diagnoses within 1-year period amongst residents of Scott County, Indiana or named by another case patient as a syringe-sharer or sexual partner; only 5 diagnoses in same county 2004-13
- 88% reported injecting extended-release oxymorphone, 92% coinfected with hep-C
- Among 159 patients who had HIV type 1 *pol* gene sequence, 99% had highly related sequences
- # times contact named as syringe-sharing partner significantly associated with likelihood of HIV infection





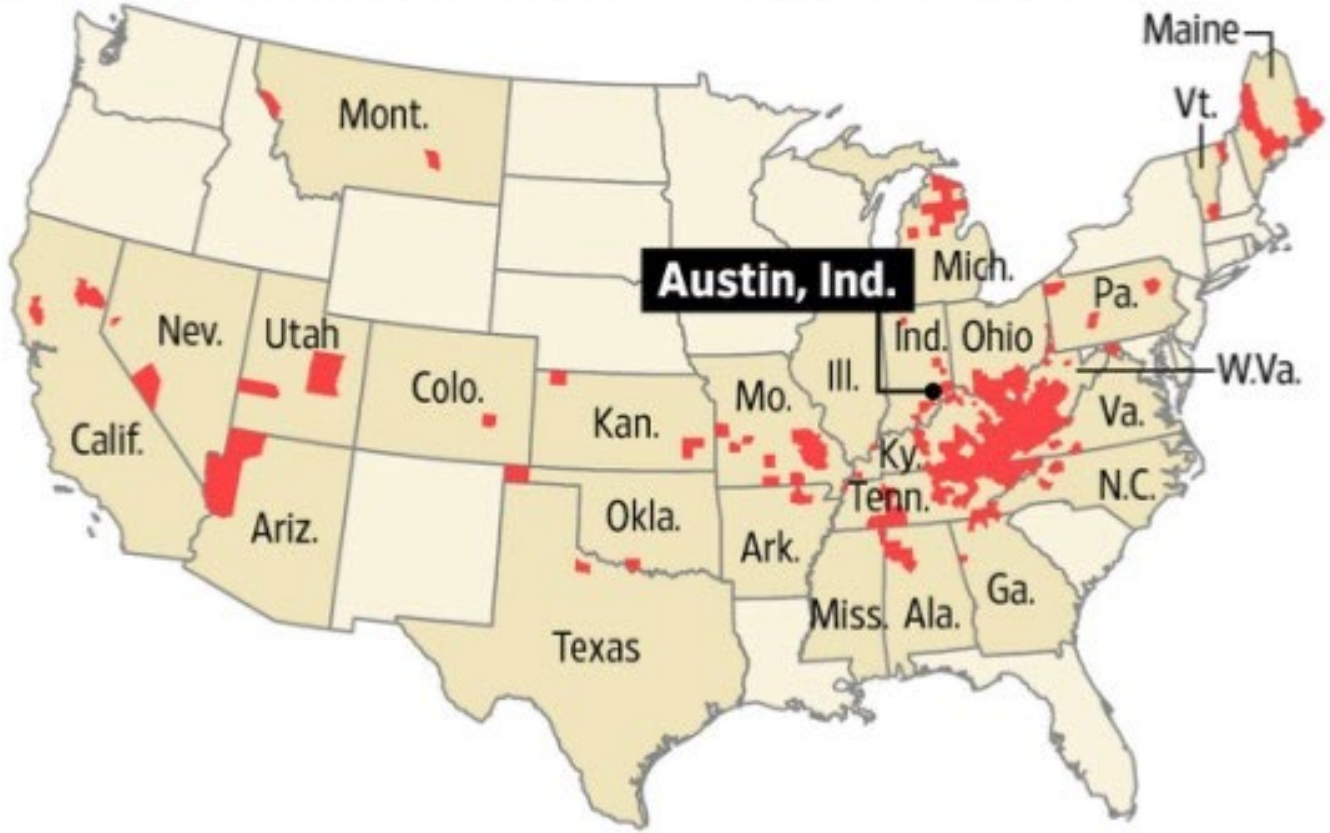
Size of circles proportional to number of syringe-sharing or sexual connections

ASAM American Society of Addiction Medicine

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.

Cities with the lowest rates of HIV that don't have SSP's are at the highest risk for increase in HIV rates

Change in HIV seroprevalence with and without needle-syringe programs

	Cities with NSPs	Cities without NSPs
All cities	-5.8% per year	+5.9% per year
Cities with seroprevalence <10%	-1.1% per year	+16.2% per year

Hurley et al. Lancet 1997:349; 1797-1800.
www.unodc.org/documents/hiv-aids/EFA%20effectiveness%20sterile%20needle.pdf

SO,
HOW DO YOU START A RURAL SYRINGE ACCESS PROGRAM?

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

This guidebook was developed as the result of a grant from the Comer Family Foundation.
Thank you to Mary Pounder of the Comer Family Foundation.
A special thanks to Amy Lansky, Emma Roberts and Sean Allen for their review of this guidebook.

Authored by Regina La Belle, July 2017

Rural Syringe Services Program

FAQs

Don't they promote drug use?

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.

A guide to establishing syringe services in rural, at risk areas, Labelle

THE BENEFITS OF SYRINGE ACCESS PROGRAMS

- Cost savings
  - $500 to provide injection supplies for a year vs $100K to treat/monitor Hep C, $500K+/lifetime cost treat HIV/AIDS
- Reduced Viral Transmission
  - Transmission of HIV/Hep C reduced by 30%
- Reduced risk-taking behavior
- 5X increased engagement in SUD treatment

Syringe Exchange Programs Myths vs. Facts

There are many misconceptions about syringe exchange. Often community members are unaware of the role syringe exchange programs play in the overall effort to build healthier communities and to provide people who inject drugs with opportunities for healthier futures. The following information provides answers to some common mistaken beliefs about syringe exchange programs.

MYTH: Drug use will increase in areas with syringe exchanges.

FACT: There is no evidence of any link between increased drug use and syringe exchange programs. The U.S. Surgeon General has determined that syringe exchange programs, when part of a comprehensive effort to reduce the spread of disease, do not increase drug use (1). Unfortunately, illicit injection drug use is a sad reality in our communities. Syringe exchange programs provide a point of contact for clients to access healthcare and treatment resources and aim to reduce the spread of disease.

MYTH: Syringe exchange doesn't fix the problem of drug addiction.

FACT: The primary goal of syringe exchange is to reduce the spread of blood-borne diseases and minimize blood infections by providing free sterile syringes and other equipment to people who inject drugs. However, syringe exchange programs also provide another point of contact for individuals to obtain access to resources for substance treatment and other health and social services. According to data from the Centers for Disease Control and Prevention and the National Institute of Health, syringe exchange participants are five times more likely to enter a substance treatment program than individuals who haven't used a syringe exchange program (2).

MYTH: People who inject drugs won't return dirty syringes.

FACT: Syringe exchange programs provide a point of contact to educate participants about the safe disposal of used syringes. There are many reasons participants may not bring their used syringes to the exchange on any given day, such as their syringes were confiscated by law enforcement or they disposed of their used syringes elsewhere. Syringe exchange providers in Utah work with participants to ensure used needles are disposed of safely by providing sharps containers to participants and conducting needle cleanups across communities.

For more information about syringe exchange in Utah, please contact syringeexchange@utah.gov.

MYTH: There is no widespread support for syringe exchange programs.

FACT: The effectiveness of syringe exchange programs in reducing the spread of disease and promoting healthier communities has led to widespread support among local and national organizations including, but not limited to the following:

- American Academy of Family Physicians
- American Academy of Pediatrics
- American Bar Association
- American Medical Association
- American Public Health Association
- American Society of Addiction Medicine
- International Red Cross-Red Crescent Society
- Latino Commission on AIDS
- NAACP
- National Academy of Sciences
- National Black Police Association
- National Institute on Drug Abuse
- Office of National Drug Control Policy
- Presidential Advisory Committee on AIDS
- US Conference of Mayors
- Utah AIDS Foundation
- Utah Department of Health
- Utah Department of Health and Human Services
- Utah Naloxone
- World Bank
- World Health Organization

1. "Syringe Services Programs". Centers for Disease Control and Prevention, 3 Aug. 2017, www.cdc.gov/hiv/risk/ssps.html
2. "Reducing Harms from Injection Drug Use & Opioid Use Disorder with Syringe Services Programs". Centers for Disease Control and Prevention, August 2017, www.cdc.gov/hiv/pdf/risk/cdchiv-fs-syringe-services.pdf

UTAH SYRINGE EXCHANGE NETWORK

WORKING TO STOP THE SPREAD OF DISEASE

USEN

GETTING TO THE POINT!

Syringe Exchange Program Myths & The Facts

Between 1991 and 1997, the US Government funded seven reports on clean needle programs for persons who inject drugs. The reports are unanimous in their conclusions that clean needle programs reduce HIV transmission, and none found that clean needle programs caused rates of drug use to increase. The federal Department of Health and Human Services currently maintains a webpage on the effectiveness of syringe exchange programs: http://www.samhsa.gov/ssp/

MYTH: Syringe Exchange Programs (SEPs) encourage, enable, and increase drug use

FACT: Decades of scientific evidence, including from health organizations such as the World Health Organization and the American Medical Association, have concluded that SEPs DO NOT cause any increase in drug use. In fact, many studies have demonstrated that SEPs decrease drug use by connecting otherwise marginalized people to treatment. It is estimated that SEP participants are five times more likely to enter drug treatment than non-participants.

MYTH: SEPs increase crime

FACT: Crime actually decreases in SEP areas because participants are connected to drug treatment, housing, food pantries and other social services. In one study, Baltimore neighborhoods with syringe exchange programs experienced an 11% decrease in crime compared to those without syringe exchange, which saw an 8% increase in criminal activity.

MYTH: Persons who use drugs will not return used syringes to a SEP

FACT: Research indicates that over 90% of syringes distributed by SEPs are returned. In Baltimore, SEPs helped reduce the number of improperly discarded syringes in the community by almost 50 percent. In Portland, Oregon, the number of improperly discarded syringes dropped by almost two-thirds after the implementation of an SEP.

MYTH: SEPs do not have public support

FACT: Numerous national medical and public health organizations support SEPs, including the American Medical Association, the American Public Health Association, the National Academy of Sciences, and the American Academy of Pediatrics. So too do leading global bodies such as the World Health Organization (WHO), the World Bank, and the International Red Cross-Red Crescent Society. The American Bar Association strongly supports SSPs, as does the U.S. Conference of Mayors.

MYTH: Only "blue" states have SEPs

FACT: With the current crisis around rising rates of injection drug use, HIV and hepatitis C, several "red" states have explicitly authorized SEPs, including Kentucky, West Virginia, Indiana, and Nebraska.

MYTH: SEPs lead to more discarded syringes in the community

Fact: SEPs actually decrease the number of syringes discarded in public areas because over 90% of program participants turn in syringes to the SEP. Also, if people do not fear being charged for possession of a syringe by law enforcement, they are more likely to carry sharps containers for syringe disposal, instead of discarding used syringes in trash cans, flushing them down the toilet, or throwing them out the window of a car.

MYTH: Law Enforcement Don't Support SEPs

Fact: Many NC Chiefs and Sheriffs have come out on record in support of syringe exchange programs, including Sheriff Elks of Pitt County, Sheriff Doughtie of Dare County, Chief Sumner of High Point, Chief Brinkley of Nags Head, Chief Hollingsed of Waynesville, Chief Cueto of Duck, Chief Barone of Statesville, and Chief Rountree of Winston Salem.

NORTH CAROLINA HARM REDUCTION COALITION
2416 Hillsborough Street • Raleigh, NC • 27607
WWW.NCHRC.ORG • +1 (336) 543-8050
ROBERT.BB.CHILDS@GMAIL.COM

Syringe Exchange Programs
Public Safety and Infectious Disease Elimination
Myth vs Fact

All scientific studies conducted over the last 20 years irrefutably demonstrate that syringe exchange programs (SEPs) play an important role in ***reducing HIV and hepatitis C infections*** and ***advancing public safety, especially for law enforcement officials and other first responders, by taking dirty needles off the streets***. There are many misconceptions, myths and misinformation about Syringe Exchange Programs and their effectiveness held by the public and lawmakers.

MYTH 1: SEPs Encourage Drug Abuse

SEPs do not encourage the initiation or frequency of use drug. 20 years of data from CDC and National Institute of Health show ***SEP participants are 5 times more likely to enter drug treatment programs than non-participants***. According to the National Office of Drug Control Policy, SEPs support recovery and break the cycle of drug use as they are critical entry points for drug users to be linked to comprehensive treatment.

MYTH 2: SEPs Do Not Eliminate Infectious Disease

SEPs take dirty needles off the streets, and out of parks, beaches and other public areas, protecting the public and first responders from exposure to dirty needles. Cities that have adopted SEPs have seen a dramatic reduction in needle sticks to law enforcement, firefighters and waste collectors. SEPs reduce the circulation of dirty needles among IDUs, and are a critical component in helping to reduce the spread of infectious diseases, such as HIV and hepatitis C. ***Since legalizing SEPs in 1992, New York State has seen a 49% reduction in newly diagnosed cases of HIV among intravenous drug users (IDU)***. Without SEPs, Miami has the highest rate of HIV infections among IDUs, increasing by 25% in 2013.

MYTH 3: SEPs Increase Crime

The presence of SEPs in communities has not been shown to increase drug-related networks or increases in crime rates ***Based on all research over the last 20 years, SEPs do not appear to increase crime, but rather greatly enhance officer and public safety.***. A study conducted in Baltimore found that neighborhoods with SEPs experienced 11% decrease in break-ins and burglaries, while those without SEPs experienced an 8% increase in crime.

MYTH 4: SEPs Waste Public Resources

The cost of a sterile syringe can be a little as 97 cents. The estimated lifetime cost of treating an HIV+ person is estimated between $385,000 and $619.000. Needle sharing is the primary driver of hepatitis C infection in the U.S., costing hundreds of millions in public dollars. ***It is estimated that if just 10% of new HIV cases from IDUs in Miami Dade had been prevented, it would represent a savings of $124 million in HIV treatment costs to Florida taxpayers***. It is far cheaper to provide sterile syringes to prevent the spread of infectious diseases, than to treat them.

LIVE UNITED United Way — United Way of Broward County | COMMISSION ON SUBSTANCE ABUSE — Building Healthier Communities

Solutions Recovery — an AAC facility

MENU

Las Vegas was the first in the country to install and maintain clean needle vending machines for people living with an active addiction. Not only can those who take part in the program get packages of clean needles every week, they also have the opportunity to get other sanitary supplies and turn in used needles as well. Currently, there are only three vending machines in Las Vegas dedicated to this purpose, but

BARRIERS TO SYRINGE ACCESS IN RURAL AREAS

-Paraphernalia laws

-Negative public perception

-Lacking expertise to develop protocols

-Choosing a location

-Finding funding

-Syringe disposal

ADVANTAGES TO RURAL SAP

Small number of people who need services means costs are low and can be met with Micro-grants and local fundraising

Don't need a permanent space (limited hours needed)

Easy to identify and recruit community partners (if they already know and trust you)

Program can be started and run with a small group of grassroots volunteers

Bureaucracy is limited and early adoption of innovative programs feasible

HOW TO GET STARTED

Talk to your local city council

Talk to local health care providers

Talk to local law enforcement

We all share a common interest in the well being of our community

Educate, educate, educate.

You have the power to change perceptions

OPIOID TASK FORCE

- Peer networks
- Families
- Clinics/Hospitals
- Law enforcement
- Pharmacists
- Active users
- Family planning
- SUD treatment programs
- Social services (food banks, shelters)
- Lawyers
- Educators

EMBRACE LOCAL MEDIA

-Local Paper

-Public Radio

-Town Hall Meetings

-Borough assembly meetings

-Hospital Board Meetings

-Health Fairs

-Roundtable Community Discussions

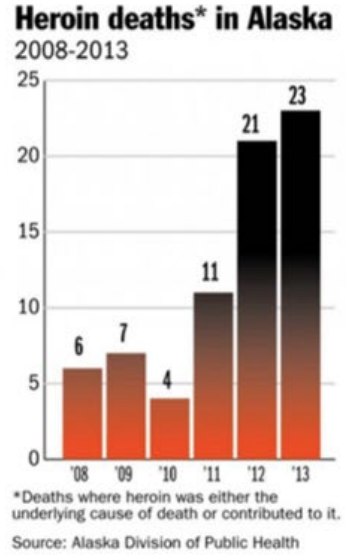
-Educational Events

Addressing Heroin Addiction on the Kenai Peninsula

Kenai Peninsula Borough Assembly Meeting

December 8th

Dr. Sarah Spencer



At South Peninsula Hospital
For Fiscal year 2015 (7/14-7/15)
There were documented:
10 opioid overdoses

CREATING HOMER'S SAP

-Meetings of interested community members to assess need and concerns

- Physicians, family planning, public health, youth services, police, lawyers

-Present evidence to city council

-Asked hospital board for space
and disposal services

-Used templates from preexisting SAPs
to compile policies and procedures

-Visited 4As (Anchorage SAP)

-Small local grants, NASEN

-Pilot program

6 month start up timeframe

CITY OF HOMER
HOMER, ALASKA

Lewis

RESOLUTION 16-008

A RESOLUTION OF THE CITY COUNCIL OF HOMER, ALASKA, SUPPORTING THE ESTABLISHMENT OF A SYRINGE EXCHANGE PROGRAM IN HOMER.

WHEREAS, Syringe exchange programs (SEPs) provide free sterile syringes and collect used syringes from injection drug users to reduce transmission of blood borne pathogens, including HIV, and Hepatitis B and C viruses; and

WHEREAS, Most SEPs also offer HIV/Hepatitis counselling and testing and referral to substance abuse treatment; and

WHEREAS, There are over 1,000 new cases of Hepatitis C and over 100 new cases of HIV in Alaska each year; and

WHEREAS, SEPs reduce virus transmission by about 30%; and

WHEREAS, There is significant cost savings associated with reducing instances of Hepatitis C, HIV, and injection drug related bacterial infections; and

WHEREAS, According to the World Health Organization there is compelling evidence that increasing the availability and utilization of sterile injection equipment by injection drug users reduces HIV infection substantially; and

WHEREAS, In 2000 U.S. Surgeon General Dr. Satcher issued a statement that SEPs are an effective HIV prevention strategy and do not encourage the use of illegal drugs; and

WHEREAS, SEPs have the added benefit of increasing recruitment into drug treatment programs and primary care.

NOW, THEREFORE, BE IT RESOLVED by the City Council of Homer, Alaska, that the City of Homer supports the establishment of a Syringe Exchange Program in the City of Homer.

PASSED AND ADOPTED by the Homer City Council this 11th day of January, 2016.

ENGAGE ACTIVE USERS

-What supplies do they need? (needle gauge, etc)

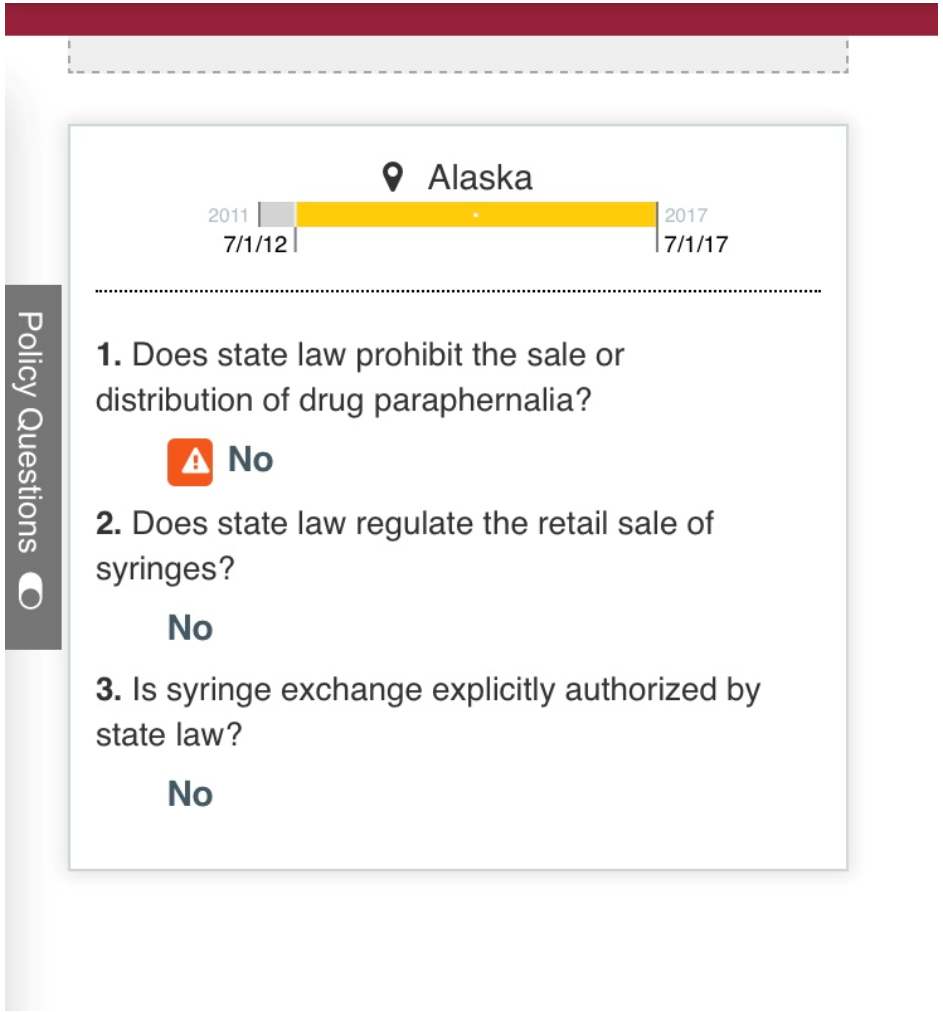
-What location do they feel comfortable coming to

-Is law enforcement supportive?

-Do they have a way to get to the exchange? (transportation)

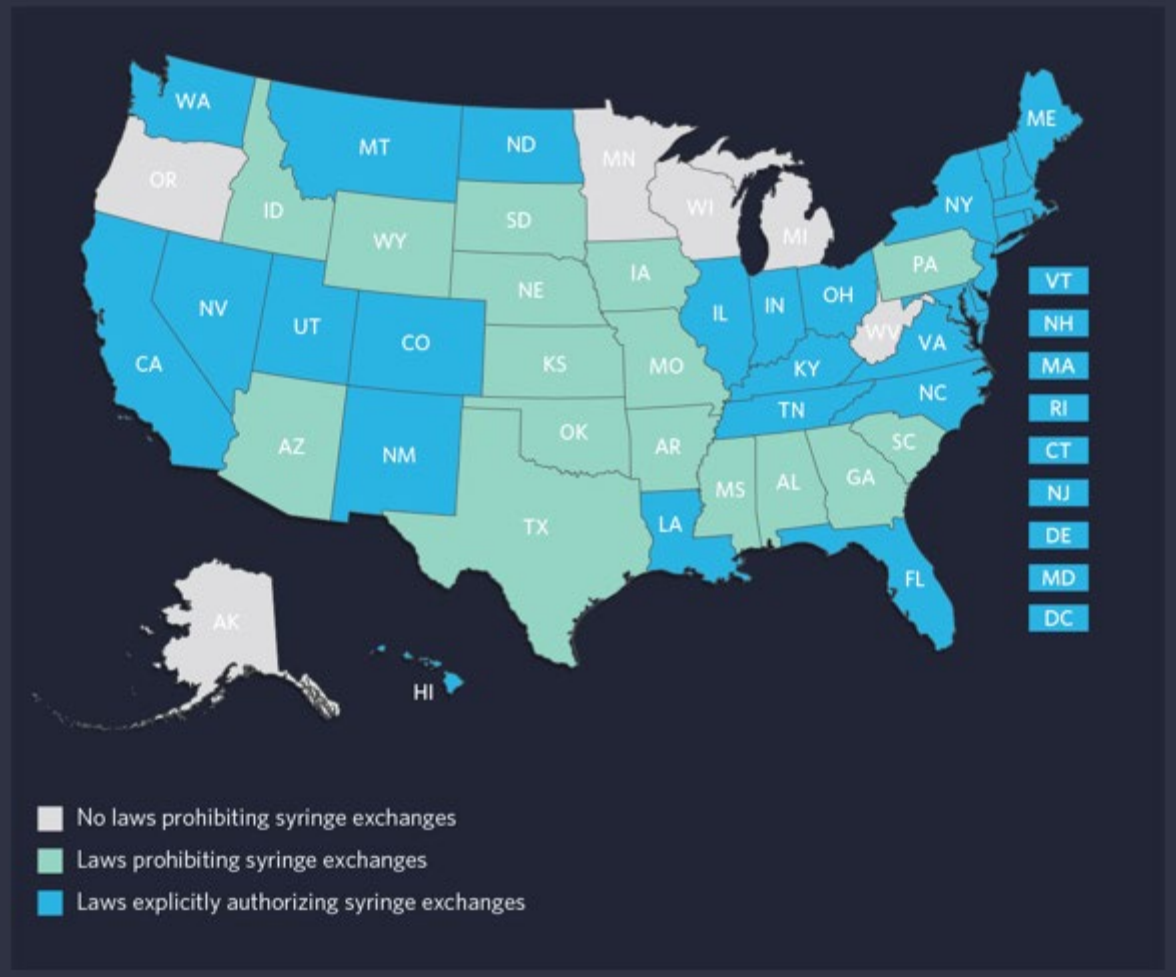
-**Consider peer/secondary distribution**

UNDERSTANDING LAWS IN YOUR COMMUNITY



State Laws Affecting Syringe Exchanges

At least 29 states have enacted laws that authorize public health organizations to distribute syringes, needles and other sterile supplies to injection drug users in an effort to mitigate the spread of infectious diseases. (Another 16 states explicitly prohibit such exchanges.) Many needle exchanges also distribute the opioid overdose antidote naloxone and help drug users get access to medical care and addiction treatment.



Source: National Alliance of State and Territorial AIDS Directors, "Syringe Service Program Policy Environments Across the United States"

PROTOCOLS

Syringe Access Manual

Guide to Developing and Managing Syringe Access Programs is a comprehensive, step-by-step manual for starting and managing syringe access programs. This pragmatic and straightforward guide can serve as a valuable tool for new and established programs alike, offering practice suggestions and guidance in several areas including: Planning and Design, Operational Issues, Organizational Issues, External Issues and Population-Specific Considerations.

The Guide's online Appendix can be found here.

View below or download as a PDF here.

Harmreduction.org

Syringe Services Programs (SSPs) Developing, Implementing, and Monitoring Programs

February 2016

Tools and Resouces

This document provides example resources for health departments and local partners that may be helpful in planning, designing, and implementing SSPs in their jurisdictions as part of a comprehensive, integrated approach to prevention of HIV and other injection-related harms among persons who inject drugs (PWID). The resources include national and international guidelines, sources for technical assistance and program supplies, and strategies for working with law enforcement and for building strong community relationships. Monitoring SSPs is a critical component in the planning, designing, and implementing stages to ensure that the program is operating in conformity to its design, reaching the population it aims to serve, and achieving the anticipated implementation goals. Some of the example resources provided in this section also include guidance on successfully monitoring and evaluating SSPs (e.g., NASTAD & UCHAPS 2012).

A comprehensive, multi-component, prevention program is the most effective approach for preventing the transmission and acquisition of HIV and other blood-borne infections among drug-using populations. SSPs are an important component of this approach and are particularly key in establishing contact with otherwise hard-to-reach populations to deliver health services, including HIV, sexually transmitted diseases (STD), and viral hepatitis counseling (including for risk reduction) and testing, overdose prevention, and substance use disorder treatment referrals. This document also provides example resources and tools to consider in implementing SSPs as part of a comprehensive prevention approach that addresses myriad health and social circumstances of PWID. Resources to guide monitoring and evaluation of comprehensive prevention programs for PWID, which are key operational activities to ensuring that the programs are meeting their implementation goals, are also provided.

Disclaimer: The resources presented in this document do not all constitute official Centers for Disease Control and Prevention (CDC) advice and may not represent the views of CDC or the U.S. Department of Health and Human Services (HHS), nor does this document provide a comprehensive review of all relevant resources available.

Table 1: Example Resources and Tools for Developing and Implementing SSPs

Name	Description	Web Link
National Alliance of State and Territorial AIDS Directors (NASTAD) and the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS). (2012) Syringe Services Program Development and Implementation Guidelines for State and Local Health Departments	Provides guidelines to assist state and local health department jurisdictions that wish to support SSPs for PWID to prevent transmission of HIV and other blood-borne viruses such as HCV and to link PWID to vital prevention, medical and social services. The guidelines provide information on the background of SSPs, structural elements to be considered before implementing SSPs, operating principles, SSP delivery models, and suggestions for monitoring SSPs and capacity building needs. The document also lists additional resources and tools.	http://www.uchaps.org/assets/NASTAD-UCHAPS-SSPGuidelines-8-2012.pdf
WHO/UNAIDS. (2007) Guide to Starting and Managing Needle and Syringe Programmes.	Provides guidance for developing and implementing effective SSPs. The guidance includes practical information on planning the program, modes of delivery, staffing, and supplies, and management guidance on the spectrum of services, managing staff and external relationships. The guide also provides additional resources, publications, and tools.	http://www.who.int/hiv/pub/idu/needleprogram/en/
WHO. (2004) Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS among Injecting Drug Users.	Provides a comprehensive review and summary of available evidence for effectiveness and cost-effectiveness of SSPs.	http://www.who.int/hiv/pub/prev_care/en/effectivenessterileneedle.pdf

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

CDC

harmreduction.org

NEW YORK STATE DEPTARTMENT OF HEALTH
AIDS INSTITUTE

POLICIES AND PROCEDURES

SYRINGE EXCHANGE PROGRAMS

cdph.ca.gov

Guidelines for Syringe Exchange Programs Funded by the California Department of Public Health, Office of AIDS

OFFICE OF AIDS

California Department of Public Health

harmreduction.org

SFHIV HIV Prevention Information, Services, and Resources for the City of San Francisco

San Francisco Department of Public Health
Population Health and Prevention
HIV Prevention Section

healthvermont.gov

Operating Guidelines for
Organized Community-based Safer Injection Support Programs
July 2010

Safer Injection Support Programs, or syringe exchange programs, are designed to prevent the spread of HIV, viral hepatitis and other pathogens, and provide a bridge to drug treatment and other prevention services for injection drug users. These guidelines are meant to ensure the safety of consumers, health care workers who serve them, community based organizations, syringe exchange program staff, and members of the public.

A) Program Requirements:

1. Syringe exchange programs (SEP) shall use a broad range of syringe access strategies in order to reach and provide services to as diverse a group of people as possible. SEP consumers shall be treated with respect and in a manner that promotes client enrollment, participation and retention. If the syringe exchange site intends to conduct syringe exchange and use outreach, this must be explicitly stated in the initial syringe exchange application or subsequently in the program's one-year plan.

2. Syringe exchange programs shall be operated by an AIDS Service Organization, substance abuse treatment provider, or a licensed health care provider or facility.

3. Needles/syringes and other disease prevention materials shall be provided through a syringe exchange program in the most effective manner possible and at no cost to consumers.

4. Syringe exchange program staff and program volunteers shall be trained annually and regularly supervised on the following topics:
   - harm reduction
   - opiate addiction overview
   - substance abuse treatment referral
   - medical referral
   - referral to other community resources
   - assessment and response to emergency situations
   - boundaries, confidentiality, and safety issues (including drug and alcohol use)
   - infection control procedures, standard universal precautions (including information on hepatitis B immunization and TB screening) and needlestick protocol.
   - Sharps disposal

   Designated syringe exchange program staff and/or volunteers shall also participate in the VDH training on HIV Counseling, Testing and Referral (CTR), and shall follow VDH protocol on CTR quality assurance. The HIV/AIDS/STD/Hepatitis C Program at the VDH will work with the syringe exchange program to offer CTR training to these syringe exchange program staff/volunteers.

   The VDH will work with the designated syringe exchange programs to create a curriculum that reflects best syringe exchange practices and reflect the topics listed in these guidelines. The training curriculum should be approved by VDH annually along with the yearly application. Syringe exchange programs shall maintain records of staff/volunteer training and of staff/volunteer hepatitis B immunization and TB screening.

5. The organization that implements a syringe exchange program shall convene an advisory committee meeting quarterly for the first two years of the exchange's operation. If the SEP operates for two years without incident, and at the end of these two years has no unresolved issues identified by the community advisory board, the SEP will be allowed to hold meetings at least once a year and as needed. This advisory committee will provide guidance to the syringe exchange program, and will support communication between the syringe exchange program and the community. The advisory committee should consist of individuals who can support the program in

LOCATION

-Options are limitless

-Convenient, safe and private

-Clinic/medical facility is ideal

-May only need space a few hours per month

Mobile Units

Snack Time Vending Machine - Perfect for holding multiple size snacks/chips!

US $150.00 +US $75.00 Shipping
or Best Offer

Vending Machines

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.

ALTERNATIVE SYRINGE ACCESS

- Partnership with local pharmacist for local purchase without Rx

-Write a Prescription for syringes: bulk/mail order

-Have sterile injection equipment available at local clinics

-Peer distributed syringes

-Educate about proper disposal

Harm Reduction

Write the RX

- **Pharmacy distribution**: "Many argue that pharmacies are an important but under-utilized resource in preventing the transmission of HIV and other blood-borne infections among people who inject drugs. Pharmacists are some of the most accessible healthcare professionals and are in an ideal position to reach this group who are often socially marginalized and wish to remain anonymous"
- By Alaska state law, a prescription is required to purchase syringes at a pharmacy (includes mail order), however, a pharmacist may dispense syringes at their discretion without a prescription. Unfortunately, some pharmacies require patients to sign logbook, and this lack of anonymity can discourage use. Pharmacies that do sell syringes may limit the number a patient can purchase, and patients living in remote areas may not have access to a pharmacy. If you have a pharmacist in your area, talk with them about allowing patients to purchase syringes anonymously there.

An example of a prescription for syringes

Diabetic syringes

29g, 1/2in *"longs"* *<u>or</u>* ***31g, 5/16in*** *"shorts"*
(ask patient which they prefer)
½ or 1 cc
(ask patient which they prefer, ½ cc is more common)

Dispense #__ boxes of 100 syringes
Refill PRN X 1year

WHAT IS

NEXT Distro?

An online and mail-based **harm reduction service** designed to reduce opioid overdose death, prevent injection-related disease transmission, and improve the lives of people who use drugs.

https://nextdistro.org/

Fentanyl Test Strips

1. Add sterile water to your **empty** baggie or the **cooker you just prepped** – mix well!

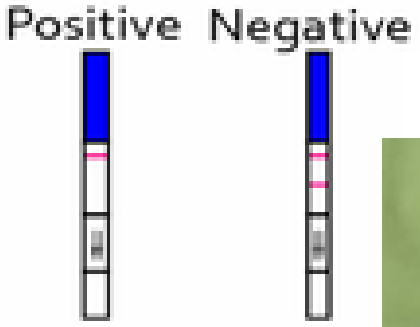
   **Load your shot FIRST! Only test your rinse water!

2. **Dip the test strip** in the water, in up to the first line & **hold for 15 seconds**

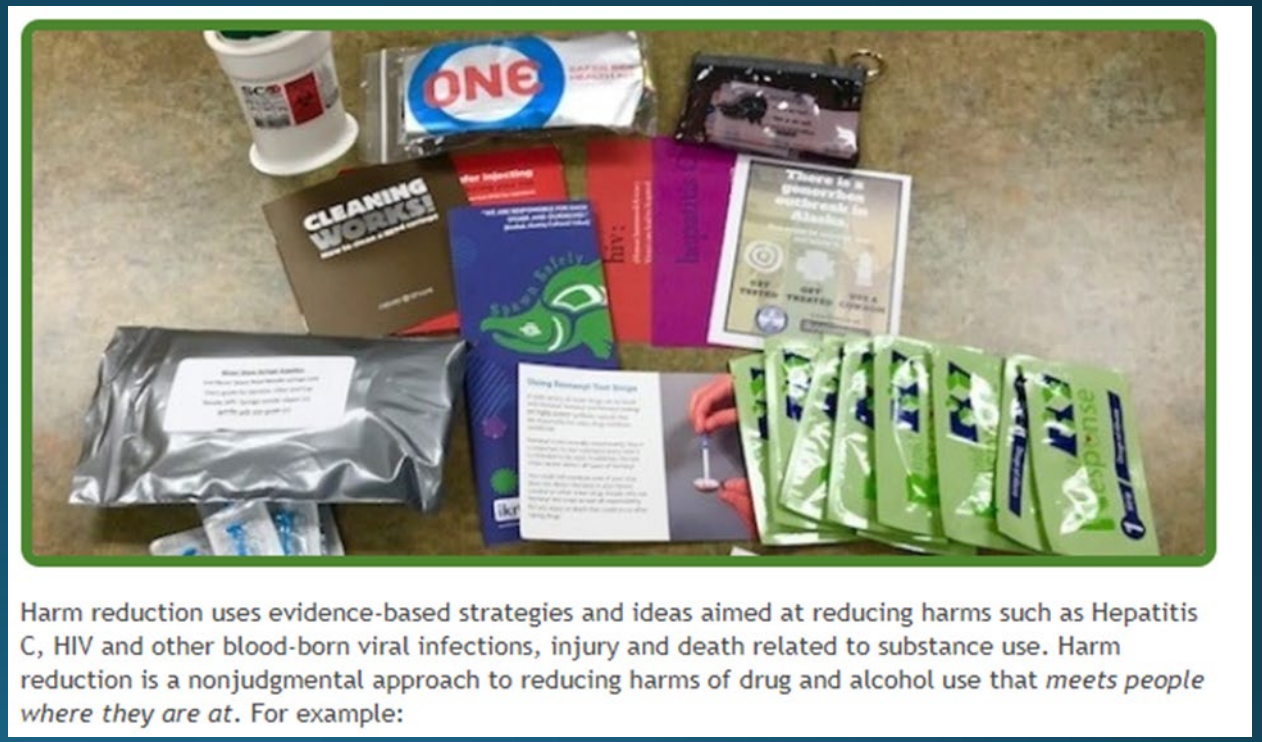
3. **Place test strip** on sterile surface or across top of cooker.

One line POSITIVE

Two lines NEGATIVE



ANTHC Harm Reduction Kits



https://www.iknowmine.org/other-cool-stuff/harmreduction

Rural Harm Reduction Toolkit
https://www.indiancountryecho.org/wp-content/uploads/2019/08/ANTHC-Harm-Reduction-Toolkit.pdf

Project Hope

- Organizations eligible to apply to distribute Narcan® as a partner in Project HOPE may include, but are not limited to: public health centers, law enforcement agencies, fire departments, community and faith-based organizations, social service agencies, substance use treatment programs, shelters and transitional housing agencies.
- Every patient who receives a prescription for opioids, a new MAT patient, a family member or someone who knows someone who knows uses opioids **should be provided a Narcan® kit.**
- The best way to make Narcan® kits available- hand them out to people who use. They can be the best first responders.

If you have questions about Project HOPE, or would like to learn more about offering kits,
email: ProjectHOPE@alaska.gov.

DISPOSAL

Partner with local hospital or clinic

Contact local municipal waste management

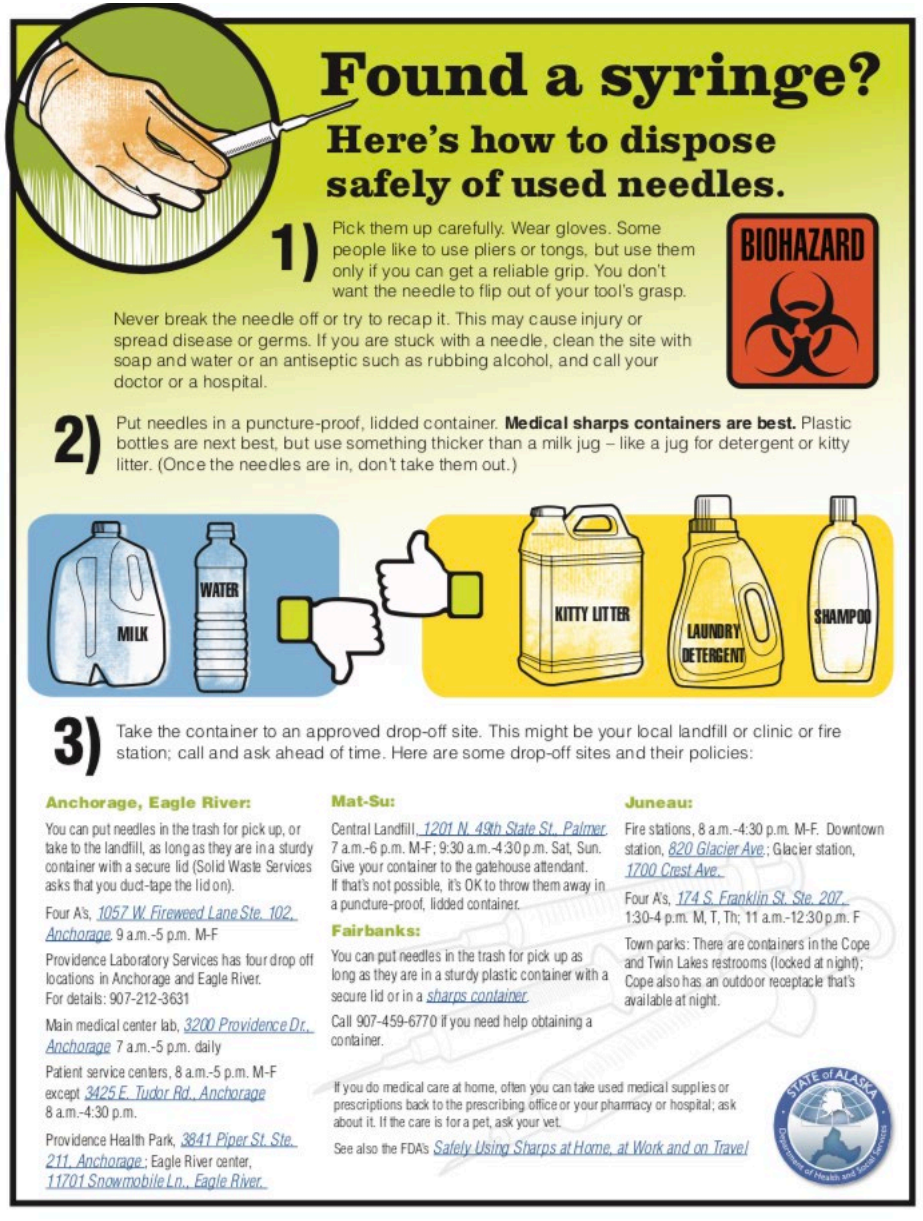
Distribute sharps containers

Provide education on proper disposal

Distribute needle safes (cutters)

ALTERNATIVE DISPOSAL

Needle Clippers



Found a syringe?

Here's how to dispose safely of used needles.

1) Pick them up carefully. Wear gloves. Some people like to use pliers or tongs, but use them only if you can get a reliable grip. You don't want the needle to flip out of your tool's grasp.

BIOHAZARD

Never break the needle off or try to recap it. This may cause injury or spread disease or germs. If you are stuck with a needle, clean the site with soap and water or an antiseptic such as rubbing alcohol, and call your doctor or a hospital.

2) Put needles in a puncture-proof, lidded container. **Medical sharps containers are best.** Plastic bottles are next best, but use something thicker than a milk jug – like a jug for detergent or kitty litter. (Once the needles are in, don't take them out.)

MILK WATER KITTY LITTER LAUNDRY DETERGENT SHAMPOO

3) Take the container to an approved drop-off site. This might be your local landfill or clinic or fire station; call and ask ahead of time. Here are some drop-off sites and their policies:

Anchorage, Eagle River:

You can put needles in the trash for pick up, or take to the landfill, as long as they are in a sturdy container with a secure lid (Solid Waste Services asks that you duct-tape the lid on).

Four A's, *1057 W. Fireweed Lane Ste. 102, Anchorage*, 9 a.m.-5 p.m. M-F

Providence Laboratory Services has four drop off locations in Anchorage and Eagle River. For details: 907-212-3631

Main medical center lab, *3200 Providence Dr., Anchorage* 7 a.m.-5 p.m. daily

Patient service centers, 8 a.m.-5 p.m. M-F except *3425 E. Tudor Rd., Anchorage* 8 a.m.-4:30 p.m.

Providence Health Park, *3841 Piper St. Ste. 211, Anchorage*; Eagle River center, *11701 Snowmobile Ln., Eagle River*.

Mat-Su:

Central Landfill, *1201 N. 49th State St., Palmer*. 7 a.m.-6 p.m. M-F; 9:30 a.m.-4:30 p.m. Sat, Sun. Give your container to the gatehouse attendant. If that's not possible, it's OK to throw them away in a puncture-proof, lidded container.

Fairbanks:

You can put needles in the trash for pick up as long as they are in a sturdy plastic container with a secure lid or in a *sharps container*.

Call 907-459-6770 if you need help obtaining a container.

Juneau:

Fire stations, 8 a.m.-4:30 p.m. M-F. Downtown station, *820 Glacier Ave.*; Glacier station, *1700 Crest Ave.*

Four A's, *174 S. Franklin St. Ste. 207*, 1:30-4 p.m. M, T, Th; 11 a.m.-12:30 p.m. F

Town parks: There are containers in the Cope and Twin Lakes restrooms (locked at night); Cope also has an outdoor receptacle that's available at night.

If you do medical care at home, often you can take used medical supplies or prescriptions back to the prescribing office or your pharmacy or hospital; ask about it. If the care is for a pet, ask your vet.

See also the FDA's *Safely Using Sharps at Home, at Work and on Travel*

STATE of ALASKA

COVID response

- Continuous operation throughout the pandemic
- Served participants outside/ in their cars
- Access point for disposal for community with hospital shut down of sharps drop-off days
- Increased peer and secondary distribution to help people in isolation access services
- Had to put testing and paper data collection on hold for 1 year but just reopened
- Provided 2 days of COVID testing by NTC
- NTC will provide walk-in Covid vaccination next week
- Text messaging service to keep participants up to date on openings and updates

The Numbers

- As of June 2021, the exchange has been in operation for 5 years
- 5 years = 116 openings = almost 500 hours of volunteer time!
- In the past year 150 participant visits (ave 9 participants per opening)
- 1-2 Peer distributors who serve an additional 12 participants per month
- Estimated number of people served per month = 40-50

The Numbers

In the past year:

- 36,000 syringes distributed
- 27,000 used syringes returned (2 out of 3)
- Hundreds of sharps disposal containers distributed (to allow safe disposal outside of the exchange)
- Rate of returns nearly tripled after adding incentive program last year
- Participants who return 100+ syringes can draw for a chance to win a $10 grocery of gas gift card

The Numbers

In the past year:

- 78 Narcan kits distributed
- About 12 overdose reversals reported
- Roughly 6 participants per year enter into substance use treatment
- 4 participants this year received Hep C treatment

Sarah Spencer DO, FASAM
Addiction Medicine Specialist
Ninilchik Community Clinic
Ninilchik, Alaska
907-299-7460
sarahspencerak@gmail.com

Surveys

Look for our surveys in your inbox!

We greatly appreciate your feedback!

Every survey we receive helps us improve and continue offering our programs.

It only takes **1 minute** to complete!