Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016

Introduction

The purpose of this document is to provide implementation guidance for programs directly funded by the Department of Health and Human Services (HHS) interested in implementing or expanding syringe services programs (SSPs) for persons who inject drugs (PWID). As described in summary guidance from the Centers for Disease Control and Prevention (CDC) and HHS[1], the term SSPs includes provision of sterile needles, syringes and other drug preparation equipment and disposal services, as well as some or all of the following services: comprehensive sexual and injection risk reduction counselling; HIV, viral hepatitis, other sexually transmitted diseases (STDs) and tuberculosis (TB) screening; provision of naloxone to reverse opioid overdoses; referral and linkage to HIV, viral hepatitis, other STDs and TB prevention care and treatment services, referral and linkage to hepatitis A virus (HAV) and hepatitis B virus (HBV) vaccination, as well as referral to integrated and coordinated f substance use disorder, mental health services, physical health care, social services, and recovery support services.

On December 18, 2015, President Barack Obama signed the Consolidated Appropriations Act, 2016 (Pub. L. 114-113),[2] which modifies the restriction on use of federal funds for programs distributing sterile needles or syringes (referred to as SSPs, or as syringe exchange programs) for HHS programs. The Consolidated Appropriations Act, 2016, Division H states:

> SEC. 520. Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: *Provided,* That such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.

While the provision still prohibits the use of federal funds to purchase sterile needles or syringes for the purposes of hypodermic injection of any illegal drug, it allows for federal funds to be used for other aspects of SSPs based on evidence of a demonstrated need (i.e., experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use) by the state or local health department and in consultation with the CDC. This guidance details what can be supported with federal funds and what criteria will be used to determine demonstrated need.

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[1] CDC. (2012) Integrated Prevention Services for HIV Infection, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis for Persons Who Use Drugs Illicitly: Summary Guidance from CDC and the U.S. Department of Health and Human Services. MMWR;61(RR05):1-40.

[2] https://www.congress.gov/114/bills/hr2029/BILLS-114hr2029enr.pdf. Accessed on December 22, 2015.

Principles guiding the use of HHS funding for SSPs

- Programs that use federal funding for SSPs must adhere to federal, state and local laws, regulations, and other requirements related to such programs or services. State and local laws may vary and will impact the ability of federally funded recipients to implement these programs.
- Recipients should coordinate with and work toward obtaining cooperation from local law enforcement officials when implementing SSPs.
- SSPs, as they are implemented, should be a part of a comprehensive service program[3] that includes, as appropriate:
    - Provision of sterile needles, syringes and other drug preparation equipment (purchased with non-federal funds) and disposal services;
    - Education and counseling to reduce sexual, injection and overdose risks;
    - Provision of condoms to reduce risk of sexual transmission of viral hepatitis, HIV or other STDs;
    - HIV, viral hepatitis, STD and TB screening;
    - Provision of naloxone to reverse opioid overdoses;
    - Referral and linkage to HIV, viral hepatitis, STD and TB prevention, treatment and care services, including antiretroviral therapy for hepatitis C virus (HCV)and HIV, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), prevention of mother-to-child transmission and partner services;
    - Referral and linkage to hepatitis A virus (HAV) and hepatitis B virus (HBV) vaccination;
    - Referral and linkage to and provision of substance use disorder treatment (including medication-assisted treatment for opioid use disorder which combines drug therapy (e.g., methadone, buprenorphine, or naltrexone) with counseling and behavioral therapy);
    - Referral to medical care, mental health services, and other support services.
- Recipients should ensure that SSPs supported with federal funds provide referral and linkage to HIV, viral hepatitis, and substance use disorder prevention, care and treatment services, as appropriate.
- HHS recipients should coordinate and collaborate with other local agencies, organizations, and providers involved in comprehensive prevention programs for PWID to minimize duplication of effort.
- SSPs are subject to the terms and conditions incorporated or referenced in the recipient's federal funding.
- Federal funds can only be used to establish a new SSP or expand an existing SSP with prior approval from the respective federal agency.

[3] CDC. (2012) Integrated Prevention Services for HIV Infection, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis for Persons Who Use Drugs Illicitly: Summary Guidance from CDC and the U.S. Department of Health and Human Services. MMWR; 61(RR05):1-40.

Use of Federal Funds

Funds may be used to support various components of SSPs[4] including, but not necessarily limited to, the following:

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of biohazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, PrEP, PEP, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;
- Provision of naloxone to reverse opioid overdoses;
- Educational materials, including information about safer injection practices, overdose prevention and reversing a opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and evaluation activities.

Note: Not all of the components listed above will be supported by all HHS agencies; use of funding will depend on each HHS agency's authorities, policies and procedures as well as state and local laws and regulations. Approval to use federal funds to support SSPs will be contingent on <u>first</u> demonstrating need, in consultation with CDC.

Process for demonstrating need in consultation with CDC

State, local, territorial, and tribal health departments should consult with CDC by providing evidence that their jurisdiction is (1) experiencing or, (2) at risk for a significant increase in viral hepatitis infections or an HIV outbreak due to injection drug use.[5] The scope of the presented evidence should address the geographic area that will be served by the SSPs and include county, city and state level data, as appropriate.

[4] CDC. (2012) Integrated Prevention Services for HIV Infection, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis for Persons Who Use Drugs Illicitly: Summary Guidance from CDC and the U.S. Department of Health and Human Services. MMWR;61(RR05):1-40.of the

[5] The state executive branch agency responsible for the administration of discretionary and/or formula grant funds authorized by Title V, Part B, Subpart 1 of the Public Health Service (PHS) Act and Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-21) awarded by Substance Abuse and Mental Health Services Administration, as applicable, must contact the state health department, if the agency believes a determination is warranted.

First, jurisdictions should assess if they are *experiencing* significant increases in viral hepatitis or HIV infections. For jurisdictions *experiencing* significant increases in viral hepatitis or HIV infections, state or local health departments may use multi-year data from surveillance systems to demonstrate an increase in acute hepatitis C virus [HCV], acute hepatitis B virus [HBV], or HIV infections (Table 1a). Health departments must also provide evidence that the significant increase in infections resulted from injection drug use. Such evidence may include transmission category (i.e., risk factor most likely to have been responsible for transmission of HIV infection, HCV or HBV) collected as part of routine case reporting, epidemiologic surveys, scientific data, or social or ethnographic community data. Health departments should assess any significant increases within the context of local surveillance practices, disease patterns and long-term trends.

Second, for jurisdictions *at risk for* – but not yet experiencing – significant increases in viral hepatitis or HIV infections due to injection drug use, data should come from multiple sources that when triangulated (combined) provide compelling evidence that there is likely an increase in injection drug use in the jurisdiction. Multiple data sources are recommended because a single data source may be insufficient. For example, increases in arrests for syringe and drug possession may be due to increased enforcement by the police force, or additional human resources for drug enforcement units. Similarly, increases in emergency department visits for drug-related overdoses may be due to new hospital initiatives to improve reporting or greater awareness of the condition among staff responsible for reporting. Evidence from multiple data sources, that when considered together, indicate likely increases in injection drug use provides reassurance that the problem assessment is accurate.

CDC recently conducted analyses to identify a set of outcomes associated with acute HCV infection, a proxy for unsafe injection drug use. Tables 1b illustrates some of these outcomes and data sources that may be useful as evidence. In addition, health departments may use local data sources not listed in these tables and that provide valuable insights unavailable from national or state sources. Examples of data triangulation are available in the National Institute on Drug Abuse Community Epidemiology Work Group reports (see http://www.drugabuse.gov/about-nida/organization/workgroups-interest-groups-consortia/community-epidemiology-work-group-cewg/meeting-reports/area-reports-june-2014). Health departments are encouraged to conduct similar analyses to provide evidence of increases in injection drug use in their jurisdictions.

Table 1a. Requested outcomes for jurisdictions *experiencing* significant increases in viral hepatitis or HIV infections*

Outcomes	Example Data Sources
Acute HCV or HBV attributed to injection drug use	• National Notifiable Disease Surveillance System (NNDSS) • State or local surveillance systems • Multi-year cohort studies of persons who inject drugs (PWID)
HIV infections attributed to injection drug use	• National HIV Surveillance System (NHSS) • State or local surveillance systems • Multi-year cohort studies of PWID

* Must provide evidence that increases resulted from injection drug use; such evidence may include transmission category from case reporting, existing published data and reports, surveys, or social or ethnographic community data.

Table 1b. Examples of outcomes for jurisdictions *at risk for* significant increases in viral hepatitis or HIV infections

Example Outcomes	Example Data Sources	Brief Rationale
Drug use, injection drug use and uptake of SSP services	• Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health (NSDUH) • Scientific surveys, syringe services program data, or social or ethnographic community data • Community poison control data • CDC, Youth Risk Behavior Surveillance System (YRBSS)	Provides evidence of injection drug use
Substance use disorder treatment admissions related to injection drug use	• SAMHSA, Treatment Episode Data Set (TEDS) • State treatment admissions data • Health care Cost and Utilization Project (HCUP)-State Inpatient Databases (SID) • State hospital discharge files	Substance use disorder treatment such as medication-assisted treatment for opioid use disorder can provide evidence of injection drug use
Drug-related crime	• State or county arrest records • Federal Bureau of Investigations (FBI), Uniform Crime Reports • Uniform Crime Reports via Inter-university Consortium for Political and Social Research (ICPRS) • National Forensic Laboratory Information System (NFLIS)	Arrests for possession of drug injection paraphernalia, possession or trafficking of heroin and other drug-related arrests provide evidence of local injection drug use
Drug-related overdose mortality	• CDC, National Center for Health Statistics (NCHS)/National Vital Statistics System (accessible through Wide-ranging Online Data for Epidemiologic Research [WONDER]) • CDC, Web-based Injury Statistics Query and Reporting System (WISQARS™) • State Vital Statistics System • State or county Medical Examiner/Coroner files	Provides evidence of ongoing substance use disorder that may be related to higher or more frequent doses or injection drug use
Emergency department or other medical care related to substance use	• Healthcare Cost and Utilization Project (HCUP): State Inpatient Databases (SID) • HCUP- State Emergency Department Databases (SEDD) • State emergency department surveillance systems and EMS systems	Measures overdoses and other medical conditions or treatments related to drug use such as diagnoses of substance

	• State hospital discharge data	use disorder, dependence, and endocarditis or administration of naloxone

As part of the consultation with CDC, state, local, territorial, and tribal health departments should submit to CDC a request for determination of need that indicates whether the jurisdiction is (1) experiencing or (2) at risk of, but not yet experiencing significant increases in viral hepatitis or HIV infections due to injection drug use. The request should specify: outcomes analyzed, data sources, geographic area covered, assessment period (beginning year/date to end year/date), type of measure (e.g., number, rate), and relative percent increase during the assessment period. For jurisdictions at risk for increases, the request should also include a brief summary of how the data when taken together (i.e., "triangulated") support this determination. An example of how the outcomes may be presented and summarized is provided in Appendix 2. Determination of need requests are strengthened by 1) the use of real-time data sources and 2) evidence of collaborative data sharing among relevant stakeholders within the jurisdiction.

State, local, territorial, and tribal health departments should submit the request for need determination to SSPCOORDINATOR@CDC.GOV. Within 30 days after receipt, CDC will notify the requestor whether the evidence is sufficient to demonstrate need for SSPs. If the evidence is sufficient, the state, local, territorial, or tribal health department will receive notice of approval regarding determination of need for the jurisdiction. This notice may be used by the state, local, territorial, or tribal health department or other eligible HHS recipients as identified by each federal agency to apply to the respective federal agency for redirection of funds. If the evidence is insufficient, no programmatic or budgetary changes will be authorized. However, jurisdictions may choose to revise and resubmit their request with additional evidence based on feedback from CDC.

APPENDIX 1

Implementation Guidance to Support Certain Components of Syringe Services Programs
TOOLS AND RESOURCES

The purpose of this document is to provide tools and resources for planning, designing and implementing effective syringe services programs (SSPs) as part of a comprehensive HIV and viral hepatitis prevention approach for persons who inject drugs (PWID), and for monitoring and evaluating SSP progress and outcomes. This document is divided into sections based on the stage of program development and activity, and each section includes a summary of key principles and a list of resources and tools.

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

Section I. Assessing Local Injection Drug Use

Effective programs are based on an understanding of the extent of injection drug use in the community, who is injecting drugs, which drugs are being used, and the key risk behaviors among PWID related to transmission of HIV, viral hepatitis, and other blood-borne infections (e.g., type of injection equipment shared). Information is also needed on potential barriers and motivators to engaging PWID in SSPs. Because non-medical injection drug use is illegal, and PWID are a highly stigmatized and marginalized population, local data on injection drug use is often limited. However, triangulating data from multiple data sources may be useful in providing a more complete picture of injection drug use in a community that may not be possible to obtain with a single data source. Data may come from national and local surveillance systems, health and prevention service providers, law enforcement, published research findings and local reports, surveys, or social or ethnographic community data.

Below are examples of national and local data sources, publications and other resources that may be used in assessing local injection drug use and in demonstrating that a jurisdiction is experiencing or at risk for a significant increase in viral hepatitis or HIV infections due to injection drug use (see also Tables 1A and 1B of the main Implementation Guidance document). Resources are organized into four tables: (1) Examples of National and Local Data Sources; (2) Examples of National and Local Data Sources Available Locally; (3) Example Surveillance Reports and Publications; and (4) Guides, Reports, Surveys, or Social or Ethnographic Community Data. The types of data and resources used in assessing local injection drug use may differ by availability, quality and relevance of the data in the local setting. In most circumstances, data available locally (see second table in Section I, Examples of National and Local Data Sources Available Locally at Request) will be most relevant and timely. For example, characteristics of admissions for substance use disorder treatment are available at the national and state levels through public access on the Substance Abuse and Mental Health Services Administration (SAMHSA) web site; however, program managers, in either a state health department or other singular agency for substance abuse within a state, who report these data to SAMHSA will likely be able to provide data for more recent time periods, smaller geographic areas, and that may include additional variables not required for SAMHSA reporting. Furthermore, in assessing local injection drug use, indicators that are more directly associated with drug injection (e.g., treatment admissions, arrests for drug injection paraphernalia, syringe services programs, overdose deaths) should be prioritized and indicators of more upstream events potentially leading to drug injection (e.g., prescribing and dispensing practices of controlled prescription drugs) may be examined as additional supporting evidence.

Examples of National, State and Local Data Sources	*Description*	*Web Link*
Substance Abuse and Mental Health Services Administration (SAMHSA), Treatment Episode Data Set (TEDS)	Information collected by States from local alcohol and substance use disorder treatment facilities and reported to SAMHSA to characterize admissions to alcohol and drug treatment. Data include demographic and drug history information about individuals admitted to treatment. State level estimates are available through the online "Quick Statistic Tables" page on the SAMHSA.gov web link; estimates at lower geographic units can be obtained through the "Online Analysis & Public Use Files/SAMHDA" page.	http://www.samhsa.gov/data/client-level-data-teds
SAMHSA, National Survey on Drug Use and Health (NSDUH)	Annual survey of prevalence, patterns, and consequences of drug and alcohol use and abuse in the general U.S. civilian non-institutionalized population age 12 and over. Available data include demographic and drug use characteristics among participants. National and state level estimates are available.	http://www.samhsa.gov/data/population-data-nsduh
CDC, Youth Risk Behavior Surveillance System (YRBSS)	National school-based survey conducted by CDC and state, territorial, and tribal governments, and local education and health agencies. Monitors health-risk behaviors and includes a question on ever injected any illegal drug (used a needle to inject any illegal drug into their body one or more times during their life). National, and select state, district, territorial, and tribal government results are available.	http://www.cdc.gov/healthyyouth/data/yrbs/
CDC, National Center for Health Statistics (NCHS)/National Vital Statistics System (accessible through Wide-ranging Online Data for Epidemiologic Research [WONDER])	Provides data on vital events (births, deaths, marriages, divorces, and fetal deaths). For help abstracting drug overdose (poisoning) data from CDC WONDER's Multiple Cause of Death file, two guidance documents found on CDC's website can be consulted: 1) Guide to CDC WONDER multiple cause of death query system (http://www.cdc.gov/drugoverdose/pdf/pdo_wonder_guide_mcod_dataset-a.pdf), and 2) Guide to ICD9-CM and ICD10 Codes Related to Poisonings and Pain, version 1.3 (http://www.cdc.gov/drugoverdose/pdf/pdo_guide_to_icd-9-cm_and_icd-10_codes-a.pdf). See Table 3 for Underlying Cause Codes and Multiple Cause Codes (T-codes) for specific drugs and/or drug categories. For drug overdose deaths, all intents, you will use Underlying Cause Codes X40-44, X60-64, X85, and Y10-Y14. You may also optionally include T-codes for specific drugs, e.g., T40.1 for heroin. National, state, and county data are available subject to suppression rules. State and county-level drug-specific overdose death rates should not be compared due to variability in the specificity of drugs implicated in a death across jurisdictions.	http://wonder.cdc.gov/
Healthcare Cost and Utilization Project (HCUP): State Inpatient Databases (SID)	Family of databases developed through a Federal-State-Industry partnership that contain encounter-level, clinical, and nonclinical information, including all-listed diagnoses and procedures, discharge status, patient demographics, and charges for all patients. The SID capture hospital inpatient stays in a given State. A number of States make their SID files available (1990-2013) for	http://www.ahrq.gov/research/data/hcup Some state-level HCUP data are also available through an online query system,

	purchase through the HCUP Central Distributor. If purchasing state-level HCUP data from the HCUP Central Distributor is not an option, a jurisdiction may alternatively contact their respective state agency for hospital discharge data files, which may be more accessible and timely. Examples of variables that may be useful include: CM_DRUG (AHRQ comorbidity measure, drug abuse). Select state-level data are available.	HCUPnet, at http://hcupnet.ahrq.gov/. The user can query specific diagnostic codes, e.g., endocarditis (ICD-9-CM 421.0), to obtain number of discharges for diagnoses associated with injection drug use.
Healthcare Cost and Utilization Project (HCUP), State Emergency Department Databases (SEDD)	Captures emergency visits at hospital-affiliated emergency departments (EDs) that do not result in hospitalization. Information about patients initially seen in the ED and then admitted to the hospital is included in the State Inpatient Databases (SID). The SEDD files include all patients, regardless of payer. States make their SEDD files available (1999-2012) for purchase through the HCUP Central Distributor. If purchasing state-level HCUP data from the HCUP Central Distributor is not an option, a jurisdiction may alternatively contact their respective state agency for emergency department data files, which may be more accessible and timely. Select state-level data are available; thirty-two States currently participate in the SEDD	http://www.ahrq.gov/research/data/hcup Some state-level HCUP data are also available through an online query system, HCUPnet, at http://hcupnet.ahrq.gov/. The user can query specific diagnostic codes, e.g., heroin poisonings (ICD-9-CM 965.01), to obtain number of ED visits for diagnoses associated with injection drug use.
Federal Bureau of Investigation (FBI), Uniform Crime Reports	The Uniform Crime Reporting (UCR) Program has been the starting place for law enforcement executives, students of criminal justice, researchers, members of the media, and the public at large seeking information on crime in the nation. The program was conceived in 1929 by the International Association of Chiefs of Police to meet the need for reliable uniform crime statistics for the nation. In 1930, the FBI was tasked with collecting, publishing, and archiving those statistics. Each year, participating law enforcement agencies contribute reports to the FBI either directly or through their state reporting programs. National and state data are available. Uniform Crime Reports may also be accessed via the Inter-university Consortium for Political and Social Research (ICPRS). The county-level data provide counts of arrests and offenses aggregated to the county level. County populations are also reported.	https://www.fbi.gov/about-us/cjis/ucr/ucr Table 69 presents drug abuse violations by State: https://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2013/crime-in-the-u.s.-2013/tables/table-69/table_69_arrest_by_state_2013.xls http://www.icpsr.umich.edu/icpsrweb/ICPSR/series/57
National Forensic Laboratory Information System (NFLIS)	The Drug Enforcement Agency (DEA) systematically collects results from drug chemistry analyses conducted by state and local forensic laboratories. As a national drug forensic laboratory reporting system, NFLIS provides timely and detailed analytical results of drugs seized by law enforcement. It is a unique source of information for monitoring and understanding drug abuse and trafficking in the United States, including the diversion of legally manufactured drugs into illegal markets. Crime laboratory data can provide information on the proportion of items seized and analyzed that test positive for drugs typically injected, e.g., heroin. National, state, and county data are available and may be requested through the DEA or a participating local forensic laboratory.	http://www.deadiversion.usdoj.gov/nflis/
CDC, Web-based Injury Statistics Query	An interactive, online database that provides fatal and nonfatal injury data,	http://www.cdc.gov/injury/wisqars/

and Reporting System (WISQARS™)	including drug poisonings and adverse drug effects. National and state data are available.	

Examples of National and Local Data Sources Available Locally at Request	***Description***	***Comments***
HIV Surveillance System	Provides HIV and AIDS diagnosis data collected by State health departments. Diagnosis reports include information on mode of transmission, including injection drug use.	For all data sources listed in this table, refer to appropriate state/local program coordinators and/or data managers for information on obtaining data and availability by geographic level. In most circumstances, data available locally will be most relevant to the local settings, may include additional variables not required for reporting at the national level, and may be available for more recent time periods.
National Notifiable Disease Surveillance System (NNDSS)	Provides National Electronic Disease Surveillance System (NEDSS) standards, tools, and resources to support reporting jurisdictions – state, local, territorial, and tribal health departments – to help them implement integrated and interoperable public health surveillance systems. For viral hepatitis, NNDSS has contained case reports for acute hepatitis C virus (HCV) infections on rotating annual cycles since 1994 and for past and present HCV infection since 2003. The amount of demographic and risk behavior collected by NNDSS for acute cases, including injection drug use, varies by state.	
Syringe services programs	Provide program data on the local population of PWID enrolled in SSPs, including their drug injection practices and service needs. Program monitoring data are often collected on ongoing basis, thus may provide information on changes over time in key characteristics of local PWID. SSP data, however, may vary in scope, completeness, and quality across programs.	
State treatment admissions data	Reflects information collected by States from local alcohol and substance use disorder treatment facilities characterizing the admissions to such facilities. Data include demographic and drug history information about individuals admitted to treatment, as well as changes in treatment admissions. Unlike the SAMHSA TEDS database, data may be available for more recent years at the State level.	
State or county arrest records	Provides arrest data for drug and drug paraphernalia possession that may be available from local law enforcement agencies.	
State Vital Statistics System	Provides data collected by jurisdictions on vital events, including death certificate.	
State or county medical examiner/coroner files	Provides data collected by local medical examiner/coroner on drug overdose deaths.	
State emergency department surveillance and EMS systems	Provides data from local emergency systems that may include drug-related health outcomes, including drug overdose.	
State hospital discharge data	Contains hospital discharge data collected by States that may be used to identify drug injection related hospital care, including drug overdose, endocarditis, soft and bone tissue infections.	

Community poison control data	Reflects information on potential poison exposures reported to local poison centers, free, confidential hotlines, including data on prescription drug and heroin overdoses.
Prescription drug monitoring programs (PDMPs)	State-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients. PDMPs are designed to monitor this information for suspected abuse or diversion (i.e., channeling drugs into illegal use). PDMPs are housed in different statewide regulatory, administrative or law enforcement agencies and the housing agency may vary by state. PDMP data are distributed to authorized individuals under state law. There is considerable variability across states in PDMP procedures and practices, including the data PDMPs collect, data quality assurances, analyses and reports that may be produced, and to which users and under what conditions data may be available. Contact your state PDMP to assess whether it is feasible to use these data for documenting local drug abuse patterns and trends. Additional information may also be found at: http://www.deadiversion.usdoj.gov/faq/rx_monitor.htm http://www.pdmpexcellence.org/sites/all/pdfs/Brandeis_PDMP_Report.pdf

Examples of Surveillance Reports and Publications	***Description***	***Web Link***
CDC, ATLAS	An interactive platform for accessing data collected by CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP). Currently, the Atlas provides interactive maps, graphs, tables, and figures showing geographic patterns and time trends of HIV, AIDS, viral hepatitis, tuberculosis, chlamydia, gonorrhea, and primary and secondary syphilis surveillance data. This tool provides trends in overall (all modes of transmission categories combined) by county. Trends in cases for the injection drug transmission category are provided by State.	http://www.cdc.gov/NCHHSTP/Atlas/
CDC, National HIV Behavioral Surveillance (NHBS)	Provides data on HIV-related risk behaviors, including injection drugs use, HIV testing, and use of HIV prevention services. NHBS has been conducted in rotating annual cycles since 2003 in three different populations at high risk for HIV infection recruited in 20 cities in the U.S., including persons who inject drugs. Health Departments participating in NHBS have access to their local data.	http://www.cdc.gov/hiv/statistics/systems/nhbs
Suryaprasad AG, White JZ, Xu F, et al. (2014) Emerging epidemic of hepatitis C virus infections among young nonurban persons who inject drugs in	This article demonstrates national increases in acute hepatitis C infection in young persons throughout the U.S., with a particular concentration east of the Mississippi river. These data indicate an emerging epidemic of HCV Infection among young, white persons residing in non-urban areas.	http://www.ncbi.nlm.nih.gov/pubmed/25114031

the United States, 2006–2012. Clin Infect Dis;59:1411–9.		
CDC. (2015) Increases in Hepatitis C Virus Infection Related to Injection Drug Use Among Persons Aged ≤30 Years — Kentucky, Tennessee, Virginia, and West Virginia, 2006–2012. MMWR; 64(17);453-458.	This report highlights significant increases in cases of acute HCV infections identified among persons aged ≤30 years in Kentucky, Tennessee, Virginia, and West Virginia at the same time as treatment admissions for opioid dependency increased across the four states. These increases indicate a strong correlation among opioid abuse, drug injecting, and HCV infection in these four Appalachian states.	http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6417a2.htm
CDC. (2008) Use of Enhanced Surveillance for Hepatitis C Virus Infection to Detect a Cluster Among Young Injection-Drug Users --- New York, November 2004--April 2007. MMWR; 57(19);517-521.	This article describes one of the earliest reports to identify a high number of new HCV Infections among persons ≤30 years to injection drug use. This outbreak occurred in Long Island, NY between 2004 and 2007. The authors call for more enhanced surveillance to identify additional clusters and outbreaks of HCV infection where IDU is widespread.	http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5719a3.htm

Examples of Guides, Reports, Surveys, or Social or Ethnographic Community Data	***Description***	***Web Link***
National Institute on Drug Abuse (NIDA), Community Epidemiology Work Group (CEWG) (1976-2014) and National Drug Early Warning System (NDEWS) (2015-present)	Synthesizes available data describing the epidemiology of drug use for both the country and participating metropolitan areas. Data include drug abuse indicator data, findings from surveys, and other quantitative information compiled from local, State, and Federal sources. Data are enhanced with qualitative information obtained from ethnographic research, focus groups, and other community-based sources.	http://www.drugabuse.gov/about/organization/CEWG/CEWGHome.html http://www.ndews.org/
World Health Organization (WHO). (1998) Rapid Assessment and Response Guide on Injection Drug Use (IDU-RAR).	Provides guidance for conducting a rapid assessment of injection drug use, including the extent, nature and diffusion of injection drug use, extent of HIV and other adverse health consequences, and risk behaviors. The rapid assessment also aims to identify and initiate effective interventions to reduce adverse health consequences associated with injection drug use.	https://www.unodc.org/documents/hiv-aids/IDU%20rapid%20ass.%20and%20resp.%20guide.pdf
HIV/STD Program, Maine Bureau of Health. (2003) HIV Prevention and Injection Drug Use in Maine – A Statewide Needs Assessment.	Presents an assessment of the HIV prevention needs of PWID in Maine. The purpose of the assessment was to describe the scope of injection drug use in Maine and to identify the HIV prevention needs of PWID in Maine. Data from multiple existing sources were triangulated with information from interviews with key community stakeholders, including service providers for PWID and current and former PWID.	http://www.maine.gov/dhhs/mecdc/phdata/non-dhp-pdf-doc/hiv-prevention-and-injection-drug-use-in-maine-a-state-need.pdf
U.S. Department of Health and Human Services (HHS). (2013). Hepatitis C Virus Infection in Young Persons Who Inject Drugs. Consultation Report, February 26-27, 2013.	Summarizes a meeting that brought together federal partners, health department officials, researchers, staff of community-based organizations, and other stakeholders to explore the complex factors influencing the HCV epidemic and to prioritize surveillance initiatives and epidemiology, prevention interventions, and research questions aimed at more effectively target efforts	https://www.aids.gov/pdf/hcv-and-young-pwid-consultation-report.pdf

	to reduce new HCV infections among young persons who inject drugs in the United States.	

Section II. Planning, Designing, Implementing, and Monitoring SSPs

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

Examples of Resources and Tools	***Description***	***Web Link***
National Alliance of State and Territorial AIDS Directors (NASTAD) and the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS). (2012) Syringe Services Program Development and Implementation Guidelines for State and Local Health Departments.	Provides guidelines to assist state and local health departments that wish to support SSPs for PWID to prevent transmission of HIV and other blood-borne viruses such as HCV, and to link PWID to vital prevention, medical and social services. The guidelines provide information on the background of SSPs, structural elements to be considered before implementing SSPs, operating principles, SSP delivery models, and suggestions for monitoring SSPs and capacity building needs. The document also lists additional resources and tools.	http://www.uchaps.org/assets/NASTAD-UCHAPS-SSPGuidelines-8-2012.pdf
WHO/UNAIDS. (2007) Guide to Starting and Managing Needle and Syringe Programmes.	Provides guidance for developing and implementing effective SSPs. The guidance includes practical information on planning the program, modes of delivery, staffing, and supplies, and management guidance on the spectrum of services, managing staff and external relationships. The guide also provides additional resources, publications, and tools.	http://www.who.int/hiv/pub/idu/needleprogram/en/
WHO. (2004) Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS among Injecting Drug Users.	Provides a comprehensive review and summary of available evidence for effectiveness and cost-effectiveness of SSPs.	http://www.who.int/hiv/pub/prev_care/en/effectivenesssterileneedle.pdf
United Nations Office on Drugs and Crime (UNODC). (2012) Needle Syringe Exchange Program for Injecting Drug Users.	Based on implementation of SSPs in India, presents standard operating procedures and offers assistance in the establishment and implementation of an SSP, as well as monitoring and evaluating of the same.	http://www.unodc.org/documents/southasia/publications/sops/needle-syringe-exchange-program-for-injecting-drug-users.pdf
UNAIDS. (2007) A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-	Provides guidance in monitoring and evaluating HIV prevention programs for most-at-risk populations, including PWID. It includes methods and tools that can be applied at the local and national level.	http://www.unaids.org/sites/default/files/sub_landing/files/17_Framework_ME_Prevention_Prog_MARP_E.pdf

Risk Populations.		
NYC Department of Health and Mental Hygiene. (2009) Recommended Best Practices for Effective Syringe Exchange Programs in the United States: Results of a Consensus Meeting.	Summarizes the consensus among SSP experts of the underlying principles and programmatic elements that enable or constrain SSP effectiveness.	https://www.cdph.ca.gov/programs/Documents/US_SEP_recs_final_report.pdf
North American Syringe Exchange Network (NASEN)	A national network of syringe exchange programs, those who support them, and the people they serve. NASEN support SEPs through technical and financial assistance programs, expand and support the network of individuals and organizations interested in syringe exchange as an effective public health intervention, and disseminate information related to syringe exchange and disease prevention.	https://nasen.org/
Harm Reduction Coalition	A national advocacy and capacity-building organization that promotes the health and dignity of individuals and communities impacted by drug use. Harm Reduction Coalition develops tools and resources that on methods for reducing drug-related harm (e.g., brochures, factsheets, training curricula), and provide training and capacity building to community-based organizations and other stakeholders.	http://harmreduction.org/
Public Health Law Research's Law Atlas: Syringe Distribution Laws Map	Provides a longitudinal dataset, displaying laws regarding access to sterile syringes from July 1, 2012 through April 30, 2015. Historically, state laws have created barriers that make it difficult for PWID to access sterile syringes by criminalizing distribution and possession of those syringes.	http://lawatlas.org/query?dataset=syringe-policies-laws-regulating-non-retail-distribution-of-drug-paraphernalia
Kentucky Harm Reduction and Syringe Exchange Program. (2015) Guidelines for Local Health Departments Implementing Needle Exchange Programs.	Provides an example of state-level guidance for local health department jurisdictions wishing to operate SSPs.	https://louisvilleky.gov/sites/default/files/health_and_wellness/clinics/2015_kydph_hrsep_guidelines_long_version.pdf

Section III. Comprehensive Prevention Programs for PWID

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

Examples of Resources and Tools	*Description*	*Web Link*
CDC. (2012) Integrated Prevention Services for HIV Infection, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis for Persons Who Use Drugs Illicitly: Summary Guidance from CDC and the U.S. Department of Health and Human Services. *MMWR; 61 (RR05):1-40.*	Summarizes current (as of 2011) public health recommendations and guidelines from multiple agencies of the HHS for science-based public health strategies for the prevention HIV infection, viral hepatitis, STDs, and tuberculosis (TB) among persons who use drugs illicitly and their contacts (sex and drug-using partners) in the United States.	http://www.cdc.gov/mmwr/pdf/rr/rr6105.pdf
CDC and Academy for Educational Development (AED). (2000) A Comprehensive Approach: Preventing Blood-Borne Infections among Injection Drug Users.	Technical assistance document that describes key strategies for prevention of HIV and other blood-borne infections among PWID. The assistance document also provides guidance on coordination of different services and coordination with providers, strategies to ensure access, coverage and high quality, and how to recognize and overcome stigma.	http://www.cdc.gov/idu/pubs/ca/comprehensive-approach.pdf
NASTAD. (2015) Maximizing Health, Minimizing Harm: The Role of Public Health Program in Drug User health	This resource highlights opportunities and provides recommendations for health department programs to address a range of drug user health issues, including HIV and HCV infections.	https://www.nastad.org/resource/maximizing-health-minimizing-harm-role-public-health-programs-drug-user-health
CDC. (2010) Toolkit for Implementing Comprehensive HIV Prevention Programs for People Who Use Drugs.	Provides an overview of tools and resources for key, effective interventions and planning programs for persons who use drugs, including designing and implementing programs, monitoring and evaluating program progress and outcomes, and supporting and developing effective drug and HIV policy.	http://www.cdc.gov/globalaids/resources/prevention/docs/toolkit-for-implementing-programs-for-people-who-use-drugs.pdf
CDC. (2015) HIV and Injection Drug Use, Factsheet.	Provides fast facts on HIV incidence and prevalence among PWID, prevention challenges, and CDC activities to maximize the effectiveness of current HIV prevention methods, and improve what we know about the behaviors and risks faced by PWID.	http://www.cdc.gov/hiv/pdf/g-l/cdc-hiv-idu-fact-sheet.pdf
SAMHSA. (2014) SAMHSA Opioid Overdose Prevention Toolkit.	Provides basic facts about opioid overdose, lists steps for first responders, and outlines key information for prescribers, patients, and family members.	http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2014/SMA14-4742
CDC. (2015) Prescription Drug Overdose: What States Need to know About the Epidemic.	Provides information on overdose prevention strategies, state programs and policies, and latest opioid overdose data reports.	http://www.cdc.gov/drugoverdose/epidemic/states.html
U.S. Public Health Service and CDC. (2014) Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2014 Clinical Practice Guidelines.	Provides comprehensive information for the use of daily oral antiretroviral preexposure prophylaxis (PrEP) to reduce the risk of acquiring HIV infection in adults, including PWID.	http://www.cdc.gov/hiv/pdf/prepguidelines2014.pdf
WHO. (2004) Evidence for Action: Effectiveness of Community-Based	Provides the evidence for the effectiveness of community-based outreach intervention as one component of a comprehensive HIV prevention model for	http://www.who.int/hiv/pub/prev_care/en/evidenceforactionalcommunityfinal.p

Outreach in Preventing HIV/AIDS Among Injecting Drug Users.	preventing HIV infection in PWID.	df
NIDA. (2000) The NIDA Community-Based Outreach Model: A Manual to Reduce the Risk of HIV and Other Blood-Borne Infections in Drug Users.	Describes a scientifically tested model of community-based outreach to reduce the risk of HIV and other blood-borne infections in drug users.	http://archives.drugabuse.gov/pdf/CBOM/Manual.pdf
NIDA. (2009) Principles of Drug Addiction Treatment: A Research-Based Guide.	Summarizes effective drug abuse and addiction treatments and a guide to their implementation.	https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/podat_1.pdf
NIDA. (2006) Methadone Research Web Guide.	Provides guidance for developing knowledge and understanding of U.S. methadone maintenance research, share best practices in methadone treatment and program design and implementation, and provide access to approved treatment protocols.	http://blog.mlive.com/chronicle/2007/12/MethadoneResearchWebGuide.pdf
SAMHSA. (2007) TIP 27: Comprehensive Case Management for Substance Abuse Treatment.	Presents an overview of case management for substance use disorder treatment providers. Discusses models, program evaluation, managed care issues, referral and service coordination requirements, linkages with other service agencies, and clients with special needs.	http://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA12-4215
SAMHSA. (2005) TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.	Gives a detailed description of medication-assisted treatment for addiction to opioids, including comprehensive maintenance treatment, detoxification, and medically supervised withdrawal. Discusses screening, assessment, and administrative and ethical issues.	http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214
WHO. (2014) Policy Brief: HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Consolidated Guidelines.	Provides an overview of key findings, data and figures of the new consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, including PWID. It also offers an overview of the comprehensive package on interventions and a table summarizing WHO recommendations concerning key populations.	http://www.who.int/hiv/pub/toolkits/keypopulations/en/
UNAIDS. (2007) A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations.	Provides guidance in monitoring and evaluating HIV prevention programs for most-at-risk populations, including PWID. It includes methods and tools that can be applied to SSPs at the local and national level.	http://www.unaids.org/sites/default/files/sub_landing/files/17_Framework_ME_Prevention_Prog_MARP_E.pdf
WHO, UNODC, UNAIDS. (2012) Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users.	Provides technical guidance to countries on monitoring efforts to prevent and treat HIV infection among PWID and for setting ambitious but achievable national targets for scaling up towards universal access.	http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf

APPENDIX 2

Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016

EXAMPLE OF A REQUEST FOR DETERMINATION OF NEED

This appendix illustrates how existing data can be summarized to provide evidence that a jurisdiction is experiencing or is at risk for significant increases in viral hepatitis or HIV infections due to injection drug use. As described in the guidance, a request for determination of need should be submitted by the state health department to SSPCOORDINATOR@CDC.GOV. Within 30 days after receipt, CDC will notify the recipient whether the evidence is sufficient to demonstrate need. If the evidence is determined to be sufficient, the recipient may apply for redirection of funds to the respective federal agency. If the evidence is determined to be insufficient, no programmatic or budgetary changes will be authorized. Jurisdictions, however, may choose to revise and resubmit their request with additional evidence based on feedback from CDC.

In order to demonstrate need, the jurisdiction has to fulfill **one of the two** following criteria; evidence on only **one** of the two criteria should be presented to demonstrate need:

A. Jurisdiction is experiencing significant increases in viral hepatitis or HIV infections due to injection drug use.

B. Jurisdiction is at risk for – but not yet experiencing – significant increases in viral hepatitis or HIV infections due to injection drug use.

Parts A1 and A2 below provide an example for jurisdictions experiencing significant increases. Part A1 provides an example of relevant data sources. Part A2 has an example of how to present evidence that the significant increases in HIV and/or viral hepatitis infections resulted from injection drug use. As described in the guidance, such evidence may include transmission category from case reporting, existing published data and reports, surveys, or social or ethnographic community data.

Parts B1 and B2 provide an example for jurisdictions at risk. The relevant data sources are described in Part B1. Part B2 provides an example of how the information can be synthesized (i.e., “triangulated”), and provides additional details to what is presented in Part B1. Synthesis of data is critical as evidence that is not sufficient for determination of need by itself may describe a clearer picture when considered together with other evidence. Therefore it is important that synthesis of information be provided as part of the request for determination of need. A sample list of data sources and outcomes is provided in the guidance document, pages 4-5 (Tables 1a and 1b) and in Appendix 1.

PART A: Jurisdiction is EXPERIENCING significant increases in viral hepatitis (acute hepatitis C virus [HCV] or acute hepatitis B virus [HBV]) or HIV infections due to injection drug use

REQUEST FOR DETERMINATION OF NEED

Requesting jurisdiction: State A
Geographic area for which the determination is requested: County X

We are submitting evidence for consultation with CDC to demonstrate our jurisdiction is **EXPERIENCING significant increases in viral hepatitis or HIV infections due to injection drug use.**

Part A1: Data Sources
The relevant row in the table below may be completed based on available data.

Outcome(s)	Data source	Geographic area	Assessment period beginning year and number or rate	Assessment period ending year and number or rate	Percent increase during the assessment period
HIV attributed to injection drug use	*N/A*		Month: Year: Value: Units:	Month: Year: Value: Units:	
Acute HCV	*Example: Viral Hepatitis Surveillance United States, 2013 (CDC, http://www.cdc.gov/hepatitis/statistics/2013surveillance/pdfs/2013hepsurveillancerpt.pdf)*	*State A*	Month: *Jan-Dec* Year: *2009* Value: *0.3* Units: *cases per 100,00 population*	Month: *Jan-Dec* Year: *2013* Value: *2.7* Units: *cases per 100,00 population*	*800% increase over 5 years*
Acute HBV	*N/A*		Month: Year: Value: Units:	Month: Year: Value: Units:	

Part A2: Summary of Evidence

Example:

Data submitted to CDC for the state of A indicate an 800% increase in annualized rates of acute hepatitis C infection from 2009 to 2013. During this period, data from at least three sources[1-3] suggest that the majority of these infections (>70%) resulted from injection drug use.

1. *Zibbell, J.E., et al., Increases in hepatitis C virus infection related to injection drug use among persons aged ≤ 30 years - Kentucky, Tennessee, Virginia, and West Virginia, 2006-2012. MMWR Morb Mortal Wkly Rep, 2015. 64(17): p. 453-8.*
2. *Suryaprasad, A.G., et al., Emerging epidemic of hepatitis C virus infections among young nonurban persons who inject drugs in the United States, 2006-2012. Clin Infect Dis, 2014. 59(10): p. 1411-9.*
3. *Centers for Disease Control and Prevention. Viral hepatitis surveillance -- United States, 2013. 2014 (Accessed October 8, 2015).*

During 2013, X County had a substantially higher rate of reported HCV cases compared with the state overall: 97 per 100,000 population compared with 69 per 100,000 population. We therefore believe that rates of acute HCV infection are rising throughout the state with an excess burden of disease in X County.

PART B: Jurisdiction is AT RISK FOR significant increases in viral hepatitis or HIV infections due to injection drug use

REQUEST FOR DETERMINATION OF NEED

Requesting jurisdiction: State XX
Geographic area for which the determination is requested: County B

We are submitting evidence for consultation with CDC to demonstrate our jurisdiction is **AT RISK FOR significant increases in viral hepatitis or HIV infections due to injection drug use.**

Part B1: Data Sources

It is recommended that data come from multiple sources that when triangulated (combined) provide compelling evidence that there is likely an increase in injection drug use in the jurisdiction. Additional sheets may be added if necessary.

Outcomes	Data source	Geographic area	Assessment period beginning year and number or rate	Assessment period Ending year and number or rate	Percent increase during the assessment period
Increase in Injection drug use among treatment admissions (any drug) to publicly funded programs	*State Division of Alcohol and Drug Abuse*	*B County*	Month: *Jan-Dec* Year: *2009* Value: *3,500* Units: *number per year*	Month: *Jan-Dec* Year: *2014* Value: *6,200* Units: *number per year*	*77%*
Heroin-related arrests	*County arrest records*	*B County*	Month: *Jan-Dec* Year: *2012* Value: *5,280* Units: *number per year*	Month: *Jan-Dec* Year: *2014* Value: *6,355* Units: *number per year*	*20%*
Opioid related hospital discharges	*State hospital discharge files*	*B County*	Month: *Jan-Dec* Year: *2009* Value: *3,345* Units: *number per year*	Month: *Jan-Dec* Year: *2014* Value: *2,792* Units: *number per year*	*-17%*
Drug overdose deaths	*State Medical Examiner/Coroner files*	*B County*	Month: *Jan-Dec* Year: *2009* Value: *9.8 per 100,000* Units: *rate*	Month: *Jan-Dec* Year: *2013* Value: *18.3 per 100,000* Units: *rate*	*87%*

Part B2: Summary of Evidence

*An example of a **summary synthesizing the evidence is** presented that indicates the jurisdiction is at risk for increases in viral hepatitis or HIV due to injection drug use. Note that additional detail and data points are included here to provide a clearer picture*

Example:
The state of XX assessed 4 variables related to injection drug use in County B that together suggest an increasing trend in unsafe injection practices that may lead to increases in viral hepatitis and HIV infections. These variables include substance use disorder treatment admissions for injection drug use, heroin-related arrests, hospital discharges related to misuse of opioids, and drug overdose deaths involving heroin or other opioid drugs.

The most direct indicator of injection drug use is the treatment admissions dataset. Treatment admissions related to injection drug use increased by 77% from 2009 to 2014. Admissions in the younger age group (15-24 years) increased almost threefold from 502 in 2009 to 1,490 in 2014, suggesting potential increases in injection initiation. Heroin-related arrests increased 20% from 2012-2014 and were 5,280 in 2012, 5,733 in 2013 and 6,355 in 2014. No new policing initiatives have been documented that may artificially inflate this trend. Heroin-related arrest reports do not distinguish between the different routes of administration, but based on treatment data, 60% of treatment admissions related injection drug use were for heroin.

Opioid-related hospital discharges did not show increases, but where high: 3,345 in 2012, 3,046 in 2013 and 2,792 in 2014. The overall number of hospital discharges in County B declined during this time period, therefore, the change in opioid-related hospital discharges may not reflect true trends in opioid use in the county. On the other hand, drug overdose deaths involving opioids increased substantially (87%) between 2009 and 2013, with the largest increases among younger people (<30 years). The overall rates per 100,000 persons and numbers of deaths (in parentheses) in drug overdose mortality were: 9.8 per 100,000 (58) in 2009, 9.1 (80) in 2010, 12.2 (110) in 2011, 15.0 (140) in 2012 and 18.3 (180) in 2013. Although these data also do not distinguish the route of administration, hospital discharges and opioid-related deaths suggest problematic use of these substances, which likely includes injection.

Together these data suggest high and increasing levels of unsafe injection drug use in this jurisdiction, and particularly among young people (<30 years) who could greatly benefit from syringe service programs and harm reduction education to prevent future spread of viral hepatitis and HIV.