# North Carolina Safer Syringe Initiative

## 2016-17 Annual Reporting Summary

State of North Carolina | Department of Health and Human Services

Division of Public Health | Injury and Violence Prevention Branch, Communicable Disease Branch

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## 2016-17 Annual Reporting Overview

There were **21 active syringe exchange programs** in North Carolina at the time of annual reporting (July 31, 2017).

As of Dec. 2017, **29 syringe exchange programs** have signed up with DPH since July 11, 2016. Of these programs, **26 are currently serving participants**.

Programs report serving participants from **52 North Carolina counties**. They also report participants from the Eastern Band of Cherokee Indians and surrounding states.

**3,983 people** received services from a syringe exchange program during the first year of legalization.

Participants made **14,997 total contacts** with syringe exchange services (average 3.77 contacts per person).

Programs distributed **1,154,420 sterile syringes**.

**489,301 used syringes were returned** to syringe exchange programs for safe disposal (42.4% return).

Syringe exchange programs distributed **5,682 naloxone kits** to people directly impacted by drug use.

Programs made an additional **1,311 referrals for naloxone** at pharmacies and health departments.

Participants reported **more than 2,187 overdose reversals** to syringe exchange programs.

Syringe exchanges made **over 3,766 treatment referrals** to substance use disorder and mental health services (combined).

**Nine syringe exchanges offer human immunodeficiency virus (HIV) and hepatitis C testing**. Programs connect participants to confirmatory testing, treatment programs and resources, and share data with the Division of Public Health.

Programs administered **2,599 HIV tests** and reported **five positive results** (.19% positivity).

Programs administered **738 hepatitis C tests** and reported **138 positive results** (18.7% positivity).

## Executive Summary

As of July 11, 2016, North Carolina (N.C.) law (G.S. 90-113.27) allows for the legal establishment of hypodermic syringe and needle exchange programs. Any governmental or nongovernmental organization "that promotes scientifically proven ways of mitigating health risks associated with drug use and other high-risk behaviors" can start a syringe exchange program (SEP). The law sets requirements for legal SEPs, including free access to exchange supplies, distribution of health education materials, connections to mental health and substance use disorder (SUD) treatment, and secure disposal of used syringes and injection supplies. Programs established under the SEP law are also required to participate in an annual reporting process to share data on program services and impact. The reporting period closes July 31 each year. Annual reporting allows the N.C. Department of Health and Human Services (NCDHHS) to track SEP development, identify areas for support and growth, and provide feedback and partnership to SEPs across the state.

The North Carolina Safer Syringe Initiative (NCSSI) is a project through the Division of Public Health (DPH) housed in the Injury and Violence Prevention Branch (IVPB). The project's aim is to promote access to sterile syringes and new injection supplies, facilitate the safe disposal of used syringes, provide preventative health information to people who use drugs (PWUD) and healthcare providers, encourage the development of syringe exchange infrastructure, and create connections to medical and social services, including mental health and SUD treatment, for PWUD. SEP services, including overdose prevention education and naloxone distribution, are also available to people taking opioid medications for prescription pain management, friends and family of PWUD, and community members.

The NCSSI workgroup includes members from IVPB and the Communicable Disease Branch (CDB) within DPH, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), and the North Carolina Harm Reduction Coalition (NCHRC). Each agency contributes area expertise, independent work, and complementary goals, partnerships and service connections. The workgroup is tasked with operationalizing program requirements, identifying strategic partnerships and areas for growth, streamlining access to existing services and programs, and facilitating program awareness and uptake.

Most SEPs are based in the practice of harm reduction. Harm reduction is an evolving set of practical strategies that reduce the negative consequences of drug use and other high-risk behaviors, operating on a spectrum of safer use to managed use to abstinence. Harm reduction strategies for safer drug use recognize that people use drugs for a variety of complex reasons and seek to meet people "where they are" in order to address both conditions of use and drug use itself. Engaging with people actively using drugs without the expectation of SUD treatment or abstinence allows greater dialogue about preventative health, safer use, and social and medical services access, and creates opportunities to build community with people who are stigmatized and criminalized for their health behaviors. Harm reduction programs provide information on SUD treatment, emphasizing availability if and when a participant is interested.

This style of delivery and connection to services is effective: SEP participants are five times more likely to enter treatment for SUDs than non-participants.[1]

[1] Hagan, H., McGough, J. P., Thiede, H., Hopkins, S., Duchin, J., & Alexander, E. (2000). Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. *Journal of Substance Abuse Treatment*, 19(3), 247-252. doi:10.1016/s0740-5472(00)00104-5

Syringe exchange began as a way to prevent transmission of bloodborne diseases,[2] and efforts to increase syringe access services in N.C. benefit from existing infectious disease testing and treatment infrastructure developed and maintained by the Communicable Disease Branch. CDB has sought to integrate SEPs with other programs with shared goals of prevention, care, and treatment for HIV, viral hepatitis, and sexually transmitted diseases (STD). All HIV Regional Networks for Care and Prevention (RNCPs) are required to ensure that exchange sites in their networks offer HIV and hepatitis C (HCV) testing. If an SEP site does not have testing capacity, the RNCP must make a prevention agency available to offer testing at the site. The RNCPs will report on how each site offers this testing in their January 2018 report. The HIV Prevention program offers participation in the HIV/STD/HCV rapid testing program to eligible organizations. The HIV Prevention program has ordered over $40,000 in injection supplies for NCHRC and Western North Carolina AIDS Project (WNCAP) to use in supporting SEPs across the state. Targeted distribution of supplies in western N.C. is in response to regional increases in HCV. The HIV Prevention and Hepatitis C programs at CDB are currently creating harm reduction kits to distribute to syringe exchange sites.

Included in the SEP law is a provision that protects syringe exchange employees, volunteers, and participants from being charged with possession of syringes or injection supplies, including those with residual amounts of controlled substances present, if obtained or returned to a SEP. Protection for paraphernalia containing drug residue encourages safe disposal of used supplies at a SEP. Exchange employees, volunteers, and participants must provide written verification (such as a participant card) to be granted this limited immunity. A law enforcement officer acting on good faith who arrests or charges a person who is thereafter determined to be entitled to immunity from prosecution under this section shall not be subject to civil liability for the arrest or filing of charges. The “Tell Law Officer Law” (G.S. 90-113.22), passed in 2013, also provides protection against drug paraphernalia charges. If a person alerts an officer that they have a syringe or other sharp object on their person, premises or vehicle prior to a search, they cannot be charged or prosecuted with possession of drug paraphernalia for that object. SEP staff and volunteers are responsible for explaining conditions of limited immunity to program participants, but these protections also require awareness and buy-in from law enforcement agencies and officers. Law enforcement and criminal justice education on the law and limited immunity is ongoing.

According to the SEP law, organizations, agencies, and individuals seeking to establish and operate SEPs must first notify DPH and provide program information, including how the SEP will meet legal requirements. The SEP sign-up form, security plan, and additional details are submitted to NCSSI. IVPB maintains lists of active programs and coverage internally and on the NCSSI webpage.

N.C. SEPs are required to provide the following services:

- Disposal of used syringes
- Distribution of syringes and injection supplies at no cost and in sufficient quantities to prevent sharing or using of syringes or injection supplies

[2] Lambert, B. (1989, November 20). AIDS Battler Gives Needles Illicitly to Addicts. The New York Times. Retrieved from http://www.nytimes.com/1989/11/20/nyregion/aids-battler-gives-needles-illicitly-to-addicts.html

- Program site, equipment, and personnel security. Programs must distribute security plans to all police departments and/or sheriff's offices with jurisdiction in operating locations. These plans shall be updated and redistributed annually.[3]
- Educational materials concerning prevention of disease transmission, overdose, and addiction, and treatment options, including medication-assisted treatment (MAT) and referrals
- Naloxone training and distribution and/or referrals
- Consultations and/or referrals to mental health and SUD treatment

N.C. law encourages syringe disposal at SEPs to ensure that used syringes and injection supplies are disposed in in a safe and secure manner, but does not require participants to return syringes in order to receive new supplies. The "one-for-one exchange" distribution model is implicitly prohibited because such programs do not provide syringes in "quantities sufficient to ensure that [they] are not shared or reused."[4] The ability to declare possession of syringes and to safely dispose of used injection equipment reduces risks to the public safety and health of law enforcement personnel, participants, and their communities.

The first SEP annual reporting period closed on July 31, 2017 and covered operations starting July 11, 2016 (date of legalization). Twenty-one programs received the NCSSI annual reporting form and instructions for completion, including technical assistance and deadline reminders. Twenty programs completed and submitted the reporting form.[5]

As of July 31, 2017, 3,983 unique individuals had been served by an SEP since legalization, with 14,997 total contacts (which includes repeat individuals) between participants and SEPs. Programs distributed 1,154,420 sterile syringes and collected 489,301 used syringes for safe disposal (return rate 42.4%). SEPs distributed 5,682 naloxone kits, made an additional 1,311 referrals for naloxone, and reported 2,187 overdose reversals. Programs made over 2,174 referrals to SUD treatment and over 1,592 referrals to mental health treatment. SEPs performed 2,599 HIV tests and 690 HCV tests, with notification and referrals for confirmatory testing as needed. Because many programs were in operation for less than a full calendar year at the time of annual reporting, these are considered conservative figures compared to the potential impacts if all had operated for a full year.

## Burden of the Opioid Overdose Crisis in North Carolina

### Prepared by the Injury and Violence Prevention Branch, N.C. Division of Public Health[6]

In N.C., as in the United States as a whole, deaths due to medication and drug overdoses have been steadily increasing since 1999, and the vast majority (~88%) of these are unintentional. The epidemic of medication and drug overdose is mostly driven by opiates, specifically prescription opioids. Historically, prescription opioids (drugs like hydrocodone, oxycodone, morphine) have contributed to an increasing number of

[3] The law does not specify a deadline for security plan update and redistribution. During the annual reporting process, programs were encouraged to complete this requirement at the same time.
[4] N.C. Gen. Stat. § 90-113.27(b)(2) (2016)
[5] The nonresponsive program has inconsistent capacity and faces staffing challenges. NCSSI is monitoring the program through direct contact and community partners.
[6] Data collected through the N.C. State Center for Health Statistics, N.C. Violent Death Reporting System, Controlled Substances Reporting System, and N.C. Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT).

medication/drug overdose deaths. More recently, other synthetic narcotics (heroin, fentanyl and fentanyl analogues) are resulting in increased deaths. The number of deaths involving cocaine is also on the rise.

In 2016, an average of four residents a day died from opioid overdose in North Carolina. Unintentional opioid deaths have increased from just over 100 deaths in 1999 to over 1,380 in 2016. These numbers include deaths from both prescription and illicit opioids.

The statewide outpatient opioid dispensing rate for 2016 was 66.5 pills per resident. Previous analyses in N.C. have shown that opioid overdose deaths are more common in counties where more opioids are dispensed.[7] Deaths involving illicit opioids are continuing to increase and are accounting for a larger proportion of the total opioid deaths.

The number of hospitalizations and emergency department (ED) visits related to opioid overdose also continue to rise. In 2016, there were over 2,700 opioid-related hospitalizations and over 4,000 opioid-related ED visits; for every one opioid overdose death, there were just under two hospitalizations and nearly three ED visits due to opioid overdose.

In 2018, the IVPB will continue with regular data monitoring of opioid-related deaths, hospitalizations, ED visits, and other key metrics. Continued efforts will be made to develop an integrated opioid data dashboard to track and monitor the epidemic, as providing automated aggregate data sharing and live statistical analysis of current trends will be a critical tool for partners at the state and local level.

## Annual Report Disease Summary

### Prepared by the Communicable Disease Branch, N.C. Division of Public Health

In North Carolina, the rates of acute hepatitis B (HBV), acute hepatitis C (HCV), and newly diagnosed HIV increased between 2015 and 2016. As transmission of these diseases can occur through injection drug use (IDU) practices, it is important to understand the epidemiology of these diseases in the state.

In 2016, 151 cases of acute HBV were reported, an increase over the 140 cases reported in 2015. The rate of cases per 100,000 population also increased, from 1.4 in 2015 to 1.5 in 2016. The highest rates of newly diagnosed acute HBV occurred among the 35- to 44-year-old age group. This age group comprised 34% of the total acute HBV cases. In 2016, acute HBV diagnoses among White/Caucasian men and women comprised 61% of the total acute HBV, at rates of 1.8 and 1.0 per 100,000, respectively. The highest rates of acute HBV in 2016 were among American Indian/Alaska Native women, at a rate of 3.2 per 100,000.[8] Acute HBV exposure through IDU has also been increasing since 2014 (13% in 2014 to 22% in 2016). The highest rates of acute HBV were among residents living in the western part of North Carolina.[11]

In 2016, 185 cases of acute HCV were reported, an increase over the 116 cases reported in 2015. The rate of cases per 100,000 population also increased, from 1.2 in 2015 to 1.8 in 2016. It is necessary to note that the

[7] Proescholdbell, S. K., Cox, M. E., & Asbun, A. (2017). Death Rates from Unintentional and Undetermined Prescription Opioid Overdoses and Dispensing Rates of Controlled Prescription Opioid Analgesics – 2011-2015. *North Carolina Medical Journal, 78*(2), 142-143. doi:10.18043/ncm.78.2.142

[8] North Carolina HIV/STD/Hepatitis Surveillance Unit. (2017). *2016 North Carolina HIV/STD/Hepatitis Surveillance Report* (North Carolina, Department of Health and Human Services, Communicable Disease Branch). Raleigh, NC.

acute HCV case definition changed in 2016.[9] The highest rates of newly diagnosed acute HCV occurred among the 20- to 39-year-old age group. This age group comprised 68% of the total acute HCV cases. In 2016, acute HCV diagnoses among White/Caucasian men and women comprised 80% of the total acute HCV, at rates of 2.5 and 2.0 per 100,000, respectively.[11] The highest rates of acute HCV in 2016 were among American Indian/Alaska Native men and women, with rates of 8.6 and 6.3 per 100,000, respectively. In 2016, the most frequently reported risk factor by people with acute HCV was IDU. Acute HCV exposure through IDU has also been increasing since 2013 (34% in 2014 to 43% in 2016). The highest rates of acute HCV were among residents living in the western part of North Carolina.[11]

In 2016, 1,399 new diagnoses of HIV were reported among the adult and adolescent (over 13 years old) population, at a rate of 16.4 cases per 100,000 population. This is a slight increase from 2015, where 1,334 persons were newly diagnosed with HIV, at a rate of 15.9 per 100,000.[11] Men made up the highest proportion of newly diagnosed HIV (N=1,135; 81%) compared to women (N=364; 19%). People between 20 and 29 years of age had the highest rates of newly diagnosed HIV in 2016, comprising 43% (N=599) of the newly diagnosed population. Black/African Americans represented 62% (N=869) of new diagnoses, with a rate of 47.2 per 100,000. For adults and adolescents newly diagnosed with HIV in 2016, men who have sex with men (MSM) was the principal risk factor indicated in 65% (N=911) of all cases.[11] The proportion of IDU and MSM/IDU among those newly diagnosed with HIV has remained stable between 5 and 6% since 2013. However, in 9% (N=23) of new diagnoses among women, women were exposed through IDU in 2016 compared to 5% (N=14) in 2015. The highest rates of HIV were among residents living in the central part of the state.[11]

Syphilis and gonorrhea rates in North Carolina have also increased since 2014. While these diseases are not generally transmitted by injecting drug use, co-infection with HIV is increasing, and they may spread among people having sex while using drugs. SEPs can promote harm reduction in sex as well as injecting practices and provide condoms and other safer sex supplies.

In 2018, the CDB will explore regular monitoring of HBV, HCV, and HIV diagnoses in hospital discharge and emergency department data. Assessment of endocarditis and sepsis diagnoses in patients is a priority, as these diagnoses are common among injection drug users. The CDB will continue with routine data monitoring, including demographics and geographic locations, at the county and state level for these diseases.

## NCSSI Priorities: Year One

### Demonstrating the Need for PWUD-Specific Health Services

Overprescription and increased prevalence of opioid pain medications have contributed to the current opioid overdose crisis. Regulatory responses seek to reduce overprescribing of opioids to reduce opioid availability and prevent initiation of drug misuse. PWUD may use illicit opioids to supplement or replace less accessible and more expensive pharmaceutical opioids. Heroin, fentanyl and other synthetic narcotics are now involved in over 60% of unintentional opioid deaths in North Carolina, and were involved in 936 deaths in 2016.[10] Changes in drug type also mean changes in method and route of administration. Pharmaceutical opioids are

[9] Hepatitis C, Acute2016 Case Definition. (n.d.). Retrieved Fall 2017, from https://wwwn.cdc.gov/nndss/conditions/hepatitis-c-acute/case-definition/2016/

[10] N.C. State Center for Health Statistics. (2016). [Vital Statistics - Deaths].

typically ingested orally or insufflated (snorted), while illicit opioids are more likely to be injected (intravenously or intramuscularly) or smoked.[11] Different routes of administration have different health risks. Illicit drugs may also be of indeterminable quality and purity, contributing to unintentional overdose. Lack of access to sterile syringes can lead to infection and bloodborne disease transmission, and public health and safety risks for PWUD, law enforcement, and community members. Restricting access to syringes and other supplies has not been shown to reduce or discourage drug use.[12]

This progression of the overdose crisis demonstrates a need for dedicated PWUD health services and information, particularly for people who inject drugs (PWID). Underground syringe exchanges began operating in North Carolina in the late 1990s, but the threat of arrest to staff and participants limited spread and participation. However, long-standing programs—with staff expertise, experience, and active relationships with PWUD – have been invaluable post-legalization. These programs have a unique perspective on the evolution of drug use in N.C.; the barriers PWUD face when seeking medical and social services, including SUD treatment; and local service provider, law enforcement, and PWUD contexts.

Demonstrating the need for PWUD-specific health services to respond to changes in the overdose crisis was and continues to be a NCSSI priority. This requires active engagement with existing SEPs and harm reduction programs; NCSSI is in regular contact with SEP leaders and seeks out opportunities to visit programs and meet with staff. Ongoing collaboration between IVPB and NCHRC to monitor naloxone distribution and overdose reversals enabled connections with harm reduction programs and SEPs that operated underground until July 2016.

## Developing the NCSSI Webpage

Developing the NCSSI webpage was an early priority. In addition to enabling SEP information access, webpage material also served to establish program norms, operations and best practices that were not specified in the SEP law. It was important to have a recognizable source for this information. A lack of awareness of SEP services and program legality affect uptake by both organizations establishing programs and by participants accessing services. Hosting the NCSSI webpage on the NCDHHS platform demonstrated state recognition of SEPs as legitimate partners and service providers. NCSSI compiled resources, received feedback from the NCSSI workgroup and SEP leaders, and worked with the NCDHHS Office of Communications to develop the webpages. Resources include the program sign-up and annual reporting forms; a regularly updated list of active SEPs with program details and contact information, references for law enforcement and medical service providers; frequently asked questions on SEP, harm reduction, and injection drug use; HIV and HCV prevention and treatment information; guides on limited immunity, participant cards, and program funding; connections to SUD treatment resources; and references for toolkits, PWUD health education, and partner organizations.

[11] Opioid pills may also be injected. Pharmaceutical companies have sought to produce “tamper-resistant” or “abuse deterrent” pill formulations to reduce the likelihood of misuse by snorting. This strategy, and the discovery that reformulated Opana ER could instead be injected, lead to the 2015 HIV and HCV outbreak in Scott County, Indiana.
[12] Human Rights Watch. (2017, August 11). Every 25 Seconds | The Human Toll of Criminalizing Drug Use in the United States. Retrieved Fall 2017, from https://www.hrw.org/report/2016/10/12/every-25-seconds/human-toll-criminalizing-drug-use-united-states

## Working with Local Health Departments

In N.C., any governmental or nongovernmental organization "that promotes scientifically proven ways of mitigating health risks associated with drug use and other high-risk behaviors" can start a SEP. This includes local health departments (LHDs). Early NCSSI workgroup discussions addressed the wide variation in sociopolitical, economic and geographic landscapes across the state. LHDs have community knowledge and presence, medical resources, and existing infrastructure, making syringe access and PWUD health education appropriate additions to LHD services. Beginning with the Wilkes County Health Department and its partnership with Project Lazarus, N.C. LHDs have been working on the overdose crisis for many years. LHDs began receiving opioid overdose prevention funding through IVPB in 2015, and are strong partners in data surveillance, monitoring and evaluation, and sharing best practices.

For low-income and uninsured people, and those in the midst of chaotic drug use, minimizing barriers and facilitating connections to additional services is vital. SEPs allow PWUD to initiate connections with healthcare providers like LHDs, and create opportunities for further health education and service delivery. LHDs can proactively incorporate services to address health issues associated with drug use, including overdose, skin and soft-tissue infections like abscesses, and bloodborne diseases. For example, public health nurses and clinic staff can provide medical advice and preliminary care for abscesses and other wounds. LHDs have also been active in promoting naloxone access and use, and have well-developed hepatitis B (HBV), HCV, and HIV testing and treatment referral systems. Additionally, PWUD may have health and social service needs around sexual and reproductive health, intimate partner violence, and pregnancy and childbirth. SEPs operated by LHDs enable connections to care for these and other health and wellness issues. Perhaps most importantly, LHD-based programs can provide reliable and current health information to a medically underserved population. This need is demonstrated by limited PWUD awareness of HCV prevention methods, transmission risks, and recent changes in HCV treatment protocol and eligibility.[13]

At the time of 2016-17 annual reporting, there were two LHD-based SEPs: Orange County Health Department and Cabarrus Health Alliance. These early programs navigated operational issues specific to LHD SEPs. As public agencies, LHDs need to examine program accessibility and confidentiality for PWUD. For example, PWUD may be uncomfortable or unwilling to enter a "government building" to freely discuss drug use. SEPs are developing best practices to address these barriers. The Cabarrus program has dedicated capacity for SEP outreach in the surrounding community, and NCSSI worked with the program lead to establish expectations for staff when delivering direct services. To better promote services, Orange County is partnering with a community-based organization (CBO) that provides mobile outreach services. Partnership with CBOs has emerged as an effective strategy for LHD SEPs to gain visibility, effectively connect with PWUD, and integrate with other community-based services. Since the 2016-17 reporting period closed, two more LHDs—Wilson County Health Department and Pitt County Health Department—have developed or are in the process of developing syringe access services in partnership with CBOs.

## Educating LHDs and SEPs on Changes to Funding Laws

Though many more LHDs expressed need for and interest in syringe access services and SEPs during the first year of legalization, the 2016 SEP law included a prohibition on the use of public funds to purchase syringes

[13] Findings from focus groups with PWID and PWUD conducted by the Urban Survivors Union, Greensboro, NC.

and injection supplies. Some LHDs already had a location, staff, biohazard disposal contracts, naloxone access, health information, and referrals systems in place but were not able to use LHD funds to purchase syringes and injection supplies for distribution. The prohibition on public funds use created a significant barrier for LHDs seeking to establish SEPs. The Strengthen Opioid Misuse Prevention (STOP) Act passed in June 2017 and addressed this issue.

Included in the STOP Act was language to change the public funds prohibition for SEP supplies. The law now prohibits the use of *state* funds to purchase needles, hypodermic syringes, or injection supplies.[14] As of July 1, 2017, local funds may be used for these SEP supplies. NCSSI shared information about the proposed funding change prior to passage of the STOP Act, and confirmed this change to SEPs and LHDs after it was signed into law. Discussion with LHDs about this policy suggests two remaining barriers: LHD budgets require approval from county commissioners, who may not support SEPs and other harm reduction efforts; and rural, low-income counties may not have sufficient local funds to establish and sustain a SEP.

The STOP Act also addresses prescribing and dispensing of prescription opioids. It limits healthcare providers to prescribing no more than a five day supply of opioids for a first prescription (seven days post-surgery). Doctors can prescribe more pain medication if needed during follow-up. This policy is intended to reduce the likelihood that people receiving short-term pain management will develop dependency on prescription opioids. Under the STOP Act, healthcare providers are required to use the Controlled Substances Reporting System (CSRS), the N.C. prescription drug monitoring program. The CSRS allows providers to check a patient's history of prescriptions for controlled substances. This addresses prescription-seeking behavior ("doctor-shopping") and can prevent overdoses caused by dangerous drug combinations. Providers are also required to submit prescriptions for opioid medications electronically. This helps prevent fraudulent prescriptions from being filled.

## NCSSI Engagement and Strategic Partnerships

Partner education was and continues to be a high priority for NCSSI. SEP legalization was a significant policy and programmatic shift for NCDHHS agencies and LHDs. Before developing partnerships and building program capacity, NCSSI first needed to survey ongoing work share information on the SEP law and program goals.

Since legalization, NCSSI has presented at the Mountain Area Health Education Center (MAHEC); Opioid Misuse and Overdose Prevention Summit; N.C. Association of Emergency Medical Services (EMS) Administrators 2017 Summer Leadership Symposium; N.C. Indian Health Board; Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC); N.C. Association of Local Health Directors (NCALHD); N.C. Society for Public Health Education (NC SOPHE); Chronic Disease and Injury Section Exchange; and LHDs. These are in addition to numerous presentations by IVPB and DPH staff that highlight the role of

[14] A similar prohibition exists for SEP use of federal funds. According to AIDS United, "Federal funding has historically been barred from supporting SSPs [syringe services programs]. However, in December 2015 the Consolidated Appropriations Act of 2016 removed parts of that funding restriction. Following this, HHS released their Guidance to Support Certain Components of Syringe Services Programs in March 2016…Under HHS guidance, federal funding can be used on nearly every component of a SSP. Federal funds are available to support costs for staffing, mobile units, office space, and supplies—including testing kits and services—everything except the purchase of sterile syringes and cookers for drug preparation. Case management and navigation services are specifically named as fundable under this guidance." Federal Funding for Syringe Services Programs. (n.d.). Retrieved Fall 2017, from http://www.aidsunited.org/resources/federal-funding-for-syringe-services-programs

SEPs in overdose crisis response work. Presentations and discussions typically explain changes in the overdose crisis and the need for dedicated PWUD health services, SEP rationale and background, and current efforts, and are tailored to identify ways each audience can support and participate in SEP work.

Several partnerships have resulted from these presentations and NCSSI presence at other public health events. IVPB has an active relationship with the N.C. Office of Emergency Medical Services (OEMS), and leadership has expressed significant interest in incorporating syringe access services and harm reduction efforts when responding to drug overdoses. The first EMS-based SEP began operating in Craven County in December 2017, providing mobile resource distribution and SEP services at the local fire department. In addition, NCSSI connected with a representative from the Eastern Band of Cherokee Indians (EBCI) Public Health and Human Services agency at the 2017 N.C. Communicable Disease Conference. NCSSI began working with EBCI on the development of an SEP within its health system, providing technical assistance, navigation of EBCI compliance with N.C. SEP law requirements, and connections to other harm reduction programs. IVPB and NCSSI have also worked with EBCI to present research on high rates of overdose deaths among American Indians in N.C. Finally, presentation attendees from LHDs have connected with NCSSI for additional presentations, technical assistance, and feedback on overdose prevention and PWUD health programming.

The Injury Free NC Academy is a partnership between IVPB and the Injury Prevention Research Center (IPRC) at the University of North Carolina at Chapel Hill. The current 2017-18 cycle of the Injury Free NC Academy guides teams from across N.C. through the development and implementation of SEPs and/or naloxone distribution programs, using a curriculum developed in collaboration with NCSSI. Each team is required to have a LHD representative and a member from a local law enforcement agency (LEA). Teams include members from mental and behavioral health services, health systems, and CBOs. The program model includes presentations from subject matter experts and DPH staff, team-based learning, guided discussions, interactive exercises and activities, and coaching and technical assistance. This is an iterative process for both the planning team and participants: the goal is for teams to find context-specific ways to support harm reduction efforts and to address PWUD health needs and resource gaps, rather than to adhere to set program models. The Injury Free NC Academy also serves as an opportunity for DPH staff to engage directly with SEP leaders and subject matter experts, and to gain a deeper understanding of local contexts, supports, and barriers to SEP implementation and access.

## Annual Reporting Process & Methods

Annual reporting accomplishes several goals. First and foremost, it satisfies the legal requirement for program reporting and allows NCSSI to ensure that SEPs, which are still gaining visibility and acceptance, are in good legal standing. Though SEPs are encouraged to contact NCSSI with questions, concerns, and requests for assistance as they arise, annual reporting formalizes this process and encourages retrospective reflection on program operations. Annual reporting allows NCSSI and its partners to recognize and share SEP work and capacity to address the current opioid overdose crisis and engage PWUD in health and wellness services generally. The first year of annual reporting data create the baseline for evaluating SEPs in N.C. over time. NCSSI also asks programs to share information on their referral networks, allowing DPH to identify local partners and resources. N.C. has robust data and surveillance systems to track overdose mortality and morbidity, overdose reversals using community-distributed naloxone, HCV, HIV, and other health outcomes

and conditions associated with injection drug use. As the overdose crisis continues, SEP data provided through the annual reporting process will inform analysis and program and policy development.

## Creation of Reporting Form

To enable these goals, the annual reporting process and required information are intentionally structured to minimize burden on SEP participation. NCSSI recognizes that many SEPs operate on limited budgets and prioritize service delivery over administrative capacity. In addition to the information specified in the SEP law, the annual reporting form includes questions on program structure and reach, service requirements, testing and referral capacity, and space for open response. Programs were also asked to share samples of the written verification (participant cards) distributed to participants or to provide details on how they educate participants on the law's limited immunity for drug paraphernalia possession.

When developing the reporting form, NCSSI solicited submissions from workgroup members, with the stated aim of keeping the form brief. NCSSI shares the form with new SEPs at the time of sign-up and provides information about the reporting requirement. Programs are encouraged to develop internal record-keeping and monitoring and evaluation mechanisms that include the areas identified in the form.

## Engagement with SEPs to Achieve Reporting Compliance

NCSSI began contacting SEPs with information about the July 31 deadline in mid-June. These emails included rationale for the annual reporting process, requirements from the SEP law, and staff availability to respond to questions and provide support. Emails included the annual reporting form as an attachment and a link to the form via the NCSSI website. They were sent to both primary and secondary contacts identified on the SEP sign-up form that was submitted to DPH. As programs contacted NCSSI for support, frequently asked questions and their answers were shared with all SEP contacts. These emails continued through June and July, with reminders sent before and after the July 31 deadline. NCSSI was in contact with programs that needed additional time to submit the form. As of early August, 20 programs had submitted their reports and NCSSI had provided any needed clarification. NCSSI engaged in follow-up with the non-responsive program through September.

## Reporting Challenges

Reporting of number of injection supplies dispensed and collected is required by the SEP law. There are challenges to collecting this information. Depending on the SEP, supplies may include cotton pellet filters, tourniquets, cookers for preparing injection solution, biohazard sharps containers, ascorbic acid to prepare crack cocaine for injection, paper bags, and alcohol pads for wound prevention and first aid. Staff limit direct handling of cookers and cotton filters to minimize contamination. This may make it difficult to itemize supplies (for example, to determine the average number of cotton filters or cookers each participant receives). For the first year, NCSSI used language from the SEP law and asked programs to report the number of "needle injection supplies dispensed by the program and returned to the program." SEPs responded to this question in different ways: reporting total supplies ordered, numbers of bags of each supply prepared for distribution, or number of safer injection kits distributed. Injection supplies, in contrast to needles and syringes, are typically not returned to SEPs. Some supplies, like tourniquets and alcohol swabs, may be discarded in municipal waste. Injection supplies may be included in sharps containers for biohazard disposal

at SEPs; however, it is SEP policy *never* to open returned sharps containers or sort through used syringes and injection supplies. NCSSI received several questions about this requirement, and advised SEPs to document any returned injection supplies as safely as able.

Variation in length of operation should also be taken into consideration. The 2016-17 reporting period began July 11, 2016 (date of SEP legalization) and ended July 31, 2017, lasting more than a full calendar year. There was significant variation in each SEP's period of operation during this time. Programs that had previously operated underground quickly submitted sign-up forms and continued services. Program sign-ups continued through 2016 and 2017. Two programs submitted sign-up forms (requiring annual reporting compliance) but were yet to serve participants. They reported null figures, but provided updates and clarification on program partnerships and protocols. Another had only operated for three months prior to the annual reporting process. Established programs had an existing participant base while some new programs, even those that operated for close to a full year, slowly gained visibility and participation. Programs may tabulate contacts and supplies distributed on a monthly basis; those SEPs did not include July data in order to meet the July 31 deadline. NCSSI therefore considers 2016-17 reporting to be a conservative representation of annual operation for twenty SEPs.

## Reporting Data

Reporting data were collected during the first SEP annual reporting process. The 2016-17 reporting period began July 11, 2016 and ended July 31, 2017.

| | |
|---|---|
| ***Connections*** | |
| Unique participants[15] | 3,983 |
| Total contacts[16] | 14,997 |
| ***Syringes and Injection Supplies*** | |
| Syringes distributed | 1,154,420 |
| Syringes collected for disposal[17] | 489,301 (42.4% return rate) |
| Injection supplies distributed | 181,911 |
| Injection supplies collected for disposal | 0[18] |
| ***Naloxone*** | |
| Naloxone kits distributed | 5,682 |
| Referrals to other sources for naloxone kits[19] | 1,311 |
| Overdose reversals reported[20] | >2,187 |

[15] Total number of discrete individuals who visited a SEP during the reporting period.
[16] Total number of visits or contacts made. Approximately 3.77 contacts per participant, wide variation likely.
[17] To count used syringes returned for biohazard disposal, programs used a rate of 281 syringes/pound. Programs may have also used participant self-reporting to track returned syringes.
[18] Reporting of number of injection supplies dispensed and collected is required by the SEP law. There are challenges to collecting this information. NCSSI received several questions about this requirement, and advised SEPs to document any returned injection supplies as safely as able.
[19] N.C. SEP law requires that programs either provide naloxone directly to participants or provide referrals to alternative sources. Some SEPs will prioritize naloxone distribution to active users or people without insurance, and encourage others to purchase naloxone through pharmacies under the statewide standing order for naloxone (adopted June 2016) or LHDs that have adopted local standing orders.
[20] One SEP responded with written descriptions for questions on overdose reversals and referrals to SUD treatment and mental health services and is not included numerically.

| *Testing and Referrals* | |
|---|---|
| SUD treatment referrals[18] | >2,174 |
| Mental health treatment referrals[18] | >1,592 |
| SEPs with HIV testing capacity[21] | 9 |
| HIV tests administered[22] | 2,599 |
| Positive HIV tests[23] | 5 |
| SEPs with HCV testing capacity[24] | 8 |
| HCV tests administered | 690 |
| Positive HCV tests[25] | 122 |

The annual reporting form also includes an open-text section for sharing additional information about program operations, including feedback from participants and staff, interactions with neighbors or law enforcement, and requests for technical assistance. Open-text responses addressed the following areas:

- Need for administrative and supply funding to meet current and increasing demand, comply with SEP law requirements, and expand program capacity
- Interest in program expansion to include peer-to-peer exchange. A change in delivery model requires additional staff protocols, NCSSI notification, and updates to the security plan, which is then redistributed to local law enforcement.
- Need for relationship-building with PWUD through outreach and increased SEP accessibility
- Existence of positive community partnerships with LHDs and CBOs
- Participant reports of negative experiences with law enforcement, including disregard of participant cards and arrests in spite of written verification of participation in a SEP
- Positive outcomes from a training NCHRC conducted with local law enforcement and the need for continued education and training opportunities, but concern that not all agencies open to similar trainings when approached by the SEP
- Participant desire for more program staff and/or full-time SEP operation and fixed SEP sites in Catawba, Burke, Caldwell, and Gaston counties

## NCSSI Trajectory

### Changes in Reporting

The first annual reporting process has shaped current program priorities and will inform future reporting cycles. Considering the diversity in models, capacity, and institutional experience, there were few complications and barriers to successful participation in the reporting process. Program familiarity with this process will grow over time, allowing SEPs to develop internal norms and guidelines for data management

[21] Includes one program not yet serving participants at the time of reporting and one that did report performing tests; only 7 SEPs administered HIV tests during the reporting period.
[22] Two SEPs—one based at an AIDS service organization, and one at a health department—performed 96.5% of reported HIV tests.
[23] Follow-up varies by SEP. People who have received positive test results are referred to LHDs for confirmatory testing and/or connected to treatment programs at health systems. Programs also notify N.C. Disease Investigation Specialists (DIS) services.
[24] Includes one program not yet serving participants at the time of reporting; only 7 SEPs administered HCV tests during the reporting period.
[25] Follow-up varies by SEP. People who have received positive test results are referred to LHDs for confirmatory testing and/or connected to treatment programs at health systems. Programs also notify N.C. DIS services.

and reporting and to create a more standardized process overall. NCSSI will perform additional analysis on the syringe return rate. There was significant variation between programs (one of which received more syringes for disposal than were distributed, demonstrating general need for biohazard disposal services).[26] The rate may increase naturally over time, as participants, law enforcement, and community partners become more accustomed to exchange routines and services and the protections provided through limited immunities. SEPs with return rates lower than the annual average of 42% may benefit from tailored education on safe syringe disposal, discussion with PWUD on rationale and barriers, and engagement with law enforcement about limited immunity protections and the importance of secure disposal of syringes.

IVPB is developing sign-up and annual reporting forms that will automatically export submitted data for analysis and enable compilation of the reporting summary. These changes in reporting format may require clarification, such as which questions require a numeric answer and how data are expected to be broken out. Because of the limited requirements specified in the SEP law and variability in SEP administrative capacity, NCSSI is hesitant to add more requested information to the reporting form. However, formalized reporting of provided services will allow greater and more detailed analysis of program impact. NCSSI plans to ask programs to break out types and amounts of injection supplies distributed in future reporting cycles, satisfying the legal requirement and providing more useable data. In the first cycle, questions read "number of injection supplies dispensed by the program in the past year" and "number of injection supplies returned to the program in the past year." In future cycles, these questions will have subsections to identify the types of supplies distributed and report itemized distribution. Some SEPs provided these data in the 2016-17 cycle, indicating existing data collection capacity and availability.

## Law Enforcement and Criminal Justice Outreach

Current NCSSI projects and plans reflect interests and feedback shared by SEPs. Based on annual reporting responses and additional feedback from programs, NCSSI is expanding law enforcement and criminal justice education efforts. DPH is working with NCHRC to ensure that information on syringe exchange, community distribution of naloxone, Good Samaritan protections, and limited immunity under the SEP and "Tell Law Officer" laws is provided during regular continuing education trainings. NCSSI is conducting outreach through the Office of Indigent Defense Services to share program and immunity information with court-appointed defense attorneys and their clients, and is developing outreach to district attorneys and assistant district attorneys. NCSSI and NCHRC law enforcement partners are also seeking opportunities to present to more law enforcement and criminal justice audiences. NCSSI has discussed implementation issues with the Attorney General's office and will update partners as appropriate on future instances of SEP staff and participant interaction with law enforcement.

## Faith-Based Community Outreach

Seven of the programs that have signed up with NCSSI are faith-affiliated—either operating with an explicit foundation in religious practice or engaging with faith communities. In addition to public health and community organizing approaches, their work provides unique framing and rationale for syringe exchange

[26] A 2004 meta-analysis found that the "overall worldwide return rate was 90%, although this ranged from a low of 15% to a high of 112%" among represented countries. US-based program return rates were comparable to SEPs outside the US. Ksobiech, K. (2004). Return Rates for Needle Exchange Programs: A Common Criticism Answered. *Harm Reduction Journal, 1*(2). doi:10.1186/1477-7517-1-2

and harm reduction practice. Exploring faith-based framing and connecting actively with religious communities may be an effective avenue for developing SEP capacity in rural areas—a DPH and NCSSI workgroup priority. These connections also enable discussion within faith communities of drug use, substance use disorders, and mental illness as sociomedical and treatable conditions. NCSSI is working with the DPH Faithful Families program, which develops curricula on healthy diet and physical activity for faith communities, and which has been generous with their explanations of current faith-based health work in N.C. and connections to external partners. Through Faithful Families, NCSSI has joined with a North Carolina divinity school to propose student projects, including the development of local resource guides for distribution through SEPs and a faith leader training for engaging with people directly affected by drug use. N.C. SEPs have significant experience navigating and working with religious communities and many have local partnerships that can inform this area of work.

## NC Opioid Action Plan, SEP- and Partner-Identified Priorities

SEPs are also significant partners in several components of the *North Carolina Opioid Action Plan* adopted in June 2017, which was developed in part by NCSSI workgroup members and partner agencies. The *Action Plan* calls for the creation of an advisory council representing people with drug use history to inform the work of the Opioid and Prescription Drug Abuse Advisory Committee and provide insight from direct experience with drug use. As NCDHHS and partners formalize the council's role and operations, SEP staff will be invaluable in helping to connect with and represent council participants. The *Action Plan* also seeks to build and sustain local coalitions' responses to the crisis. Identified aims of local coalitions include increasing naloxone access, establishing SEPs, and increasing linkages to substance use disorder and pain treatment support. Experienced SEPs are often the best sources of guidance for new programs and for engaging PWUD in services. NCSSI is included as an *Action Plan* strategy, with the aims of increasing the number of SEPs and distributing naloxone to participants. To improve linkages to care, the *Action Plan* recommends working with health systems to develop and adopt model overdose discharge plans and to link patients receiving office-based opioid treatment to counseling services through case management or peer support specialists. Health systems-based care linkages and peer counseling for PWUD and those with history of overdose can include syringe exchange and harm reduction programs.

The *Action Plan* identifies pregnant women and justice-involved persons as special populations requiring intentional engagement and response. Some SEPs, like the Urban Survivors Union in Greensboro, provide gender-based services, including programs for pregnant women and mothers. Others, like the NCHRC exchange in Durham, work with people involved in the criminal justice system. Their experience can inform *Action Plan* strategies to support special populations. Community paramedicine programs are another way to connect people to SEP services and are included as a priority in the *Action Plan*. Community paramedicine may be an especially effective way to engage PWUD because referrals can be made during the delivery of preventative health services, and not solely during an emergency or point of crisis. Finally, through program sign-up and annual reporting participation, SEPs contribute data and programmatic context for public health surveillance.

Involvement in these strategies is in addition to the local relationships, connections, and opportunities for growth and capacity-building that SEPs seek independently. Some SEPs have shared internal program and development priorities with NCSSI. Staff are invested in responding to emergent demand and health concerns while maintaining relationships and support for populations long affected by drug use, including urban

residents, communities of color, and people who identify as lesbian, gay, bisexual, transgender, and queer (LGTBQ). SEP priority areas expressed to NCSSI include integration of HCV and HIV services; introduction of buprenorphine treatment services; partnership with hospitals and health systems to promote wound care and endocarditis prevention for PWUD; engagement with treatment centers for overdose prevention and HCV education, social support services for PWUD; and exploration of innovative harm reduction programming.

NCSSI and the Communicable Disease Branch are working with SEPs to increase availability of HCV and HIV testing services through exchanges and other harm reduction programs. All people who test positive for HIV are immediately linked to care and medication with the goal of viral suppression. They are also provided with partner notification services and in-field notification of their HIV results. People who test positive for HCV are also referred to their LHD or local medical provider to learn about liver health and eventual linkage to cure. CDB is not yet able to track the number of HIV/STD/HCV tests done at SEP sites, and so are reliant on annual reporting from programs. Data entry forms at the State Laboratory for Public Health test forms and rapid testing data forms will need to be modified to collect testing-site data. This enables active linkages between CDB, statewide and local partners, and SEPs to maintain and expand testing and treatment infrastructure. There may also be opportunities to expand sexual health capacity at SEPs and to incorporate services for vaccine preventable infectious diseases. Harm reduction programs' commitment to non-judgment and engagement with people with limited access to routine healthcare makes them well-prepared to address a variety of health outcomes.

Pursuing strategies outlined in the *N.C. Opioid Action Plan* and responding to infectious disease burden thus depend on comprehensive syringe exchange and harm reduction program access in N.C. To be most effective, these programs should be seen not only as rapid response to the overdose crisis and hepatitis C prevalence, but as a means to proactively identify and respond to future changes in drug user health, morbidity, and mortality, including changes in drug type and route of administration. Building and sustaining access requires operational support and dedicated funding to expand SEP capacity, facilitate partnerships, and meet increasing demand.

# North Carolina Syringe Exchange Annual Reporting Form

***Complete and submit to SyringeExchangeNC@dhhs.nc.gov by July 31st annually.***

Please save your completed form and submit as an email attachment to SyringeExchangeNC@dhhs.nc.gov.
Visit www.ncdhhs.gov/divisions/public-health/north-carolina-safer-syringe-initative for more information.

**Thank you!**

**1. Legal name of the organization or agency operating the Syringe Exchange Program:**

_____

**1a.** Name of the Syringe Exchange Program, if different:

_____

**2. Contact Information**

| Primary Contact | Secondary Contact |
|---|---|
| Name _____ | Name _____ |
| Phone _____ | Phone _____ |
| Email _____ | Email _____ |

**3. Type of Syringe Exchange Program** (check all that apply)**:**

- ☐ Fixed site: Exchange run from a permanent, fixed location
- ☐ Mobile: Exchange run from a mobile vehicle
- ☐ Peer-based: Exchange run through peer networks distributing in the community
- ☐ Integrated: Exchange built into an existing agency/program, such as a drug treatment program or pharmacy

**4. County(ies) served by the Syringe Exchange Program** (check all that apply)**:**

Note: North Carolina syringe exchange law only legalizes programs within North Carolina

| | | | |
|---|---|---|---|
| ☐ Alamance | ☐ Alexander | ☐ Alleghany | ☐ Anson |
| ☐ Ashe | ☐ Avery | ☐ Beaufort | ☐ Bertie |
| ☐ Bladen | ☐ Brunswick | ☐ Buncombe | ☐ Burke |
| ☐ Cabarrus | ☐ Caldwell | ☐ Camden | ☐ Carteret |
| ☐ Caswell | ☐ Catawba | ☐ Chatham | ☐ Cherokee |
| ☐ Chowan | ☐ Clay | ☐ Cleveland | ☐ Columbus |
| ☐ Craven | ☐ Cumberland | ☐ Currituck | ☐ Dare |
| ☐ Davison | ☐ Davie | ☐ Duplin | ☐ Durham |
| ☐ Edgecombe | ☐ Forsyth | ☐ Franklin | ☐ Gaston |
| ☐ Gates | ☐ Graham | ☐ Granville | ☐ Greene |
| ☐ Guilford | ☐ Halifax | ☐ Harnett | ☐ Haywood |
| ☐ Henderson | ☐ Hertford | ☐ Hoke | ☐ Hyde |
| ☐ Iredell | ☐ Jackson | ☐ Johnston | ☐ Jones |
| ☐ Lee | ☐ Lenoir | ☐ Lincoln | ☐ McDowell |

| | | | |
|---|---|---|---|
| ☐ Macon | ☐ Madison | ☐ Martin | ☐ Mecklenburg |
| ☐ Mitchell | ☐ Montgomery | ☐ Moore | ☐ Nash |
| ☐ New Hanover | ☐ Northampton | ☐ Onslow | ☐ Orange |
| ☐ Pamlico | ☐ Pasquotank | ☐ Pender | ☐ Perquimans |
| ☐ Person | ☐ Pitt | ☐ Polk | ☐ Randolph |
| ☐ Richmond | ☐ Robeson | ☐ Rockingham | ☐ Rowan |
| ☐ Rutherford | ☐ Sampson | ☐ Scotland | ☐ Stanly |
| ☐ Stokes | ☐ Surry | ☐ Swain | ☐ Transylvania |
| ☐ Tyrrell | ☐ Union | ☐ Vance | ☐ Wake |
| ☐ Warren | ☐ Washington | ☐ Watauga | ☐ Wayne |
| ☐ Wilkes | ☐ Wilson | ☐ Yadkin | ☐ Yancey |
| ☐ County outside of NC | ☐ Eastern Band of the Cherokee Nation | | |

**5. List physical address(es) of Syringe Exchange Program:**

**Location 1**

Street Address _____

City/Town _____ Zip Code: _____

**Location 2**

Street Address _____

City/Town _____ Zip Code: _____

**Location 3**

Street Address _____

City/Town _____ Zip Code: _____

If you have more than three program locations, please submit additional address information with this form.

**6. Special population(s) served by the program** (check all that apply)**:**

☐ Injection drug users (people who inject or otherwise use illicit drugs or drugs not as prescribed)
☐ Diabetic insulin users
☐ Sex hormone/hormonal therapy injection users
☐ HIV/HCV injection medication users
☐ HGH, steroid users
☐ Other:_____

**7. How does the Syringe Exchange Program dispose of used syringes and/or needles?** (Check all that apply.)

☐ Biohazard company (please list): _____
☐ Clinic or hospital partnership (please list): _____
☐ Local health department (please list): _____
☐ Waste disposal site (i.e. dump or transfer station)
☐ Other (please list): _____

**8. On which of the following topics does the Syringe Exchange Program offer information and educational materials?**

- ☐ Overdose prevention
- ☐ How to identify and respond to an overdose, including how to use naloxone
- ☐ Drug abuse (misuse) prevention
- ☐ Prevention of HIV transmission
- ☐ Prevention of viral hepatitis (including hepatitis C) transmission
- ☐ Treatment of mental illness, including treatment referrals
- ☐ Treatment for substance abuse (use disorders), including referrals for medication-assisted treatment

**9. Number of unique individuals** served by the Syringe Exchange Program in the past year: _____

**10. Number of total contacts** the Syringe Exchange Program had in the past year: _____

**11. Number of syringes dispensed** by the program in the past year: _____

**12. Number of syringes returned** to the program in the past year: _____

**13. Number of injection supplies dispensed** by the program in the past year: _____

**14. Number of injection supplies returned** to the program in the past year: _____

**15. Number of naloxone kits distributed by the program** in the past year (leave blank if not applicable): _____

**16. Number of referrals made to obtain naloxone from another source** in the past year: _____

**16a.** Where were people referred? _____

**17. How many overdose reversals have been reported to the program?** _____

**18. Number of people the program referred to substance use disorder treatment:** _____

**18a.** Where did you refer them? (Please list multiple referral sites as necessary.)

**19. Number of people the program referred to mental health services or treatment:** _____

**19a.** Where did you refer them? (Please list multiple referral sites as necessary.)

**20. Do you offer HIV testing?** Yes ○ No ○

**20a.** If yes, what kind of test(s) do you offer? (Check all that apply.) Rapid test ☐ Blood ☐

**20b.** How many unique individuals have you tested in the last year? _____

**20c.** How many tests have you conducted in the last year? _____

**20d.** How many tests were positive for HIV in the last year? _____

**20e.** Where did you refer individuals who tested positive for treatment?

**21. Do you make referrals for HIV testing?** Yes ○ No ○

**21a.** If yes, where do you refer people for testing? _____

**22. Do you offer hepatitis C (HCV) testing?** Yes ○ No ○

**22a.** If yes, what kind of test(s) do you offer? (Check all that apply.) Rapid test ☐ Blood ☐

**22b.** How many unique individuals have you tested in the last year? _____

**22c.** How many tests have you conducted in the last year? _____

**22d.** How many tests were positive for HCV in the last year? _____

**22e.** Where did you refer individuals who tested positive for treatment?

**23. Do you make referrals for HCV testing?** Yes ○ No ○

**23a.** If yes, where do you refer people for testing? _____

NC law protects SEP employees, volunteers, and participants from being charged with possession of syringes or other injection supplies, including those with residual amounts of drugs present, if obtained or returned to an SEP. People affiliated with an SEP must provide written verification (such as a participant card) to the arresting officer or law enforcement agency to be granted limited immunity. The SEP law does not specify verification format or content.

**24. Please submit an example of the written verification the Syringe Exchange Program distributes with this completed form. If you are not distributing written verification of participation in a Syringe Exchange Program, please provide details below on how the program educates participants about limited immunity.**

**25. Have you updated your security plan in the past year?** Yes ○ No ○

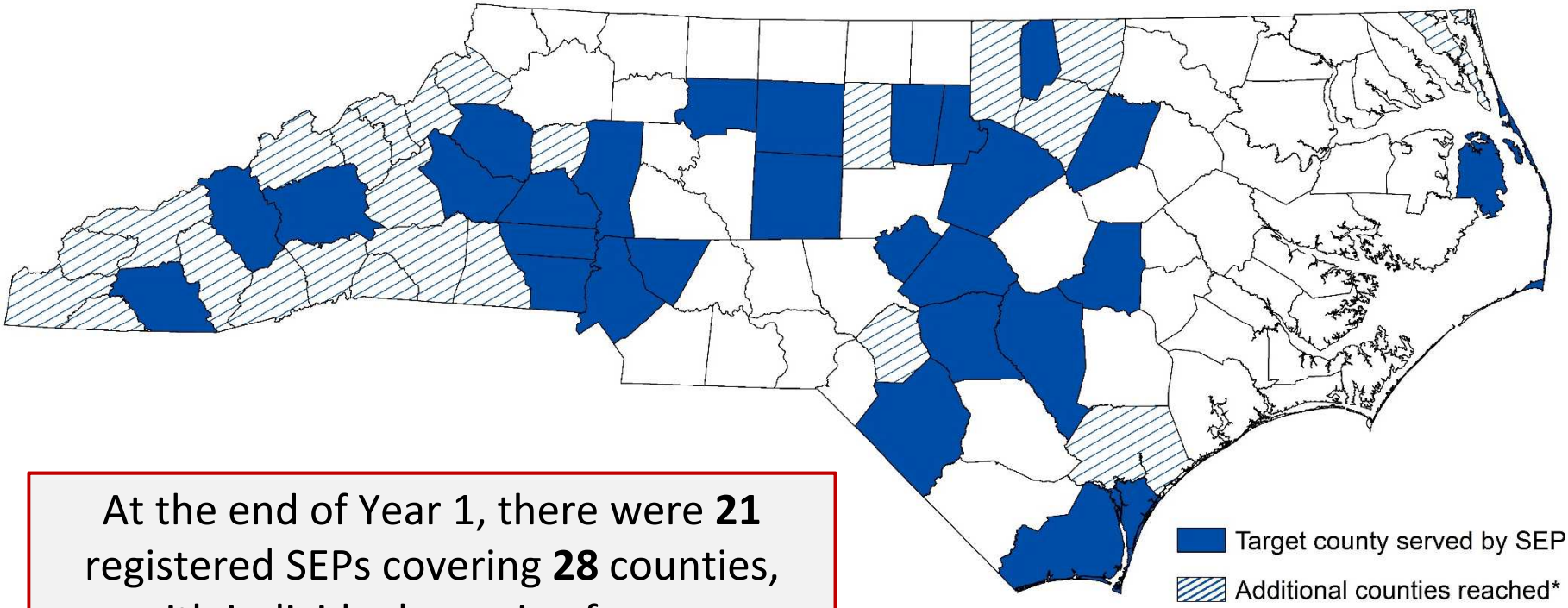
**26. Have you shared your updated security plan with the local law enforcement agencies with jurisdiction over your program area(s)?** Yes ○ No ○

**27. Please share any feedback about program operations** (including feedback from participants or staff, interactions with neighbors or law enforcement, requests for technical assistance). Contact DPH to share additional information.

***Please submit completed form and any additional information to SyringeExchangeNC@dhhs.nc.gov. Thank you!***

# Counties served by Syringe Exchange Programs (SEPs)

as of Year 1 Annual Reporting (July 2017)




At the end of Year 1, there were **21** registered SEPs covering **28** counties, with individuals coming from an additional **24** counties and out of state

*Residents from these counties without SEP coverage traveled to receive services in a SEP target county. Not all SEPs reported participant county of residence; more additional counties likely reached.

Source: North Carolina Division of Public Health, October 2017
Analysis: Injury Epidemiology and Surveillance Unit

North Carolina Injury & Violence PREVENTION Branch