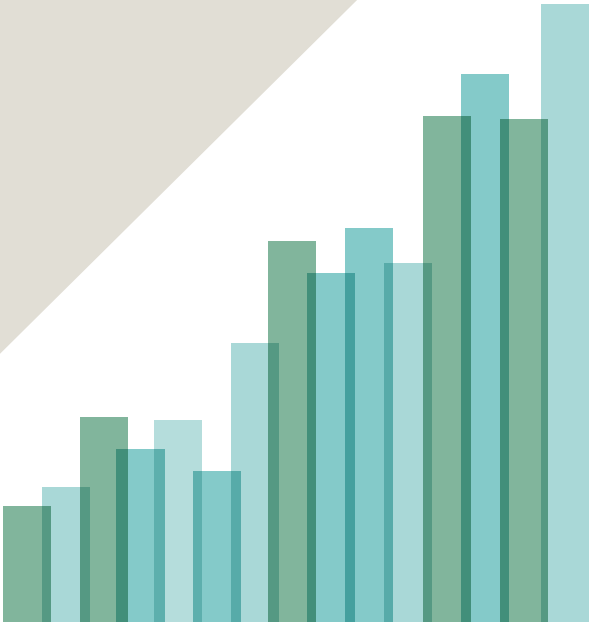
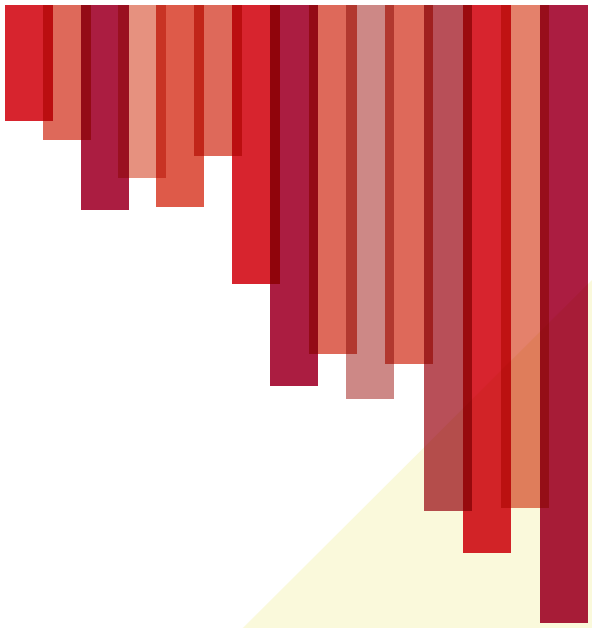


MAXIMIZING HEALTH, MINIMIZING HARM

The Role of Public Health Programs in Drug User Health



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INTRODUCTION

Since the earliest days of the HIV epidemic, people who inject drugs (PWID) have been disproportionately impacted. This population has also been disproportionately impacted by hepatitis A (HAV), hepatitis B (HBV) and hepatitis C (HCV). The National Alliance of State & Territorial AIDS Directors (NASTAD) and the health department members we represent have long been concerned about the role of substance use in the transmission of HIV and hepatitis, health outcomes for people living with HIV and hepatitis with substance use disorders, and the structural and policy barriers to effectively address the prevention, care and treatment needs of persons who inject drugs. To address the prevention, care and treatment and policy needs related to drug user health, NASTAD has advanced the issues through technical assistance, policy change and coalition engagement. To best meet the needs of people who inject drugs, NASTAD has partnered with federal, state and local governments and for- and not-for-profit community partners to continue to raise awareness of and action to best meet the health needs of this population.

While there has been tremendous progress in reducing HIV transmission among people who inject drugs, transmission continues to occur. There remains an epidemic of HCV transmission and overdose among this population with an increase in new HCV infections among young people who inject drugs. Health departments play an essential role in assuring an adequate response to public health – this includes the prevention, care and treatment needs of people with substance use disorders. Historically, HIV and hepatitis programs have focused primarily on the infectious disease needs of this population, though increasingly there is a movement to collaborate with other health and social justice organizations to address the holistic health needs of people with substance use disorders. Just as the health needs of this population are complex and multi-layered, our response to these needs will include multiple stakeholders and approaches. Health department infectious disease programs have unique perspectives and skills to bring to this response. According to ***A Comprehensive Approach: Preventing Blood-Borne Infections Among Injection Drug Users***, a resource produced by the Centers for Disease Control and Prevention: "Potential partners in the effort to reduce infection among IDUs may not agree on everything, but they do need to find ways to work together so that a critical mass of IDUs can obtain sufficient, high-quality services."[1]

Maximizing Health, Minimizing Harm highlights opportunities for health department infectious disease programs to address a range of drug user health issues, identifies potential collaborators and provides recommendations for health department programs to consider to best meet the comprehensive health needs of people who inject drugs. In addition to this document, NASTAD offers a range of technical assistance to health departments seeking to increase their response to the needs of people who use drugs.

[1] The Centers for Disease Control and Prevention. (2005). *A Comprehensive Approach: Preventing Blood-Borne Infections Among Injection Drug Users.* Retrieved January 15, 2015 from http://www.cdc.gov/idu/pubs/ca/forword.htm

Contents

HIV AND HCV PREVENTION AMONG PEOPLE WHO INJECT DRUGS

People who inject drugs are at increased risk for acquiring HIV and HCV. It is not only the injection of drugs that increases this risk, but also the preparation equipment and surfaces that may be contaminated with blood. Aside from refraining from injecting drugs, the most effective method to prevent HIV or HCV infection is to use new sterile needles, syringes and other preparation and injection equipment each time a person injects. Health department HIV and hepatitis programs have long prioritized the infectious disease prevention needs of people who inject drugs. From the earliest days of the HIV epidemic – health departments have called for and where possible, supported access to clean drug injection equipment. Where syringe services programs (SSPs) were implemented, HIV cases among people who inject drugs dropped considerably. Unfortunately, the same cannot be said for HCV. This is due to several issues, including: HCV prevalence of as high as 90% in some communities, the need for prevention messages that include all preparation equipment and the fact that HCV is more infectious than HIV.

Health departments have also prioritized HIV and HCV testing for people who inject drugs. By targeting testing among this population, individuals have the opportunity to learn their status, make changes to behavior to prevent additional transmission and receive access to medical and substance use treatment.

Health department HIV and HCV surveillance programs should continue to monitor disease trends in this population – especially considering an alarming trend of new HCV cases among people who inject drugs under the age of 30. There is an extremely limited infrastructure and funding available to support HCV surveillance nationally, which has the possible effect of missing outbreaks and trends. With effective prevention intervetions, we can: prevent further spread of HCV; link infected persons to medical care; and prevent HIV from entering these networks.

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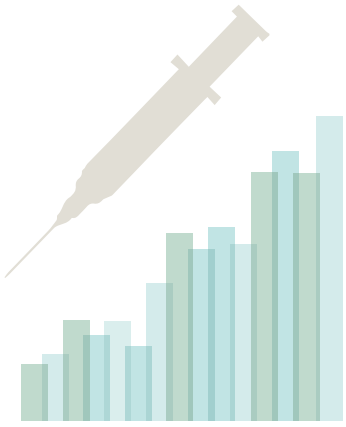
POLICY ACTION *Syringe Service Programs (SSPs) and Syringe Safety*

In 1994, NASTAD released the policy statement "Reducing transmission of HIV through increased access to clean needles and syringes" which called on federal and state policymakers to lift bans on the use of public funds to support the provision of needles and syringes as well as to authorize the creation of SSPs.

PREPARATION EQUIPMENT & SERVICES

Providing new drug preparation equipment (e.g. needles, syringes, cookers) to people who inject drugs can be traced to the early 1970s in the US. The first syringe services program (SSP) to operate publicly was started in 1988 in Tacoma, Washington. Around this same time, the U.S. Congress instituted a ban on any federal funding supporting the distribution or exchange of needles. This ban continues today, and SSPs rely on state and local government and private foundation funding. As of 2011, at least 221 SSPs operated in the US.

Many SSPs also provide related services including: wound and vein care, triage/medical assessments, HIV and HCV testing and referral; hepatitis A and B vaccination, overdose prevention kits, food in pre-packaged units, personal hygiene kits, referral for shelter, referral to soup kitchens, financial aid, legal assistance, and distribution of bus passes and/or other incentives.



YOUNG PEOPLE & HCV

In Wisconsin, and at least one half of other states, HCV cases among young people continue to rise — in 2013, 27% of new HCV cases in Wisconsin were among people under age 30. The state health department chose to direct the majority of its HCV testing funds towards four HCV and HIV outreach programs with co-located syringe services as they are well-positioned to effectively provide both services to this population. Yet the health department realizes that supporting testing is not enough on its own as a comprehensive response to these increases in HCV cases. Medicaid and other third party payers have placed restrictions on HCV treatment for individuals with a minimum number of days of sobriety and/or those that do not yet have advanced liver disease, posing a significant challenge for linking to care those persons who inject drugs and have tested positive for HCV. As a result, the health department continues to monitor and advocate for eligibility expansion where possible.

27%

of new HCV cases in Wisconsin were among people under age 30.

RECOMMENDATIONS FOR THE PREVENTION OF HIV AND HEPATITIS

- **Provide** HIV and hepatitis B and C testing to people who inject drugs
- **Provide** hepatitis A and B vaccination to people who inject drugs
- **Provide** sterile drug preparation and injection equipment to people who inject drugs
- **Provide** access to medication assisted treatment for people with substance use disorders
- **Ensure** state and local policies support access to sterile needles, syringes and other drug preparation equipment
- **Ensure** there are appropriate and accessible disposal systems for drug preparation equipment
- **Provide** access to substance use treatment for people who inject drugs
- **Ensure** people who inject drugs are linked to insurance services and a medical home equipped to respond to their needs

HIV AND HCV TREATMENT FOR PEOPLE WHO INJECT DRUGS

People with a history of injecting drugs or who are currently injecting drugs and are living with HIV and/or HCV deserve access to HIV and HCV treatment. Federal recommendations and research have shown that individuals with substance use disorders can effectively manage treatment of HIV and HCV. HIV treatment providers have successfully supported people with substance use disorders through HIV treatment for many years. Unfortunately, persons living with HCV who have substance use disorders are being denied access to HCV treatment because of the belief that they may not be able to successfully complete a course of treatment and some providers are not comfortable treating this population. Many HIV providers, including infectious disease clinicians as well as primary care providers have the expertise to support individuals with co-occurring conditions such as HCV and substance use disorders.

The Ryan White Program has served an essential need in providing care and treatment services for people living with HIV. While the Program can also address the needs of individuals co-infected with HIV and hepatitis, there remains significant room for improvement in the provision of HCV treatment uptake among people who are co-infected. Unfortunately, for individuals who are mono-infected with hepatitis, there is not a comparable federal program to serve their medical needs. The Affordable Care Act (ACA) increases access to care and treatment for HIV and HCV by establishing state- and federally-run insurance marketplaces; expanding Medicaid eligibility in many states; and eliminating restrictions in coverage for those individuals with pre-existing conditions. While the ACA has increased opportunities for insurance coverage, the cost of new HCV therapies has caused some insurers to institute eligibility restrictions to individuals with the most advanced liver disease, require proof of sobriety for an arbitrary time frame, and/or place HCV treatments on specialty drug tiers with cost prohibitive co-pays. Health departments must ensure that people who inject drugs benefit equitably from these changes to the health care system.

The Affordable Care Act (ACA) increases access to care and treatment for HIV and HCV by establishing state- and federally-run insurance marketplaces; expanding Medicaid eligibility in many states; and eliminating restrictions in coverage for those with pre-existing conditions.

Health department Ryan White Programs have increased coverage of HCV treatments through inclusion on AIDS Drug Assistance Program (ADAP) formularies, yet many programs still do not include these drugs, and where included, uptake has been low. Health departments play an important role in assuring HIV clinicians are up to date on the most recent HIV and HCV treatment guidelines and that Ryan White eligible patients have access to the treatments they need – either directly through ADAP or through other programs (e.g. Medicaid or private insurance).

Health departments also play a critical role in assuring that individuals who are mono-infected with HCV have access to insurance that covers HCV treatment. By linking individuals to public or private insurance plans, health departments can assure that individuals are receiving ongoing assessment and management of their HCV infection. If public or private insurers institute restrictive eligibility for HCV treatment and individuals are excluded – health departments can play a role in assuring individuals are aware of pharmaceutical patient assistance programs.

Despite the absence of a publicly funded infrastructure for HCV treatment, health department infectious disease programs are applying their expertise and lessons learned from HIV to increasing access for people mono-infected with HCV, including individuals with substance use disorders.

In addition to the implementation of the ACA, a new wave of HCV treatments with shorter duration, fewer side effects and higher cure rates will continue in the coming years. Health departments must stay up-to-date in the release of these new therapies in order to promote access to the most effective treatment regimens.

USER INVOLVEMENT IN PREVENTION

Some health departments have chosen to involve current or past substance users in their various HIV/STD/HCV prevention and treatment activities directed towards people who use drugs. The Massachusetts Department of Public Health funds a network of low threshold, community and clinic-based integrated HIV, STD, and HCV prevention and screening sites that work directly with active and past users to conduct client recruitment, risk assessment testing, support for wound and vein care, overdose education and naloxone distribution, sterile drug preparation equipment access and linkage treatments, care, and support services.

PROVIDER EDUCATION THROUGH AETC

New Mexico Department of Health has had success in communicating harm reduction messages to clinical providers of HIV and HCV care by conducting trainings through the AIDS Education and Training Center (AETC) for which up to six and a half continuing medical education (CME) credits are granted free of charge.

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FACT SHEET *Pharmaceutical Companies' Patient Assistance Programs (PAPs)*

In December 2014, NASTAD released the **fact sheet** "Pharmaceutical Company Patient Assistance Programs and Cost-Sharing Assistance Programs" for hepatitis medications. The fact sheet provides background on what patient assistance and cost-sharing assistance programs are, how to apply for them, and an overview of PAP and CAP contact information, drugs covered, and financial eligibility criteria. The fact sheet also includes a list of additional resources and information on foundations that provide access to care assistance for people living with hepatitis. NASTAD also maintains a corresponding **fact sheet** for HIV medications.

RECOMMENDATIONS FOR EXPANDING ACCESS TO TREATMENT FOR HIV AND HCV FOR PEOPLE WHO INJECT DRUGS

- **Ensure** providers are aware of public and private insurer policies regarding HCV treatment coverage and eligibility
- **Ensure** providers are aware of pharmaceutical company patient assistance programs
- **Request** AETCs to provide HCV co- and mono-infection trainings for providers, including treatment of individuals with substance use disorders
- **Collaborate** with the state Medicaid and ACA marketplace to ensure outreach and enrollment practices are inclusive and accessible to people with substance use disorders
- **Encourage** state officials to prohibit insurance restrictions on HCV eligibility (e.g. minimum number of days sober, most advanced liver disease)
- **Monitor** and disseminate information regarding newly-approved HIV and HCV treatment options to providers and affected populations

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PROJECT HIGHLIGHT *ADAP Formulary Coverage*

In June 2014, NASTAD released the **2014 Online AIDS Drug Assistance Program (ADAP) Formulary Database** and accompanying **User's Guide**. The Database details ADAP coverage of medications both individually and by drug class. Medications included in the Database include antiretroviral (ARV) treatments and "A1" Opportunistic Infections medications, as well as treatments for hepatitis B and C, substance use treatment medications and various vaccines and laboratory tests. The Database includes formulary information from all 50 states as well as the District of Columbia, Guam and Puerto Rico.

MENTAL HEALTH AND SUBSTANCE USE TREATMENT

Mental health issues disproportionately impact people living with HIV, HCV and/or substance use disorders. Mental health and substance use disorders pose challenges to people living with HIV and/or HCV in terms of their broader health and well-being and can impact the overall effectiveness of HIV or HCV treatment. Individuals with mental health and/or substance use disorders may not seek treatment for these issues because of stigma or a lack of available and adequate services. This can be particularly difficult in rural areas where availability of services may be even more limited.

In addition to improving access to care and treatment for HIV and HCV, the ACA strengthens the availability of mental health and substance use treatment services by increasing insurance coverage overall and maintaining parity in coverage for substance use and mental health treatment. The Mental Health Parity and Addiction Equity Act of 2008 extends federal parity protections by ensuring that when coverage for mental health and substance use conditions is provided, it is generally comparable to coverage for medical and surgical care. The ACA builds on the parity law by requiring coverage of mental health and substance use disorder benefits in the individual and small group markets who currently lack these benefits, and expanding parity requirements to those whose coverage did not previously comply with those requirements.

ADAP COVERAGE

11 ADAPs cover one or more substance use treatment medication such as buprenorphine, methadone or syringes/needles

- **10** ADAPs cover buprenorphine
- **7** ADAPs cover methadone
- **6** ADAPs cover naltrexone
- **1** ADAP covers syringes/needles

25 ADAPs cover one or more mental health treatment medication

There are a number of medications and services, that when used in combination, are effective in managing substance use disorders. Medication assisted treatment (MAT) is an effective treatment option that minimizes the symptoms of withdrawal. Methadone and buprenorphine are used as medication assisted treatment for opioids such as heroin. People living with HIV may be able to access MAT through ADAPs' direct provision of medications (if covered by ADAP formulary) or through their purchasing of insurance coverage for medications. Individuals mono-infected with HCV who could benefit from MAT need to ensure that their insurance plan covers MAT.

Additional integration of mental health/substance use disorder treatment and HIV and HCV treatment is necessary to effectively address the comprehensive needs of individuals with co-occurring health issues. Similarly, drug treatment or use of syringe services programs (SSPs) is associated with increased awareness of HIV and HCV infection status. There is a need to expand access to age-appropriate drug use prevention and treatment services for adolescents and young adults that represent the majority of new HIV and HCV infections. Programs and interventions used for adults may not be as successful when applied to youth.

Health department infectious disease programs should work with other governmental and nongovernmental stakeholders to assure that mental health and substance use disorder services are available to individuals at risk and/or living with HIV or HCV.

RECOMMENDATIONS FOR EXPANDING ACCESS TO MENTAL HEALTH AND SUBSTANCE USE TREATMENT FOR PEOPLE LIVING WITH HIV AND/OR HCV

- **Collaborate** with the state ADAP, Medicaid and ACA marketplace to ensure outreach and enrollment practices are inclusive and accessible to people who use drugs and/or are living with mental health issues
- **Work** with counterparts in behavioral health/substance use to expand access to MAT for people living with HIV/HCV (and those at risk for acquiring either disease)
- **Engage** with ADAP staff regarding the inclusion of mental health treatment medications and MAT for substance use on your state's ADAP formulary

OVERDOSE PREVENTION

Health department HIV and hepatitis programs have a long-established commitment to support the health of people who use drugs. In addition to infectious diseases, people who use injection and/or non-injection drugs are at risk for overdose. Health department HIV and hepatitis programs are well-situated to address overdose in light of their expertise and commitment to meeting the full range of needs for this population. Naloxone is a medication that is used to "reverse" an opioid overdose by counteracting the depression of the central nervous system and respiratory system that occurs during an overdose.[2] It is also the primary tool employed in many health department responses to overdose.

Police, fire, emergency medical technicians (EMTs) and other emergency personnel are often considered the "first response" to a suspected overdose incident and therefore an effective dispenser for naloxone. But emergency medical personnel may not arrive in time as a result of delays in reaching the scene or a delayed recognition of an overdose by witnesses. Family, friends or others present could also act to administer naloxone. There are several policy options available to states to address opioid overdose, including:

- **911 Good Samaritan laws.** Provide immunity for individuals experiencing overdose and witnesses who "act in good faith" to seek medical assistance when they believe an overdose is occurring. Some also allow witnesses who call 911 (in good faith) to cite that action during criminal prosecution.
- **Naloxone prescribing and administration protections.** Allowing a prescription for naloxone to be written for a friend or family member of someone considered at risk of opioid overdose (third party prescription); allowing for the use of "standing orders" by medical providers so that naloxone may be dispensed to any individual that meets certain criteria; and/or provides legal protection for providers that prescribe naloxone or bystanders that administer it "in good faith."
- **Naloxone distribution programs.** Provide naloxone and education about its use to opioid users and/or their families and/or friends.[3] In many states, naloxone distribution programs are led and/or supported collaboratively by both behavioral health and infectious disease programs.

[2] Harm Reduction Coalition. (2015). "Understanding Naloxone," Retrieved January 15, 2015 from http://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/understanding-naloxone/

[3] National Association of State Alcohol and Drug Abuse Directors (NASADAD). (2013). *Overview of State Legislation to Increase Access to Treatment for Opioid Overdose*. Retrieved January 15,2015 from http://nasadad.org/wp-content/uploads/2010/12/Opioid-Overdose-Policy-Brief-Final8.pdf

OVERDOSE PREVENTION IN NEW YORK

Since 2006, the health department in New York State (NYS) has been actively engaged in increasing the overdose prevention capabilities of New Yorkers. The vast majority of the 30,000 individuals trained thorough the state's Community Opioid Overdose Prevention Program, which is now comprised of over 200 registered programs, are believed to be current or former drug users. Since the inception of the regulated program, there have been approximately **1,000 reversals** reported by trained overdose responders. This number is thought to represent just a small portion of the actual number of reversals administered through this program.

'BYSTANDER PROGRAM' TRAINING IN MASSACHUSETTS

Beginning in 2007, Massachusetts has supported a "bystander program" to train potential bystanders (drug users, friends, family members) to an overdose on how to reduce overdose risk, recognize signs of an overdose, how to access emergency medical services, and administer intranasal naloxone.[4] In 2010, Massachusetts expanded the bystander program to four new communities with high incidences of fatal opioid overdoses.

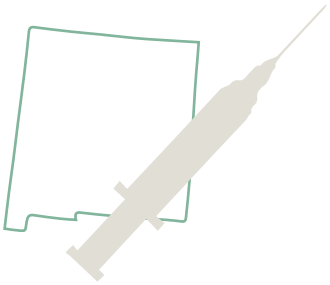
[4] Massachusetts Executive Office of Health and Human Services. (2015). "Opioid Overdose Prevention." Retrieved January 15, 2015 from http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/prevention/opioid-overdose-prevention.html#naloxone

NALOXONE TREATMENT RESPONSE IN MASSACHUSETTS

In March 2014, a public health emergency was declared in Massachusetts in response to the growing abuses and addiction to opioids. This response included universally permitting first responders to carry and administer naloxone (Narcan), expanding Narcan access to family, friends, and drug users through "standing order" prescription in pharmacies, increasing available treatment options and recovery support services.

OVERDOSE PREVENTION & RESPONSE STRATEGY IN NEW MEXICO

The New Mexico Department of Health works with a number of contract providers who provide syringe services, naloxone distribution and HIV/HCV testing as well as community-based organizations that co-prescribe naloxone for opiates. As well, the health department's HIV and HCV programs collaborate with their counterparts in behavioral health to conduct joint harm reduction trainings for naloxone distribution and integrated HIV/HCV testing. New Mexico's primary strategy for expanding emergency personnel and law enforcement's capacity to administer overdose prevention has been to ask those who are currently dispensing naloxone to promote the effectiveness of the approach among others.



RECOMMENDATIONS FOR EXPANDING ACCESS TO NALOXONE AT STATE AND CITY LEVELS

- **Consider** using funds from the **Substance Abuse Prevention and Treatment Block Grant** (SABG) for purchasing naloxone for distribution and training naloxone providers.
- **Include** naloxone and other substance use treatment medications on the ADAP formulary in order to increase access for people living with HIV and/or HCV
- **Seek** endorsement of the state health official in addressing overdose prevention
- **Train** law enforcement and emergency services personnel on recognizing overdose and administering naloxone
- **Require** grantees serving people who use drugs to include messages and services to prevent overdose
- **Monitor** and support legislation that aims to increase naloxone access
- **Encourage** community-based providers to co-prescribe naloxone with prescription opiates and provide prescriptions for family members of people who use drugs

COLLABORATIONS AND RELATIONSHIPS

Health department HIV and hepatitis programs have historically played a critical role in addressing the health needs of people who use drugs. A key component of this evolution is the strategic partnerships that health departments have cultivated with other state agencies, local governments and community based organizations.

A fundamental partner for health department responses to the health needs of people who use drugs are the individuals whom themselves are using or have used drugs. Meaningfully engaging impacted individuals in health department drug user health activities provides them with the opportunity to articulate their specific needs and unique challenges and concerns. Actively working in harm reduction, testing and prevention services also enables them to assist in reaching other members of this historically disenfranchised, stigmatized and thus hard-to-reach population.

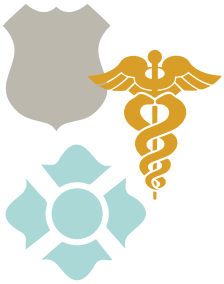
Many health department HIV and hepatitis programs work collaboratively with their state behavioral health, mental health and correctional health colleagues to comprehensively meet the health needs of individuals who use drugs. Also in state and local government, departments of public safety, emergency medical services, injury control, law enforcement and corrections have proved to be vital collaborators in addressing drug user health, particularly in the areas of overdose prevention and access to sterile drug preparation equipment.

Community based organizations (CBOs) are the implementers of many of the health services for people who use drugs. In addition to providing these services, the CBOs also lead advocacy efforts which bolster effective policies to support the health of people who use drugs. In addition to CBOs, health departments have collaborative relationships with colleges, universities and academic medical centers that provide services, training and research.

PARTNERSHIP STRUCTURES IN MASSACHUSETTS

In Massachusetts, the Office of HIV/AIDS (OHA) works seamlessly with the Bureau of Substance Abuse Services (BSAS) on drug user health prevention, treatment, and recovery support initiatives and attributes some of this success to a long-standing partnership to respond to communicable diseases impacting drug users. The health department has also forged several partnerships outside of the state government, including parent groups that provide support, overdose education, and naloxone training for family members of those at risk for overdose. The health department also cites the importance of community coalitions and the media's positive portrayals of individual and local community responses to substance use in helping to humanize the affected population and to reduce the stigma associated with the disease.

COLLABORATIVE PUBLIC SERVICE TRAINING IN NEW YORK



The formation of key partnerships during the past few years has enabled New York's health department to expand opioid overdose training to first responders, including police, firefighting personnel, and emergency medical technicians. For example, through a collaboration that includes the New York State Division of Criminal Justice Services, the Office of Alcoholism and Substance Abuse Services, the Harm Reduction Coalition, Albany Medical Center and other local partners, a series of statewide law enforcement overdose trainings took place during the last seven months of 2014, with the aim of equipping at least 5,000 law enforcement officials with naloxone. By the end of 2014, 3,700 officers had already been trained. These trainings will continue in 2015. 2015 will also see a partnership between the health department, the Harm Reduction Coalition and the state's Department of Corrections and Community Supervision (DOCCS) to train and equip soon to be released individuals and their families on naloxone administration. A pilot at Queensboro Correctional Facility is slated for February with the expectation to expand to all correctional facilities in NYS.

PUBLIC POLICY COLLABORATION IN WISCONSIN

Wisconsin's health department provided the state legislature with background information on the rise in heroin and other opiate overdose mortality and how those are correlated with increases in the number of HCV cases among young people who inject drugs. As a result, the **Heroin Opiate Prevention and Education (H.O.P.E.)** legislative package was passed in 2014, spearheaded by a Republican representative. This series of bills includes Good Samaritan policies as well as the implementation of a program for naloxone distribution by emergency medical technicians and police officers. For a comprehensive list of state overdose prevention policies, please see **this resource** from the National Association of State Alcohol and Drug Abuse Directors.

HIV & HEPATITIS SUPPORT GROUPS IN CALIFORNIA

In California, the health department's HIV and hepatitis programs have engaged with support groups for people living with HIV and HCV in San Francisco and Oakland, which are mostly comprised of former drug users. Health department staff members attend meetings in order to introduce themselves to the population and solicit their feedback as to what the state can and should be doing.

RECOMMENDATIONS FOR ESTABLISHING AND STRENGTHENING PARTNERSHIPS TO SUPPORT DRUG USER HEALTH ON STATE & CITY LEVELS:

- **Meet** regularly with counterparts in behavioral health, substance use, injury control, and corrections to discuss ways in which your programs might work together to meet the full breadth of needs of people who use drugs
- **Partner** with law enforcement and emergency services personnel on the provision of overdose prevention
- **Engage** the affected population as well as their friends and family in efforts to understand and promote the issues impacting people who use drugs
- **Work** with state and local policymakers as well as other community organizations to promote policies that aim to improve drug users' health

ADDITIONAL RECOMMENDATIONS

RECOMMENDATIONS FOR **FEDERAL PARTNERS TO SUPPORT DRUG USER HEALTH**

- Provide resources and funding at the Centers for Disease Control and Prevention (CDC) to implement science-based prevention services for people who inject drugs, including HIV/HCV testing, linkage to HIV/HCV care and treatment programs, hepatitis A and B vaccination, overdose prevention interventions and community education on the benefits of access to medication assisted treatment and sterile drug preparation equipment (e.g. needles, syringes, and cookers)
- Provide resources and funding at the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement science-based prevention services for people who inject drugs, including HIV/HCV testing, linkage to HIV/HCV care and treatment programs, hepatitis A and B vaccination, overdose prevention interventions and community education on the benefits of access to medication assisted treatment (MAT)and sterile drug preparation equipment (e.g. needles, syringes, and cookers)
- Prepare health programs for the rapidly changing treatment to cure landscape for HCV
- Integrate infectious disease prevention into new and emerging overdose and opioid reduction activities across federal agencies

RECOMMENDATIONS FOR **POLICY MAKERS**

- Lift the **ban** that prevents states from using federal funds for syringe service programs
- Increase funding and programming at the CDC Division of Viral Hepatitis (DVH) targeted towards people who inject drugs
- Increase funding and programming at the CDC Division of HIV/AIDS Prevention (DHAP) targeted towards people who inject drugs
- Invest in the creation of nationally coordinated surveillance activities to monitor acute and chronic infections

RECOMMENDATIONS FOR **PEOPLE WHO HAVE EVER INJECTED DRUGS**

Any person who has ever injected drugs should:

- Be tested for HBV
- Be tested for HCV
- Be tested for HIV
- If not immune, be vaccinated against HAV and HBV
- Be vaccinated for HPV (if under 26 years of age)
- Consider substance use treatment
- Seek out syringe services in your area including needle exchanges

If sexually active with partner(s) of unknown status, be tested for:

- Syphilis
- Gonorrhea
- Chlamydia

CONCLUSIONS AND NEXT STEPS

NASTAD, our members and partners continue to be concerned about the health effects associated with substance use disorders. Working collectively, we can address the infectious disease, overdose, treatment and policy needs to effectively address these concerns. Through ongoing technical assistance and support, health departments are positioned to continue or scale up their efforts to provide lifesaving services to people with substance use disorders. NASTAD encourages members to share your experiences with peers and seek technical assistance as needed.

LEARN MORE

Substance Abuse and Mental Health Services Administration (SAMHSA): *Opioid Overdose Toolkit*

http://store.samhsa.gov/shin/content/SMA13-4742/Overdose_Toolkit_2014_Jan.pdf

harm reduction COALITION

HarmReduction.org

astho™

Association of State and Territorial Health Officials (ASTHO): National Prevention Strategy: Preventing Drug Abuse and Excessive Alcohol Use

http://www.astho.org/NPS/Toolkit/Preventing-Drug-Abuse-and-Excessive-Alcohol-Use/

NASADAD National Association of State Alcohol and Drug Abuse Directors

NASADAD.org

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April 2015

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