DELAWARE COUNTY
SYRINGE SERVICE PROGRAM PROPOSAL

AGENDA

- Syringe Service Program Member-Led Group
- Syringe Service Program Components
- County Profiles, SSP Evidence-Base, & SSP Outcomes
- Indiana Syringe Support Program Profiles
- Next Steps

BALL STATE
UNIVERSITY

ACDC
Addictions Coalition of Delaware County

SYRINGE SERVICE PROGRAM
MEMBER-LED GROUP

The Addictions Coalition of Delaware County (ACDC) represents a strategic community-academic partnership between Delaware County and Ball State University that seeks to increase the harm-reduction, prevention, treatment, and recovery community capacities in Delaware County and unify the effort to address addiction in the region.

ACDC

ACDC Co-Founders

- Dr. Jean Marie Place PhD, MSW
  - Operations Officer
  - Associate Professor of Health Promotion & Education, Ball State University
- Dr. Jonel Thaller PhD, LSW, CRS/CHW
  - Operations Officer
  - Associate Professor of Social Work, Ball State University
- Dr. Dane Minnick PhD, LSW, CPS, BCPG
  - Director
  - Assistant Professor of Social Work, Ball State University

ACDC

- Dane Minnick
- Keely Green
- Lindsey Bonfiglio
- Danica Fultz
- Justina Johnson
- Jordan Quinn
- Katie Bittermann
- Raegan Monk
- Seth Rawlings
- Tami Rankin
- Kourtney Gallegos
- Catherine Frazee

M.L.G. MEMBERS

Our mission is to create a pathway for the implementation of a strategic, cost-saving, and evidence-based public health intervention designed to:

1. Reduce the spread of HIV and Hepatitis-C (HCV) in Delaware County.
2. Increase access and referrals to health care services and addiction treatment programs for vulnerable populations in Delaware County.
3. Improve community and first responder safety protocols in Delaware County.

M.L.G MISSION

SYRINGE SERVICE PROGRAMS: COMPONENTS, LOGISTICS, & GATE KEEPERS

Physical Resources

1. Sterile syringes.
2. Naloxone.
3. Personal syringe disposal equipment.
4. Community resource guide.
5. Health products.
6. Food and clothing.
7. Mental and behavioral healthcare professionals.

COMPONENTS

Services

1. Comprehensive injection-risk reduction counseling and health education.
2. Community syringe disposal boxes.
3. Referral and linkage to:
    a. Substance use treatment.
    b. Mental, physical, and behavioral health services.
    c. Social support services.
    d. Insurance navigators.

COMPONENTS

Indiana Regulations

1. Syringe Service Programs must be established, run, or be contracted out to a qualified entity by the County Department of Health.
2. State funds cannot be used to purchase syringes and must be funded through external grants.

LOGISTICS

Indiana Regulations

3. Syringe Service Programs are illegal in Indiana without approval from the State Department of Health and the local county commissioners.
4. Dr. Kris Box is currently the State Health Commissioner who approves proposed SSPs and is a strong advocate for syringe service programs.

LOGISTICS

State Health Commissioner

LOGISTICS

Department of Health

- Donna Wilkins M.D.
  - Health Officer
- Jammie Bane
  - Administrator

County Commissioners

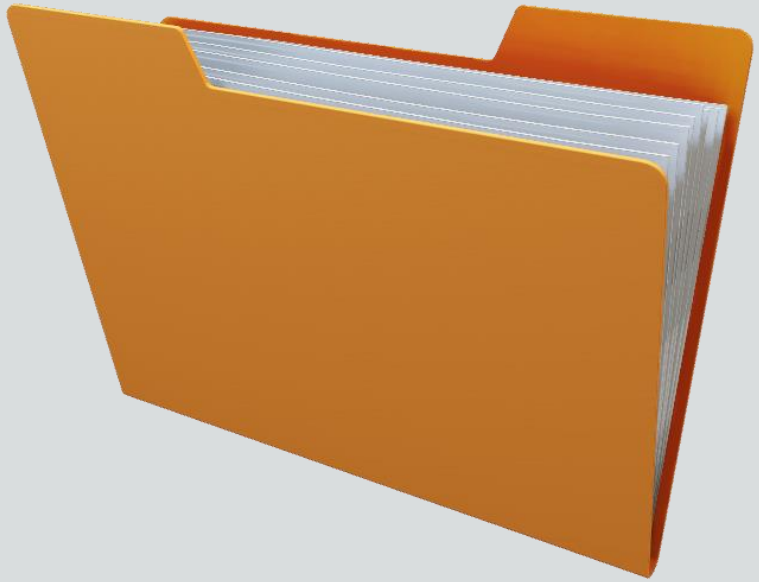
- James King Honeycutt
- Sherry Riggin
- Shannon Henry

GATE KEEPERS

Board of Health

- Judith Harris
  - Chairperson
- John Peterson M.D.
  - Vice-Chairperson
- Phyillies Burks-Beatty
- Anthony Dowell M.D.
- David Grasso D.V.M.
- Joe Russell P.E.

GATE KEEPERS



COUNTY PROFILE

Hepatitis-C is a liver infection transmitted by blood contact that can cause cirrhosis and/or cancer.

1. HCV is most frequently contracted through injection-drug use in the United States.
2. HCV can be present without symptoms until the disease is advanced.
3. There is no vaccine for HCV.
4. Acute HCV is defined as the 1st six months of infection.
5. Chronic HCV occurs when the disease is present for longer than six months.
6. More than half of people who become infected with HCV will develop a chronic infection.

HEPATITIS C

National Trends

AT A GLANCE
ACUTE HEPATITIS C in 2018

Rates of acute hepatitis C **increased** in 2018, particularly among those aged **20–39 years**, consistent with age groups most impacted by the nation's opioid crisis.

GROUPS MOST AFFECTED
BY ACUTE HEPATITIS C IN 2018

By Age†

20–29 years: 3.1 cases per 100,000 people

30–39 years: 2.6 cases per 100,000 people

40–49 years: 1.3 cases per 100,000 people

By Sex†

Males: 1.3 cases per 100,000 people

By Race/Ethnicity†

American Indian/Alaska Native: 3.6 cases per 100,000 people

By Risk

Injection Drug Use (IDU):
Among the 1,535 reported cases with IDU information available,
1,102 (72%) report IDU

* 95% Bootstrap Confidence Interval: (39,800-171,600)
† Indicates groups above the national average in 2018

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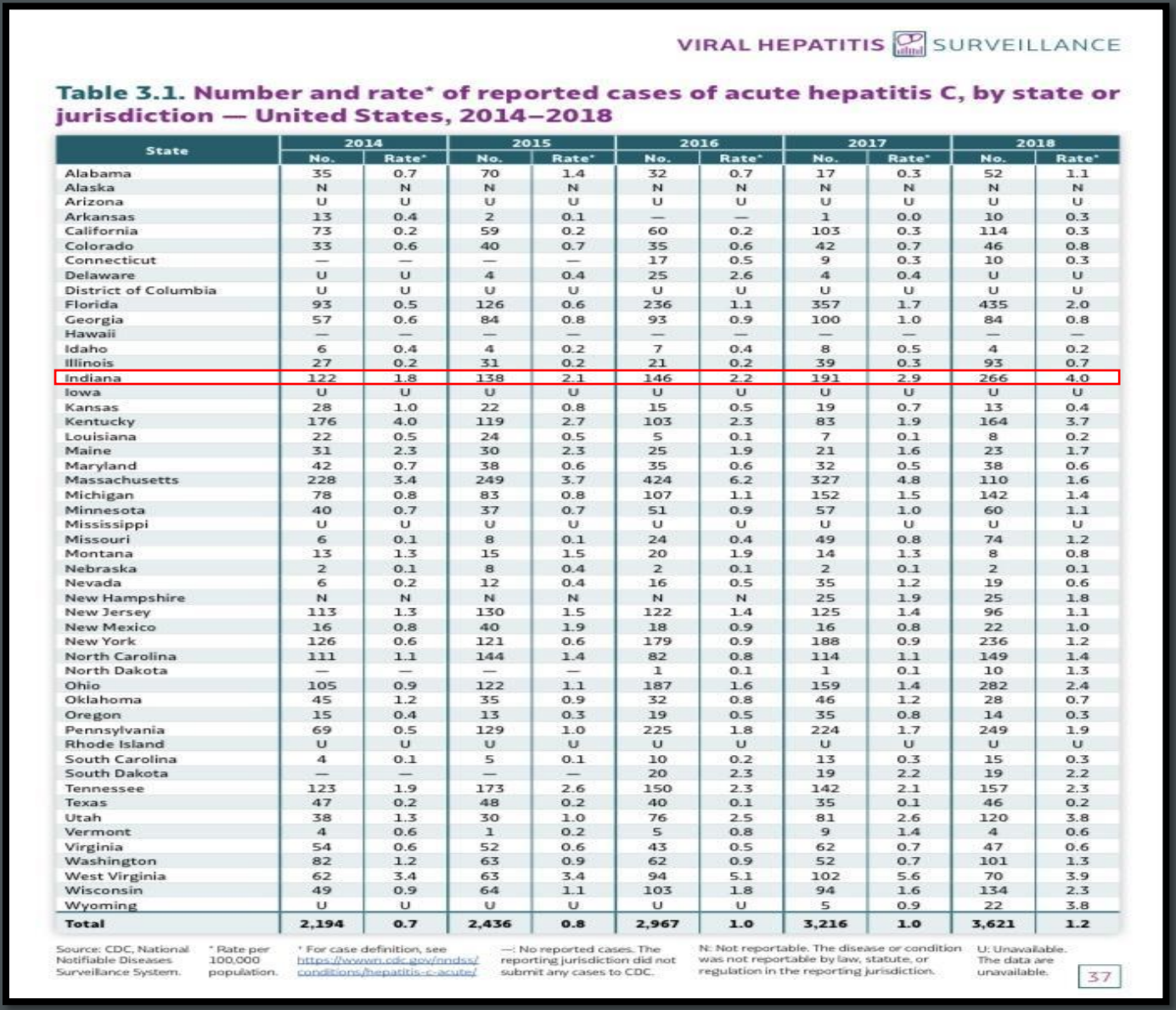
HEPATITIS C

State Trends



VIRAL HEPATITIS SURVEILLANCE

Table 3.1. Number and rate* of reported cases of acute hepatitis C, by state or jurisdiction — United States, 2014–2018

State	2014		2015		2016		2017		2018	
	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*
Alabama	35	0.7	70	1.4	32	0.7	17	0.3	52	1.1
Alaska	N	N	N	N	N	N	N	N	N	N
Arizona	U	U	U	U	U	U	U	U	U	U
Arkansas	13	0.4	2	0.1	—	—	1	0.0	10	0.3
California	73	0.2	59	0.2	60	0.2	103	0.3	114	0.3
Colorado	33	0.6	40	0.7	35	0.6	42	0.7	46	0.8
Connecticut	—	—	—	—	17	0.5	9	0.3	10	0.3
Delaware	U	U	4	0.4	25	2.6	4	0.4	U	U
District of Columbia	U	U	U	U	U	U	U	U	U	U
Florida	93	0.5	126	0.6	236	1.1	357	1.7	435	2.0
Georgia	57	0.6	84	0.8	93	0.9	100	1.0	84	0.8
Hawaii	—	—	—	—	—	—	—	—	—	—
Idaho	6	0.4	4	0.2	7	0.4	8	0.5	4	0.2
Illinois	27	0.2	31	0.2	21	0.2	39	0.3	93	0.7
Indiana	122	1.8	138	2.1	146	2.2	191	2.9	266	4.0
Iowa	U	U	U	U	U	U	U	U	U	U
Kansas	28	1.0	22	0.8	15	0.5	19	0.7	13	0.4
Kentucky	176	4.0	119	2.7	103	2.3	83	1.9	164	3.7
Louisiana	22	0.5	24	0.5	5	0.1	7	0.1	8	0.2
Maine	31	2.3	30	2.3	25	1.9	21	1.6	23	1.7
Maryland	42	0.7	38	0.6	35	0.6	32	0.5	38	0.6
Massachusetts	228	3.4	249	3.7	424	6.2	327	4.8	110	1.6
Michigan	78	0.8	83	0.8	107	1.1	152	1.5	142	1.4
Minnesota	40	0.7	37	0.7	51	0.9	57	1.0	60	1.1
Mississippi	U	U	U	U	U	U	U	U	U	U
Missouri	6	0.1	8	0.1	24	0.4	49	0.8	74	1.2
Montana	13	1.3	15	1.5	20	1.9	14	1.3	8	0.8
Nebraska	2	0.1	8	0.4	2	0.1	2	0.1	2	0.1
Nevada	6	0.2	12	0.4	16	0.5	35	1.2	19	0.6
New Hampshire	N	N	N	N	N	N	25	1.9	25	1.8
New Jersey	113	1.3	130	1.5	122	1.4	125	1.4	96	1.1
New Mexico	16	0.8	40	1.9	18	0.9	16	0.8	22	1.0
New York	126	0.6	121	0.6	179	0.9	188	0.9	236	1.2
North Carolina	111	1.1	144	1.4	82	0.8	114	1.1	149	1.4
North Dakota	—	—	—	—	1	0.1	1	0.1	10	1.3
Ohio	105	0.9	122	1.1	187	1.6	159	1.4	282	2.4
Oklahoma	45	1.2	35	0.9	32	0.8	46	1.2	28	0.7
Oregon	15	0.4	13	0.3	19	0.5	35	0.8	14	0.3
Pennsylvania	69	0.5	129	1.0	225	1.8	224	1.7	249	1.9
Rhode Island	U	U	U	U	U	U	U	U	U	U
South Carolina	4	0.1	5	0.1	10	0.2	13	0.3	15	0.3
South Dakota	—	—	—	—	20	2.3	19	2.2	19	2.2
Tennessee	123	1.9	173	2.6	150	2.3	142	2.1	157	2.3
Texas	47	0.2	48	0.2	40	0.1	35	0.1	46	0.2
Utah	38	1.3	30	1.0	76	2.5	81	2.6	120	3.8
Vermont	4	0.6	1	0.2	5	0.8	9	1.4	4	0.6
Virginia	54	0.6	52	0.6	43	0.5	62	0.7	47	0.6
Washington	82	1.2	63	0.9	62	0.9	52	0.7	101	1.3
West Virginia	62	3.4	63	3.4	94	5.1	102	5.6	70	3.9
Wisconsin	49	0.9	64	1.1	103	1.8	94	1.6	134	2.3
Wyoming	U	U	U	U	U	U	5	0.9	22	3.8
Total	**2,194**	**0.7**	**2,436**	**0.8**	**2,967**	**1.0**	**3,216**	**1.0**	**3,621**	**1.2**

Source: CDC, National Notifiable Diseases Surveillance System. * Rate per 100,000 population. † For case definition, see https://wwwn.cdc.gov/nndss/conditions/hepatitis-c-acute/ —: No reported cases. The reporting jurisdiction did not submit any cases to CDC. N: Not reportable. The disease or condition was not reportable by law, statute, or regulation in the reporting jurisdiction. U: Unavailable. The data are unavailable.

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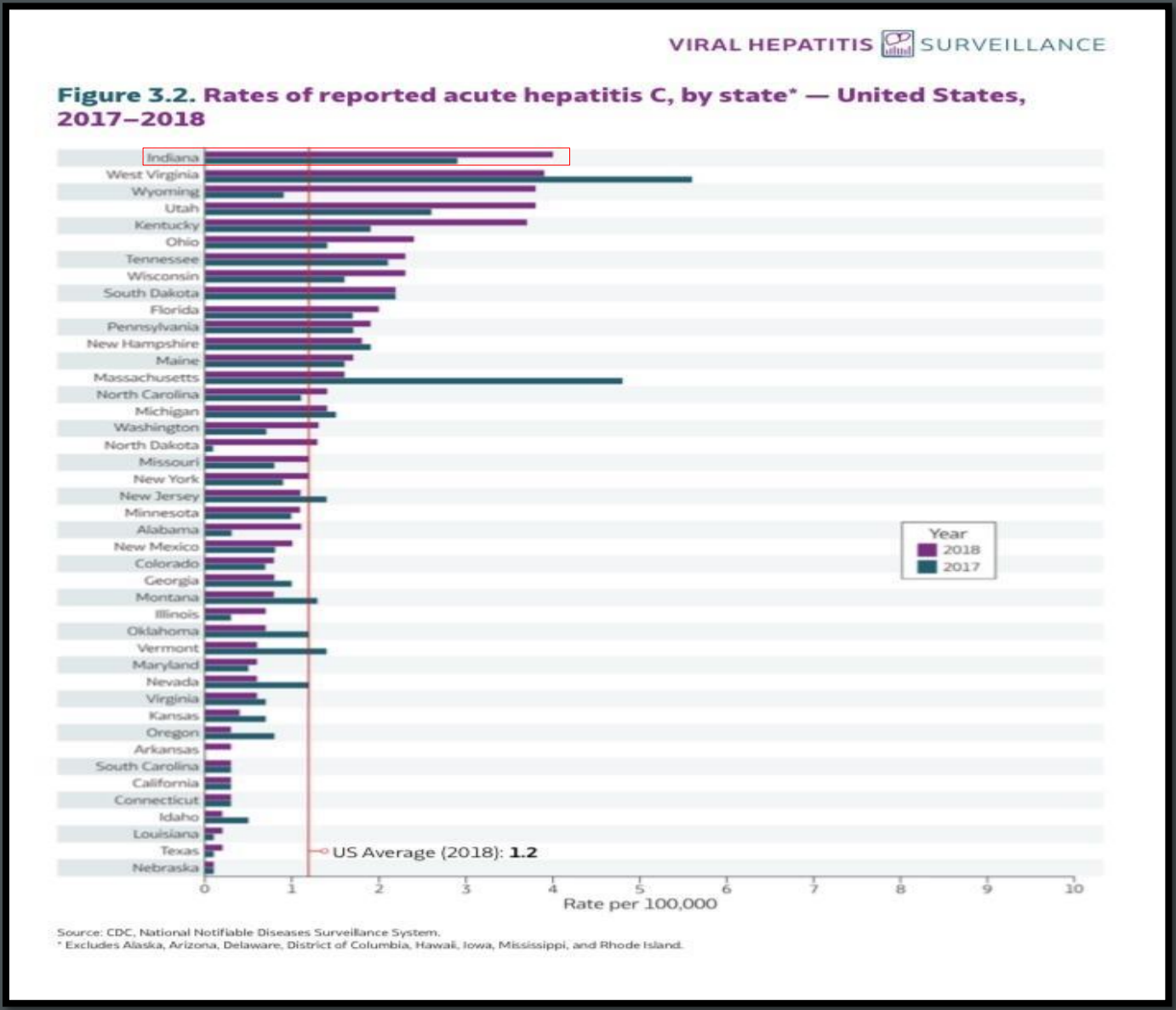
HEPATITIS C

National Trends

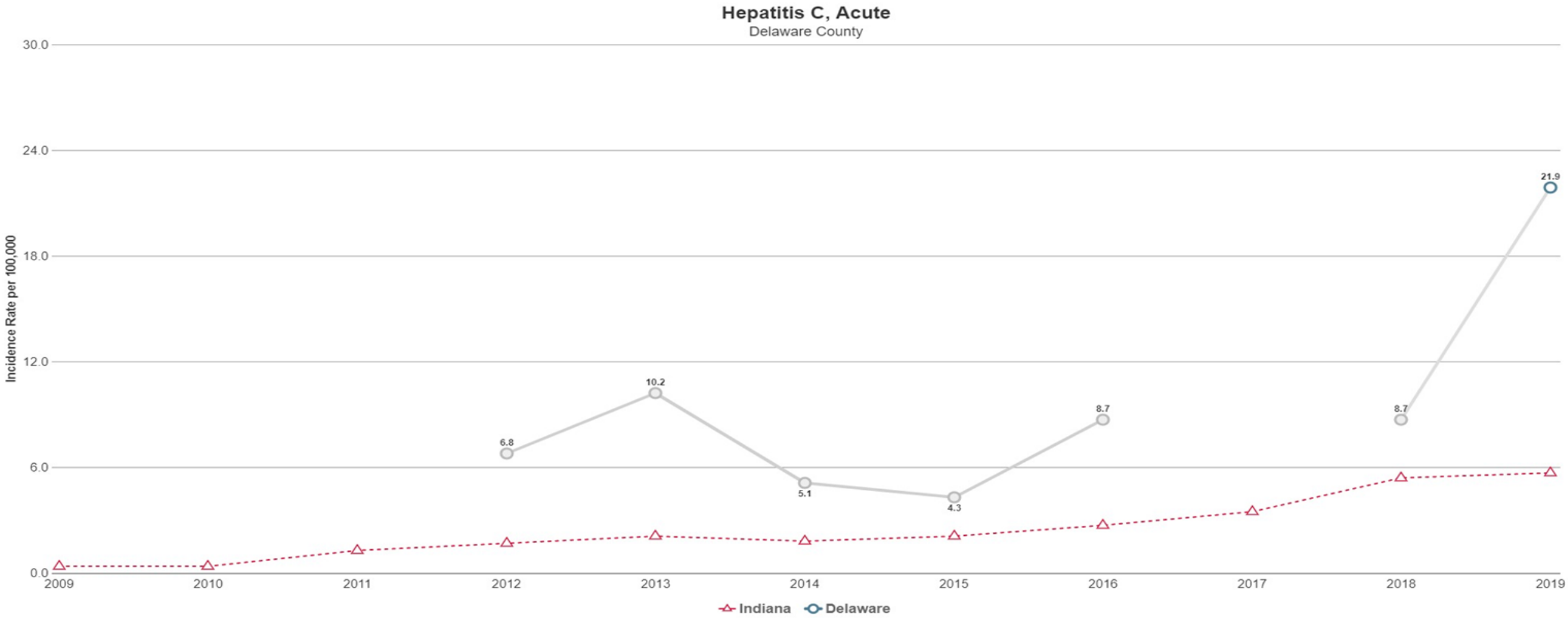


HEPATITIS C

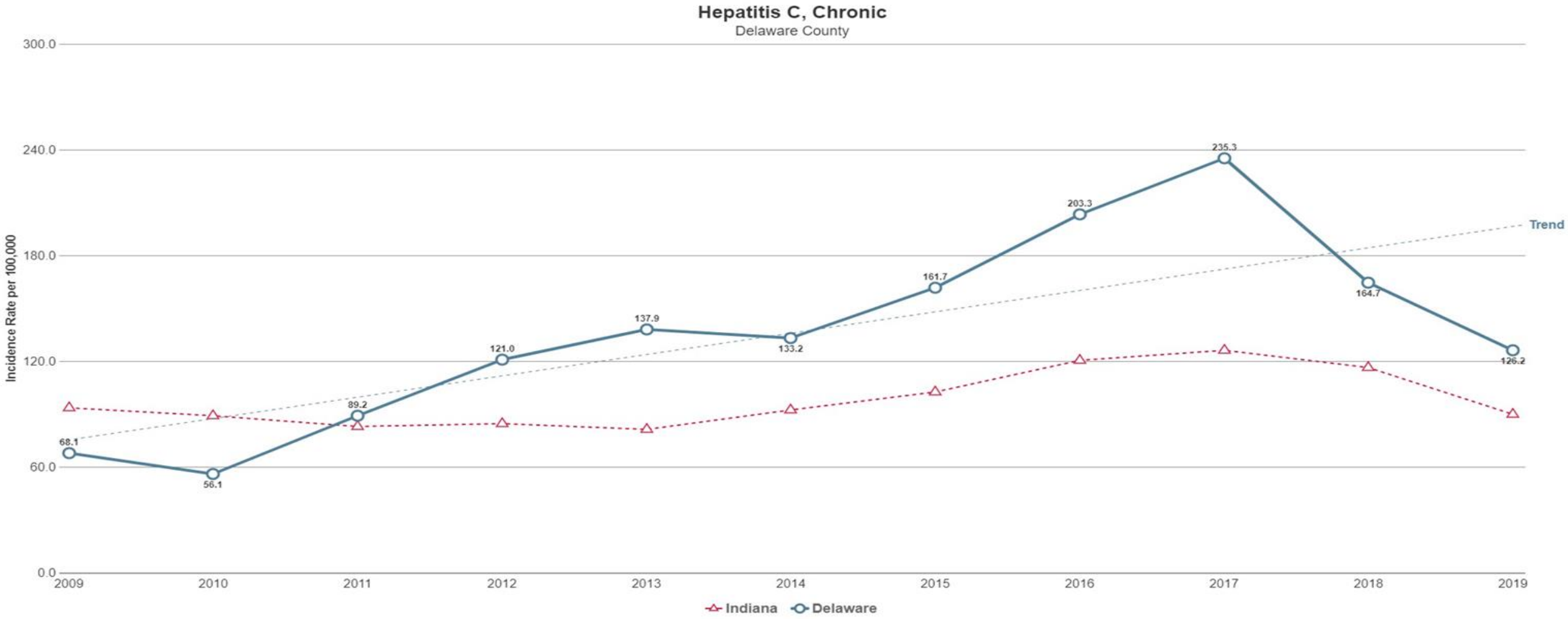
2019 Delaware County HCV Statistics

Category	Number	Rate	County Rank
Chronic HCV Incidences	144	126 per 100,000	18th Highest
Acute HCV Incidences	25	22 per 100,000	3rd Highest

HEPATITIS C



DELAWARE COUNTY ACUTE HCV TRENDS



DELAWARE COUNTY CHRONIC HCV TRENDS

HIV is a virus that attacks the body's immune system and results in AIDS if left untreated.

1. Sharing syringes is the 2nd most frequent way of contracting HIV.
2. The risk for getting or transmitting HIV is very high if an HIV-negative person uses injection equipment that someone with HIV has used.
3. HIV can survive in a used syringe for up to 42 days, depending on temperature and other factors.
4. There is currently no effective cure or vaccine for HIV.*
5. Coinfection with HIV and HCV is common (62%–80%) among injection-drug users who have HIV.

HIV

State Trends

1. In 2018, a total of 12,708 individuals in Indiana were living with HIV or AIDS, representing an annual HIV/AIDS prevalence rate of 189.9 per 100,000 population.
2. In 2018, there were 522 new cases of HIV/AIDS.

Delaware County

1. There have been 41 new cases of HIV reported in Delaware County since 2014 (2018*) at a rate of 7.1 people per 100,000 which is the 9th highest rate per county.

HIV

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Delaware County

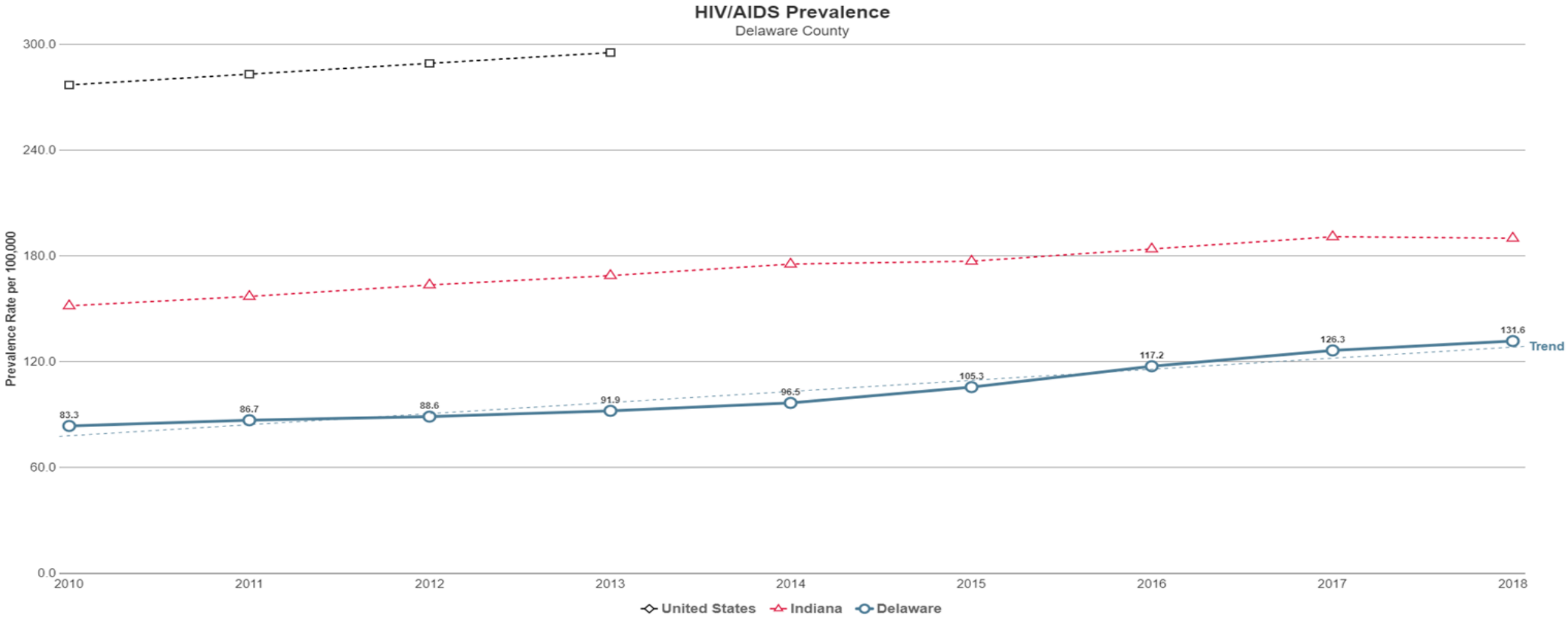
1. There have been 41 new cases of HIV reported in Delaware County since 2014 (2018*) at a rate of 7.1 people per 100,000 which is the 9th highest rate per county.

HIV

2018 Delaware County HIV/AIDS Statistics

Category	Number	Rate	County Rank
HIV/AIDS Prevalence	151	132 per 100,000	18th Highest

HIV



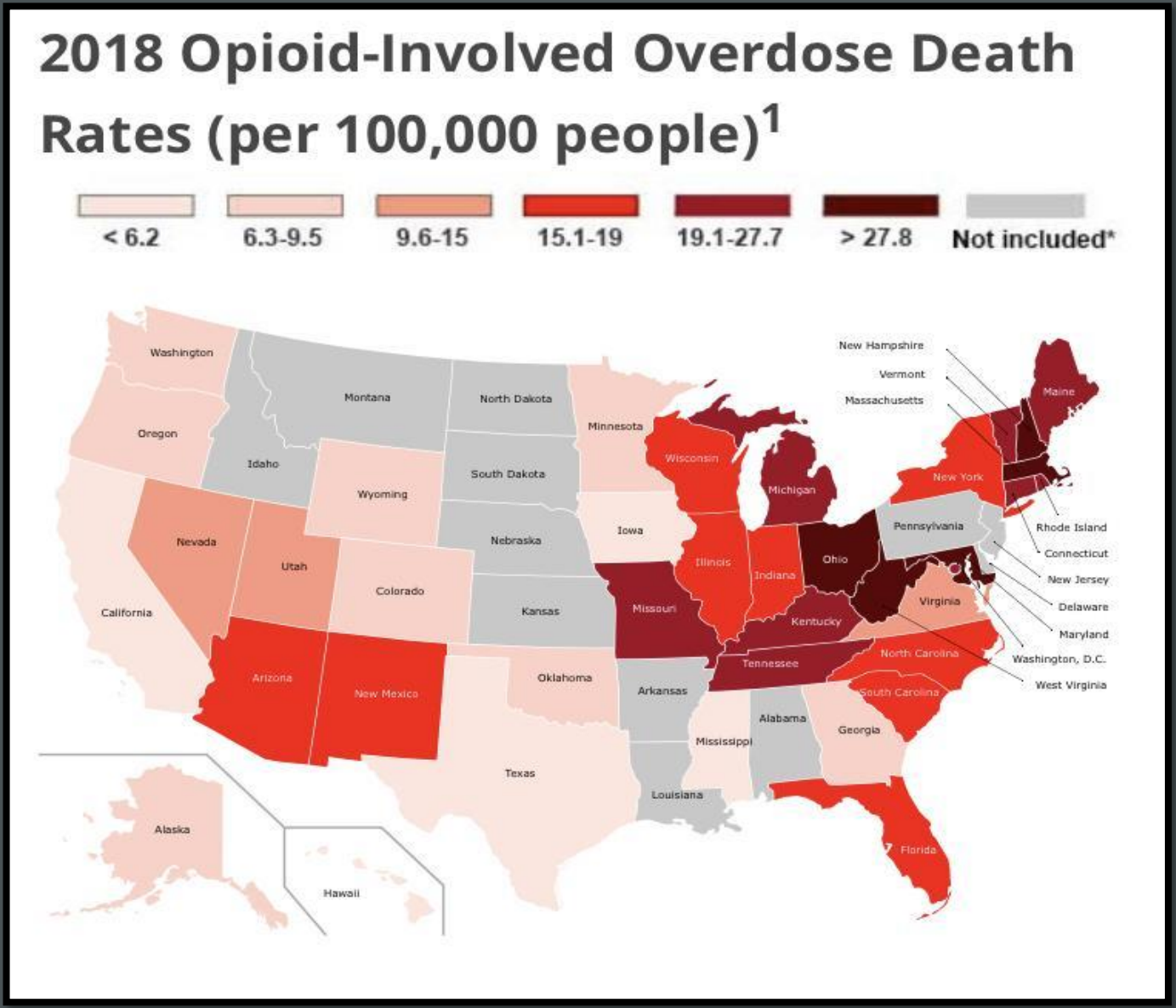
DELAWARE COUNTY HIV/AIDS TRENDS

Treatment

1. The estimated lifetime cost of treating one person living with HIV is around $450,000.
2. The initial market prices of HCV treatment ranges from $84,000 to $96,000.

ECONOMIC COSTS

State Trends



OVERDOSES

State Trends

1. Drug overdose deaths in Indiana have been on the rise for almost two decades, with a loss of more than 15,000 Hoosiers due to drug overdoses since 1999.
2. In 2017, there were over 1,800 drug overdose deaths in Indiana equaling nearly five Hoosiers per day.

OVERDOSES

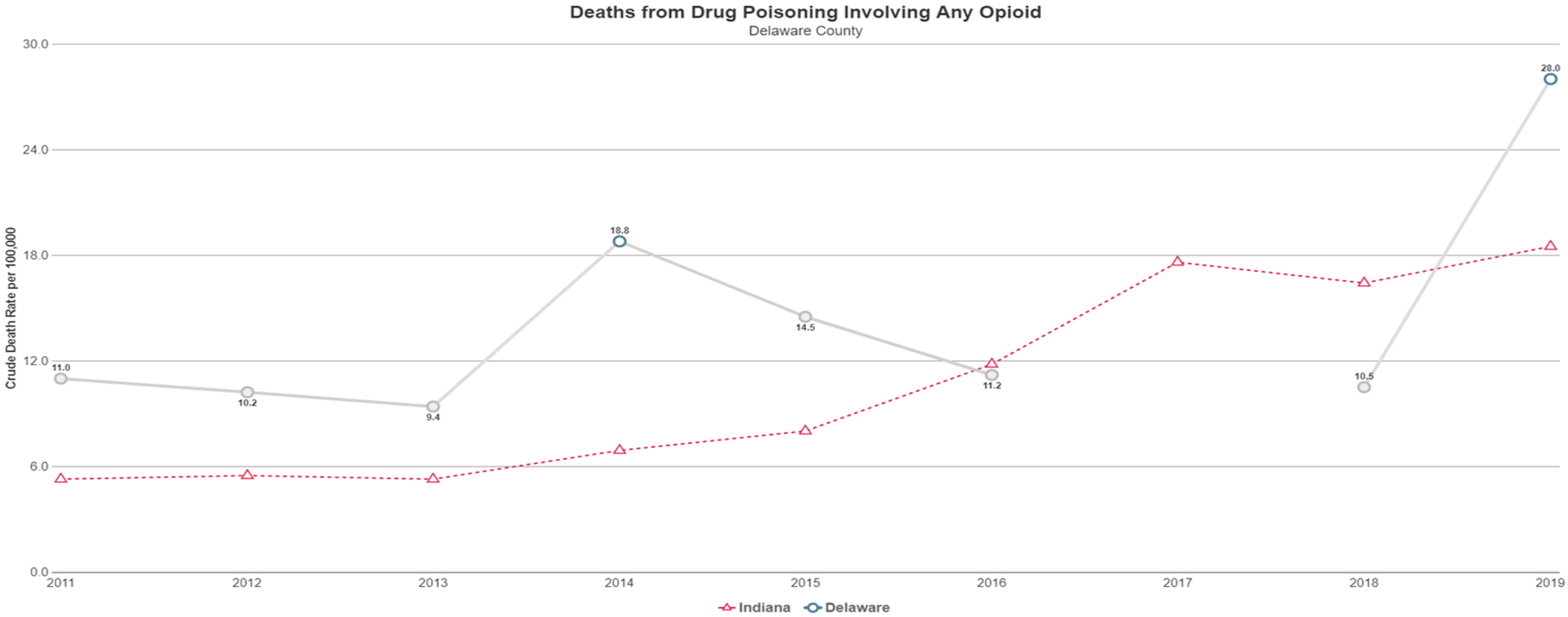
State Trends

1. In 2017, Indiana reached its highest age-adjusted drug overdose rate at 29.4 per 100,000, a 22% increase from 2016.
2. From 2016-2017, Indiana had the third-highest drug overdose rate increase (22%) in the nation behind only New Jersey (29%) and Nebraska (26%).

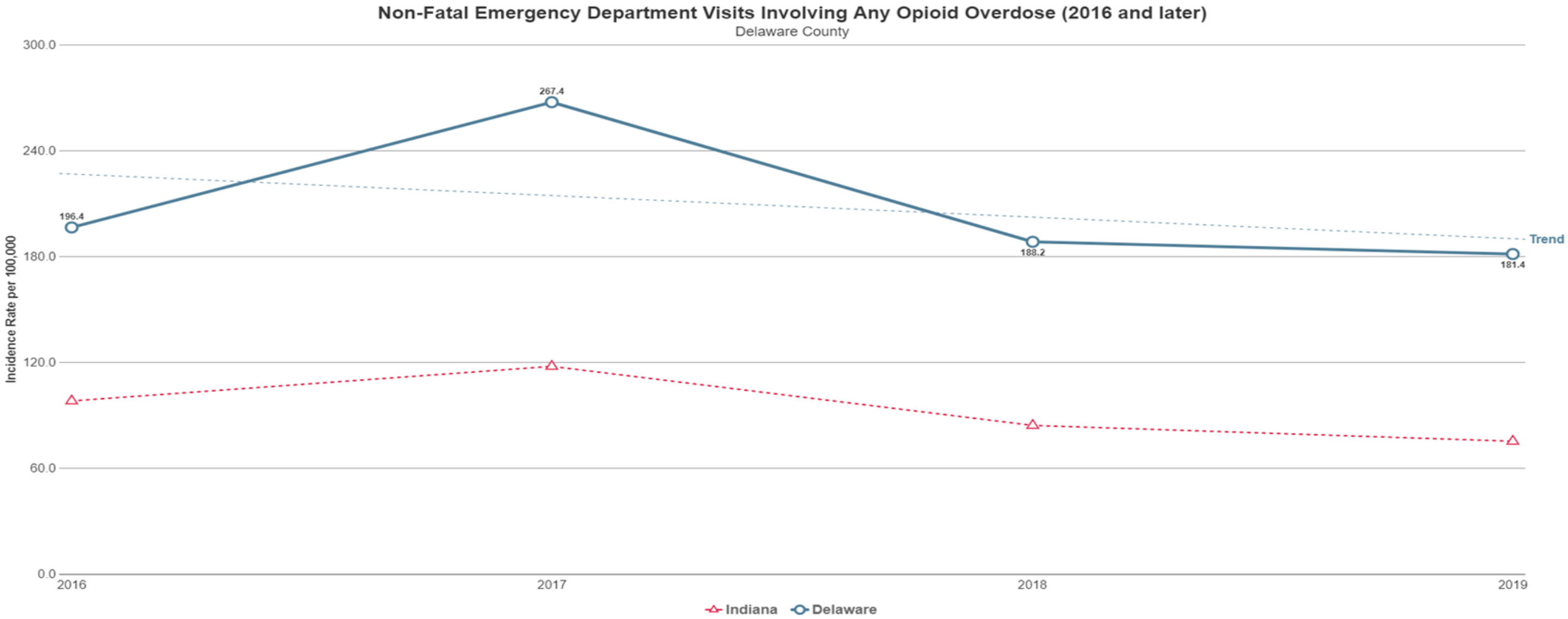
OVERDOSES

Category	Year	Number	Rate	County Rank
Deaths – Any Opioid	2019	32	28 per 100,000	7th Highest
Non-Fatal E.R. Visits – Opioids	2019	207	181 per 100,000	4th Highest
Non-Fatal Hospitalizations – Opioids	2019	46	40 per 100,000	6th Highest
Deaths – Heroin	2019	2	-	-
Non-Fatal E.R. Visits – Heroin	2019	105	92 per 100,000	4th Highest
Non-Fatal Hospitalizations – Heroin	2019	16	14 per 100,000	3rd Highest
Indiana Treatment Episodes – Heroin	2011-2015	391	67 per 100,000	20th Highest

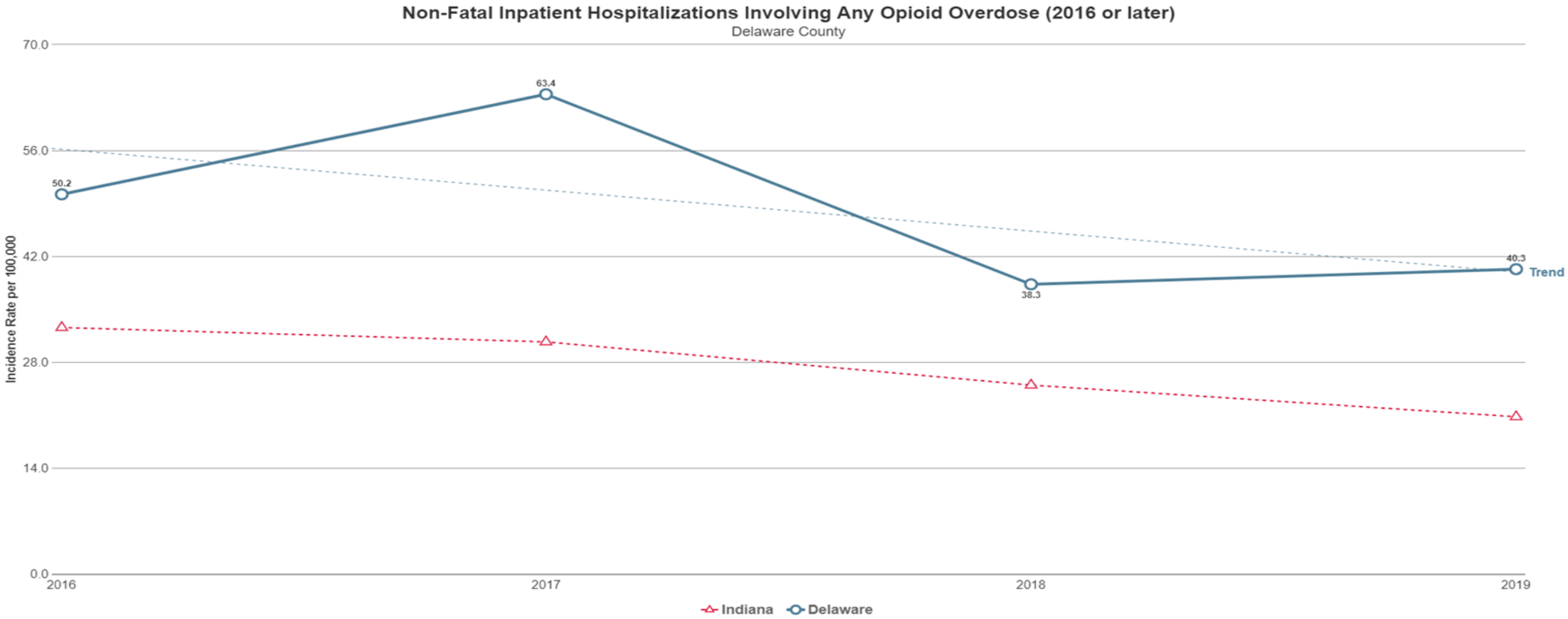
DELAWARE COUNTY OPIOID PROFILE



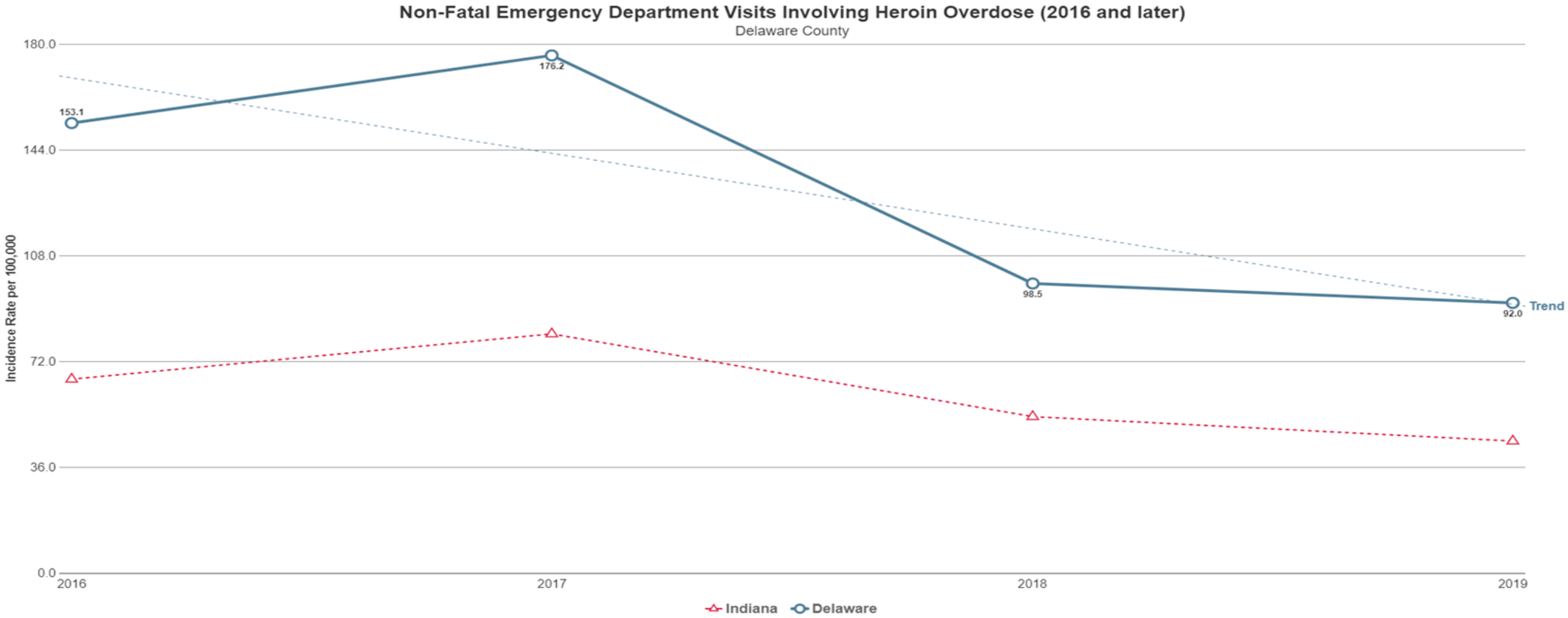
DELAWARE COUNTY OPIOID OVERDOSE DEATH TRENDS



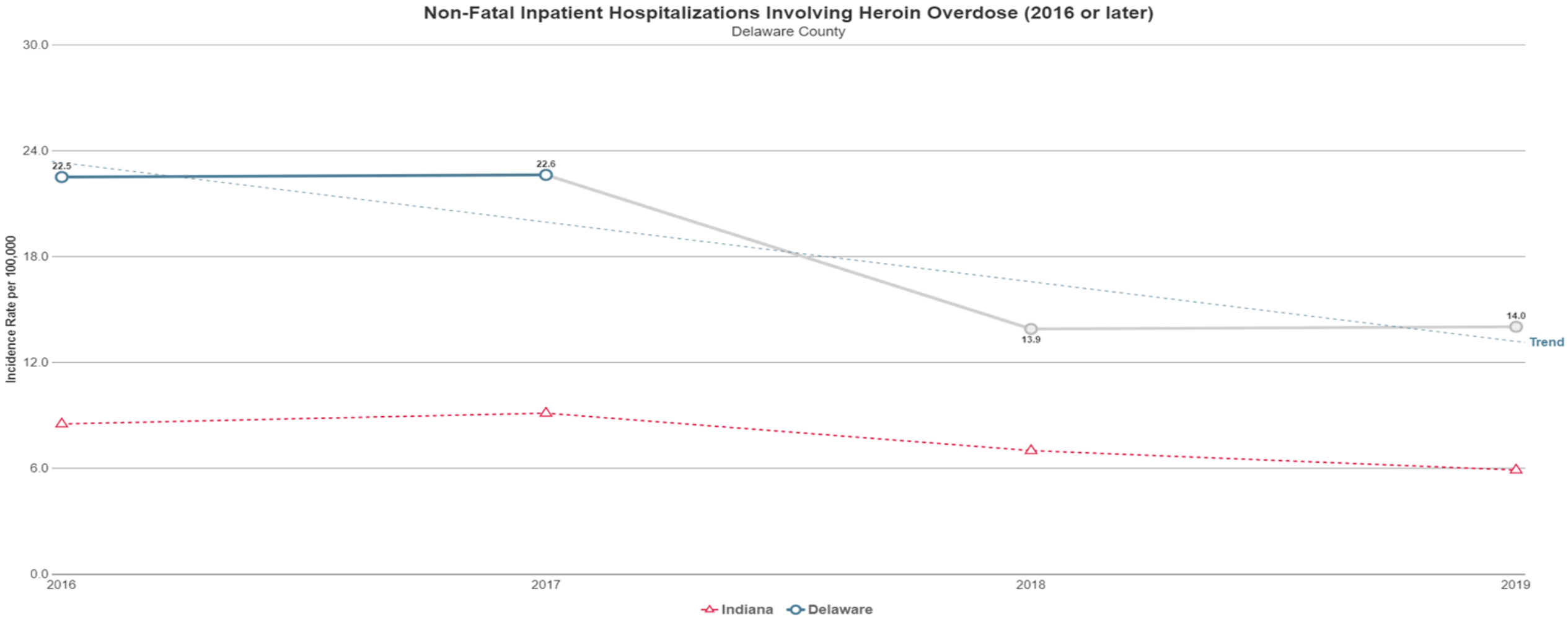
DELAWARE COUNTY NON-FATAL EMERGENCY ROOM VISIT TRENDS (OPIOIDS)



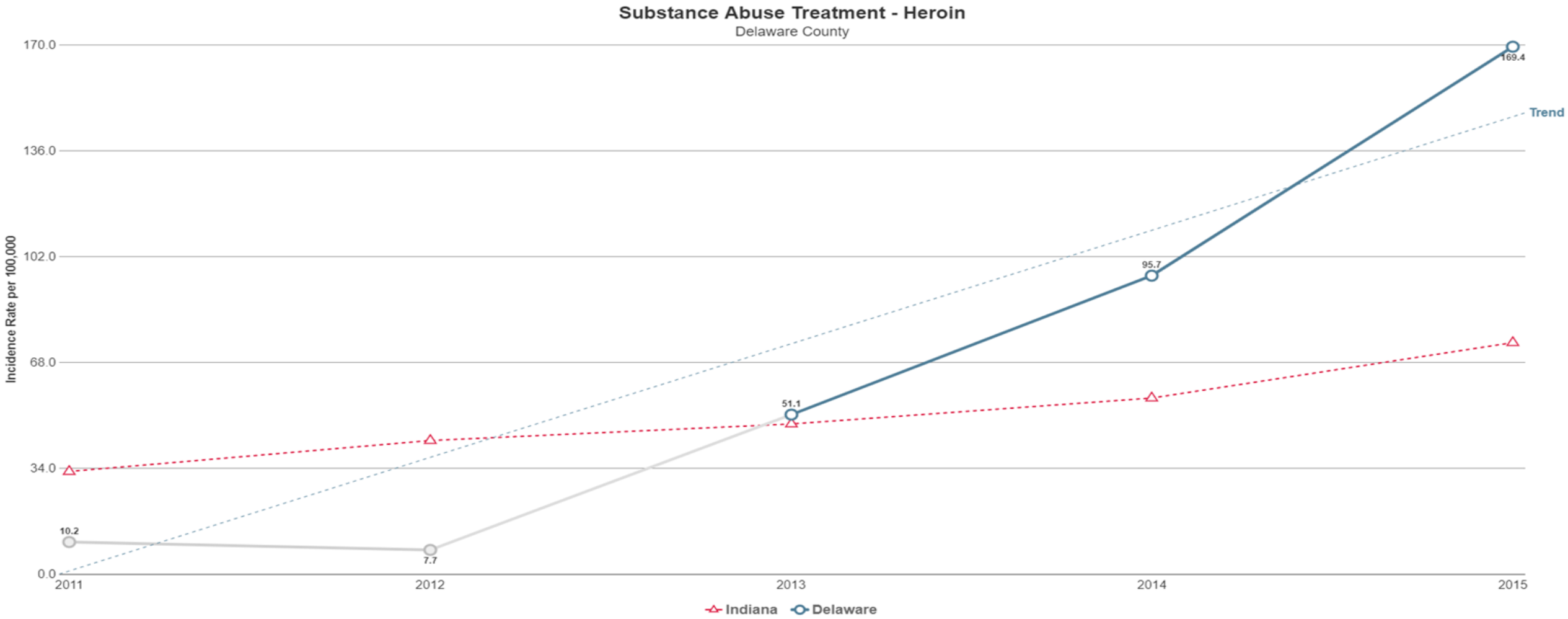
DELAWARE COUNTY NON-FATAL HOSPITALIZATION TRENDS (OPIOIDS)



DELAWARE COUNTY NON-FATAL EMERGENCY ROOM VISIT TRENDS (HEROIN)



DELAWARE COUNTY NON-FATAL HOSPITALIZATION TRENDS (HEROIN)



INDIANA TREATMENT EPISODE TRENDS (HEROIN)

Law Enforcement

1. A study of police officers in Rhode Island found that nearly 30% had been stuck by a needle at one point in their career.
2. More than 27% experienced two or more needle stick injuries.

FIRST RESPONDERS

SYRINGE SERVICE PROGRAM OUTCOMES

SSPs are cost-saving, evidence-based public health interventions for reducing the spread of infectious diseases, increasing treatment service access and utilization among vulnerable populations, and enhancing the safety of communities and first responders.

EVIDENCE-BASE

The efficacy and implementation of SSPs as a public health intervention is supported by 40 years of research conducted by the primary mental and behavioral health organizations in Indiana and the United States. These organizations include:

1. Substance Abuse and Mental Health Services Administration (SAMHSA).
2. National Institute of Health (NIH).
3. Centers for Disease Control (CDC).
4. U.S. Department of Health and Human Services (USDHHS).
5. Indiana State Department of Health (ISDH).

EVIDENCE-BASE

SSPs do not produce iatrogenic (negative) effects within communities.

1. Research has shown that SSPs do not cause or increase injection drug use in communities.
2. Research has shown that SSPs do not cause or increase crime in communities.

EVIDENCE-BASE

SSPs are effective at reducing the spread of infectious diseases such as HIV and HCV.

1. SSPs are associated with an estimated 50% reduction in HIV and HCV transmission rates following implementation.
2. When combined with medication-assisted treatment, HCV and HIV transmission can be reduced by over two-thirds.

EVIDENCE-BASE

SSPs are effective at increasing access and the utilization of treatment services.

1. New users of SSPs are five times as likely to enter drug treatment as those who don't use the programs.
2. People who inject drugs and use an SSP regularly are nearly three times as likely to report reducing or stopping illicit drug injection as those who have never used an SSP.

EVIDENCE-BASE

SSPs protect the public and first responders by creating safe needle disposal options.

1. SSPs can reduce the improper disposal of syringes within a community by up to 65%.
2. SSPs can reduce needle stick injuries for first responders by up to 66%.

EVIDENCE-BASE

SSPs reduce healthcare costs for communities.

1. $20,947 per averted HIV infection.
2. A cost-effectiveness analysis of a New York City SSP estimated that the program would result in a baseline one year savings to the government of $1,300 to $3,000 per client.
3. A return on investment of $7.58 for every $1 spent.

EVIDENCE-BASE

Summary

1. SSPs do not increase injection drug use or crime.
2. SSPs reduce HIV and HCV infection rates.
3. SSPs increase the access and utilization of addiction treatment services.
4. SSPs create safer and healthier communities.

EVIDENCE-BASE

Summary

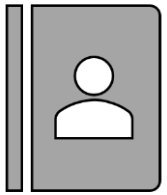
5. SSPs increase the environmental safety conditions for law enforcement officers and other first responders.
6. SSPs are a cost-saving intervention for the county and state.
7. SSPs are supported by SAMHSA, the Indiana DOH, and other prominent mental and behavioral health organizations across the United States.

EVIDENCE-BASE

INDIANA CASE STUDIES

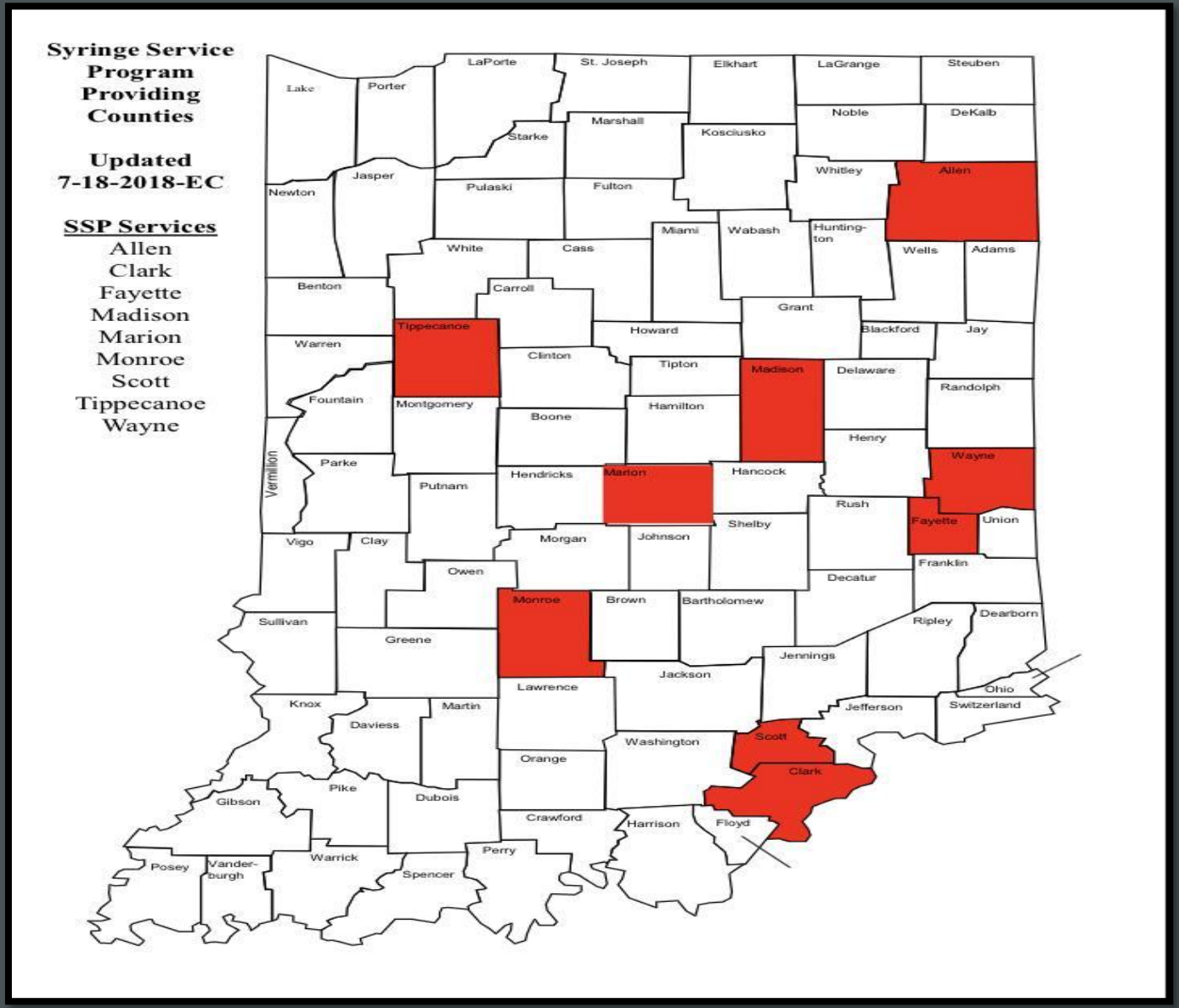
10% of Indiana counties have an SSP.

1. Allen County
2. Clark County
3. Fayette County
4. Madison County
5. Marion County
6. Monroe County
7. Scott County
8. Tippecanoe County
9. Wayne County



CASE STUDIES

Indiana Programs

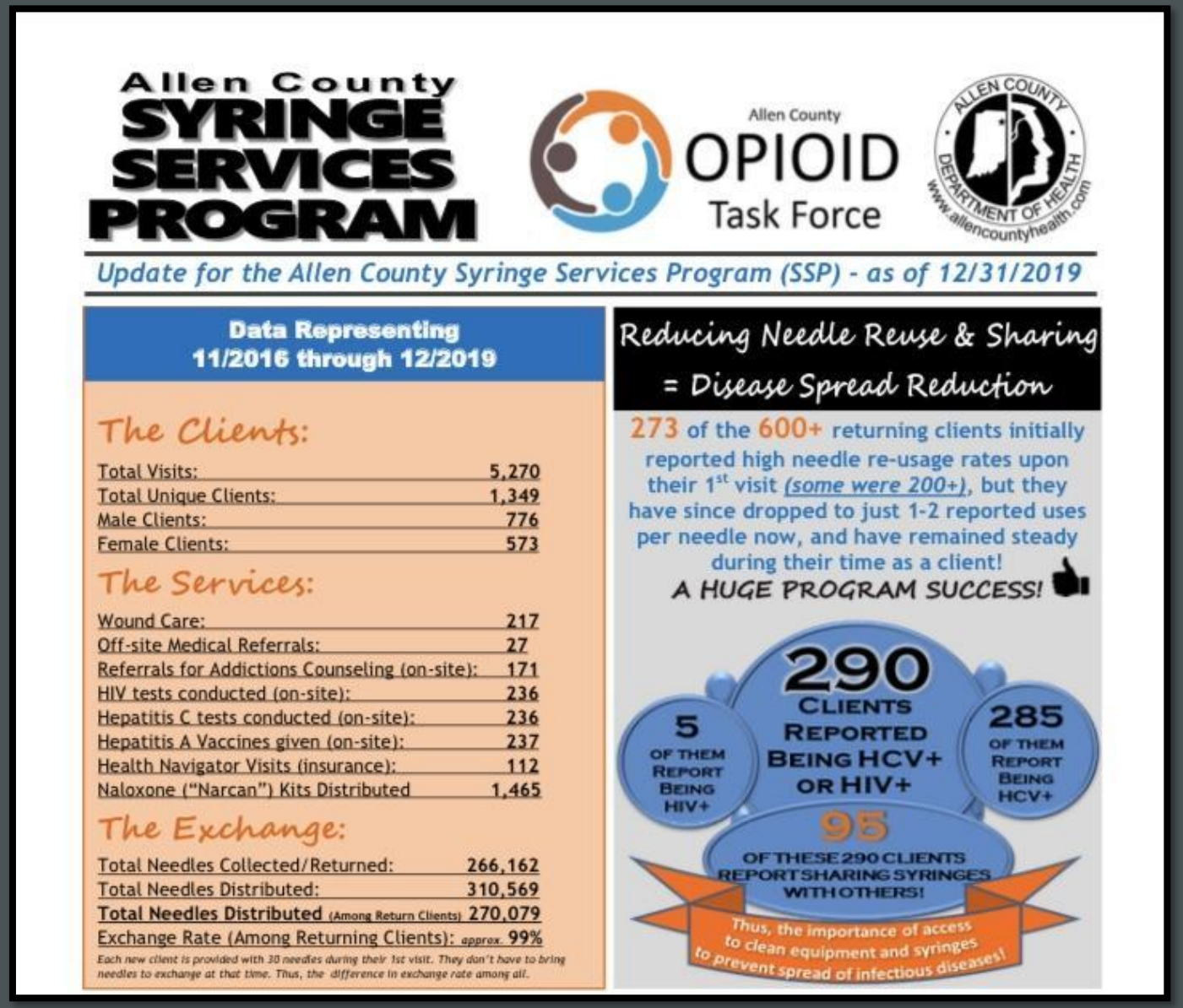


CASE STUDIES

Indiana Programs

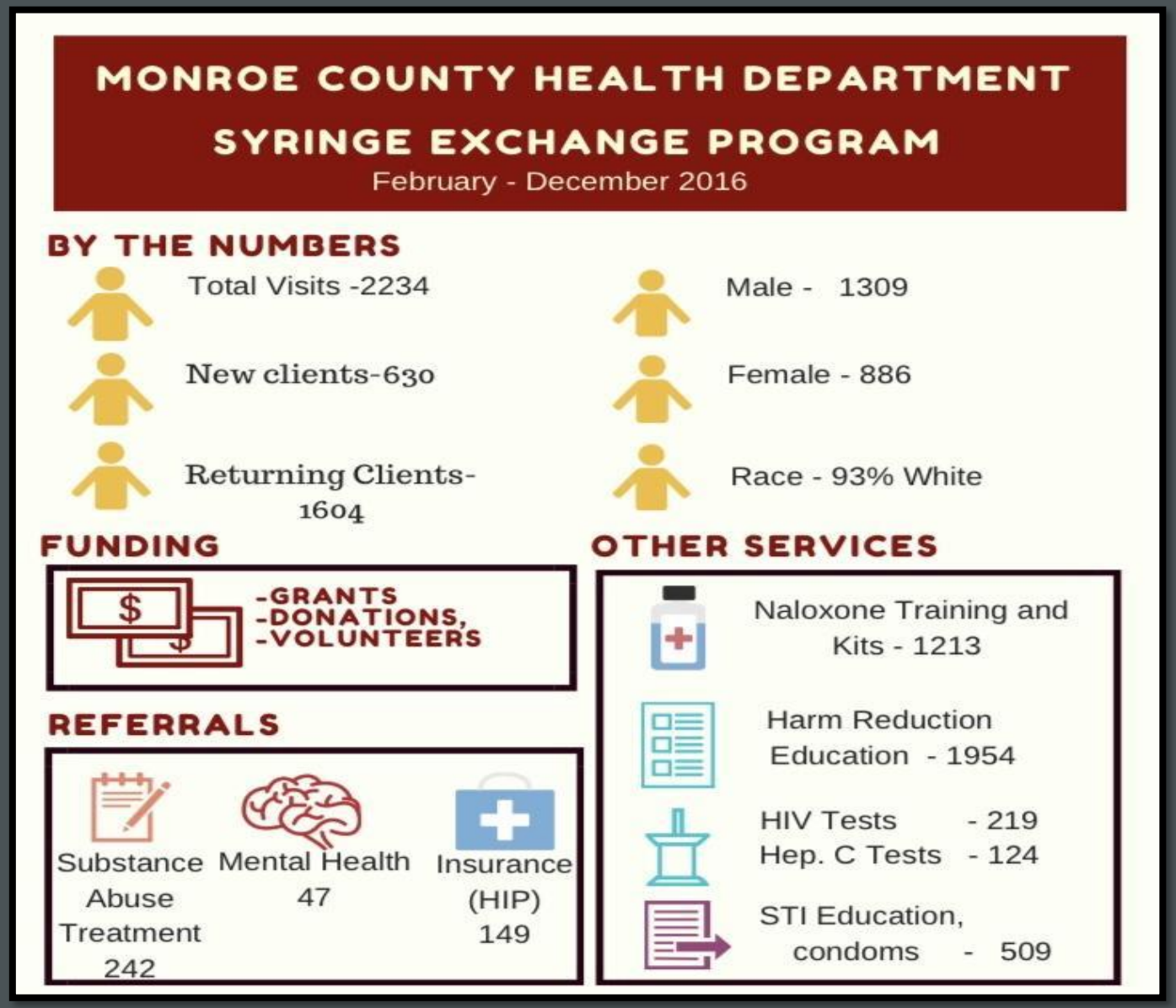
CASE STUDIES

Allen County



CASE STUDIES

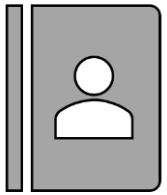
Monroe County



CASE STUDIES

Scott County

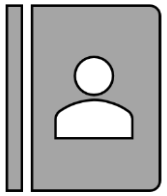
1. In November 2014, a cluster of HIV infections was detected among people who inject drugs in Scott County with a total of 215 HIV infections eventually attributed to the outbreak.
2. Research suggests that an earlier public health response could have reduced the total number of HIV infections.
   a. Less than 56 if implemented in January 2013, representing at least 127 infections averted.
   b. Less than ten if implemented in April 2011, representing at least 173 infections averted.



CASE STUDIES

Scott County

1. It is estimated that the SSP in Scott County, Indiana, which was implemented in response to the HIV outbreak, will save Indiana taxpayers approximately $120 million in costs associated with treating those with HIV.



CASE STUDIES

Scott County

CASE STUDIES

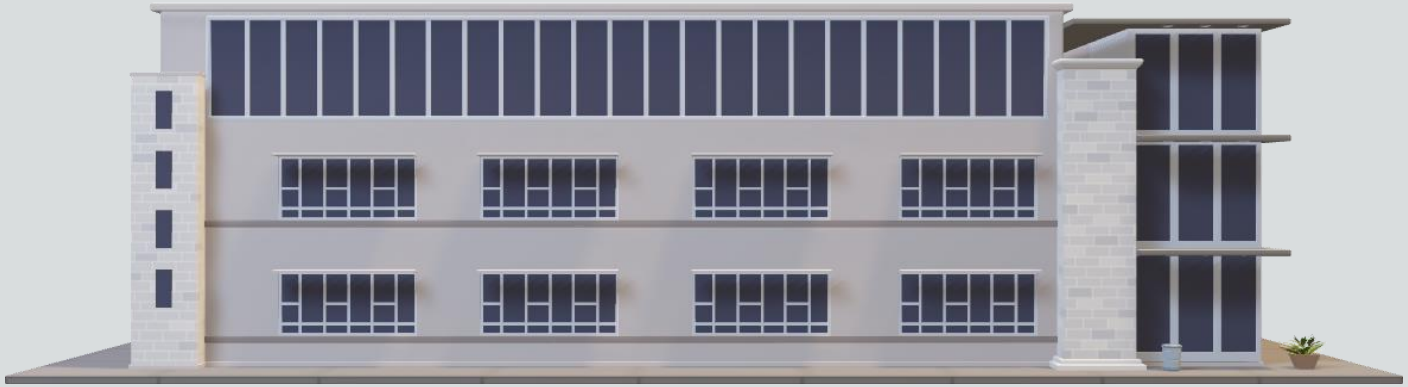
Tippecanoe County

1. Tippecanoe's syringe service program, *Gateway to Hope,* has been operating since August 11, 2017.
2. Between August 11th and September 30th, 2017, the program had 83 participants and distributed 4475 sterile syringes while collecting 2,327 used syringes.

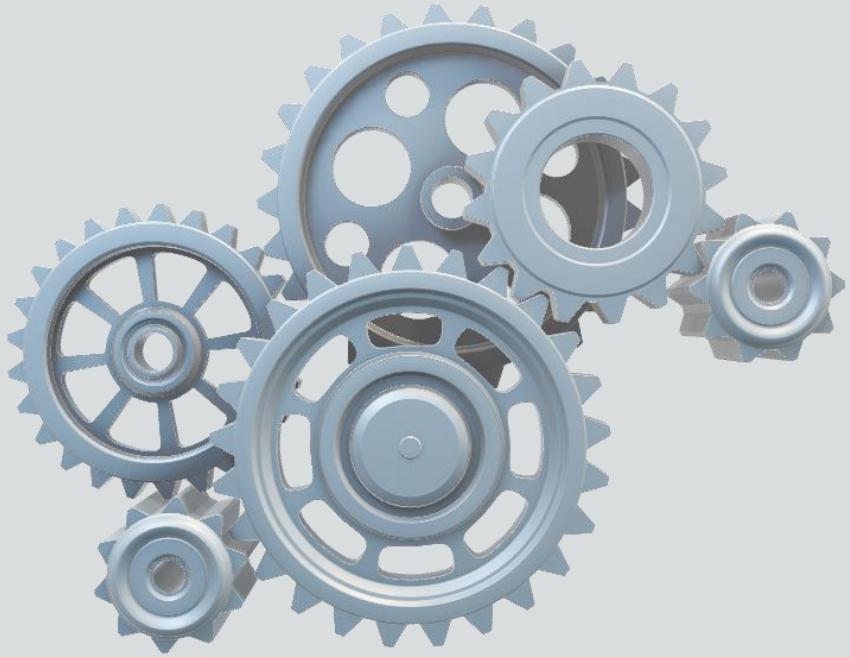
CASE STUDIES

FINAL THOUGHTS

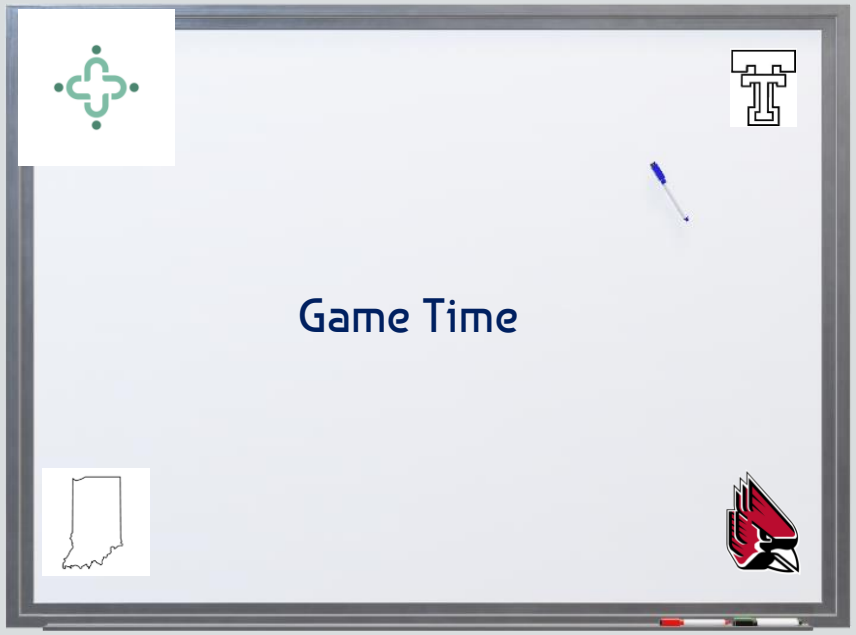
PROPOSAL PART II



HOST SITE

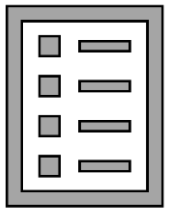


PROGRAM COMPONENTS & IMPLEMENTATION PLAN



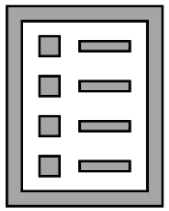
NEXT STEPS

1. Complete Part II of the proposal.
    a. Find a community partner.
    b. Establish a program plan.
2. Meet with the county gatekeepers.
3. Secure organizational and community support via a proposal support letter.
4. Host a townhall meeting.



NEXT STEPS

5. Formally present the proposal to the county gatekeepers.
    a. Department of Health
    b. County Commissioners
    c. Board of Health
6. Acquire funding for the SSP.
    a. Syringes cannot be purchased with state funds.
7. Implement and evaluate the program.



NEXT STEPS

QUESTIONS & COMMENTS

CONTACT INFORMATION

- Dr. Dane Minnick PhD, LSW, CPS, BCPG
  ACDC Co-Founder & Director
  dminnick@bsu.edu
- Dr. Jean Marie Place PhD, MSW
  ACDC Co-Founder & Operations Officer
  jsplace@bsu.edu
- Dr. Jonel Thaller PhD, LSW
  ACDC Co-Founder & Operations Officer
  jthaller@bsu.edu

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