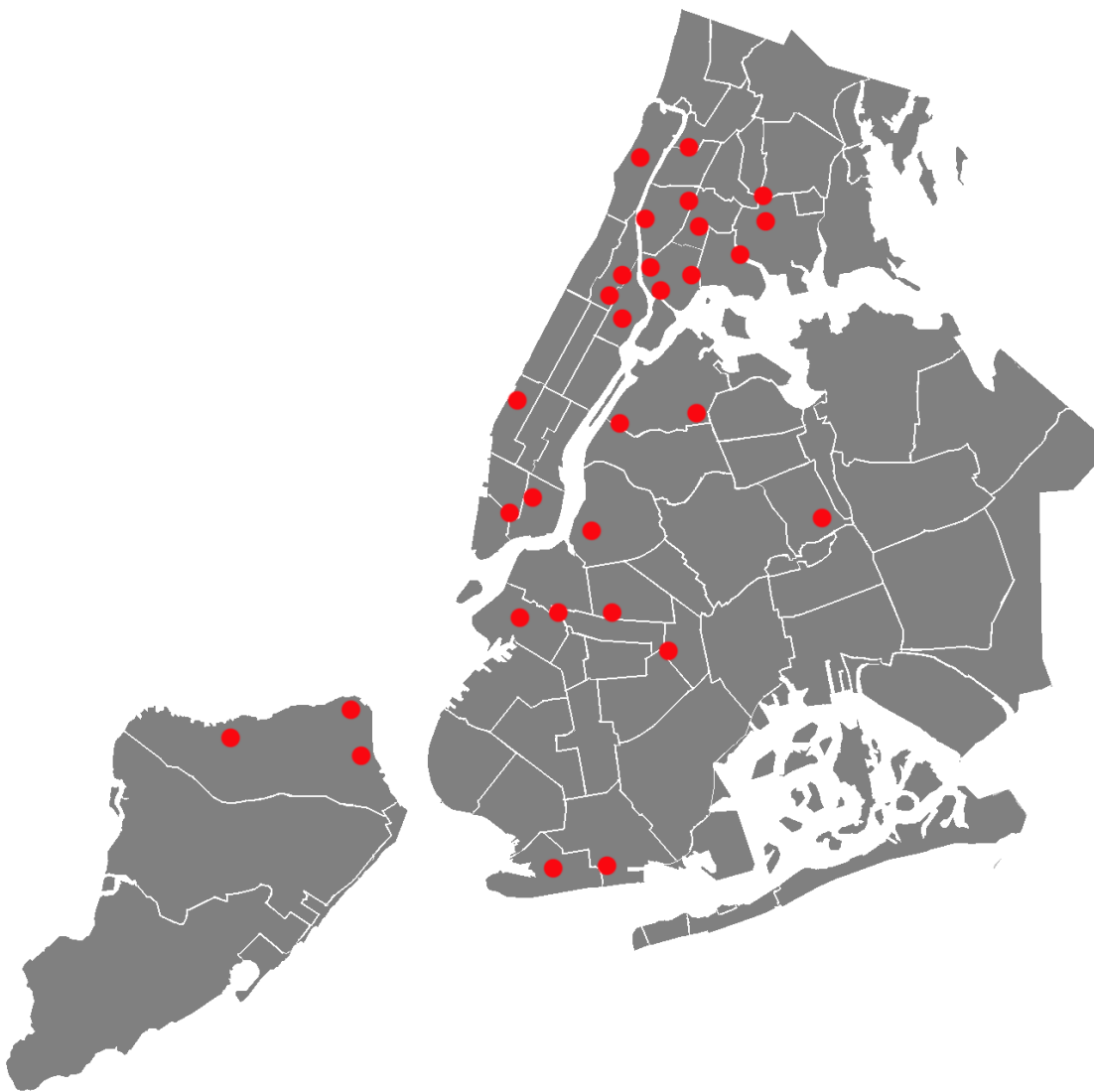


IDUHA Injection Drug Users Health Alliance

Harm Reduction in New York City



Citywide Evaluation Study
2015 Report

Who is IDUHA?

The Injection Drug Users Health Alliance is a coalition of harm reduction providers across the five boroughs of New York City. IDUHA works to promote and implement strategies that prevent the spread of diseases such as HIV/AIDS, and hepatitis C, prevent death by overdose and disease, support healthy behaviors, and facilitate participants into medical care, mental health care, and drug treatment.



ST. ANN'S CORNER OF HARM REDUCTION

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To learn more visit

www.iduha.org

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Support of the IDUHA citywide survey project provided by



BACKGROUND

The Injection Drug User's Health Alliance (IDUHA) is a coalition of New York City based syringe access programs. In October 2013, IDUHA created a Monitoring & Evaluation (M&E) sub-committee as a direct response to the deficiency in comprehensive healthcare and service utilization data from syringe exchange programs (SEPs) – this gap prevented SEPs from demonstrating the value of their wrap-around harm reduction services. The goal of the M&E Committee was to conduct a city-wide survey of syringe exchange participants in order to gather data on harm reduction service access and utilization, health status, healthcare utilization, drug use, overdose, insurance, and care coordination to demonstrate the impact of harm reduction programs in New York City.

THE STUDY

- Cross-sectional survey of clients of 14 Syringe Exchange Programs in New York City
- Brief self-report survey completed in-person by trained Field Interviewers
- Interviews took place at SEP offices, mobile vans, and street sites.
- Participant eligibility: currently enrolled as participant at a Syringe Exchange Program, at least 18 years of age, and able to complete survey in English or Spanish

Phase 1 – January 2014 (1,050 participants)

The IDUHA M&E Committee completed a pilot “Phase 1” of the study in January 2014. Over two weeks, volunteer Field Interviewers completed the survey with 1,050 participants across all five boroughs of New York City. The success of the pilot established feasibility of the study, and demonstrated the overwhelming interest of the SEPs and their participants in this research. There was extensive community buy-in following this phase of the study, prompting a second round of data collection within six months.

Phase 2–June 2014 (1,340 participants)

The IDUHA M&E Committee prepared for this larger roll-out of the study by heavily revising the survey based on challenges faced in the pilot, extending Field Interviewer training, and integrating unique identifiers in order to match responses in upcoming survey waves to demonstrate program impact. The data collection took place over three weeks in June 2014; Field Interviewers surveyed 1,340 participants. **The results included in the following briefs are derived from the Phase 2 data set.**

FUTURE DIRECTIONS

Phase 3 of the survey will include expanded questions on healthcare access and utilize the unique identifier codes to demonstrate change between survey waves among repeat participants and is planned for June 2015.

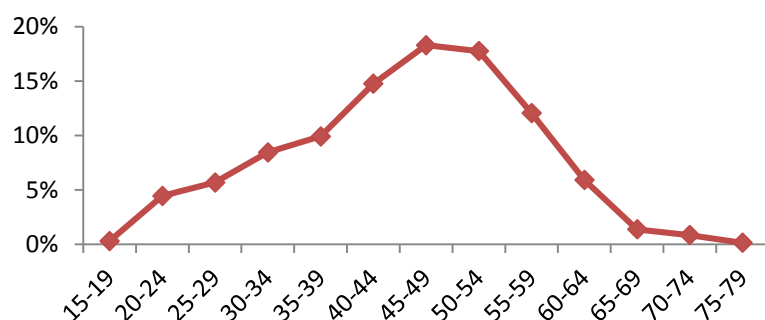
Committee members include Jamie Favaro, LMSW (*IDUHA*), Anne Siegler, DrPH (*NYCDOHMH*), Matt Curtis, MPH (*VOCAL-NY*), Maria Caban, PhD (*BOOM!Health*), Carolina Lopez (*NYHRE*), and Taeko Frost, MPH (*Washington Heights CORNER Project*)

Special thanks to the IDUHA Survey Project Coordinators Jessica MacFarlane, MPH and Heather Zaccaro

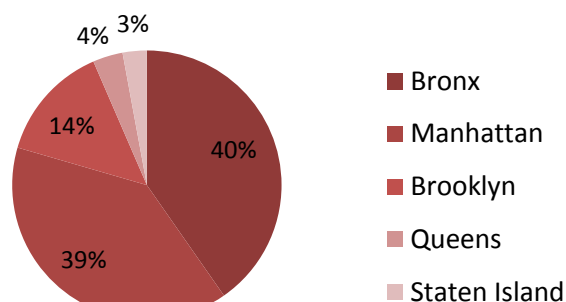
Overview of Harm Reduction Services in New York City

Harm reduction is both a model of service provision and a social justice movement for the empowerment of people who use drugs. It includes a set of “practical strategies and ideas aimed at reducing negative consequences associated with drug use.”¹ Beyond syringe exchange, programs offer services ranging from education and counseling, case management, medical services, overdose prevention and training programs, peer education and development, support groups and access to basic living supplies. In New York City, syringe exchange programs arose primarily in response to the HIV epidemic among people who inject drugs.² These highly successful program models have been adopted nationwide, resulting in an 80% decrease in HIV transmission among people who inject drugs.³ Recently, there have been significant demographic and geographic shifts in injection drug use behaviors: for example, although rates of drug-related overdose are highest in high-poverty neighborhoods of New York City, they are rising most rapidly in the lowest poverty areas of the city.⁴ National trends in recent years also reflect an increase in the proportion of people who inject drugs who are White.⁵ These data reinforce that persons of all ages, races, genders, and income levels are injecting drugs; however, harm reduction programs are especially critical in reaching high-risk, marginalized, and disconnected populations to reduce HIV and hepatitis C transmission, fatal overdose, and other drug-related harms.

Harm Reduction Participant Age Distribution



Survey Participants by Location of Harm Reduction Program



- ✓ **The majority of harm reduction participants were male (69%)** while 30% were female and 1.2% were transgender
- ✓ **Almost half (49%) identify as Hispanic or Latino/a**, while 29% were Black and 16% were White
- ✓ The average age among interviewees was 45, **with a range from 18 to 77 years of age**
- ✓ Approximately one-fifth (21%) of interviewees report that they speak Spanish most often, while **the majority (79%) spoke primarily English**
- ✓ Almost two-thirds (62%) of harm reduction participants report ever injected drugs; **34% report injecting drugs in the past three months**
- ✓ The average age of first injection was 24, but **participants began injecting drugs as early as 9 years old and as late as 58 years old**

¹ Harm Reduction Coalition. (2015). Principles of harm reduction. Retrieved from <http://harmreduction.org/about-us/principles-of-harm-reduction/>

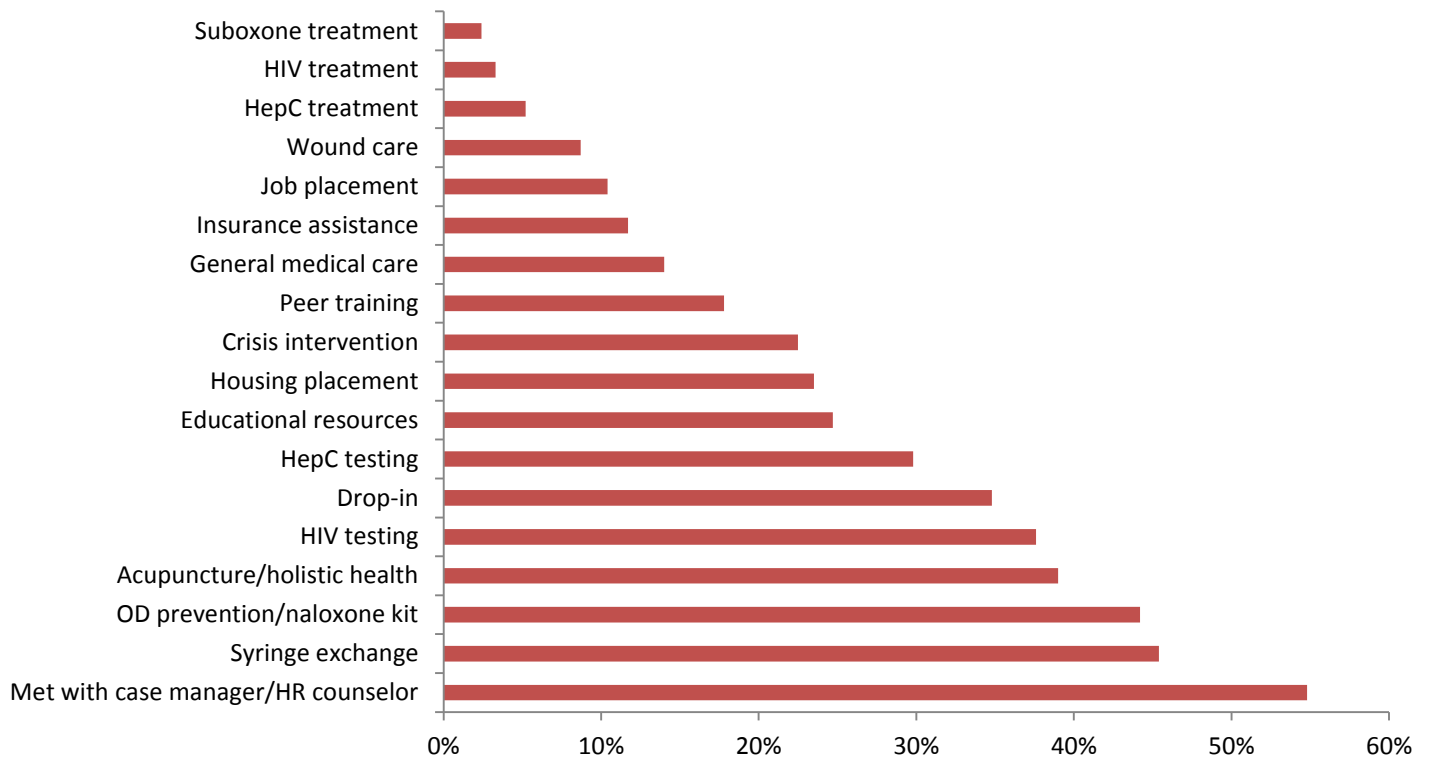
² Heller, D., & Paone, D. (2011). Access to sterile syringes for injecting drug users in New York City: Politics and perception (1984-2010). *Substance Use & Misuse*, 46(2-3), 140-149.

³ Hall, H. I., Song, R., Rhodes, P., Prejean, J., An, Q., Lee, L. M. et al. & HIV Incidence Surveillance Group. (2008). Estimation of HIV Incidence in the United States. *Journal of the American Medical Association*, 300(5), 520-529.

⁴ New York City Department of Health and Mental Hygiene (2015). Epi data brief: Unintentional drug poisoning (overdose) deaths involving opioids in New York City, 2000-2013. Retrieved from <http://www.nyc.gov/html/doh/downloads/pdf/epi/databrief50.pdf>

⁵ Armstrong, G. L. (2007). Injection drug users in the United States, 1972-2002: An aging population. *Archives of Internal Medicine*, 167(2), 166-173.

Use of Harm Reduction Services in the Last Month



Participants who received syringes from a harm reduction program were 40% less likely to share syringes than those who did not; those who received syringes from friends, relatives, shooting galleries, and off the streets were over 3 times more likely to share syringes

- ✓ **More than a quarter (27%) of harm reduction participants have used the same harm reduction agency for 6 or more years;** 42% have frequented their agency for 1-5 years, and 31% have used theirs for less than a year indicating that harm reduction programs are both identifying new people in need and retaining people in care long-term
- ✓ Only about a third (35%) of harm reduction participants are stably housed in their own homes; **39% live in unstable or temporary housing such as shelters, jail and drug treatment programs and 26% are homeless** (ranging from 33% in the Bronx to 9.7% in Brooklyn)
- ✓ The vast majority of harm reduction participants (89%) are enrolled in Medicare/Medicaid; **only 1.8% have private insurance while 9.2% have no health insurance**
- ✓ Harm reduction organizations provide a unique environment for supporting people who use drugs who are often discriminated against in the broader healthcare system; **96% of harm reduction clients reported that they were very or somewhat satisfied with the services received at their harm reduction agency**
- ✓ **Almost all (94%) of participants who report injecting drugs in the past 3 months received syringes from harm reduction programs;** other locations where syringes were obtained include pharmacies (47%), from friends (25%), and from shooting galleries (14%)
- ✓ In the year preceding the survey, more than a third (36%) of harm reduction participants were arrested or incarcerated

Where are harm reduction programs located?



In New York City, there are 14 harm reduction organizations that operate syringe exchange programs (SEPs) which aim to reduce drug-related harm. SEPs provide services in variety of venues, including drop-in centers, mobile-units, and street-based outreach.

SEPs are supported with funds provided by the New York State Department of Health AIDS Institute, the New York City Department of Health & Mental Hygiene, and private sources of funding.

Syringe exchange programs frequently reassess where harm reduction services are most needed and update their hours and locations based on participant needs. For the most up-to-date information on syringe access in New York City, please visit www.iduha.org.

Word Cloud Displaying Additional Services Requested by Harm Reduction Participants



One of the central tenants of harm reduction is to respect the dignity of people who use drugs and provide non-judgmental services to meet their needs.⁶ The needs of people who inject drugs are multifaceted: in addition to their increased risk of blood-borne infectious diseases such as HIV and Hepatitis C, this population is often subject to discrimination in housing and employment and must contend with criminalization of their behavior leading to arrest or incarceration. In fact, arrest rates for drug possession have nearly tripled since the 1980's, and a NYC evaluation found that syringe exchange programs in areas with high arrest rates were significantly less effective at reducing unsafe injection practices such as the sharing of needles.⁷ This highlights the importance of advocating for and understanding the complex needs of harm reduction participants.

Policy & Program Recommendations

- ☑ Harm reduction programs provide a valuable opportunity for expanded services, including but not limited to mental health services, job training, buprenorphine drug treatment, medical services, and therapeutic groups. Existing service providers require more resources in order to continue to maintain and expand services to an already-engaged community of people who use drugs. People who inject drugs continue to report inadequate access to sterile syringes, resulting in the reuse and/or sharing of injection equipment.⁸ New York must expand syringe access to ensure every person who injects drugs has a sterile syringe and equipment for every injection. The dramatic decline in new HIV infections in previous decades in New York City demonstrates the importance of continuing the expansion of syringe access to effectively curb epidemics of blood-borne infections.⁹
- ☑ Harm reduction programs are effective at engaging with people who use drugs, connecting individuals to health and social services, and promoting autonomy to empower individuals to achieve their self-defined wellness goals. Social service and health providers would benefit from integrating a harm reduction approach in working with people who use drugs to engage and retain individuals in life-saving services.
- ☑ People who use drugs report harm reduction services as having a consistently positive impact on many areas of their lives and request additional services. Public and private funders should increase resources to support the additional services that harm reduction participants most frequently requested: housing services, food, medical and mental health services, job placement, and computer access.
- ☑ Despite concerns from critics in the past over the potential to enable or prolong drug use by focusing on reducing harm instead of on abstinence, research reflects strong evidence of long-term cessation of injection drug use through involvement with harm reduction programs. A recent study of people who inject drugs in Vancouver, for example, found that over the period of 1996-2010, injection drug use among participants decreased progressively, consistent with expansion of harm reduction services in the region.^{1,3} The established health, humanitarian, and societal gains of similar harm reduction programs recommends harm reduction as an effective public health policy.¹⁰
- ☑ New York State government should aggressively lobby to end the ban on federal funding for syringe exchange programs in the United States. Support on a federal level would better enable state programs to be proactive in HIV and hepatitis C prevention instead of reactive to emerging epidemics.¹¹

⁶ Harm reduction coalition. (2015). Principles of Harm Reduction. Retrieved from <http://harmreduction.org/about-us/principles-of-harm-reduction/>

⁷ Cooper, H. L. F., Des Jarlais, D. C., Tempalski, B., Bossak, B. H., Ross, Z., & Friedman, S. R. (2012). Drug-related arrest rates and spatial access to syringe exchange programs in New York City health districts: combined effects on the risk of injection-related infections among injectors. *Health Place*, 18(2), 218-228.

⁸ Heller, D. I., Paone, D., Siegler, A., & Karpati, A. (2009). The syringe gap: an assessment of sterile syringe need and acquisition among syringe exchange program participants in New York City. *Harm Reduct J*, 6(1).

⁹ Heller, D., & Paone, D. (2011). Access to sterile syringes for injecting drug users in New York City: politics and perception (1984-2010). *Substance Use & Misuse*, 46(2-3), 140-149.

¹⁰ Werb, D., Kerr, T., Buxton, J., Shoveller, J., Richardson, C., Montaner, J., & Wood, E. (2013). Patterns of injection drug use cessation during an expansion of syringe exchange services in a Canadian setting. *Drug and Alcohol Dependence*, 132(3), 535-540.

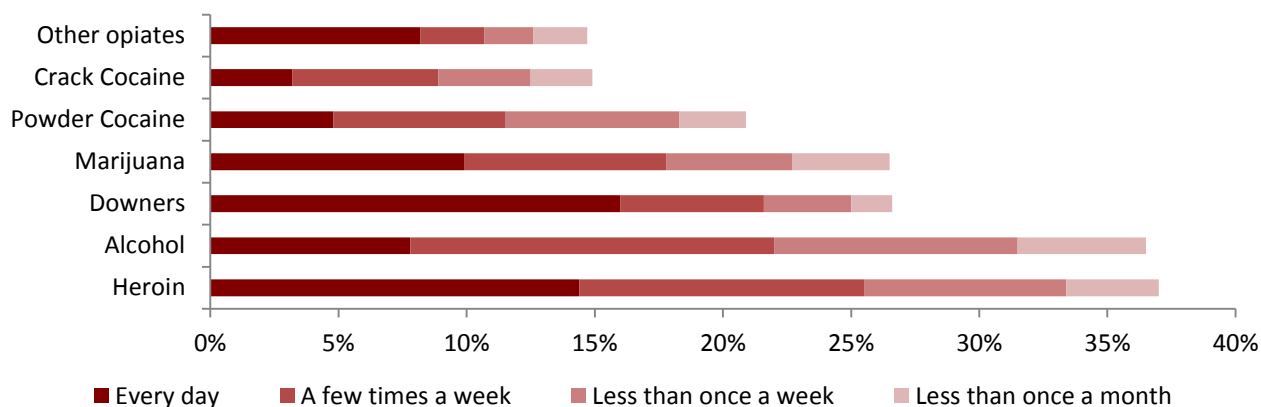
¹¹ Rich, J. D., & Adashi, E. Y. (2015). Ideological Anachronism Involving Needle and Syringe Exchange Programs: Lessons From the Indiana HIV Outbreak. *JAMA*.

Drug Use Overview

New York City has long been an epicenter of injecting and other drug use in the United States. This was perhaps most notable during the early HIV epidemic when more than 50% of people who inject drugs became HIV infected, a crisis that was reversed through the implementation of syringe exchange and other harm reduction services.¹² In recent years, New York has recently experienced part of a national trend in increased heroin use and overdose deaths following restrictions on access to prescription opioid painkillers.¹³ Ultimately, people use drugs for many reasons: pleasure, insight, coping with trauma or mental illness,¹⁴ or out of dependence. For the minority of people who use drugs who experience addiction or other significant problems,¹⁵ harms associated with drug use are profoundly shaped by not only drugs themselves, but by social and public policy factors ranging from stigma and discrimination to policing, poverty, family issues, disparities in access to healthcare, and more.¹⁶⁻¹⁷ IDUHA believes that accepting the reality of drug use in our society, understanding how and why people use drugs, and how social attitudes and public policy affect individual drug use, are crucial to reducing harms associated with drug use. Doing so first of all demands that we listen to people who use drugs.

What drugs are harm reduction participants using and why does it matter?

Recent Drug Use Frequency



- ✓ In the month preceding the survey, 42% of harm reduction participants utilized syringe exchange services at their agency
- ✓ Almost two-thirds (61%) of harm reduction participants report ever injecting drugs; **one third (34%) report injecting drugs in the 3 months preceding the survey**
- ✓ **People who inject drugs were 3.4 times more likely to experience an overdose compared to people who do not inject drugs;** people who inject drugs were also more likely to be white, homeless, and not have health insurance
- ✓ 15% of participants received residential drug treatment in the past year; **almost a quarter (23%) underwent detox within this time period**
- ✓ Among participants who reported mental health problems, 41% used drugs and/or alcohol to cope; **participants who do not have health insurance were 78% more likely to cope with drugs and/or alcohol than those with insurance**

¹² New York State Department of Health AIDS Institute. (2014). Comprehensive Harm Reduction Reverses the Trend in New HIV Infections. New York State Department of Health: Albany, NY.

¹³ Lankenau, S. E., Teti, M., Silva, K., Bloom, J. J., Harocopos, A., & Treese, M. (2012). Initiation into prescription opioid misuse among young injection drug users. *International Journal of Drug Policy*, 23(1), 37-44.

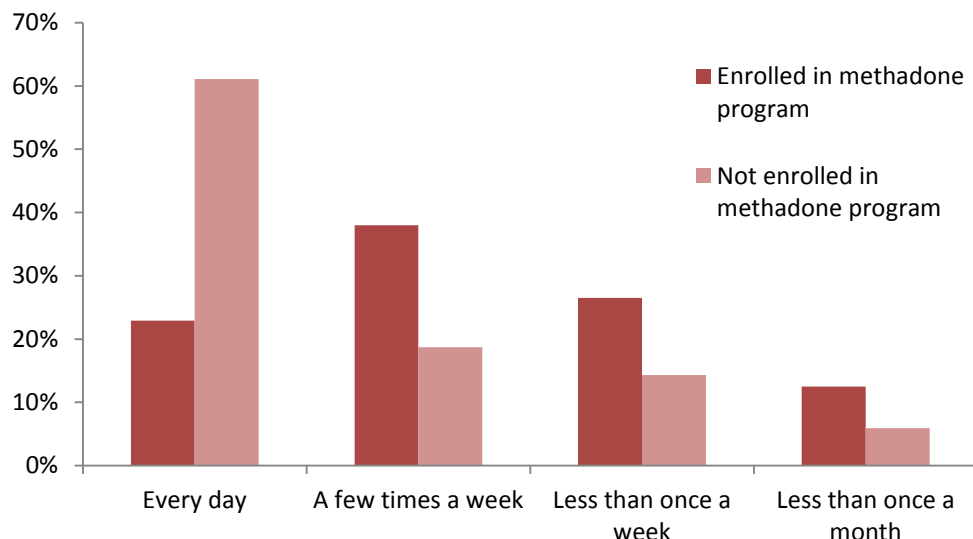
¹⁴ Flórez-Salamanca, L., Secades-Villa, R., Hasin, D. S., Cottler, L., Wang, S., Grant, B. F., & Blanco, C. (2013). Probability and predictors of transition from abuse to dependence on alcohol, cannabis, and cocaine: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *American Journal of Drug and Alcohol Abuse*, 39(3), 168-179.

¹⁵ Degenhardt L, & Hall W. (2012). Extent of illicit drug use and dependence, and their contribution to the global burden of disease. *The Lancet* 379(9810), 55-70.

¹⁶ Brook, J. S., Lee, J. Y., Rubenstone, E., Finch, S. J., Seltzer, N., & Brook, D. W. (2013). Longitudinal determinants of substance use disorder. *Journal of Urban Health*, 90(6), 1130-1150.

¹⁷ Rhodes T. (2009). Risk environments and drug harms: A social science for harm reduction approach. *International Journal of Drug Policy*, 20(3), 193-201.

Methadone Enrollment Reduces Frequency of Heroin Use (n=485)



- ✓ Almost half (49%) of participants reported being enrolled in a methadone program while only 3% reported having a prescription for buprenorphine; **nearly half (44%) of methadone patients also report current heroin use** and 18% used opioid analgesics in the previous month
- ✓ **14% of harm reduction participants reported using prescription drugs that they received from a friend or off the streets;** this includes non-prescribed methadone (6%), buprenorphine/Suboxone (3%), and opioid painkillers such as Percocet, OxyContin, Morphine, or Vicodin (4%)

Policy & Program Recommendations

- ☑ By engaging individuals in low threshold and non-judgmental ways, harm reduction agencies create opportunities to help people reduce risks for disease transmission, overdose, and other negative health and social outcomes. Because of this, public and private funders should increase resources for harm reduction services in order to improve access for those in need.
- ☑ Scientific evidence shows that harm reduction programs both reduce drug use and support cessation of drug use. Studies have found that the prevalence of injection drug use decreases concurrent with expansion of harm reduction services,¹⁸ and that people who engage with harm reduction services are more likely to enroll in detox or drug treatment.¹⁹ Drug treatment and behavioral health providers, health insurance companies, and public funders should recognize that harm reduction is a crucial component of the drug treatment system and seek to integrate such services wherever people who use drugs encounter healthcare.
- ☑ Government agencies, including health and public safety authorities, should promote accurate, nonjudgmental drug education that destigmatizes people who use drugs and promotes safety and access to a full spectrum of assistance, from basic harm reduction to drug treatment.
- ☑ Harm reduction providers, health authorities, and advocates should pursue additional evidence-based interventions including supervised injection facilities and heroin maintenance therapy in order to maximize the positive impact of harm reduction services and reduce infectious disease transmission and overdose.

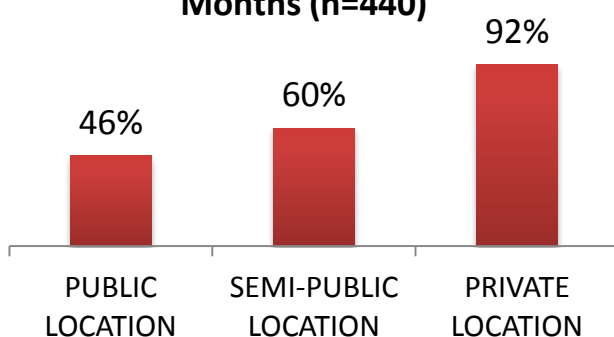
¹⁸ Werb, D., Kerr, T., Buxton, J., Shoveller, J., Richardson, C., Montaner, J., & Wood, E. (2013). Patterns of injection drug use cessation during an expansion of syringe exchange services in a Canadian setting. *Drug and Alcohol Dependence*, 132(3), 535-540.

¹⁹ Tyndall, M.W., Kerr, T., Zhang, R., King, E., Montaner, J. G., & Wood, E. (2006). Attendance, drug use patterns, and referrals made from North America's first supervised injection facility. *Drug and Alcohol Dependence*, 83(3), 193-198.

Public Injection Drug Use

Public injection drug use has individual health, social, and legal implications, as well as consequences for the community as a whole.²⁰⁻²¹ For example, people who inject in public locations (such as parks) or semipublic locations (such as abandoned buildings and restaurant bathrooms) are two to five times more likely than those who inject in private residences to share syringes and other paraphernalia, leading to increased risk of blood-borne diseases such as hepatitis C and HIV.²²

Reported Locations of Injection Drug Use by Type in the Past 3 Months (n=440)



“ As a former nurse and injection drug user, I know public injection is a problem. In my own experience, I've had staph and MRSA infections because I didn't have a safe, clean place to inject. People injecting in public are forced into isolated areas, and when people finally do find a "safe" space everyone goes, shares equipment, it's outside of mainstream society-- a breeding ground for disease, crime, death and rape ... People would use [safer injection facilities] and word would spread quickly. We need them and people who care. ”

-Patty, syringe exchange program participant

Public: street, park, subway/bus/train, stairwell, telephone booth

Semi-Public: abandoned building, public bathroom, shooting gallery, car/other vehicle, SEP bathroom, hospital, methadone clinic, shelter

Private: own home, friend or family's home, hotel room

Who is injecting in public and semi-public locations and why does it matter?

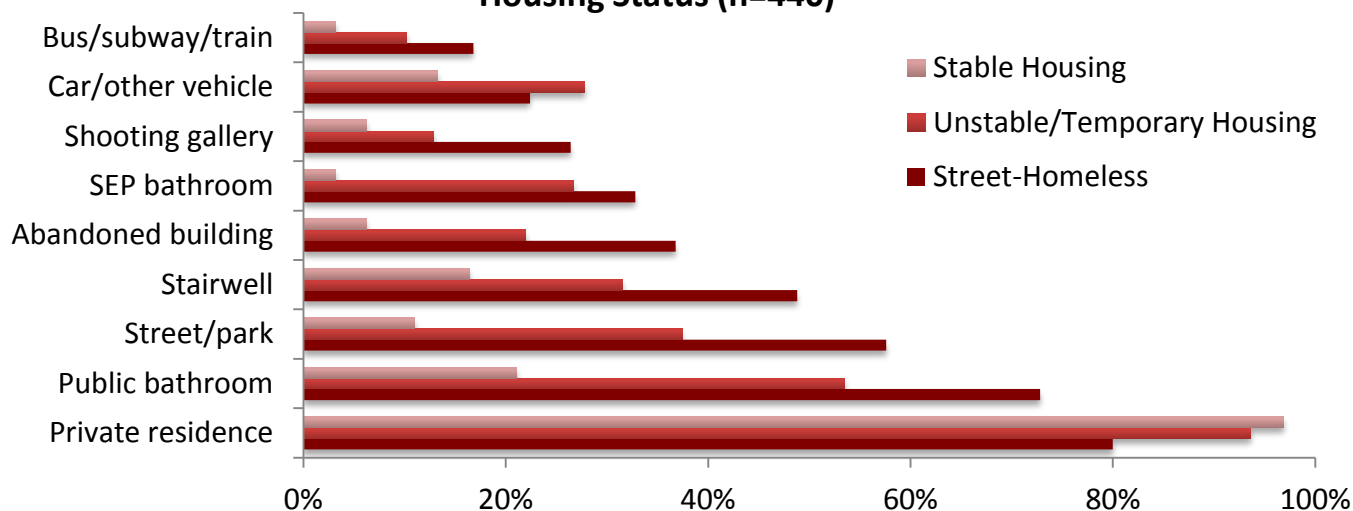
- ✓ **One third of harm reduction program participants reported injecting drugs in the past 3 months;** the majority were male (72%), Latino (54%), and over the age of 40 (64%)
- ✓ **Public injectors were almost twice as likely to have been arrested or incarcerated in the past year compared to people who do not inject drugs in public**
- ✓ **Participants who inject drugs were more likely to report being street-homeless; those who were street-homeless were 9.2 times more likely to report injecting drugs in a street or park and 8.2 times more likely to inject in a public bathroom**
- ✓ **More than a quarter (27%) of people who inject drugs reported reuse of at least one type of drug preparation paraphernalia in the past 3 months (syringes, cookers, cotton); public injectors were 4.1 times more likely to report reuse of drug paraphernalia, which is implicated in hepatitis C and bacterial infections**
- ✓ **Participants who use heroin were 2.5 times more likely to report injecting in a non-residential location compared to other types of drug use**
- ✓ **Public and semipublic injectors are twice as likely to have overdosed in the past year compared to those who inject in only in private residences;** participants who had reported injecting in a public location such as a street, park, bus or subway were 62% more likely to have witnessed an overdose in the past year

²⁰ Beletsky, L., Heller, D., Jenness, S. M., Neaigus, A., Gelpi-Acosta, C., & Hagan, H. (2014). Syringe access, syringe sharing, and police encounters among people who inject drugs in New York City: a community-level perspective. *International Journal of Drug Policy*, 25(1), 105-111.

²¹ Hagan, H., Pouget, E. R., & Des Jarlais, D. C. (2011). A systematic review and meta-analysis of interventions to prevent hepatitis C virus infection in people who inject drugs. *Journal of Infectious Diseases*, 204(1), 74-83.

²² Rhodes, T., Kimber, J., Small, W., Fitzgerald, J., Kerr, T., Hickman, M., & Holloway, G. (2006). Public injecting and the need for 'safer environment interventions' in the reduction of drug-related harm. *Addiction*, 101(10), 1384-1393.

Reported Locations of Injection Drug Use in the Past 3 Months by Housing Status (n=440)



Policy & Program Recommendations

- ☑ Public injection increases the risk of fatal overdose, disease transmission, and compromises public safety through improperly discarded injecting equipment. Measures to prevent injection in locations where people who inject drugs receive services, such as policies for limiting bathroom access at syringe exchange programs, are not effective at reducing drug use²³ and increase risk by inadvertently encouraging drug use in streets and parks where community members could be exposed to discarded syringes.
- ☑ Programs serving people who inject drugs should adopt policies and procedures to reduce health and public order risks related to injection drug use or improperly discarded injection equipment. Steps such as integrating syringe disposal containers, instituting monitoring systems, training staff members to respond to on-site overdose and improperly discarded paraphernalia, and maintaining accessible naloxone onsite are crucial first steps in reducing the consequences associated with public injection.
- ☑ Individual and community-level health risks would be reduced by implementing supervised injection facilities (SIFs) in New York City. SIFs operate in at least 66 cities in ten countries around the world. Numerous scientific studies have demonstrated that they decrease HIV, hepatitis C, and fatal overdose,²⁴ reduce publicly discarded syringes and other public disorder,²⁵ and increase access to drug treatment and other supportive services.²⁶
- ☑ The criminalization of people who use drugs and the housing and homelessness crisis in New York City are root causes of public injection drug use.²⁷⁻²⁸ Access to affordable housing, especially for currently homeless people, and integrated supportive services including mental and behavioral health care, are key components to reducing the prevalence of public injection drug use and its effects.

²³ Crabtree, A., Mercer, G., Horan, R., Grant, S., Tan, T., & Buston, J. A. (2013). A qualitative study of the perceived effects of blue lights in washrooms on people who use injection drugs. *Harm Reduction Journal*, 10, 22.

²⁴ International Drug Policy Consortium. (2012). Drug Consumption Rooms: Evidence and Practice. Retrieved from <http://idpc.net/publications/2012/06/idpc-briefing-paper-drugconsumption-rooms-evidence-and-practice>

²⁵ Dagmar, H., Kerr, T., & Dubois-Arber, F. (2010). Chapter 11: Drug consumption facilities in Europe and beyond. In *Harm reduction: evidence, impacts and challenges* (pp. 305-331). Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

²⁶ Tyndall, M. W., Kerr, T., Zhang, R., King, E., Montaner, J. G., & Wood, E. (2006). Attendance, drug use patterns, and referrals made from North America's first supervised injection facility. *Drug and Alcohol Dependence*, 83(3), 193-198.

²⁷ DeBeck, K., Wood, E., Qi, J., Fu, E., McArthur, D., Montaner, J., & Kerr, T. (2012). Socializing in an open drug scene: The relationship between access to private space and drug-related street disorder. *Drug and Alcohol Dependence*, 120(1), 28-34.

²⁸ Linton, S. L., Celentano, D. D., Kirk, G. D., Mehta, S. H. (2013). The longitudinal association between homelessness, injection drug use, and injection-related risk behavior among persons with a history of injection drug use in Baltimore, MD. *Drug and Alcohol Dependence*, 132(3), 457-465.

Overdose

Unintentional drug poisoning, or overdose, is one of the top three causes of premature death in New York City.²⁹ More than three-quarters of these deaths involve opioids including heroin³⁰ and prescription opioids such as OxyContin, Vicodin, Percocet, morphine,³¹ or methadone.³² The risk of overdose is dramatically heightened when multiple substances, such as opioids and alcohol or benzodiazepines, are used simultaneously.¹⁻³ Recent release from prison and undergoing a period of sobriety or reduced drug use can also increase the risk of fatal overdose by up to 40 times.³³ Fatal overdose can be prevented by administering a life-saving drug called naloxone, also known as Narcan, which is being distributed to the general population as a component of overdose prevention trainings at all syringe exchange programs in New York City.³⁴

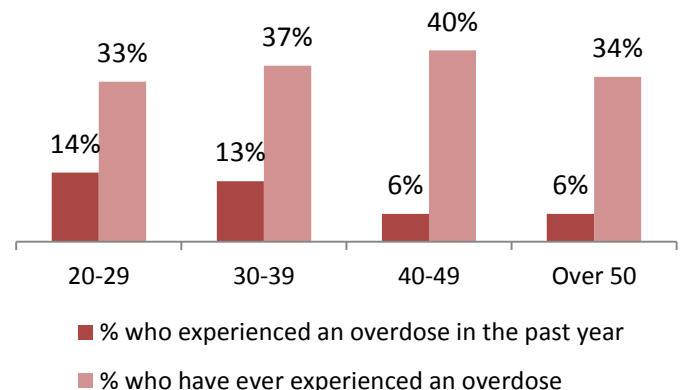
Who is experiencing overdose and why does it matter?

- ✓ Over a third (36%) of harm reduction participants reported ever experiencing an overdose and 8% experienced an overdose within the year preceding the survey
- ✓ Among people who currently inject drugs, **those under age 30 were three times more likely to experience a nonfatal overdose in the past year** compared to people age 30 or older who inject drugs
- ✓ All genders experienced overdose at similar rates. **White participants were 3.3 times more likely as all other groups to have overdosed in the past year**
- ✓ **Those who are unstably housed or homeless were 3.5 times more likely to overdose in the past year**
- ✓ Those who were arrested or incarcerated within the past year were 2.5 times more likely to experience an overdose in this same time period; **those who went through detox in the past year were 4 times more likely to overdose**
- ✓ **Those who report injecting in a street or park were 2.6 times more likely to overdose** than those who inject in other locations

“I’m a peer educator and I teach people about the importance of naloxone, or Narcan, to prevent overdose and save lives. Naloxone is important because of the lifesaving results that come from the use of it when someone is overdosed. My experience using Narcan felt literally like I had a PhD because I was able to bring somebody back from a non-response state, basically dead in my arms, to breathing life again...**and it was like a second chance for them.** I’m a lifesaver and everyone can be a lifesaver if they have Narcan.”

-Jimmy, peer educator

Rate of Nonfatal Overdose Among Harm Reduction Participants by Age



²⁹ Siegler, A., Tuazon, E., O'Brien, D. B., & Paone, D. (2014). Unintentional opioid overdose deaths in New York City, 2005-2010: a place-based approach to reduce risk. *International Journal of Drug Policy*, 25(3), 569-574.

³⁰ DOHMH. (2015). Epi Data Brief: Unintentional Drug Poisoning (Overdose) Deaths Involving Opioids in New York City, 2000-2013. Available from

<http://www.nyc.gov/html/doh/downloads/pdf/epi/databrief50.pdf>

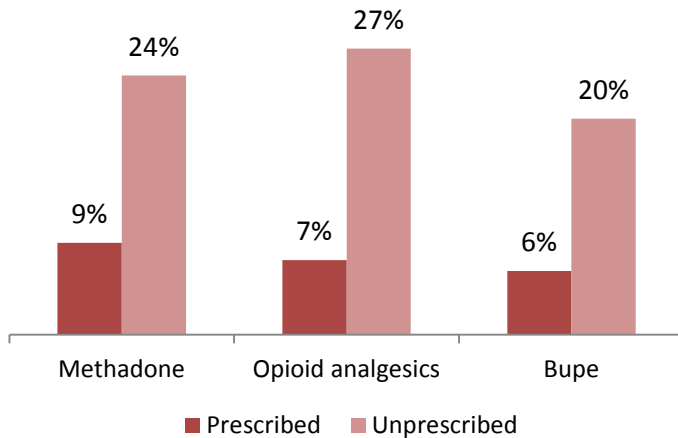
³¹ Frank, D., Mateu-Gelabert, P., Guarino, H., Bennett, A., Wendel, T., Jessell, L., & Teper, A. (2015). High risk and little knowledge: overdose experiences and knowledge among young adult nonmedical prescription opioid users. *International Journal of Drug Policy*, 26(1), 84-91.

³² Hendrikson, H., & Hansen, M. (2014). Methadone and prescription drug overdose. *National Conference of State Legislatures Brief*, 22(45), 1-2.

³³ Leach, D., & Oliver, P. (2011). Drug-related death following release from prison: a brief review of the literature with recommendations for practice. *Current Drug Abuse Reviews*, 4(4), 292-297.

³⁴ Heller, D. I., & Stancliff, S. (2007). Providing naloxone to substance users for secondary administration to reduce overdose mortality in New York City. *Public Health Reports*, 122(3), 393-397.

Protective Effect of Prescribed Opioids on Overdose Rates



- ✓ Among people who use opioid analgesics, people who have a prescription for medical reasons overdose at far lower rates than those who use such drugs non-medically
- ✓ 42% of interviewees reported witnessing an overdose in the previous year
- ✓ More than three-quarters (77%) of participants stated that they knew what naloxone was; **67% knew where to get naloxone, and 62% thought it would be somewhat or very easy to get**
- ✓ 41% of harm reduction participants report undergoing overdose prevention training or receiving a Narcan kit within 30 days of the survey
- ✓ **15% of harm reduction participants reported having used naloxone to reverse an overdose.** Rates of naloxone usage were highest among those interviewed in Manhattan (19%) and lowest in Staten Island (7.7%)

Policy & Program Recommendations

- ✓ Syringe exchange programs continue to be the leading resource for access to naloxone and overdose education. Harm reduction providers engage with people who use drugs to understand the what, when and how of drug use and conduct risk assessments to prevent, identify, and respond to overdose. New York City and State should increase funding for harm reduction services to fill critical gaps in geographic coverage and operating hours.
- ✓ Make high-quality, evidence-based drug treatment available for everyone including expanding access to and support of opioid agonist therapy (buprenorphine or methadone) as part of standard treatment for opioid dependence. Require that drug treatment programs integrate with harm reduction programs.
- ✓ Expand access to naloxone for high-risk populations including those living in or newly released from correctional institutions, detox, and abstinence-based drug treatment facilities.³⁵
- ✓ Make naloxone available through pharmacies, especially for people in areas with limited or no access to harm reduction services and to young people at higher risk of overdose. Furthermore, increasing education on New York's 911 Good Samaritan Law is critical to ensuring individuals call 911 during an overdose.³⁶
- ✓ New York should establish supervised injection facility (SIFs) as part of the spectrum of routine substance use services. Since the opening of the first and only SIF in North America, InSite (Vancouver, Canada) has significantly reduced opioid overdose mortality.³⁷ In Europe and Australia, similar research has found that overdose deaths decrease when SIFs are available.³⁸

³⁵ Binswanger, I. A., Blatchford, P. J., Mueller, S. R., & Stern, M. F. (2013). Mortality after prison release: opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009. *Annals of internal medicine*, 159(9), 592-600.

³⁶ Davis, C., & Chang, S. (2013). Legal interventions to reduce overdose mortality: Naloxone access and overdose good Samaritan laws. *The Network for Public Health Law*

³⁷ Milloy, M.J., et al., *Non-fatal overdose among a cohort of active injection drug users recruited from a supervised injection facility*. *Am J Drug Alcohol Abuse*, 2008. 34(4): p. 499-509.

³⁸ Dolan, J.K., Craig Fry, David McDonald, John Fitzgerald, Franz Trautmann, Kate, *Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia*. *Drug and alcohol review*, 2000. 19(3): p. 337-346.

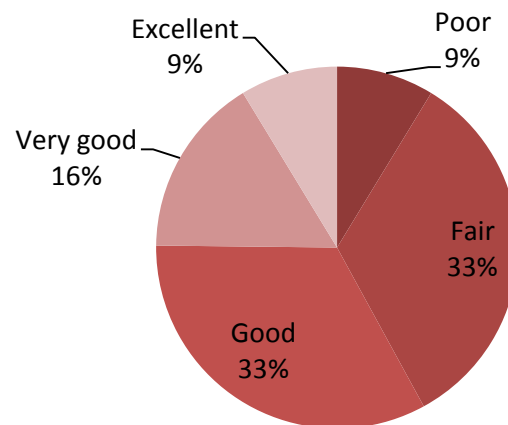
Physical & Mental Health

People who use drugs are at high risk for infectious and chronic diseases as well as mental health conditions. Blood-borne infectious diseases, such as Hepatitis C and HIV, can be transmitted between people who use drugs through shared syringes, cottons, and cookers. While syringe exchange programs have been associated with a significant reduction in the sharing of syringes, the sharing of other injection equipment remains too common.³⁹⁻⁴⁰ Factors associated with drug use, such as incarceration and socioeconomic status have been found to increase risk of certain chronic conditions such as asthma⁴¹ and kidney disease.⁴² Mental health disorders have also been associated with the use of illicit drugs and non-medical use of prescription drugs.⁴³ The health needs of this stigmatized population are extensive and complex, and addressing them effectively and comprehensively is critical to improving community health, reducing racial and economic health disparities, and reducing healthcare system costs.

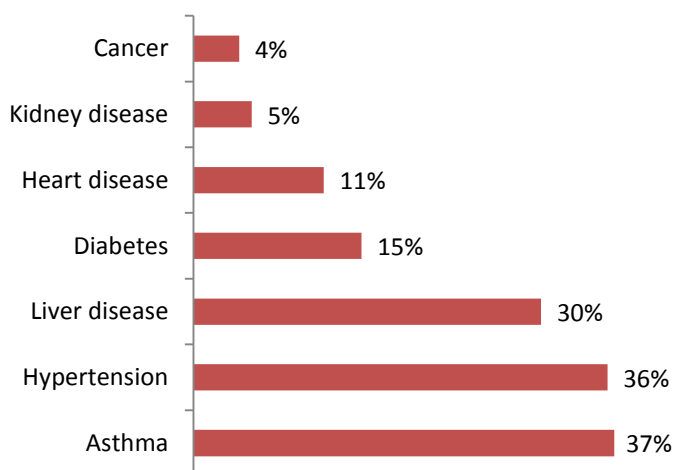
Who is experiencing infectious, chronic, and mental disorders and why does it matter?

- ✓ 12% of harm reduction participants interviewed reported being HIV+; **compared to all other groups, Black harm reduction participants were 2.5 times more likely to be HIV+**
- ✓ **Only 13% of interviewees living with HIV were diagnosed within the past 5 years**, while 86% were diagnosed more than 5 years ago
- ✓ Almost 90% of HIV+ harm reduction participants received benefits from the HIV/AIDS Services Administration (HASA); **over three-fourths of HASA-enrolled harm reduction participants received rental assistance**

Harm Reduction Participants' Self-Reported Overall Health Rating



Lifetime Prevalence of Chronic Diseases among Harm Reduction Participants



- ✓ Almost three-fourths (73%) of harm reduction participants reported being diagnosed with at least one chronic disease; **39% of participants reported comorbidity of two or more chronic conditions**
- ✓ Uninsured participants were 60% less likely to report having multiple chronic conditions, which could reflect a **lack of access to diagnostic services**
- ✓ Compared to other racial and ethnic groups, **White participants were 40% less likely to be diagnosed with multiple chronic conditions and 30% less likely to be diagnosed with asthma**

³⁹ Hagan, H., & Thiede, H. (2000). Changes in injection risk behavior associated with participation in the Seattle needle-exchange program. *Journal of Urban Health*, 77(3), 369-382.

⁴⁰ Koester, S., Glanz, J., & Barón, A. (2005). Drug sharing among heroin networks: implications for HIV and hepatitis B and C prevention. *AIDS and Behavior*, 9(1), 27-39.

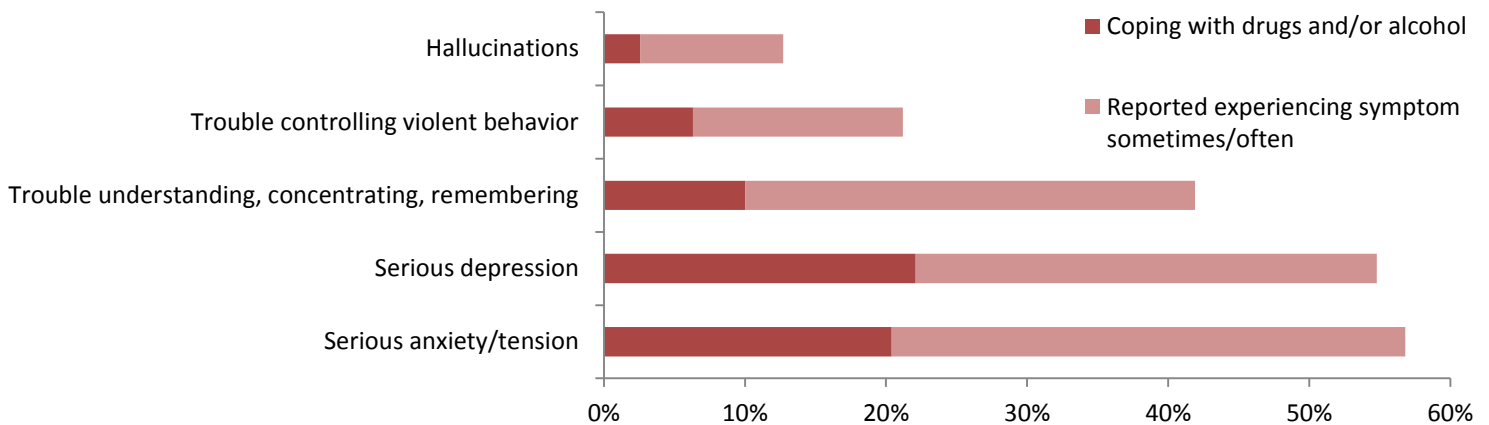
⁴¹ Wang, E. A., & Green, J. (2010). Incarceration as a key variable in racial disparities of asthma prevalence. *BMC Public Health*, 10, 290.

⁴² Crews, D. C., Pfaff, T., & Powe, N. R. (2013). Socioeconomic factors and racial disparities in kidney disease outcomes. *Seminars in Nephrology*, 33(5), 468-475.

⁴³ Baggio, S., Studer, J., Mohler-Kuo, M., Daeppen, J. B., & Gmel, G. (2014). Non-medical prescription drug and illicit street drug use among young Swiss men and associated mental health issues. *International Journal of Adolescent Mental Health*, 26(4), 525-530.

IDUHA Injection Drug Users Health Alliance

Mental and Behavioral Health Experience in the Past 3 Months



- ✓ Almost three-fourths (74%) of harm reduction participants reported sometimes or often experiencing one or more mental or behavioral health issues; **women and those who are homeless or unstably housed were 50% more likely to experience mental or behavioral health issues compared to men and the stably housed, and White participants were 89% more likely than other racial/ethnic groups to report experiencing these issues**
- ✓ 12% of harm reduction participants reported psychiatric hospitalization in the past year; **almost half (48%) reported being prescribed medications for psychological or emotional problems in the past 3 months**
- ✓ 18% of participants who experienced mental or behavioral health issues reported receiving prescription medications from friends or off the street; **34% of those who were receiving prescription medications from a doctor also used alcohol and/or drugs to cope**
- ✓ Black participants were 75% more likely than other racial/ethnic groups to use alcohol to cope with mental and behavioral health issues; **white participants were more than twice as likely as other groups to use drugs for this purpose**

Policy & Program Recommendations

- ☑ Differences in approach between the harm reduction and medical models contribute to challenges in connecting and retaining people who use drugs in healthcare.⁴⁴ Harm reduction programs should identify medical providers who are willing to work with patients who use drugs in a respectful, patient-centered manner. In turn, medical providers should partner with harm reduction organizations to organize training on harm reduction-based approaches to care for medical professionals who serve this population.
- ☑ To develop effective treatment plans, medical providers must not only establish treatment plans centered on drug use but also consider each individual's social context, such as housing status, criminal justice involvement, and access to support systems.
- ☑ The vast majority of NYC harm reduction participants are Medicaid enrollees. Healthcare networks should prioritize integrating harm reduction providers into DSRIP networks and other healthcare coordination systems, such as Health Homes and Health and Recovery Plans, in order to most effectively reach people who use drugs and fulfill NYS Medicaid Redesign goals.

⁴⁴ Heller, D., McCoy, K., & Cunningham, C. (2004). An invisible barrier to integrating HIV primary care with harm reduction services: philosophical clashes between the harm reduction and medical models. *Public Health Reports*, 119(1), 32.

Emergency and Hospital Service Utilization

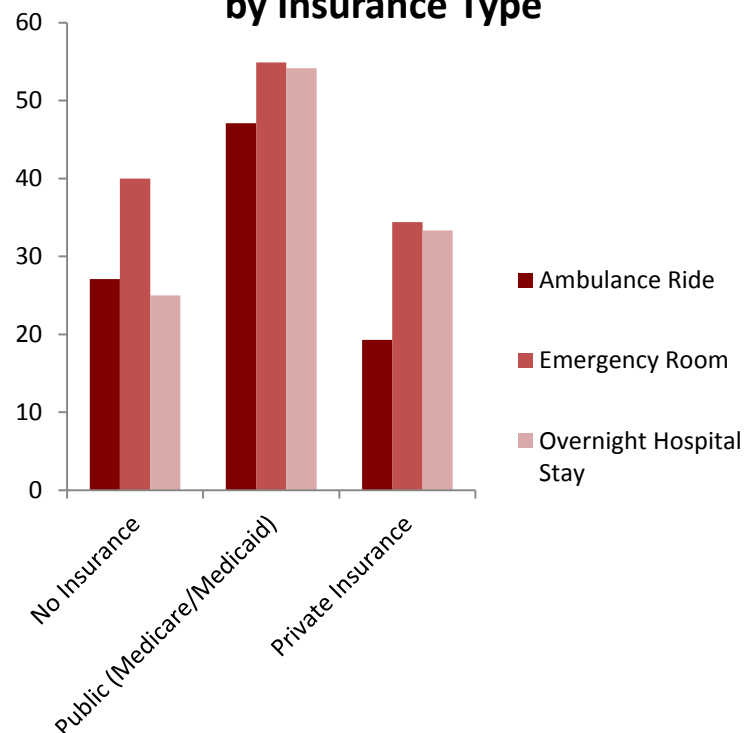
Access to primary healthcare services is limited among many people who use drugs and results in use of avoidable and costly emergency services.⁴⁵ People who use drugs access emergency department services more frequently compared to people who do not use drugs.⁴⁶ The majority of participants of harm reduction programs report having health insurance, yet they often utilize expensive emergency and hospital services as a primary means of accessing healthcare. One study found that syringe exchange programs can potentially reduce annual expenses associated with injection drug use-related infections by up to \$11.4 million.⁴⁷ Injection drug use compounded with unstable housing increases the likelihood of utilizing emergency services for preventable or unnecessary reasons, at great cost to the health system.

Who is accessing emergency services and why does it matter?

“ I used to go to the emergency room for everything before there was a clinic at this syringe exchange program. Having a doctor here [at the syringe exchange program] is more convenient and I’m much more open with her than at the ER – you’re in and out there and don’t really get to figure out what’s going on... My doctor here gives me time and I see her every month or so instead of waiting for my asthma to get so bad that I can’t breathe... I wait for hours at the ER and sometimes I don’t even get the inhaler I need... ” -Rob, syringe exchange program participant

- ✓ Nearly 60% of participants reported using at least one emergency service (Emergency Room Admission, Ambulance Ride, and/or Overnight Hospital Admission); **23% reported utilizing all three services in the past 3 months**
- ✓ **More than a quarter (26%) of participants reported going to their harm reduction agency instead of the emergency room for medical care**
- ✓ Participants of all ages and race/ethnic backgrounds accessed emergency services; **white participants were 79% more likely to be admitted to the emergency room (ER) than all other racial/ethnic groups**
- ✓ 65% of participants reported being unstably housed and were **44% more likely to report going to the emergency room in the past year compared to those who are stably housed**
- ✓ 39% of participants report having 2 or more chronic conditions and were **80% more likely to utilize emergency services compared to those with one or fewer chronic conditions**
- ✓ People who report using opioid painkillers not prescribed to them were almost twice as likely to ride in an ambulance or stay overnight in the hospital

Emergency and Hospital Service Utilization in the Past 3 Months by Insurance Type



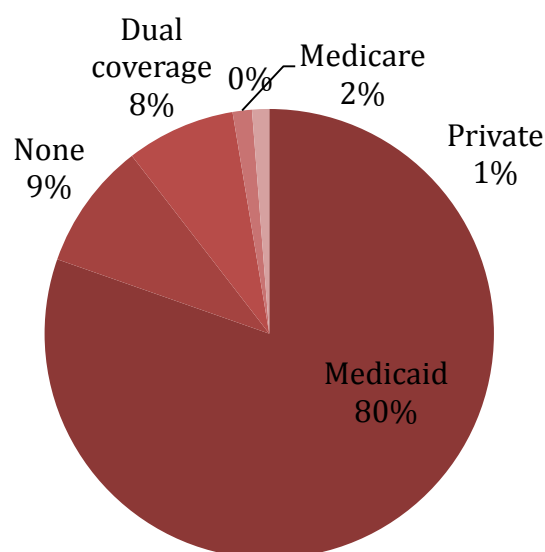
⁴⁵ Islam, M. M., Topp, L., Day, C. A., Dawson, A., & Conigrave, K. M. (2012). The accessibility, acceptability, health impact and cost implications of primary healthcare outlets that target injecting drug users: A narrative synthesis of literature. *International Journal of Drug Policy*, 23(2), 94-102.

⁴⁶ D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., ... & Fiellin, D. A. (2015). Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial. *Journal of the American Medical Association*, 313(16), 1636-1644.

⁴⁷ Tookes, H., Diaz, C., Li, H., Khalid, R., & Doblecki-Lewis, S. (2015). A cost analysis of hospitalizations for infections related to injection drug use at a county safety-net hospital in Miami, Florida. *PLoS ONE*, 10(6), e0129360.

- ✓ White participants were more likely to have private insurance; **participants who were unstably housed were 62% more likely to be uninsured compared to those who are stably housed**
- ✓ Over 80% of Medicaid recipients who have an assigned health home have received services or met with their care coordinator; however, **only 7% of Medicaid recipients reported having an assigned health home**
- ✓ **11% of Medicaid recipients report that their coverage is not active**; this includes 5% with restricted coverage, 4% with coverage pending, and 1% undergoing recertification

Health Insurance Type



Medicaid type

	n	%
MetroPlus	280	26%
Straight Medicaid	226	21%
HealthFirst	176	16%
Fidelis Care	93	9%
HealthPlus	74	7%
Affinity	54	5%
Health Insurance Plan of Greater New York (EmblemHealth)	39	4%
Amida	35	3%
UnitedHealthcare	31	3%
AMERIGROUP	28	3%
Other	43	5%
Total	1079	100%

Policy & Program Recommendations

- ✓ By providing case management⁴⁸ referrals to care, peer navigation, and onsite medical services⁴⁹ harm reduction programs can reduce emergency department costs by increasing the utilization of clinics as alternative sources of primary care.
- ✓ In the absence of co-located services within harm reduction programs (which are optimal), emergency department-based interventions for people who inject drugs and expanded resources for primary care services in harm reduction programs are critical to improving access to preventive care.^{2,4-5}
- ✓ New York City and State and healthcare providers should investigate opportunities to finance and establish co-located healthcare and harm reduction services and/or strengthened referral networks between harm reduction programs and clinical care in order to increase primary and preventive healthcare for this population and reduce emergency department and hospital utilization.
- ✓ People who are homeless or unstably housed disproportionately use emergency rooms. New York City and State should urgently prioritize permanent housing for the homeless, including supportive housing for those with disabilities or mental health or substance use issues, through a new NY/NY IV program, truly accessible affordable housing initiatives, increasing NYCHA access for the homeless, and other means.
- ✓ Providers and health departments should identify individuals without insurance or with inactive Medicaid and support insurance enrollment with the goal of 100% coverage.

⁴⁸ Wilkinson, J. D., Zhao, W., Arnsten, J. H., Knowlton, A. R., Mizuno, Y., Shade, S. B., ... & INSPIRE Study Team. (2007). Longitudinal correlates of health care-seeking behaviors among HIV-seropositive injection drug users: how can we intervene to improve health care utilization? *Journal of Acquired Immune Deficiency Syndromes*, 46(S2), S120-126.

⁴⁹ Laine, C., Lin, Y. T., Hauck, W. W., & Turner, B. J. (2005). Availability of medical care services in drug treatment clinics associated with lower repeated emergency department use. *Medical Care*, 43(10), 985-995.

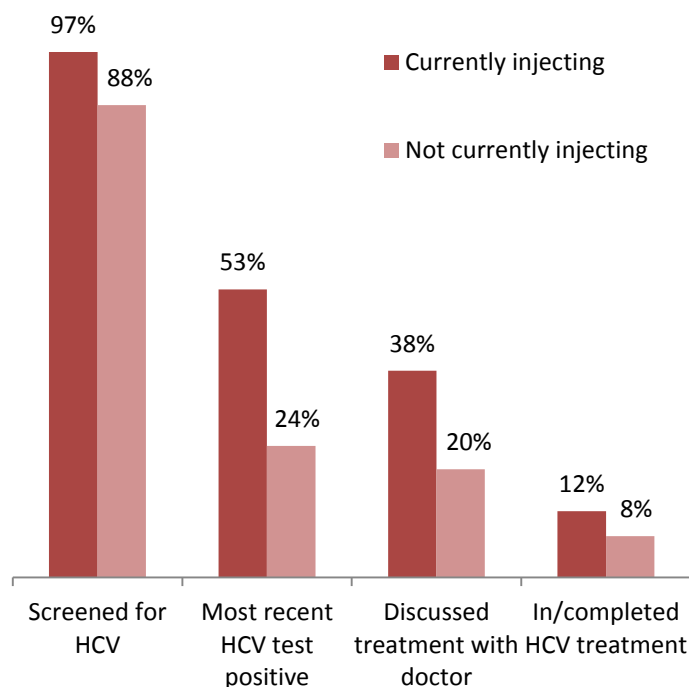
Hepatitis C

At least 215,000 New Yorkers have chronic hepatitis C (HCV) infection, with half unaware of their status.⁵⁰ Injection drug use is the leading risk factor for HCV infection, and new local outbreaks among young people have been identified alongside an increase in heroin use in New York⁵¹ and nationally.⁵² Transmission among young injectors is a particular concern, with studies showing 10-35% of new injectors are infected each year.⁵³ HCV is the leading cause of serious liver disease, which may lead to disability or death related to fibrosis, cirrhosis, liver cancer, and the need for transplantation. As many as 30% of people living with HIV (PLWH) in New York are HCV co-infected,⁵⁴ and HCV is a leading cause of death among PLWH.⁵⁵ Nationally, an estimated 3.2 million Americans are living with chronic HCV, and the disease kills more Americans each year than AIDS.⁵⁶ Both in New York and the rest of the country, HCV-related mortality has risen steadily during the past decade.⁵⁷ Harm reduction programs should ensure that their participants, particularly those that inject drugs, are screened for HCV and connected promptly to treatment.

Who is infected with hepatitis C and why does it matter?

- ✓ **91% of all harm reduction participants have been tested for HCV;** almost two-thirds (62%) were screened within the past 6 months including 28% who were tested within the past month at their harm reduction program
- ✓ Over a third (38%) of harm reduction participants who have been tested for HCV had a positive test result on their most recent test; **women were 30% less likely than men to test positive for HCV and risk of HCV infection increased with age**
- ✓ Hepatitis C status varied significantly by race and ethnicity: **Black participants were 60% less likely than other groups to have screened positive for HCV**
- ✓ **Those who have ever injected drugs were 8.8 times more likely to test positive for HCV;** those who injected in the past 3 months were 40% more likely than past injectors to be HCV positive
- ✓ Other risk factors for HCV infection include unstable housing (1.3 times greater risk), current cocaine or heroin use (1.9 times greater risk), and **reusing injection paraphernalia, especially cottons and cookers (3.5 times greater risk)**

Hepatitis C Screening and Treatment by Current Injection Drug Use Status



⁵⁰ Hart-Malloy, R., Carrascal, A., DiRienzo, A. G., Flanagan C., McClamroch, K., & Smith, L. (2013). Estimating HCV prevalence at the state level: a call to increase and strengthen current surveillance systems. *American Journal of Public Health, 103*(8), 1402-1405.

⁵¹ Zibbell, J. E., Hart-Malloy, R., Barry, J., Fan, L., & Flanagan, C. (2014). Risk factors for HCV infection among young adults in rural New York who inject prescription opioid analgesics. *American Journal of Public Health, 104*(11), 2226-2232.

⁵² Page, K., Hahn, J. A., Evans, J., Shiboski, S., Lum, P., Delwart, E., ... & Busch, M. P. (2009). Acute hepatitis C virus infection in young adult injection drug users: a prospective study of incident infection, resolution, and reinfection. *Journal of Infectious Diseases, 200*(8), 1216-1226.

⁵³ Hahn, J. A., Page-Shafer, K., Lum, P. J., Bourgois, P., Stein, E., Evans, J. L., ... & Moss, A. R. (2002). Hepatitis C virus seroconversion among young injection drug users: relationships and risks. *Journal of Infectious Diseases, 186*(11), 1558-1564.

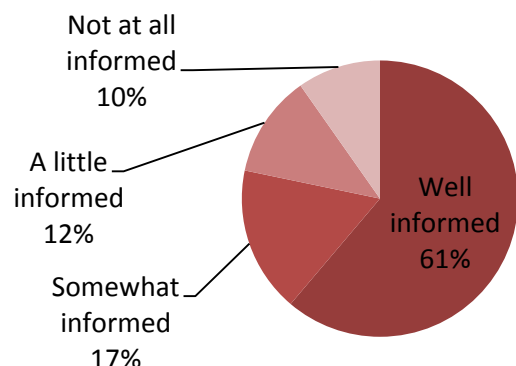
⁵⁴ Taylor, L. E., Swan, T., & Mayer, K. H. (2012). HIV coinfection with hepatitis C virus: evolving epidemiology and treatment paradigms. *Clinical Infectious Diseases, 55*(S1), S33-42.

⁵⁵ Pinchoff, J., Drobnik, A., Bornschlegel, K., Braunstein, S., Chan, C., Varma, J. K., & Fuld, J. (2014). Deaths among people with hepatitis C in New York City, 2000-2011. *Clinical Infectious Diseases, 58*(8), 1047-1054.

⁵⁶ Ly, K. N., Jian, X., Kleven, R. M., Jiles, R. B., Ward, J. W., & Holmberg, S. D. (2012). The increasing burden of mortality from viral hepatitis in the United States between 1999 and 2007. *Annals of Internal Medicine, 156*(4), 271-278.

⁵⁷ NYC Department of Health & Mental Hygiene. (2013). Hepatitis C in New York City: state of the epidemic and action plan. New York, NY.

How Informed Hepatitis C Patients Feel About Treatment Options (n=437)



“ I’m proud to say I’m Hep C free today and I’m spreading the news so my community isn’t scared to get treatment. They can’t give up hope and they don’t need to. ”

-Ellery Perdomo, HCV Peer Navigator

- ✓ **Of those who have tested positive for HCV, only 27% reported receiving treatment;** the most commonly reported barriers to treatment include low viral load, fear of the treatment’s adverse side-effects, and lack of insurance coverage for treatment
- ✓ **Current injectors who tested positive for HCV were 32% less likely to discuss treatment options with their doctors compared to non-injectors;** there was no significant difference in access to treatment by gender, race, or ethnicity
- ✓ **HIV positive participants were 80% more likely to be HCV positive compared to HIV negative participants**

Policy & Program Recommendations

- ☑ Currently the state budget provides only \$1.17 million annually for viral hepatitis programs. New York City and State governments should significantly increase HCV funding to support expanded prevention, testing, surveillance, and the development of care and treatment infrastructure.
- ☑ HCV prevention demands universal access to harm reduction services. Increased public funding should prioritize closing geographic gaps in coverage for sterile injection equipment and education on HCV (including the potential for transmission through non-syringe injection equipment),⁵⁸ and particularly for new injectors and those who may be using drugs with peers who have hepatitis C.⁵⁹
- ☑ State and city governments should aggressively promote HCV testing and linkage to care, including by promoting the 2014 ‘baby boomer’ state HCV testing law and targeting testing through programs serving people with a history of injection drug use.
- ☑ Highly effective and safe curative treatment for hepatitis C is available, but major barriers to patient access exist due to high drug prices adopted by pharmaceutical manufacturers and consequent treatment rationing by insurance providers, including NYS Medicaid. Drug manufacturers should immediately reduce prices. In turn, public and private health insurance providers should remove treatment restrictions, including those based on liver disease severity and alcohol and drug use.
- ☑ New York should develop a plan to eliminate HCV in parallel to the recently adopted Plan to End AIDS by 2020⁶⁰

⁵⁸ Hagan, H., Thede, H., Weiss, N. S., Hopkins, S. G., Duchin, J. S., & Alexander, E. R. (2001). Sharing of drug preparation equipment as a risk factor for hepatitis C. *American Journal of Public Health*, 91(1), 42-46.

⁵⁹ Mateu-Gelabert, P., Gwadz, M. V., Guarino, H., Sandoval, M., Cleland, C. M., Jordan, A., ... & Friedman, S. R. (2014). The staying safe intervention: training people who inject drugs in strategies to avoid injection-related HCV and HIV infection. *AIDS education and prevention: official publication of the International Society for AIDS Education*, 26(2), 144.

⁶⁰ Edlin, B. R., & Winkelstein, E. R. (2014). Can hepatitis C be eradicated in the United States?. *Antiviral research*, 110, 79-93.

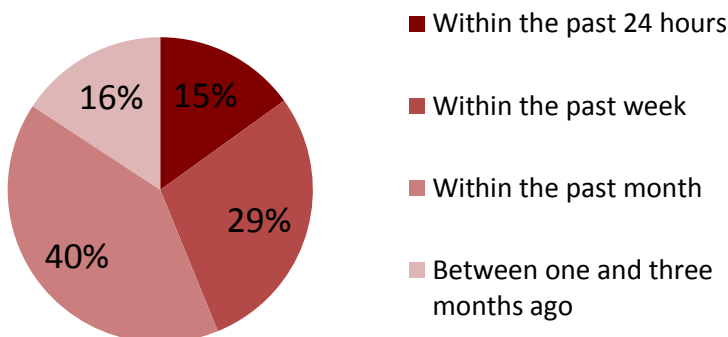
Syringe Access in New York City

Access to sterile syringes remains inadequate for many New Yorkers who inject drugs. Geographic proximity to syringe exchange programs (SEPs) plays a large role in determining access to sterile syringes: 81% of people who inject drugs in New York who live within a 10 minute walk of an SEP use their services compared to only 59% of those who live farther away.⁶¹ In some cases, pharmacies that participate in the Expanded Syringe Access Program (ESAP) can compensate for this spatial gap in SEP access; however, Black and Hispanic people who use drugs tend to use ESAP less than White people who use drugs due to differences in ESAP knowledge and experiences of discrimination.⁶² Even regular SEP participants experience syringe gaps: 54% of SEP participants report injecting more times per month than the number of syringes they received, and young, homeless, or public injectors are most at risk of having insufficient syringes.⁶³ One important limitation to syringe access is law enforcement: studies have found that syringe distribution decreased by 26% following increased police presence⁶⁴ and New Yorkers who have been stopped by the police were significantly less likely to attend SEPs regularly and more likely to report sharing syringes.⁶⁵ Adequate access to sterile syringes from syringe exchange programs and pharmacies is essential to reduce the reuse and sharing of syringes and halt the spread of HIV and Hepatitis C.

Who has access to syringes and why does it matter?

- ✓ In the past 3 months, a **third (33%)** of participants who inject drugs report at least one occasion where they didn't have a sterile syringe when they needed one
- ✓ Those who report gaps in syringe access had a **8.9 times increased risk of reusing a syringe that someone else already used** compared to those who did not experience a syringe gap
- ✓ Some groups were more likely than others to report not having sterile syringes when they needed them including **Latinos (60% more likely) and participants under age 40 (40% more likely)**
- ✓ Our study found gaps in syringe access near the locations of syringe exchange programs, which likely reflects where current harm reduction participants live rather than the actual distribution of poor syringe access among all people who inject drugs in NYC. The number of syringe gap reports was highest in the South Bronx, reflecting a concentration of study respondents, and potentially other factors such as higher rates of police encounters.

Time of Most Recent Syringe Gap Experience



⁶¹ Rockwell, R., Des Jarlais, D. C., Friedman, S. R., Perlis, T. E., & Paone, D. (1999). Geographic proximity, policy and utilization of syringe exchange programmes. *AIDS Care*, 11(4), 437-442.

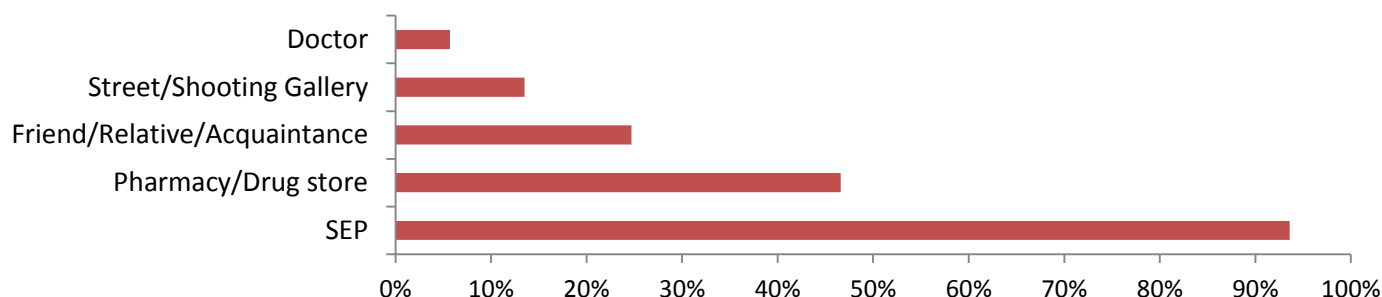
⁶² Fuller, C. M., Galea, S., Blaney, S., Ompad, D. C., Deren, S., Des Jarlais, D., & Vlahov, D. (2004). Explaining the relationship between race/ethnicity and pharmacy purchased syringes among injection drug users in New York City. *Ethnicity & Disease*, 14(4), 589-596.

⁶³ Heller, D. I., Paone, D., Siegler, A., & Karpati, A. (2009). The syringe gap: an assessment of sterile syringe need and acquisition among syringe exchange program participants in New York City. *Harm Reduction Journal*, 6, 1.

⁶⁴ Wood, E., Kerr, T., Small, W., Jones, J., Schnechter, M. T., & Tyndall, M. W. (2003). The impact of a police presence on access to needle exchange programs. *Journal of Acquired Immune Deficiency Syndrome*, 34(1), 116-118.

⁶⁵ Beletsky, L., Heller, D., Jenness, S. M., Neaigus, A., Gelpi-Acosta, C., & Hagan, H. (2014). Syringe access, syringe sharing, and police encounters among people who inject drugs in New York City: a community-level perspective. *International Journal of Drug Policy*, 25(1), 105-111.

Sources of New Syringes among Harm Reduction Participants who Injected Drugs in the Past 3 Months (n=440)



- ✓ **Harm reduction participants who reported daily heroin use or an unstable housing situation were twice as likely to experience a syringe gap;** participants who injected in public or semipublic locations (including parks, abandoned buildings, and shooting galleries) were almost 3 times as likely to experience a syringe gap compared to participants who only injected in residences
- ✓ **Harm reduction participants who received syringes primarily from pharmacies were 1.6 times more likely to experience a syringe gap compared to those who receive syringes primarily from syringe exchange programs; receiving syringes from friends or acquaintances, off the street, or from a shooting gallery increased the risk of experiencing a syringe gap by almost 3 times**

Policy & Program Recommendations

- ☑ Large parts of New York City have no syringe exchange services. New York City and State should increase funding for syringe access programs in such a way that prioritizes closing geographic and time-of-day coverage gaps.
- ☑ Syringe exchange providers should consider surveying participants about solutions to gaps in syringe access and adjust program operating hours or other factors when possible.
- ☑ New York State should (a) repeal article 220.45 of the Penal Law, which criminalizes possession of syringes, (b) amend section 850 of the General Business Law to explicitly state that syringes are not considered drug paraphernalia for purposes of the law, and (c) amend section 3381 of the Public Health Law to allow ESAP programs to advertise and furnish an unlimited number of syringes.
- ☑ The New York State Department of Health should consider loosening syringe exchange waiver rules and other regulations that impede syringe exchange programs' ability to respond to needs in particular geographic areas.
- ☑ The State and/or City departments of health should undertake a review of ESAP providers to ensure that registered pharmacies and other locations are actually providing syringes and doing so in ways that meet the needs of people who inject drugs.

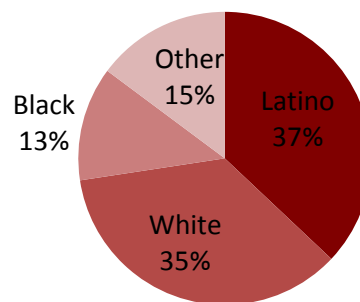
Trends among Harm Reduction Participants under Age 30

Although injection drug use at all ages carries with it increased risk of health complications and stigmatization, there are distinct trends among young harm reduction participants that merit examination. Studies have found that early initiators into injection drug use were significantly more likely to be arrested or incarcerated, engage in sex work, or experience HIV infection.⁶⁶ The rate of hepatitis C infection has also increased among young people who inject drugs.⁶⁷ Young people who inject drugs have distinctive patterns of drug use, including transitioning from using prescription opioids into heroin use.⁶⁸ Young people who use prescription opioids in New York City were found to be at especially high risk of overdose and to be less knowledgeable about overdose prevention including naloxone use.⁶⁹ They were also more likely to report risky behaviors such as sharing drug paraphernalia and engaging in unprotected sex.⁷⁰ The specific needs and vulnerabilities of young people who inject drugs should be taken into special consideration when designing harm reduction services.

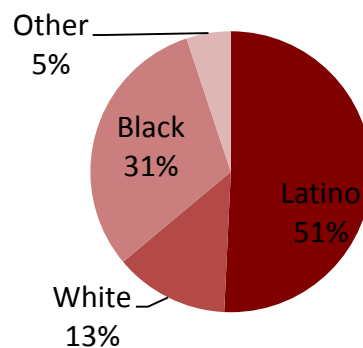
How does drug use differ among harm reduction participants under age 30 compared to older participants and why does it matter?

- ✓ Harm reduction participants under age 30 were 2.8 times more likely to have injected drugs in the past 3 months; **they were also almost twice as likely to have been arrested or incarcerated in the past year**
- ✓ **In the past year, young people who inject drugs were 3.4 times more likely to have experienced a nonfatal overdose than older people who inject drugs; they were also 40% less likely to know what naloxone is or where to get it**
- ✓ Young harm reduction participants were 60% more likely to be street homeless and **2.5 times more likely to be uninsured**
- ✓ **Young people who inject drugs were almost twice as likely to report not having sterile syringes when they needed them compared to older people who inject drugs; they were also 60% less likely to have been tested for hepatitis C**

Race/Ethnicity: Younger than 30 (n=136)



Race/Ethnicity: 30 and Older (n=1165)



⁶⁶ Miller, C. L., Strathdee, S. A., Kerr, T., Li, K., & Wood, E. (2006). Factors associated with early adolescent initiation into injection drug use: implications for intervention programs. *Journal of Adolescent Health*, 38(4), 462-464.

⁶⁷ Valdiserri, R., Khalsa, J., Dan, C., Holmberg, S., Zibbell, J., Holtzman, D., ... & Compton, W. (2014). Confronting the emerging epidemic of HCV infection among young injection drug users. *American journal of public health*, 104(5), 816-821.

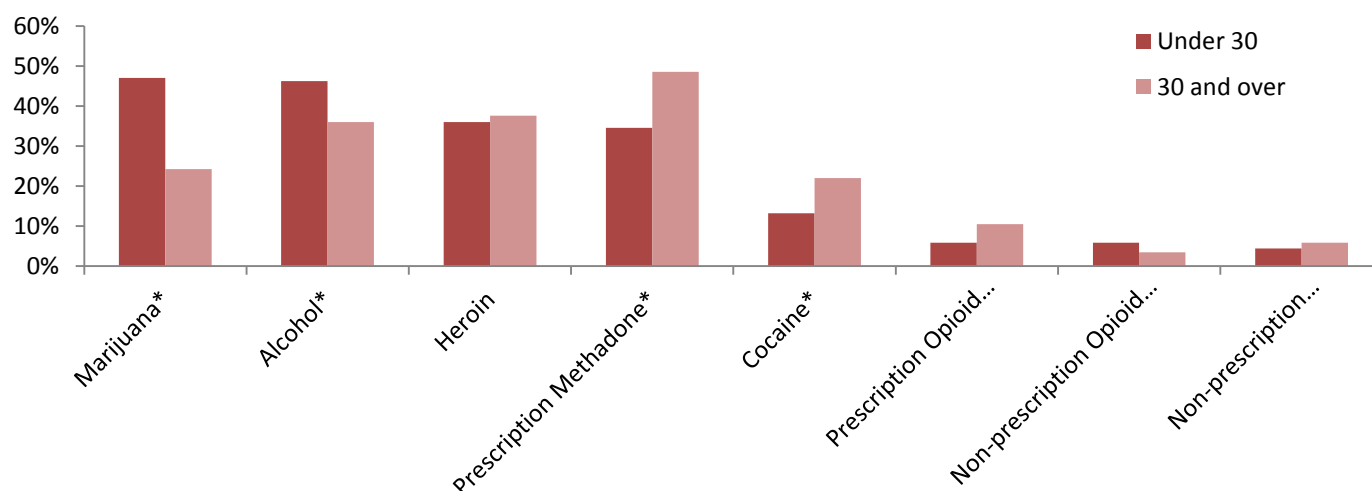
⁶⁸ Lankenau, S. E., Teti, M., Silva, K., Bloom, J. J., Harocopos, A., & Treese, M. (2012). Initiation into prescription opioid misuse amongst young injection drug users. *International Journal of Drug Policy*, 23(1), 37-44.

⁶⁹ Frank, D., Mateu-Gelabert, P., Guarino, H., Bennett, A., Wendel, T., Jessell, L., & Teper, A. (2015). High risk and little knowledge: overdose experiences and knowledge among young adult nonmedical prescription opioid users. *International Journal of Drug Policy*, 26(1), 84-91.

⁷⁰ Mateu-Gelabert, P., Guarino, H., Jessell, L., & Teper, A. Injection and sexual HIV/HCV risk behaviors associated with nonmedical use of prescription opioids among young adults in New York City. *Journal of Substance Abuse Treatment*, 48(1), 13-20.

- ✓ Among harm reduction participants who experience mental or behavioral health problems, **younger participants were 57% more likely to cope with drugs and/or alcohol**
- ✓ Young harm reduction participants with mental or behavioral health problems were **72% more likely to report receiving prescription medications from friends or off the street**

Rate of Drug Use by Age Group



* rate of use differs significantly at $p < 0.05$

Policy & Program Recommendations

- ✓ Syringe exchange programs should consider alternative strategies for engaging young people who inject drugs. Such interventions should be guided by existing participants of syringe exchange programs under age 30 and should incorporate social media or online outreach and peer-to-peer models.
- ✓ Despite significant experience with overdose, young non-medical prescription opioid users have limited knowledge of what naloxone is and where to obtain it.⁷¹ Harm reduction and other health agencies should prioritize efforts to expand access to naloxone and overdose prevention and response training to this population, as well as to increase access through pharmacies and other means for young people who use opioids who may not be connected to harm reduction programs.
- ✓ New York City and State should increase funding for youth harm reduction services. Currently only one dedicated youth program exists in the entire state.
- ✓ New York City and State should initiate and expand criminal justice diversion programs for young people (and others) who use drugs, such as the Law Enforcement Assisted Diversion (LEAD) program originally founded in Seattle.

⁷¹ Frank, D., Mateu-Gelabert, P., Guarino, H., Bennett, A., Wendel, T., Jessell, L., & Teper, A. (2015). High risk and little knowledge: Overdose experiences and knowledge among young adult nonmedical prescription opioid users. *International Journal of Drug Policy*, 26(1), 84-91.

To learn more about harm reduction and resources to improve the health and quality of life of people who use drugs, please visit
www.IDUHA.org

