Reviews of the

2018 WVDHHR-BPH Report
of the
Kanawha-Charleston Health Department
Harm Reduction Syringe Services Program

Distributed to the Kanawha-Charleston Board of Health

September 20, 2018
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Summary of 7 Reviews to
WVDHHR Audit of KCHD HRSSP

Brenda Isaac RN, KCHD Board Chairperson

Reviews conducted by:

1. Tessie Castillo, Advocacy and Communications Coordinator, North Carolina Harm Reduction Coalition, Raleigh, NC.
2. Dan Ciccarone MD, MPH, Professor of Family and Community Medicine, University of California, San Francisco, CA.
3. Peter J. Davidson PhD, Associate Professor, Division of Infectious Disease and Global Public Health, Department of Medicine, University of California, San Diego, CA.
4. Corey Davis JD, MSPH, EMT-B, Teaching Professor, Brody School of Medicine, East Carolina University and Leo Beletsky JD, MPH, Associate Professor of Law and Health Sciences, School of Law & Bouve College of Health Sciences, Northeastern University
5. Matthew LaRocco CADC, Community Liaison, Louisville Metro Syringe Exchange Program, Louisville, KY.
7. Robin Pollini MPH, PhD, Associate Director and Associate Professor, West Virginia University School of Public Health.

Everyone who performed these reviews has worked for several years, most in excess of 10 years, in the substance abuse, prevention of infectious disease and harm reduction areas.

There was general agreement that the audit report did point out valid concerns about the HRSSP program run by KCHD. “Good data is an essential element in identifying community needs, gaps in services, and planning for future interventions.” (LaRocco) However, all the reviewers also pointed out that it is essential in HRSSP programs to maintain a low threshold for data collection because of the population that uses the program. “In this unique setting, extensive patient registration and/or data collection efforts act as explicit barriers to service access.” (Davidson). There was also consensus that the rapid growth of KCHD’s program showed a true need but also hindered data collection from an overworked staff that depended on volunteers to assist with the work. Most reviewers suggested that this lack of complete data was not a valid reason to discontinue the program. However, the state should be doing more training and providing more funds and better tools for consistent data collection, helping to keep the essential services going, not shutting them down. “To me, incomplete data does not constitute a reason to close a program, especially since a large part of the reason that data entry has errors is because the program is overwhelmingly popular among people who use drugs and it is not adequately funded.” (Castillo)

The audit evaluators stated that they were using the state certification criteria and the Program Procedure Manual to evaluate the program, however, most of the deficiencies noted were not addressed in these documents. The state appears to actually be using clinical guidelines, even though a HRSSP program is not a clinical program but rather a public health program and cannot be fairly evaluated using clinical standards. The state appears to understand this in their certification criteria but not in this audit.
All of the reviewers agreed that “A clinic-based model such as that advocated by the state audit, requiring ID, only in person receipt of syringes, mandatory primary care and offer of referral to treatment – makes the proposed program a high threshold clinical model. Such a model would increase benefits to the minority of individuals who choose and have the wherewithal to engage with this service, but would greatly reduce public health benefits by raising barriers for engaging the majority.” (Ciccarone).

Of serious concern to all the reviewers was the fact that while there are numerous quotes from city officials opposed to the program, there are no quotes from staff or volunteers who support the program. There was also grave concern that the audit contains no interviews done with participants who utilized the program until it was closed. It appears that no effort was made to find participants and conduct these interviews. “However, no quotes from KCHD staff or exchange participants were provided. Because of this, the report reads as one-sided. The lack of interviews with participants is a particular concern, as this could highlight some of the benefits of the program.” (Ciccarone)

Most reviewers point out that even though incomplete data appears to be a concern of the auditors, there is no data documentation at all to indicate that syringe litter was a problem, nor any data showing that any syringes found came from the program. Only accounts from those who opposed the program were given but not concrete evidence and no statistical numbers. There are also several quotes that cite information that has been proven false, such as that needle stick injuries have increased, and drug use has gone up but there is absolutely no evidence to back up either of these claims.

All of the reviewers indicated concerns that now that the program has been closed (or at least the SSP portion has closed) the majority of these participants are now without services. The reviewers feel that there will most definitely be an increase in infectious diseases and any opportunities to provide services for these participants is now gone.

These reviews are very thorough and I certainly want to thank these dedicated professionals who responded and provided us with this information.
To: Kanawha-Charleston Health Department’s Board of Health  
Re: Audit recommending the suspension of KCHD’s harm reduction program  

Dear Board of Health,

I am writing as a senior staff member at the North Carolina Harm Reduction Coalition (NCHRC), the state’s largest and most comprehensive harm reduction program. In 2016 NCHRC led legislative efforts to authorize syringe exchange programs in our state and over the past two years we have implemented six harm reduction programs in six counties, both rural and urban. Our exchanges are a combination of mobile units and fixed site locations.

Last November 2017 I was fortunate enough to visit KCHD and to witness the harm reduction program in action. I was impressed with the number of people using the program and with the number of services offered to them. In fact I remember commenting that KCHD staff should visit our North Carolina exchanges to teach us how to recruit so many participants in such a short time. Indeed, not even all our exchanges combined can reach as many patients as the KCHD program reached in a single day. I believe the rapid growth and demand for the program may have triggered some issues that resulted in an audit and consequent suspension of the program.

I am writing because I have recently reviewed this audit and would like to offer my thoughts. I appreciate the thorough review of the program and the acknowledgement of how important harm reduction programs are to disease prevention and overdose prevention. I understand some of the reviewer’s concerns with issues such as ID duplication, data errors and syringe litter. I wanted to go over some of the salient points made:

1. Concerns over data errors – data errors and incomplete data are fairly common in harm reduction programs, especially when they are dealing with a low budget, few staff, high demand, and reliance on volunteers. In my opinion, these issues could be rectified through training, program resources and assistance with data entry. To me, incomplete data does not constitute a reason to close a program, especially since a large part of the reason that data entry has errors is because the program is overwhelmingly popular among people who use drugs and not adequately funded.

2. Concerns over shared ID numbers – most harm reduction programs use a combination of initials, date of birth, and other identifiers to form a unique ID. It seems that the KCHD program used too few identifiers and that indeed these could be duplicated. Additionally, there should be a system for tracking when a patient returns for subsequent visits. Here in North Carolina we use initials, birth year, gender, race, and location of exchange to form
identifiers. We haven’t had issues with duplication. We are also able to track when participants return through entering their ID number in our electronic system. This is a solution that would be easy to set up at KCHD and should not be a factor in suspending the program.

3. No steering committee – It seems to me that a steering committee would be helpful to aid KCHD in addressing concerns with data entry, discarded syringes and public concerns.

4. Increase in syringe litter – An increase in syringe litter and potential needle-stick injury would certainly be a cause for concern. However, in the report I didn’t see any documentation of an increase in syringe litter or evidence of increased needle-stick injury among first responders or the public. This claim was repeated often throughout the report, but not substantiated with evidence. Only one actual needle-stick injury was mentioned, and that was a volunteer at the exchange, not someone coming across syringes outside. I know that staff at KCHD harm reduction program were made aware of concerns about discarded syringes at least a couple months prior to the suspension of the program, but the report did not clearly document if KCHD had begun efforts to remedy this problem and whether adequate time was given to respond to the concerns. The report mentioned first responders saying that a discarded needle should be picked up “within 10 minutes” and this seems a hostile and unrealistic demand.

5. Proxy patients – The practice of secondary exchange, or syringe exchange participants distributing needles to their peer network, is extremely common among harm reduction programs. This enables programs to reach far more people than could be available to come out to an exchange. One could argue, as this report does, that this practice enables proxy patients to avoid contact with services such as treatment referrals and medical care. But consider that the KCHD program only operates during work hours in the middle of the week. Many proxy patients are working during this time. Others have small children and don’t want to bring them to an exchange. Others may face hardship getting to the exchange because of transportation issues. Proxy patients are not necessarily “avoiding” services. For many of them, coming to an exchange in the middle of the week is simply not possible. But by providing them with syringes through secondary exchange, we can still reach them with tools to reduce the spread of disease.

6. Being given a syringe prior to primary care or treatment services – I don’t know a single harm reduction program in the country that mandates that participants see a primary care or treatment provider prior to receiving syringes. This is not best practice for providing services to people who use drugs. Harm reduction programs are, by definition, supposed to be as low threshold as possible. If all someone wants (for now) is a clean syringe, then that is what a harm reduction program will provide. Even that small service represents positive change in that person’s life. The harm reduction model emphasizes meeting people where they are at on
the recovery continuum, whether in pre-contemplation (not ready for treatment), contemplation (thinking about it), preparation, action, etc. We allow our participants to move through these stages at their own pace. Some never make it past pre-contemplation, others move all the way into long term recovery. I think that mandating that people see a treatment provider prior to (or as a requisite) for receiving syringes could be interpreted by participants as trying to push them along the continuum faster than they are ready. Additionally, the report does not define what “seeing” a treatment provider or primary care person means. If the participant has no medical concerns and does not wish to seek treatment at this time, what would their “consultation” look like? If they merely had to state to the providers, “I have no medical concerns” and “I don’t want treatment at this time” and they can move on and get their syringes, then that seems an unnecessary step and a waste of time for everyone. But worse, if at every visit to the exchange they are mandated to undergo a physical exam and/or to listen to a treatment provider tell them that they need to stop using drugs, this could be a humiliating experience for patients that would certainly affect their interest in the syringe exchange services.

Other concerns with the report: The report provides quotes from interviews with first responders, City Council, and the Mayor’s Office, all groups with serious reservations about the harm reduction program. However, no quotes from KCHD staff or exchange participants were provided. Because of this, the report reads as one-sided. The lack of interviews with participants is a particular concern, as this could highlight some of the benefits of the program.

There were many claims in the report that were not documented with evidence: 1) that more people are using meth because free injection equipment is available (in reality, meth use is rising across the country regardless of the availability of syringes. It has been documented repeatedly in evidence-based studies that the availability of syringes does not lead to an increase in drug use. If this were true, harm reduction programs would not be allowed to exist.); 2) that a pregnant woman getting syringes constitutes a threat to the unborn child (in reality, HIV and hepatitis C are threats to an unborn child); 3) that crime, needle-stick injury, and drug use have gone up due to the exchange (again, these claims were made but no evidence was provided in the report to substantiate them).

Interestingly, the report mentioned the WV Health Right program as a more effective model for syringe exchange. I would have liked to know more about the program and how it is run. The report concluded that it was not necessary to have two exchanges in the same city; I would argue that the fact that the KCHD program saw hundreds of people a day would negate that. The report also mentioned that the WV Health Right program links 30% of patients to treatment. I don’t know a single harm reduction program in the country with numbers that high, especially after so little time in operation. I would like more information about what constitutes “linkage to treatment” and how this is measured. I am also very curious to know how patients responded to
being offered retractable syringes. In North Carolina, these syringes are deeply unpopular among drug users.

In conclusion, I see areas of growth for the KCHD harm reduction program, particularly around better data collection, being able to track participants through multiple visits, having records of what services they received, etc. I would agree with modifying the ID number for participants and coming up with a plan to address the issue of discarded syringes around the premises. A steering committee would likely to helpful to address these issues.

However, other concerns outlined in the report over proxy patients and the requisite that patients see treatment and medical providers prior to receiving syringes are not best practices for harm reduction programs. It is concerning that the report offers makes several claims against the program that are not documented, such as increases in litter, crime and drug use. Finally, the report offers quotes from opposition to the program, including quotes that make inaccurate claims (such as that meth use is rising because of the availability of free injection equipment or that pregnant women using syringes constitutes a threat to the unborn child) that are clearly rooted in stigma against people who use drugs, without offering quotes from program supporters or patients.

It appears to me that the KCHD harm reduction program is in need of funding, staffing and technical assistance to meet overwhelming demand, but that suspending a much-needed program was unnecessary and detrimental to the health and safety of its patients. Without a harm reduction program, those patients go back into the shadows to continue to share potentially contaminated syringes and to be without access to primary care, treatment services, STD testing and all the other services the program provided. They won’t be as visible to City Council or members of the public, and perhaps this was the ultimate goal of suspending the program, but they are still there. Ultimately, the city will still have to face this issue. I hope they will reconsider the suspension of this program.

I can be reached for further questions at tswopecastillo@gmail.com or 919-809-7718.

Thank you for your time.

Sincerely

Tessie Castillo
Advocacy and Communications Coordinator
North Carolina Harm Reduction Coalition
Brenda Isaac, RN, President
Kanawha-Charleston Board of Health
PO Box 927, Charleston, WV, 25323.

June 7, 2018

RE: 2018 State Evaluation of the Kanawha-Charleston Health Department
Harm Reduction Syringe Services Program

Dear Brenda Isaac and Kanawha-Charleston Board of Health,

Thank you for the invitation to serve as part of a panel of national experts to review the recent state audit that decertified the KCHD harm reduction program. What I bring to this effort is my 30 years of experience as a physician and addiction medicine specialist as well as 18 years in the field of public health. My public health expertise is in HIV/HCV and substance use, esp. heroin use and the medical consequences of heroin use. I have served on the Board of Directors for a harm reduction program in San Francisco, as well as Medical Director for another. I have in depth experience with and knowledge of best practices for syringe exchange and other services to reduce the harms of injection drug use.

I am currently Principal Investigator of the NIH/NIDA funded Heroin in Transition study. The aim of this study is to explore new forms of heroin and the synthetic opioid phenomenon sweeping our country. As part of this study I have been to West Virginia on two visits and have done research activities (recruitment of study subjects etc.) through KCHD HRSSP with the approval and guidance of then Director Dr. Michael Brumage.

My impression of HRSSP, from direct observation over one week, is that of a well-run high-volume clinic model syringe exchange. “Clinic models” are still unusual and that this one was high volume (>300 persons per week) makes it unique in the US. I have discussed this with several experts on syringe exchange and they were impressed that a clinic model could serve so many clients. The staff, with exceptional leadership from Dr. Brumage, was professional, highly engaged and caring towards the clients, with an overarching – and challenging – goal of balancing individual needs with its public health mandate.
This gets me to my review of the state audit. I appreciate the concern and high level of work put into this audit by the fourteen members of the evaluation team. They have produced an impressive evaluation. There are many things I see as strengths of the report including encouraging HAV/HBV vaccination, reduction of nuisance issues, e.g. syringe litter, and improving community engagement. These issues have challenged every syringe exchange I have known and are surmountable. One central strength of the audit is the stated concern for balancing needs of the clients with community needs. And this strength of the report also, perhaps paradoxically, leads down a challenging path which may be the central source of confusion, disagreement and sadly, discrediting of the tremendous work already performed by the HRSSP Director and his staff. It is challenging to run a clinic-based model for syringe exchange. The desire to do the best for individuals (increase engagement, primary care services, referral to treatment) runs somewhat counter to the goal of public health; to engage the highest number of persons. The evidence base for syringe exchange strongly supports the latter: maximizing the number of persons and number of syringes distributed so that the theoretical goal of 100% of injections are with sterile new syringes. To achieve this, the evidence base supports low-threshold, needs-based exchange with allowance for secondary exchange (in-person clients receiving and distributing syringes to their substance using peers). A clinic-based model such as that advocated by the state audit, requiring ID, only in-person receipt of syringes, mandatory primary care and offer of referral to treatment – makes the proposed program a high-threshold clinical model. Such a model would increase benefits to the minority of individuals who choose, and have the wherewithal to engage with, this service, but would greatly reduce public health benefits by raising barriers for engaging the majority.

The WVDHHR, West Virginia Bureau for Public Health, Harm Reduction Program (HRP) Guidelines and Certification Procedures (2/2018) document states, “Prior research has shown that the needs based negotiated distribution model is best at achieving the goal of reaching as close to 100 percent coverage as possible...” This goal is also stated in the audit. According to the audit, HCV rates are unacceptably high in WV. According to my research, southern WV has many young naïve injectors who are taking many blood-borne viral risks. HIV rates typically pick up after HCV rates. The time to act to prevent an upsurge in HCV/HIV in southern WV is now.

Respectfully,

Daniel Ciccarone, MD, MPH
Professor
UCSF School of Medicine
June 11, 2018

To whom it may concern,

I am an Associate Professor in the Department of Medicine of the University of California, San Diego. I have been conducting research on the prevention of overdose and blood borne virus transmission among people who use drugs in Australia, the United States, and Mexico since 1997. Please find following my expert review of the Kanawha-Charleston WV Harm Reduction Program audit report.

The overarching purpose of any Syringe Services Program (SSP) anywhere in the world is primary prevention, and the gold standard approach to achieving that purpose revolves around low threshold access. By this I mean that decades of research have demonstrated that SSPs are most effective at preventing the spread of HIV and other blood borne viruses when they concentrate on providing enough syringes to people who use drugs for them to use a new syringe for every injection, and avoid doing anything that impedes that goal in any way.

My main observation is that, as written, the current ‘Conclusions and Recommendations’ of the Audit report of the Kanawha-Charleston WV Harm Reduction Program appear to see the primary purpose of SSPs as being data collection and the integration of service users into a broader medical system, so much so that primary prevention becomes almost an afterthought. As a consequence of this framing, almost all of the Recommendations in the Audit represent severe and in some cases unconscionable barriers to effective, evidence-based, primary prevention of blood born virus transmission.

I have two further comments about the purpose of SSPs and the role of data collection at SSPs.

The highest risk individuals for acquiring or living with HIV and other blood borne viruses are people who are currently unable or unwilling to interact with other health services. This unwillingness may be due to past poor experiences with healthcare systems, or due to fear of police, or due to drug-induced or mental illness-induced paranoia. SSPs represent unique opportunities to respectfully engage with such individuals, to provide essential primary prevention supplies, and to (often slowly) build the trust relationships necessary to facilitate effective referrals to other highly desirable services such as drug treatment. In this unique setting, extensive ‘patient registration’ and/or data collection efforts act as explicit barriers to service access. SSPs exist because other parts of the healthcare system have failed to provide these members of the community with supportive and effective service provision, and requiring that an SSP take on the characteristics of other healthcare services which have driven people who use drugs away (eg patient registration) will simply lead to drug users receiving no HIV prevention services.
Secondly, as a medical researcher, I value data enormously. However, for research to be ethical, the benefits of collecting data must be commensurate with the risks associated with collecting data. Collecting data from service users at SSPs comes with well known risks – namely that some service users will not be willing to access the SSP due to drug-induced paranoia, mental illness, and/or fear of police (often those at highest risk of acquiring or living with HIV and other blood borne virus transmission), and that data collection activities can represent considerable burdens on often under-resourced SSPs, reducing the resources and time available for actual service delivery. As such, for a research or surveillance project conducted at an SSP to be ethical, the benefits of any data collection need to be such that they justify the above risks and burdens, and data collection should be the minimum possible to achieve a well articulated and clear research or surveillance question, and where possible, be both time limited and involve directly questioning service users as little as possible. Collecting data indefinitely with no clear, articulated, high benefit purpose is inherently unethical.

SSPs, due to their controversial nature, are one of the best studied public health interventions of the past four decades. There are few overarching research questions relating to SSP efficacy or impact that have not already been extensively documented in the literature. As such, unless new questions which are not already addressed in the literature emerge, data collection should be limited to, at most, documenting number of syringes distributed and counting the number of individuals served. Even here, thought should be given to limiting such data collection to periodic data collection (e.g., two weeks of data collection conducted every third month) rather than continuous data collection in order to minimize the burden on SSP resources. Obviously, any externally-required data collection should be funded above and beyond normal SSP funding to avoid cutting into essential primary prevention services.

I am happy to be contacted for more detail on any of the above points.

Sincerely,

[Signature]

Peter J. Davidson, Ph.D.
Associate Professor
Division of Infectious Disease and Global Public Health
Department of Medicine
University of California, San Diego
pdavidson@ucsd.edu
415-271-9474
RE: KCHD Syringe Exchange Services

June 15, 2018

Dear Ms. Issac:

Thank you for the opportunity to comment on the materials relating to KCHD syringe service programs. These programs are a vital element of the response to the ongoing crisis is drug misuse and overdose. We hope that our recommendations will facilitate KCHD continued support, improvement, and expansion of syringe services to improve the lives of citizens in Kanawha-Charleston County. Below please find detailed comments on two documents: the KCHD review report titled “2018 Evaluation Report of the Kanawha-Charleston Health Department Harm Reduction Syringe Services Program” (hereafter “State Review Report”) and the “West Virginia Bureau for Public Health Harm Reduction Program (HRP) Guidelines and Certification Procedures” (hereafter “HRP Policies and Procedures”).

State Review Report

As the Report rightly notes, people who inject drugs “can substantially reduce their risk of getting and transmitting HIV, viral hepatitis, and other blood borne infections by using a sterile needle and syringe for every injection.” Provision of such sterile injection equipment is the primary goal of syringe services programs, such as the one operated by the Kanawha-Charleston Health Department.

As the Report further notes, “The current model at KCHD HRSSP indicates that patients are given clean injection equipment prior to receiving primary health care services.” The program is, in other words, doing exactly what it is intended to do: provide low-threshold, accessible access to sterile syringe equipment. However, the Report then continues: “This evaluation team believes it is important for patients to obtain primary care and behavioral health services (specifically linkage to substance use disorder treatment) before syringes are dispensed so that medical attention is seen as the top priority over syringe exchange.”

This belief on the part of the evaluation team must be reconsidered in view of the overwhelming evidence to the contrary. The principal purpose of syringe service programs is to provide access...
to sterile syringes. Such programs are effective, efficacious, and cost-effective in substantially reducing HIV and HCV transmission, among a number of other benefits. It is true that many, including the HRSSP, also provide other wraparound services, including linkage to care and treatment. But that is not the primary aim of the program, and to prioritize it over the provision of sterile injection equipment is to create an unnecessary resource, logistical, and structural barrier to many clients and potential clients, especially those whose experience of trauma and stigmatization would substantially deter help-seeking under the proposed framework. This would undermine the very concept of harm reduction-oriented syringe access.

Other aspects of the Report perpetuate this misconception. The ability to track individual patients is emphasized, while neither the state certification requirements nor the general practices of harm reduction programs require that type of tracking. The Report mentions that medical histories were only available for patients who entered treatment; medical histories are not required to dispense syringes. Examples like this occur throughout the report.

It was sorely disappointing to see that the Bureau of Public Health (to our knowledge) neglected to interview KCHD HRSSP’s clients or potential clients in preparation of the Report. The absence of perspective from people who use drugs severely limits the insight offered by this Report, because it misses a grounded view on how the services offered there have changed or improved their lives.

The BPH’s Harm Reduction website lists a variety of services that HRSSPs may offer, in addition to the distribution of sterile syringes. This illustrates how an SSP should work, by prioritizing the provision of sterile injection supplies needles. If the BPH is truly interested in the health and welfare of all West Virginians, a comprehensive plan of legal and policy changes is necessary. Decriminalization of syringe possession, extending the hours that HRPs are open to the public, and expanding access to safe disposal containers will reduce the syringe litter without withholding the critical access to clean syringes for people who use drugs.

**HRP Guidelines and Procedures**

We recommend that the guidelines and procedures mentioned in Chapter 1 under Section 1.3(b) relating to coalition-building activities with law enforcement be expanded. Especially given the recent events in the state, it is imperative that police feature much more prominently among constituents who are included in the “laying the groundwork” phase of program development. This can boost the impact of the program and help prevent future conflict, perhaps even

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1 “In addition to syringe exchange, HRPs may include the following services:
- Distribution of disease prevention material (e.g. alcohol swabs, condoms)
- Distribution of educational material related to substance abuse
- Distribution of educational material related to prevention of HIV and other sexually-transmitted diseases
- Referral to substance abuse disorder treatment programs
- Counseling and testing for HIV and/or hepatitis B and C
- Screening for tuberculosis, hepatitis B, hepatitis C, and/or HIV
- Linkage to HIV care”

[https://dhhr.wv.gov/oeps/harm-reduction/Pages/default.aspx](https://dhhr.wv.gov/oeps/harm-reduction/Pages/default.aspx)
engaging police as community advocates for harm reduction. There is a considerable body of research to inform such efforts. Silverman et al. outlines a framework for how to engage police in preparation for the opening of a syringe services program. Police trainings bundling occupational safety with harm reduction and legal content (see Davis and Beletsky) have been positively evaluated as addressing officer health concerns, while harnessing the power of intrinsic motivation to engage rank-and-file police and police management. Assuring that officer knowledge, attitudes, and practices are enabling of programmatic public health efforts is imperative to the success and sustainability of harm reduction programs.

We also recommend that, in addition to the items outlined in Table 1, syringe exchange providers collect basic information about police encounters to monitor emerging problems such as syringe or other supply (e.g. naloxone) confiscation, arrest at or around the service agency. Ideally, positive interactions, such as service referrals, should also be monitored. This information should be used to inform interventions to align policing with program goals, as well as to evaluate the impact of efforts to increase police referrals of people who inject drugs to health services.

Thanks for the opportunity to comment. Please let us know if you have any questions or concerns.

Sincerely,

Corey S. Davis, JD, MSPH, EMT-B
Teaching Professor
Brody School of Medicine
East Carolina University

Leo Beletsky, JD, MPH
Associate Prof. of Law and Health Sciences
School of Law & Bouvé College of Health Sciences, Northeastern University

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Kanawha-Charleston Board of Health  
PO Box 927  
Charleston, WV, 25323.

Dear Kanawha-Charleston Board of Health:

My name is Matthew La Rocco. I am the Community Liaison for the Louisville Metro Syringe Exchange Program (LMSEP) at the Louisville Department of Public Health and Wellness. I am writing you in response to West Virginia’s State Board of Health’s 2018 evaluation of KCHD’s Syringe Services Program and share you with my assessment of the evaluation.

In reviewing the state’s evaluation, I found both areas of agreement and disagreement with the state’s recommendations. In addition to these, there are areas of KCHD’s SSP not mentioned in the evaluation that were of concern to me. The five areas of most concern are the collection of data, linkage to care, recommended use of retractable syringes, unique identifiers, and best practices. I’ll address each of these areas individually.

Data

I share the state’s concerns about KCHD’s data practices. Good data is an essential element in identifying community needs, gaps in services, and planning for future interventions. However, data collection also increases the threshold for participant engagement in a SSP. For that reason, data collected face-to-face from participants should be limited to data essential for the provision of services. Other data, such as someone’s use of contraception, past history of treatment for an SUD, syringe sharing practices, etc., should be collected through the use of anonymous surveys. Collecting this data anonymously provides a space for the participant to share data of a sensitive nature without feeling uncomfortable. This not only shows respect for the participant but also increases the likelihood that their answers are reflective of their actual experience.

The use of a data collection tool that allows for data to be inputted at the point of service decreases the rate of errors in data collection and entry. There are programs similar to electronic medical records that have been designed specifically for SSPs, e.g. Neo360. Web based survey tools like SurveyMonkey can also be used for data collection.
Data collection issues are also compounded by the sheer number of people that attend the program in a five hour period. Seeing hundreds of people in five hours, with a staff that includes volunteers, can be chaotic and overwhelming. This has the potential to lead to errors in data collection. I would suggest that KCHD consider increasing the number of days they operate their SSP. Along with increasing access to services, being open multiple days a week should decrease the volume of people seen daily.

Linkage to Care

In the evaluation it was stated that, “Syringe exchange is secondary to primary care” and suggested that participants be linked to services prior to receiving syringes. This practice is coercive and goes against the core principles of Harm Reduction. The prevention of HIV, HCV, and other viral or bacterial infections related to injection drug use is the primary reason for SSPs.

Based on both my experience here at the LMSEP, the experience of other Harm Reductionists with decades of experience in the field, and Prochaska & DiClemente’s Transtheoretical Model of Change, behavioral change is more likely to occur when the change is identified and driven by the individual making the change. Requiring people to discuss areas of their life that they are not ready, willing, or feel able to discuss, or engage in services to receive syringes, reduces the likelihood of them following through with referrals.

Retractable Syringes

The use of retractable syringes is not a best practice for SSPs. Retractable syringes are not preferred by most people who inject drugs and this can lead to decreased utilization of SSPs. Additionally, in situations where individuals are going to share or reuse a syringe, using a retractable syringe eliminates the individual’s ability to clean the syringe before sharing or reuse. This increases the risk for contracting HIV, HCV, or other viral or bacterial infections related to injection drug use.

Retractable syringes can be converted to fixed point syringes. The needle can be removed from the plunger, placed back into the syringe, and melted into place. This modified syringe has a small gap at the bottom of the barrel, where the bottom of the plunger does not meet the bottom of the barrel. This results in a syringe that, if shared, is more likely to transmit HIV or HCV as it can’t be easily cleaned out.

The goal of retractable syringes is to reduce the risk of HIV or HCV being transmitted due to community-acquired, non-occupational needlestick injuries (CANSI). Worldwide, there have been only three reported cases each of HBV and HCV and no documented case of HIV transmission from non-healthcare-associated needlestick injuries. Empirical data, scientific evidence and theoretical considerations all support that pathogen transmission from a CANSI is extraordinarily unlikely. (J. Jason; Community-acquired, non-occupational needlestick injuries treated in US Emergency Departments, Journal of Public Health, Volume 35, Issue 3, 1 September 2013, Pages 422–430, https://doi.org/10.1093/pubmed/fdt033)

We do know that HIV prevalence among people who inject drugs is 28 times higher than among the rest of the population. Additionally, it is estimated that 60% of people who inject drugs are infected with HCV. These rates of infection are mainly due to the sharing of syringes and other injection equipment. Establishing practices like 1-for-1 syringe exchange and only providing retractable syringes does little to nothing to reduce the transmission of HIV or HCV from
CANSI. These practices do significantly increase the risk of transmission of HIV and HCV for people who inject drugs.

Unique Identifiers

I am in agreement with the state that the formula used to create an unique identifier lacks the complexity required to produce unduplicated identifiers. At the LMSEP we use a participant’s first and last initial, mother’s first name initial, birth month, birth year, and last two digits of their social security number. We used two other formulas to generate unique identifiers and found them to be insufficient. We have used our current formula for over two years and rarely see replicated unique identifiers. In addition, it is rare that we have participants who express discomfort or unwillingness to provide the requested information. We do not require participants to give us any information to participant in services. These participants are given a generic unique identifier, XXX099999.

I am concerned with the state’s recommendation that participants be required to provide personal identification to receive services. Due to the criminalization of drug use and the stigma surrounding the use of drugs, people who inject drugs highly value anonymity. This requirement, that eliminates participant anonymity, raises the threshold for engaging in services and will likely result in decreased participation.

Best Practices

Lastly, I’d like to point out that many of recommendations made by the state are contrary to best practices in Harm Reduction. These best practices have been developed through years of working with people who use drugs and validated by a myriad of studies. I’d suggest that the state and the KCHD take a close look at available scientific literature before they make any changes to the KCHD SSP or any other SSP in the state.

Both the state and the KCHD have my sincere gratitude for their efforts to engage people who use drugs in life saving services. While I may not fully agree with elements of KCHD’s SSP or the state’s recommendations, I appreciate the intention to reduce the harms associated with drug use for both the people who use drugs and for the people whose lives intersect with the lives of people who use drugs. If I can be of any assistance, please don’t hesitate to contact me at Matthew.LaRocco@LouisvilleKy.gov.

Regards,

Matthew LaRocco, CADC
Community Liaison
Louisville Metro Syringe Exchange Program
To members of the Kanawha-Charleston Board of Health,

I am writing today to offer a review of the recent audit of the Kanawha County Health Department Harm Reduction Program (KCHD-HRP), performed by the state of West Virginia Department of Health and Human Services, Bureau for Public Health, that resulted in the suspension of the program. I also offer thoughts on the purpose and efficacy of these important, life-saving and cost-saving harm reduction programs (HRPs) and provide suggestions on how both the state of West Virginia and the Kanawha-Charleston Board of Health could resolve this issue.

First, allow me to provide some background on NASTAD and my role within the organization. NASTAD (National Alliance of State and Territorial AIDS Directors) is a leading non-partisan non-profit association that represents public health officials who administer HIV, hepatitis, and drug user health programs in the U.S. and around the world. We aim to end the intersecting epidemics of HIV, viral hepatitis, and related conditions by strengthening domestic and global governmental public health through advocacy, capacity building, and social justice. Specifically, I am NASTAD’s Manager of Drug User Health and assist states, territories, and jurisdictions to create effective and timely programmatic responses to the infectious disease consequences of injection drug use and improve the health of people who use drugs. I have been working on issues related to infectious disease, behavioral health, and drug use for nearly a decade in a variety of roles and serve as NASTAD’s content area specialist on drug user health.

I approach this letter out of genuine concern for the health and well-being of your county and community members and hope this helps to inform your response to the recent suspension of the KCHD-HRP.

Upon initial review of the audit performed by the State of West Virginia Bureau for Public Health, Division of STD and HIV, I found the audit to be well-conducted and the program well-reviewed overall. The evidence in the review provided both a recognition of the positive aspects of the KCHD-HRP program and a few areas that were identified as needing continued attention, guidance, and modification. It was clear in the audit, that the KCHD-HRP was successful in most of its designed intentions and proved to reach a highly stigmatized, high priority, and often, hard-to-reach population and that there were also areas for potential improvement. Overall, given the evidence presented in the audit, I believe that the decision to suspend the program to be unfounded and cannot be substantiated when compared to the West Virginia HRP guidance. This discrepancy indicates a larger underlying issue.

While the audit provided several suggestions to improve the program and tailor its offerings to better meet the needs of the community and clients, I found little in the audit’s data to indicate that the KCHD-HRP was negligent in the services they were providing—especially not so negligent as to warrant
suspension of the program and resultant withdrawal of services for program participants. Upon review, the real issue that is apparent is the disconnect between community/board of health expectations for HRPs and the expectations laid out in the West Virginia Harm Reduction Program Guidelines and Certification and Procedures. This guidance document describes harm reduction programs as low-barrier, low-threshold services designed to refer clients to care, provide sterile injection equipment to reduce the spread of infectious disease, and provide an avenue for disposal of used injection materials. Many of the key findings from the audit suggest that there is an expectation for a HRP program to provide services outside of the scope of HRP programs set out in the state-level guidance. This is an unreasonable expectation and the KCHD-HRP should not be suspended for not meeting guidelines that are not formal, written, and publicly available. Such ambiguous expectations set a dangerous precedent for all local and county operated programs and needs to be remedied.

To illustrate this point, I plan to discuss several of the key findings of the audit compared to what was noted in the West Virginia HRP guidelines, overall harm reduction program fidelity, and programmatic best practices for preventing infectious disease among people who use drugs.

**Syringe Disposal and Collection**

Within the audit there were several mentions of improper disposal of injection equipment and syringes in public spaces. While this is never ideal for a community or program, the audit did find that nearly 70% of syringes were returned to the KCHD-HRP which is not out of a normal and acceptable range for most harm reduction programs throughout the country. Since there are other acceptable and legal disposal options within West Virginia, we cannot assume that the remaining 30% of syringes were improperly disposed of nor can we assume that any improperly discarded syringes originated from KCHD-HRP. There are many possible options for biohazardous waste disposal including legally (as per WV law) disposing of syringes at home in a #2 plastic container marked ‘biohazard’, seizures by law enforcement, disposal within a pharmacy or public disposal box, etc.

Additionally, there is no requirement within the state HRP guidance and certification guidelines for syringes to be disposed of only at the HRP of their origin. Such a requirement would be untenable and nearly impossible to enforce. Lastly, it is important to note that the audit provides only anecdotal reference to an increase in improperly discarded syringes. If we are talking about the KCHD-HRP being suspended for not keeping appropriate data it is also important to require counties and jurisdictions to track improper disposals to justify their claims, especially when such claims are being used to shutter a vital and effective public health program.

**HRP Referrals**

Another major area we see a disconnect between the scope and intention of HRP programs and the Bureau of Public Health review is primary and behavioral health referrals. The audit suggests that the KCHD-HRP was unable to consistently track the referrals that the HRP staff provided and effectively linked to care. It even goes so far as to suggest that the KCHD-HRP was somehow responsible for tracking whether a client followed the referrals, entered into continued care, or engaged with treatment/other services. This level of follow up is not typical or reasonable within the scope of harm reduction programs that are intended to provide limited services and referrals. The audit is suggesting
that the KCHD-HRP program provide comprehensive case management rather than referrals and there is nothing in the West Virginian HRP guidelines that indicates an expectation of comprehensive case management for all HRP clients. If this were to become a requirement for any HRP program, the state or jurisdiction would need to increase financial support to these programs.

The notion that comprehensive case management would be possible within the current scope of the KCHD-HRP program, considering limited staffing, funding, and operational hours, is untenable. There are other models of harm reduction programs housed within federally-qualified health centers, clinics, or AIDS service organizations that might be able to provide this degree of case management, yet it is unreasonable to expect a stand-alone HRP to provide such intensive care. Each type of program has strengths and limitations and to effectively reach most people who are injecting drugs, it is best practice to actively support a diverse range of programs within a community at risk. As noted in the West Virginia HRP guidelines, harm reduction programs are intended to serve as a point of referral and access point for sterile syringes, injection equipment, and safe disposal; there is no requirement for them to provide any services beyond these. As such, the KCHD-HRP should not be judged on informal requirements or community hopes.

Data Collection
The state audit noted several general issues regarding the data collection and input methods utilized by the KCHD-HRP program. While data collection was an issue in this case, it also seems that the program had limited staff capacity and a lack of clear, uniform expectations from the state as to both, what data they were supposed to collect, and a uniform system to collect it within. It also is clear that the data points collected by the KCHD-HRP were aligned with best practices for HRPs and with the guidance put forth by the state. Rather than using data collection as grounds for program suspension, we should ask the state to create unified systems for HRP data collection and partner with community stakeholders to create clear, formal expectations for what data metrics are to be collected. This is an opportunity to both build infrastructure and create continuity among programs statewide. Again, suspending a program for an issue that is the responsibility of the state or county feels inappropriate.

Building and Maintaining Community Support
Community support is integral to the acceptance and support of any community-based program or policy. The audit notes that the KCHD-HRP has had broad appeal to people who use drugs and was a vital link to services and supports to prevent overdose and infectious disease and only recently came under more intensive scrutiny for inconsistencies within their operating practices. ‘Building and maintaining community support’ for any program is a long-term practice and cannot be one-sided. It is unfair of the state to suggest that the responsibility for maintaining this relationship belongs solely to the KCHD-HRP. The audit notes that the KCHD-HRP held numerous forums and community sessions to include stakeholders which indicates they were committed to building and maintaining community support, yet they can only be responsible for their part of this; there is a corresponding responsibility of stakeholders to engage in building this relationship as well and I have seen no indication or evidence of that. Additionally, for a program to evaluated or judged there has to be a metric that is clearly defined, written, and formal. Without a means to measure a program requirement, there is no way for that program to ever effectively meet it.
Services, Program Fidelity, and Promoting Public Health and Safety

The state audit suggests that participants must be present at the HRP to attain services. While I can understand that what drives this suggestion is intended to create more opportunities for referrals and other testing and linkage activities, it is also important to be understanding of the daily lived realities of the program participants. People who use drugs are no different than other people, they have complicated lives and schedules and obligations that might not always be able to fit within a specified, weekly, limited timeframe. This is also a highly stigmatized group for whom public exposure as a person who uses drugs might endanger their employment, social standing, or stability so it is important to provide serves that are anonymous and low threshold. Considering these barriers as well as distance and lack of transportation options available it is difficult to image that an HRP could ever reach a majority of the people using drugs in its community.

To ensure we are meeting the goals of harm reduction programs and maintain program fidelity, an HRP hopes to attain as close to 100% coverage and access to sterile injection materials as is possible. We know that without those supplies people will likely inject unsafely and be at increased risk of acquiring HIV, hepatitis, and corollary infections that are devastating to the participant’s wellbeing and costly to the state and jurisdiction. By forcing participants to be present for each exchange we are limiting the potential reach and effectiveness of these programs and putting our communities at risk for outbreaks and an increased burden of disease. If in-person attendance becomes a requirement for HRP participation, then I strongly encourage the state and county to increase operating hours for the HRPs. An increase of hours would allow for each participant to access services in a more reasonable timeframe that could fit within their work and family schedules and decrease the perceived ‘rush’ of participants during a 3-hour, weekly timeframe that is described in the audit.

In summary, after review of the audit, I found little connection between the evidence it presents and the suggestion that the KCHD-HRP’s program certification be suspended. I see clear avenues and action steps to address the programmatic concerns presented and these solutions will require cooperation and participation from the state, the city and county, community stakeholders, and the KCHD-HRP. I also see that this collaboration is not impossible and will be necessary to protect the health of your community, particularly those community members who are now at increased risk due to the KCHD-HRP program’s suspension. Lastly, I see a community that clearly cares about the health and public safety of its members and that is grappling with the growing pains of a vital program that has experienced rapid growth.

I appreciate you taking the time to consider the review offered herein. I welcome any thoughts, questions, or concerns you may have and I offer my continued support to help your community work through this issue and improve the health and services for people who are using drugs.

Best,

Laura Pegram, MSW, MPH
Manager, Drug User Health

NASTAD | 444 North Capitol Street NW, Suite 339 | Washington, DC 20001
Assessment of 2018 Evaluation Report of the Kanawha-Charleston Health Department Harm Reduction Syringe Services Program
Robin Pollini, Phd, MPH, Associate Director and Associate Professor
WVU School of Public Health

Page 7: “The evaluation seeks to assess the following public health components of the harm reduction program using the KCHD’s goals defined in the Program Procedure Manual [PPM].”

- It is not clear why the assessment was conducted with respect to the PPM rather than the state certification criteria. Was the PPM submitted to BPH as part of the certification process?

Page 9: “In an effort to ensure that SSPs provide appropriate and competent services, the WVDHHR, BPH developed Harm Reduction Program Guidelines and Certification Procedures to aid entities interested in implementing SSPs and allow for a mechanism for entities to receive federal funding to support SSPs upon being certified by BPH. To be BPH-certified, an HRP must meet criteria outlined in the Guidelines with the aim of reducing “drug-related harm while enhancing individual, family, and community wellness.”

- Based on this, not the PPM, it is not clear what specific criteria is KCHD not meeting.

Page 17: “The purpose of the current document is to evaluate the effectiveness of KCHD’s HRSSP. Of the four purposes of evaluation described in CDC’s Framework for Program Evaluation in Public Health evaluations with the intent of assessing the effects of a program ‘examine the relationship between program activities and observed consequences. This type of evaluation is appropriate for mature programs that can define what interventions were delivered to what proportion of the target population.’ (Koplan, Director and Higgins Peter M Jenkins, 1999)”

- Not clear that the KCHD HRSSP should be considered and evaluated as a “mature” program given that it has been in existence for less than three years. The cited CDC guidelines do not give a specific definition of mature but note that “Programs that have recently received initial authorization and funding will differ from those that have been operating continuously for a decade.”

Page 20: “To maintain anonymity, the KCHD HRSSP attempted to create a unique identifier by combining the first and last name initial with month and year of birth. However, it is possible that multiple patients had the same identifier. This imposes limitations on data analysis and conclusions.”

- First, program users are not “patients” they are participants – this is reflective of what appears to be a fundamental misunderstanding by DHHR/BPH personnel regarding the difference between a public health-oriented harm reduction program and a clinically-based medical program.
- Second, the method of constructing participant IDs used by KCHD is commonly used by SSPs across the country and is consistent with guidelines in the Harm Reduction Coalition’s Guide to Developing and Managing Syringe Access Programs (see page 34). Even where participants have the same ID code, the number of unique patients with that code can be enumerated using new patient intake forms.
- Third, use of this code does not impose limitations on data analysis and conclusions because the only data required by state certification (and indeed, this is the case for all harm reduction programs nationwide to the best of my knowledge) is aggregate data for the program. In the case of WV BPH’s certification program the minimum data requirements are quoted as follows on
Three minimum essential data elements are recommended for every syringe transaction occurring at HRPs, without regard to the type of service delivery model:

- number of participant contacts (i.e., duplicated participant counts);
- number of syringes distributed; and
- estimated number of syringes returned for disposal

Page 20: Because of multiple individuals having the same ID code “Data from the initial visit is unable to be linked to return visits. Consequently, the characteristics of the individuals that remain engaged with the KCHD HRSSP are unable to be described. Another consequence of the identifier is that an accurate count of unique individuals served is not available and further limits assessment of outcomes. For instance, a change in hepatitis status cannot be tracked because hepatitis status is only assessed on the initial visit. Furthermore, even if a patient indicates a change in status has occurred, the lack of a true unique identifier would not allow this change to be associated with the record of the patient’s initial visit.”

- There is no requirement in the state certification program guidelines that a harm reduction program be able to track individual patients for seroconversion, drug treatment engagement, or any other individual-level outcomes. Indeed, this would be unusual for a harm reduction program (vs a clinical program or longitudinal research study).

Page 20: “The inability to link a return visit with the initial visit resulted in most analysis being conducted with new patient data only. It is possible that new patients and return patients have different characteristics, but this was not able to be assessed due to the above-mentioned data considerations.”

- Again, there is nothing in the state certification guidelines that requires programs to be able to link data by individual participant across time or compare the characteristics of new and returning patients.

Page 20-21: “Data from the HRSSP database appears to be free entry, which increases data entry errors, and decreases the quality of data, which in turn further limits conclusions. Not counting missing data, at least 25% of the visits recorded in the 2017 KCHD HRSSP database had errors comprised of misspellings, entries that matched other fields, inconsistency in reporting style, etc. This issue could be easily corrected with the implementation of a database with dropdown tabs or set choice and designing a form to match this methodology.”

- KCHD has already developed and implemented a REDCap database to address this, but this program improvement is not reflected in state’s report.

Page 21: “It also appears that some of the data reported to the media is associated with patient self-reported data from the initial intake form. Additionally, the new patient form only assesses interest in other services. There are no additional fields in the database to indicate if services were received. BPH is unable to determine linkage to care, recovery services, and lives saved by naloxone via the data supplied by the KCHD.”

- All data collected by harm reduction programs from participants at intake is self-reported. This is common practice at every harm reduction program nationally and globally, as well as research conducted with people who inject drugs. Indeed, there is no way other than self-report to collect
information on drugs used, injection frequency, etc. Interest in other services is assessed so that harm reduction staff can make the appropriate referrals; again, there is nothing in the state certification guidelines that requires participant-level assessment of whether these services were received (although these data are tracked by KCHD in aggregate for the program).

- Note that “lives saved by naloxone” is not a reasonable measure as individuals who administer naloxone are often not aware of outcomes after a patient is transported to the hospital. Naloxone doses administered (or in some cases reversed) is the only reasonable outcome measure beyond doses distributed.

Page 21, Table 1: “Evaluation staff could estimate the number of patients that received services at the HRSSP. Unable to determine the number of IDUs reached that did not receive services in the HRSSP.”

- It is unclear what the latter number refers to; regardless, this is not a measure that is required of state-certified programs. I am aware of no other harm reduction program that tracks information on individuals who do not receive their services.

Page 21, Table 1: “Medical history was available only for those patients served by Cabin Creek Health Systems.”

- This is appropriate – harm reduction programs do not collect medical histories unless clinical services are provided.

Page 21, Table 1: “Overdose history was available in the database, but information regarding linkages to treatment was not available.”

- See above regarding individual-level vs. aggregate reports of treatment linkage. Also, this point seems to confuse the “history” taken at intake (e.g. overdose history) with treatment linkages that may take place once a patient is enrolled in the program (i.e., retrospective vs prospective data).

Page 22: “While most patients (71%) indicated that they resided within Kanawha County, 17%-18% of records were missing this information.”

- Missing data is common for harm reduction programs as participants may be apprehensive regarding the provision of personal information, especially at the first/intake visit. This is widely understood and accommodated by harm reduction programs given the illegal nature of injection drug use and the relative importance of providing preventive services over collecting pristine data.

Page 23: “The number of reported unique identifiers can be assessed, but this is likely an underestimate of actual patients.”

- Correct, that is why new participant intake forms, not participant identifiers, are used to quantify the number of program participants.

Page 23: “…minimal analysis could be conducted on the complete dataset because most data was only collected on the first visit and there is no way to link subsequent visits.”

- See above. Statistics are analyzed for the program in aggregate. There is no state requirement for individual patient-level tracking. As noted on page 25 of the state’s certification document, “Descriptive statistics are usually sufficient to answer process monitoring questions.” Assessing
longitudinal patient data, as referred to in the evaluation report, is actually a relatively complex and
time-consuming statistical analysis that most harm reduction programs in West Virginia and
elsewhere do not have the capacity to conduct.

[Note that at this point I will cease addressing additional references to the patient linkage issue except as
an overall critique of the program, to reduce repetition of comments.]

Page 31, Table 3: “KCHD syringe distribution and disposal practices are well defined for the health
department site. Syringe litter and its disposal remains a concern. 421,208 syringes were returned (a 66%
return rate), leaving 220,919 syringes unreturned.”

- The report fails to acknowledge that home-based disposal of medical sharps is legal in West Virginia
and all program participants at KCHD and other SSPs across West Virginia receive information on
how to legally/responsibly dispose of syringes in household trash. Many, including KCHD, also
provide participants with puncture-proof containers for this purpose.

Page 31, Table 3: Regarding distributive and receptive syringe sharing…”This data is recorded in the
database; however, there is no corresponding data collection fields on the forms provided to the
evaluation team. Thus, it is unclear how this data was collected.”

- These measures are not required for state certification. They are identified as “key domains” in the
quantitative outcome monitoring assessments described on page 26 of the state’s certification
guidelines, but these assessment “should occur, at a minimum annually or every other year and
include a representative sample of participants.” Since the state certification guidelines were issued in
late 2017, KCHD has not yet conducted such an assessment.

Page 32: “In 2017, a patient could leave KCHD HRSSP with a maximum of 300 clean syringes if 30
syringes were brought to exchange for themselves and 30 to exchange for each of up to nine other
individuals. To be able to pick up syringes for others, the patient must have visited the program at least
once and the patient picking up syringes for others must have each patient’s ID card.”

- This is a practice referred to as “secondary exchange” and is a common practice among SSPs. While
it is true that persons who do not visit the SSP in person may not benefit from directly-delivered
information services, this practice does insure access to sterile injection equipment for individuals
who for a variety of reasons cannot, or will not, visit the SSP on a particular day. Reasons for not
coming to the SSP in person may include transportation barriers, concerns about
confidentiality/anonymity when entering or exiting the building, concerns about syringe
confiscation/arrest, illness, work schedule, child care issues, and so on. Secondary exchange is
particularly useful for programs like KCHD that have limited hours of operation.

Page 34: “KCHD HRSSP staff reported that when patients were asked the reason used syringes were not
returned, many stated the syringes had been confiscated by law enforcement, given to/taken by someone
else, or safely disposed of at home. This was anecdotal information and could not be verified during the
evaluation.”

- The reasons stated are all commonly reported reasons for not returning syringes to a SSP. They can
only be self-reported and can never be “validated” even if included as a data collection field.

Page 35, Table 6: Prior to late 2017, KCHD HRSSP did not directly track screening and results for the
number of persons tested for HIV, HBV, and HCV because patients were anonymous. In addition, KCHD
does not track the number of condoms distributed or the number of persons given condoms at the
HRSSP.”

- None of these measures are required under state certification, although KCHD does now voluntarily
  track screening uptake and results.
- Few SSPs track the number of condoms distributed or number of persons receiving condoms as
  condom distribution – unlike syringe distribution – is not restricted.

Page 36: “Due to the increase risk of Hepatitis and HIV in PWID regular testing would provide more
accurate incidence rates. Furthermore, it may lead to less spread of disease due to knowledge of disease
status and subsequent behavioral changes.”

- HIV and hepatitis testing are offered to participants at every program visit. It is the right of each
  participant to decide when to accept testing. Mandatory testing for program participation is widely
  considered unethical and, at minimum, would constitute a barrier to program participation.

Page 38, Table 8: “…the Harm Reduction Database only documents interest in service, not service
delivery.”

- Data on receipt of services is not required under the certification guidelines. Receipt of clinical
  services would be recorded by the appropriate medical care provider following referral, not the
  referring harm reduction program.

Page 38, Table 8: Regarding changes in drug use behavior: “This information was not collected in the
database until February 2018. Information was only documented for 25% of patients after this data field
was implemented.”

- These data are not required under the certification guidelines.

Page 41: “The KCHD HRSSP assessed patient interest in other services. However, patients did not have
documentation for these services within the Harm Reduction Database. Furthermore, there was no
documentation of linkage to the services patients expressed interest in receiving. It is possible that
patients received these services, but without supporting documentation, it cannot be confirmed. Patient
education can increase the uptake of additional services to decrease the risk of overdose,
and transmission of disease. Furthermore, services beyond the needle syringe were conducted on alternate
days, only referrals to additional services were provided at the harm reduction clinic. There was no data
associated with the referrals that the harm reduction clinic made.”

- See above. Documentation of information beyond referrals is not required under state certification.
The statement that “only referrals to additional services were provided at the harm reduction clinic” is
unclear in its meaning, as no involvement beyond referrals is required. Once referred, data on clinical
care is kept in the records of the providing physician.

Page 45: “Because KCHD HRSSP is currently suspended, patients were not engaged as stakeholders, a
significant limitation to the program evaluation.”

- This is an egregious omission that could have been addressed easily via recruitment by KCHD staff
  or others experienced in conducting outreach with people who inject drugs.
Page 46: City of Charleston stakeholders “did not believe there was a need for two syringe exchange programs and reinforced consistently during the interview that West Virginia Health Right’s program was the better program because patients are viewed as identifiable, named patients. Syringe exchange is secondary to primary care. The stakeholders reported that West Virginia Health Right is able to link one-third of patients to recovery compared to 1.5% from KCHD HRSSP, though they indicated that KCHD HRSSP’s number were not credible. City officials believe that West Virginia Health Right would be able to serve KCHD HRSSP patients in addition to their current patient load.”

- This assessment is not based on science or knowledge of best practices for HIV/HCV prevention among people who inject drugs. Best practices for harm reduction programs is to not collect patient names, as this serves as a barrier to program participation. Similarly, incorporating syringe exchange into a primary care program serves as a barrier and is not consistent with providing low-threshold harm reduction services that are necessary to achieve the 100% syringe coverage that is necessary to prevent disease epidemics. The fact that the vast majority of KCHD program participants have not switched over to the Health Right program follow closure of the former demonstrates the impact of these barriers on program participation.

- If Health Right is “linking one-third of its patients to recovery” it would be useful to know a) if these are evidence-based treatment programs, and b) if this represents not just “linkage” but treatment entry. Regardless, it should be noted that Heath Right, by virtue of the fact that it is serving patients already receiving primary care, is likely dealing with a less vulnerable and more treatment-ready population than that served by the KCHD program.

Page 47, Table 13:
- Regarding “syringe litter” – there has never been any objective assessment of the contribution of KCHD syringes to the “syringe litter” problem.
- Regarding retractable syringes – these syringes increase the risk of HIV/HCV when compared to regular syringes and are not recommended for use in harm reduction programs.
- Little impact on disease rates – this should not be expected at a community level given the short time the program has been in operation.
- Other concerns listed in Table 13 – these show a general lack of understanding regarding the purpose and practices of evidence-based harm reduction programs.

Page 48, Table 14: There is no way to link any increase in structure fires in Charleston with KCHD harm reduction operations and it therefore should not have been included in the report. Similarly, the increase in needlesticks depicted in Figure 29 on page 49 cannot be factually attributed to the KCHD program.

Page 50, summary of findings: “This concern is further supported by the West Virginia Board of Medicine’s rules related to the licensing and discipline of physicians which provides that the Board may deny an application for a license, place a licensee on probation, suspend a license, limit or restrict a license, or revoke any license issued by the Board, upon satisfactory proof that the licensee has “[f]ailed to keep written records justifying the course of treatment of the patient, including, but not limited to, patient histories, examination results and test results and treatment rendered, if any”. W.Va. Code R. § 11-1A-12.1. u”

- This is inappropriately cited given that the evaluation is of a public health prevention program, not provision of clinical services.

Page 50, summary of findings: Regarding tracking of individual patients via the ID code: “This poses a challenge to tracking a patient’s progress to recovery from substance use disorder, which is a primary goal of City stakeholders.”
• If accurately stated, the city stakeholders have a fundamental misunderstanding of the purpose and operations of a harm reduction program such as that provided by KCHD.

Page 50, summary of findings: KCHD HRSSP participated in a variety of community and stakeholder meetings; however, to the best knowledge of the evaluation team, a steering committee as described in the manual did not exist.

• Steering committee is not required under the state certification requirements.

Page 51, summary of findings: “With over 421,000 syringes reportedly dispensed in 2017 and a return rate of 66%, it is plausible that much of the syringe litter were ones that were dispensed by KCHD HRSSP.”

• While “plausible” this cannot be stated with any degree of certainty.

Page 51, summary of findings: “Reportedly, KCHD HRSSP staff were available to pickup syringe litter within 24 hours on weekdays and within 48 hours on weekends. This time period was not acceptable to officials from the City of Charleston who stated that syringe litter should be picked up within 10 minutes.”

• This expectation is patently unreasonable, given that even an immediately available staff person might be dispatched from a location that is more than 10 minutes away from the reported syringe. This statement is indicative of the unreasonable expectations of some City staff who were interviewed for this report.

Page 51, summary of findings: “Additionally, the concept of ‘syringe exchange’ is not being optimally practiced. Instead, ‘syringe access’ is employed. Access to clean syringes should be supplemental with additional harm reduction services.”

• This statement demonstrates a fundamental misunderstanding of how SSPs and harm reduction programs work. Access to clean syringes is the cornerstone of any harm reduction program, not a supplemental service, and should be the priority of any harm reduction program focused on preventing the spread of infectious diseases.

Page 51, summary of findings: “The current model at KCHD HRSSP indicates that patients are given clean injection equipment prior to receiving primary health care services. The evaluation team believes it is important for patients to obtain primary care and behavioral health services before syringes are dispensed so that medical attention is seen as the top priority over syringe exchange.”

• This similarly reflects an alarming lack of knowledge regarding how syringe services/harm reduction programs operate. By definition, a program that uses referrals to primary care and behavioral health services cannot provide these services prior to dispensing syringes. Further, there is absolutely no evidence base for this recommendation, which amounts to establishing unnecessary barriers to HIV/HCV preventive services for program participants. I am unaware of any reputable harm reduction program operating in the US or anywhere else that takes this approach or any regulating entity that requires it.

Page 51, recommendations: See comments above regarding tracking of patients and public health vs. medical/clinical recordkeeping requirements.