



Kentucky Public Health
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At A Glance: Kentucky Harm Reduction and Syringe Exchange Program (HRSEP) Guidelines for Local Health Departments Implementing Needle Exchange Programs

May 11, 2015

In accordance with SB 192 enacted by Kentucky General Assembly in the 2015 Regular Session and signed by Governor Steven L. Beshear as an emergency bill went into effect on March 24, 2015. This bill amended KRS 218A.510 to allow a local health department to operate an outreach program in which individuals can exchange used hypodermic needles and syringes for clean needles and syringes. In Kentucky this program is named the “Harm Reduction and Syringe Exchange Program” (HRSEP). These HRSEP guidelines provide assistance to local health department jurisdictions that wish to operate HRSEPs. For health departments interested in initiating a HRSEP, these guidelines address key issues to be considered before implementation.

SB 192 can be found in its entirety at: <http://www.lrc.ky.gov/record/15RS/SB192.htm>.

Kentucky’s law provides that the development and implementation of a HRSEP in a given county shall be a local decision. Approval by three separate entities is required: the local health department Board of Health must agree to operation of a HRSEP; the city government legislative body; and the county government legislative body in which the program will be operated must give consent for operation of the program.

The following are considerations for implementation of a HRSEP:

1. **Community Need:** The first step in considering whether to implement a HRSEP is to determine whether the need exists in the health department jurisdiction.
2. **Local Collaboration:** Begin by working to garner community support and assistance from those in the community who can assist with developing the program and ensuring its success. Some examples:
 - a. Local Officials
 - b. Law Enforcement
 - c. Civic and Religious Leaders
 - d. Healthcare Professionals
 - e. Behavioral Health and Substance Abuse Treatment Providers
 - f. Neighborhood Groups
 - g. Waste Management

3. **Reaching Potential HRSEP Participants:** Once collaborative relationships have been developed and community support earned, consider how the HRSEP will reach potential participants. There are many options and what works best in one community may not work in another. Some examples include:
 - a. Street Outreach
 - b. Emergency Department Referrals
 - c. Pharmacist and Healthcare Provider Referrals
 - d. Behavioral Health and Substance Abuse Treatment Provider Referrals

4. **Operating Principles:** Some of the general considerations for developing a HRSEP are:
 - a. Program Registration: Will you require participants to register? Until trust is built, participants may be unwilling to give the HRSEP identifying information. However, without participant registration, any data collection the local agency may wish to collect will be more difficult.
 - b. Syringe Transaction Model: How will your community set up the syringe exchange element of the HRSEP? Three models are common:
 - i. Needs-Based Negotiation: allows for distribution of needles based upon participant need, even if needles are not turned in for exchange.
 - ii. Strict One-for-One Exchange: provides HRSEP participants with the exact same number of sterile syringes that the participant brings in for disposal.
 - iii. One-for-One Plus Exchange: modifies the basic concept of the strict one-for-one exchange programs by providing some predetermined number of extra syringes beyond one-for-one. For example, two-for-one or ten-for-one, at the discretion of the program.
 - c. Worker and Volunteer Safety:
 - i. Safe Syringe Disposal: All disposal venues, including HRSEPs, must comply with federal, state and local regulations for disposing of used syringes, which qualify as regulated medical waste (RMW). Local health department should already be participating in some form of RMW disposal and should work to extend that contract to assist the HRSEP.
 - ii. Prevention of Occupational Blood Borne Pathogen Transmission among HRSEP Staff: Staff and volunteers should be thoroughly trained in routine safety protocols such as:
 1. Routine use of gloves, goggles, etc. when expecting to come in contact with blood.
 2. Immediate washing of hands and other skin surfaces after contact with blood or body fluids and
 3. Careful handling and disposing of sharp instruments before and after use.
 - iii. Health and Social Service Provision and Links: Consider community resources and referral or provision of the following services as part of the HRSEP:
 1. Insurance enrollment
 2. Medical Treatment Referrals

3. HIV and Hepatitis C Testing
 4. Counseling on Safe Sex and Needle Use
 5. Listing of Behavioral Health and Substance Abuse Treatment Providers in the community
 6. Other Community Services (legal aid, clothing, shelter, food, etc.)
 7. Overdose Prevention: A health department should consider including the following to assist with overdose prevention both within the HRSEP and the community at large.
 - a. Keep Naloxone on site and train staff in the appropriate administration of it should it be necessary for a participant on site.
 - b. Provide education to HRSEP participants and their family and friends regarding the identification of the signs of overdose and knowing how to respond.
 - c. Provide community education on overdose prevention and the signs of overdose and how to respond.
- d. Service Delivery: How will the HRSEP be made available to the public?
- i. Fixed Site: Typically in fixed-site models, the HRSEP is located in a building or specific location, such as the local health department, office, or other space with street-level access. Fixed sites work best in health jurisdictions where Intravenous Drug Users (IDUs) are clustered in a somewhat centrally located area.
 - ii. Collaboration or Satellite Structure: In the collaboration or satellite structure model, existing HRSEPs provide syringe services at partner social service agencies in fixed sites in the community (such as a homeless shelter).
 - iii. Mobile/Street Based Programs: Mobile/street-based programs are conducted on foot, by bicycle or by vehicle (e.g., van, bus or recreational vehicle). This method is also referred to as outreach. Many mobile HRSEPs stop at specified locations and times.
 - iv. Delivery Model: The delivery model involves the delivery of injection supplies to a prearranged site, such as a house, apartment, hotel, or other prearranged location. Service delivery can take place on a regular schedule or by appointment. Security concerns can be a barrier to this model.
 - v. Combination of the above: If a community feels it most effective for the HRSEP to combine two or more of the above to achieve the best outcome, that is also an acceptable practice.
- e. Monitoring: The main goal of monitoring local HRSEPs is to assess whether a program is operating in conformity to its design, reaching its specific target population and achieving anticipated implementation goals.
- i. Process Monitoring: The overarching goal of process monitoring is to document whether the program is being implemented as intended. The process outcomes to be monitored depend on the type of service delivery model selected and the type and number of additional services provided.

- ii. **Outcome Monitoring:** Quantitative assessments should occur periodically with HRSEP participants for outcome monitoring. Outcome monitoring provides important information for improving program efficiency, quality and effectiveness.
 - iii. **Program Quality Improvement:** Program quality improvement relies on the systematic collection and use of process monitoring and periodic outcome monitoring to determine if and how well program objectives are being met and to reassess program goals. If goals are not being met, program quality improvement can help HRSEPs decide if and how to change services to better meet the needs of the target population.
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