New Jersey Syringe Access Program Demonstration Project

FINAL REPORT

Implementation of P.L. 2006, c. 99 "Blood-borne Disease Harm Reduction Act"

October 2012

New Jersey Department of Health

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Commissioner

New Jersey Sterile Syringe Access Program Demonstration Project:
A Review and Recommendations

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Executive Summary:

Injection Drug Users (IDUs) most often contract the human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HCV) by sharing contaminated needles and other drug injection paraphernalia with infected individuals. Through December 2010, for example, IDUs accounted for more than 40% of all adult/adolescent HIV/AIDS cases reported in New Jersey. These diseases are life-threatening, cause significant pain and suffering among infected individuals and their families, can be transmitted to other people, and are costly to treat. Society assumes a cost burden as well.

Stopping the spread of injection-related diseases through cost-effective prevention programs is therefore the goal. Sterile syringe access programs (SAPs) which include drug treatment and behavioral interventions are one model proven to significantly prevent/reduce the transmission of these diseases. These programs have also been shown to facilitate enrollment of IDUs into drug rehabilitation programs. As most people become infected with HCV and other bloodborne pathogens within their first year of using injection drugs, well-designed SAPs are most effective when targeting early injection-drug use.

On December 19, 2006, the "Bloodborne Disease Harm Reduction Act" (P.L. 2006, c. 99, or BDHRA) was signed into law, allowing for the establishment of up to six demonstration SAPs in New Jersey. The Division of HIV, STD and TB Services (DHSTS), located within the Public Health Services Branch of the Department of Health and (DOH), was charged with implementing the provisions of the law, including identifying those municipalities most in need and capable of implementing a program. Municipalities were thus chosen through a competitive grant process, wherein interested applicants had to demonstrate that within their municipalities there was a large number of persons living with HIV/AIDS ($\geq$ 350), a high prevalence of HIV attributable to IDU (300/100,000), and the existence of an ordinance permitting the establishment of such a program. Five municipalities were subsequently authorized by DHSTS to operate SAPs: Atlantic City (November 27, 2007), Camden (January 5, 2008), Jersey City (July 6, 2009), Newark (February 19, 2008) and Paterson (January 30, 2008).

Each of the five SAPs collaborates with a variety of health care facilities and programs through meaningful linkages to provide supportive services, such as substance abuse treatment, as mandated by BDHRA. This includes linking SAP participants to the Medication Assisted Treatment Initiative (MATI). This initiative was developed as a result of this law through funding to the Division of Mental Health and Addiction Services (DMHAS) within the Department of Human Services (DHS). It is a statewide program which began on April 20, 2009 and uses mobile medication units and fixed site clinics and offices to provide for the medical and psychosocial management and treatment of addiction. The five SAPs also each house an Access to Reproductive Care and HIV (ARCH) Nursing Program, a unique prevention program designed to prevent the perinatal transmission of HIV through the early identification of hard-to-reach high-risk women (i.e., female IDUs of reproductive age). The municipalities of the five SAPs

represent nearly half (45%) of the HIV-infected children born in New Jersey between 1993 and 2008.

The SAPs in New Jersey have not been financially supported by State funding. Acquisition of CDC funds was made possible on December 16, 2009 when President Obama signed the Consolidated Appropriations Act of 2010, lifting a ban in place since 1989 which did not allow the use of federal dollars for needle exchange programs. Through the CDC, New Jersey SAPs received $600,000 in the latter half of CY2010 and an additional $150,000 for CY2011. These monies have allowed the SAPs to provide and expand their services as intended by BDHRA. As a result of re-instatement of the ban on the use of federal funds to support SAPs, no additional funds have been provided to the SAPs in 2012.

Through November 2011:

- 9,912 participants have enrolled in the SAP demonstration program;
- 2,160 (22%) of the participants have been admitted into drug treatment through MATI; and
- 843,585 (49%) of the 1,708,332 sterile syringes distributed have been returned since November 27, 2009, with a steady increase in the return rate in 2011 (54% in 3rd quarter) as a result of strengthening compliance.

Based on these and other program achievements, we recommend:

- **Continue SAPs as permitted by P.L. 2006, c. 99.**
- **Continue to conduct and support outreach efforts.**
- **Subject to available funding, expand existing screening, treatment and outreach services to SAP participants.**
- **Subject to available funding, expand SAP services to include on-site mental health counseling hours.**
- **Increase collaboration with local health departments for the provision of public health services, subject to available funding, including influenza vaccinations and TB testing and treatment, as appropriate for SAP participants.**
- **Increase collaboration with the Division of Mental Health and Addiction Services (DMHAS) to improve Access to Substance Abuse Treatment for SAP participants.**
- **Subject to available funding, enhance syringe return by installing disposal kiosks or "drop boxes" at sites such as HIV prevention programs, drop-in centers, community health centers, hospitals, substance abuse programs, pharmacies and local boards of health.**
- **Improve relationships with law enforcement.**
- **Continue financial support for primary care and public health services.**

- **Improve data collection.**
- **In light of P.L. 2011, c. 183, which permits limited pharmacy sales of syringes and needles without a prescription, conduct legislative review of P.L. 2006, c.99, to evaluate the impact of the new legislation on the SAPs.**

Introduction:

Disease burden and injection drug users

The CDC estimates that 50,000 more people in the United States were newly infected with the human immunodeficiency virus (HIV) in 2009 and that 43,000 were newly infected with Hepatitis B Virus (HBV) in 2007. In New Jersey, there were 1,782 and 298 newly reported with HIV and HBV, respectively, in 2010. The number of newly infected individuals with HCV in the State was 7,000 in 2010, representing a significant increase from 2006 (4,949). HIV/AIDS and hepatitis are major public health concerns for the State because they are life-threatening, cause significant pain and suffering among infected individuals and their families, can be transmitted to other people, and are costly to treat and to society.

Injection Drug Users (IDUs) most often contract HIV, HBV, and HCV – bloodborne pathogens – by sharing contaminated needles and other drug injection paraphernalia with infected individuals. Through December 2010, for example, IDUs accounted for more than 40% of all adult/adolescent HIV/AIDS cases reported in New Jersey. In addition, it is estimated that one in every five, or 20%, of New Jerseyans who are living with HIV/AIDS do not know that they are infected and are not yet included in these statistics.

Reporting from 1981 shows New Jersey ranks fifth in the nation in overall cumulative AIDS cases, third in the nation in cumulative pediatric AIDS cases, and has one of the highest proportions in the nation of cumulative cases of women with AIDS (31%).

In New Jersey:

- 35% of those living with HIV/AIDS are females;
- 59% of females living with HIV/AIDS are currently 20 - 49 years old;
- over four out of five females living with HIV/AIDS are minorities;
- the reported number of women living with HIV/AIDS in 2010 with a risk exposure of injection drug use is 2,953, or 24%, and a risk exposure of heterosexual sex with an injection drug user is 1,275 ,or 10%; and
- publicly funded HIV counseling and testing activities from January – December 2010 saw 53,946 females tested (51.29% of total tested) with 143 testing positive (.27% positive).

The goal is to stop the spread of injection-related diseases through cost-effective prevention programs. Sterile syringe access programs (SAPs) which include drug treatment and behavioral interventions are one model proven to significantly prevent or at least slow the transmission of these diseases. SAP programs also facilitate enrollment of IDUs into drug rehabilitation programs. Moreover, at least one recent study has found that 64.7% of IDUs who had been injecting for less than one year were already infected with HCV.[1] Therefore, early identification and intervention with IDUs is critical.

National and international consensus recommendations

Established medical, scientific and legal bodies involved in the study of issues related to syringe exchange concur with the efficacy of improved access to sterile syringes to reduce the spread of infectious diseases. These include: the National Academy of Sciences, American Medical Association, American Public Health Association, National Institutes of Health Consensus Panel, CDC, Office of Technology Assessment of the U.S. Congress, American Bar Association, President Bush's and President Clinton's AIDS Advisory Commissions. In July 1997, the U.S. Conference of Mayors formally endorsed federal and state policy changes to improve access to sterile syringes. In October 1999, the American Medical Association, the American Pharmaceutical Association, the Association of State and Territorial Health Officials, the National Alliance of State and Territorial AIDS Directors, and the National Association of Boards of Pharmacy issued a joint statement in support of removing legal barriers to pharmacy sale of syringes without a prescription.

According to Lurie and Drucker, if the United States government had embraced harm reduction and implemented a national needle exchange program from 1987 through 1995, a conservative estimate of between 4,394 and 9,666 HIV infections could have been prevented.[2]

As the number of people living with HIV in the United States continues to grow, opportunities for HIV transmission and the burden on the health care system also intensify. This has become particularly important as the projected life expectancy, after diagnosis, for individuals in treatment has now increased from around 10 years in the 1990s to 24.2 years since the introduction of antiretroviral therapy. The operational costs of an SAP are cost effective in comparison to the lifetime cost of care. The lifetime per person HIV care cost is now $618,000.[3]

At a January 11, 2010 Global Conference on HIV and Drug Use held in Washington, DC, Dr. Kevin Fenton, Director of the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), highlighted public health strategies that would

[1] NIDA Notes, Volume 15, Number 1, March 2000 available online at http://archives.drugabuse.gov/NIDA_Notes/NNVol15N1/DirRepVol15N1.html.

[2] http://www.harmreductionjournal.com/content/1/1/2

[3] National Institute of Allergy and Infectious Diseases, the National Institute on Drug Abuse, and the Agency for Healthcare Research and Quality, Lifetime Cost and Life Expectancy for Current HIV Care in the U.S. , Nov. 2006.

help prevent and control HIV, hepatitis, STDs, and TB in persons who use drugs. He called for the integration, coordination and expansion of prevention interventions, including syringe and needle exchange programs, drug treatment, outreach, testing and counseling, linkage to HIV care for HIV-positive individuals, STD treatment and vaccines, condom distribution, structural interventions and educational information. Recommendations included: identifying drug users through outreach and conducting risk assessments; screening, diagnosis, and counseling; treatment and vaccines; managing persons with infections through prevention counseling, linkage to care, treatment adherence, and partner services; prevention of mother-to-child transmission; and reduction of risk behaviors among drug users through substance abuse treatment, syringe exchange programs, condoms, health education, and risk-reduction programs.[4]

State and federal mandates

In an effort to reduce HIV transmission rates in the State of New Jersey, P.L. 2006, c. 99 (Attachment 1), or the "Bloodborne Disease Harm Reduction Act" (BDHRA), was signed into law by Governor Corzine on December 19, 2006. This law allowed for up to six municipalities in New Jersey to establish a demonstration syringe access program (SAP) with non-State dollars and appropriated $10,000,000 to the Department of Human Services (DHS) for inpatient and outpatient drug treatment services through its Division of Mental Health and Addiction Services (DMHAS).

The Division of HIV, STD and TB Services (DHSTS), within the Public Health Services Branch of the Department of Health (DOH), was charged with implementing the provisions of the law.[5] The administrative rules establish purpose, provide definitions, eligibility prerequisites and criteria. The rules also include an appendix which establishes an operational guideline for a syringe exchange program (Attachment 2). The DHSTS conducted activities designed to closely collaborate and partner with local departments of health and community agencies interested in establishing an SAP in their communities.

On December 16, 2009, President Obama signed the Consolidated Appropriations Act of 2010, which lifted the 1989 ban on using federal dollars for needle exchange programs. The repeal was part of a $153.5 billion appropriations bill for labor, health and education and did not contain any new money for needle exchange. The Consolidated Appropriations Act of 2010 did, however, allow disease-prevention programs to use federal funds to provide clean needles and other injecting equipment, subject to approval by local police and health officials.

In July 2010, the CDC offered implementation guidelines on the use of federal funds by syringe services programs (Attachment 3). New Jersey, Connecticut, New Mexico, New

[4] CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment, DRAFT Record of Proceedings, May 12, 2010 (http://www.google.com/search?hl=en&source=hp&q=CDC%2FHRSA+advisory+committee+draft+record&aq=f&qi=m1&aql=&oq=).

[5] The implementing regulations which took effect April 9, 2007 can be found at N.J.A.C. 8:63-1.1 through 3.1 and its Appendix (Attachment 2).

York, Vermont and Washington, applied to use a portion of their 2010 CDC HIV Prevention Cooperative Agreement funding for syringe service programs.

In the second half of CY2010, New Jersey SAPs received a total of $600,000 from FFY2010 CDC funds. In CY2011, the SAPs each received $30,000 for a total of $150,000.

Program updates and highlights:

To date, SAPs are operational in five municipalities: Atlantic City (opened its doors November 27, 2007), Camden (January 5, 2008), Jersey City (July 6, 2009), Newark (February 19, 2008) and Paterson (January 30, 2008). Programs use a comprehensive approach to be more effective. Such an approach incorporates a range of pragmatic strategies that address both drug use and sexual risk behaviors. Through the introduction of the Access to Reproductive Care and HIV Services Nursing Program (ARCH) in 2010, the New Jersey SAPs have been bridging major health gaps in services for IDUs. Specifically HIV/HCV/HBV testing with links to treatment, gonorrhea/chlamydia testing, and immunizations (e.g., to prevent Hepatitis A and B, human papilloma virus, tetanus, diphtheria, pertussis, influenza, and pneumococcal diseases). One challenge is that current availability of vaccines does not meet the demand.

Through ARCH, SAPs also provide health screening and early intervention linkages, pregnancy testing and linkage to prenatal care, reproductive counseling for women of child bearing age, wound care, safe injection practices, safe sex education, nutritional counseling, and drug overdose prevention and reversal. ARCH services were expanded in March 2011 with the addition of TB symptomatic screening at four sites and piloting TB testing at one site with referral for TB testing, or treatment as appropriate, thus continuing with the full integration of HIV, STD and TB services (Attachment 4).

Since 2009, the ARCH program has received $250,000 annually from CDC funding with each demonstration project receiving $50,000 annually. In 2010, the ARCH program received an additional $40,000, with each demonstration project receiving $8,000 for limited vaccine purchase, totaling an additional $48,000 for each program in that year. Beginning in 2011, and into 2012, each of the five ARCH programs receives $100,000 annually.

Below are some highlights of the SAP Initiative to date:

- Five municipalities authorized the establishment of SAPs and received DOH DHSTS authorization to implement the SAPs subject to administrative requirements. They are: Atlantic City (opened November 27, 2007); Camden (January 15, 2008); Paterson (January 30, 2008); Newark (February 19, 2008) and Jersey City (July 6, 2009).

- A total of 9,912 participants have enrolled in New Jersey SAPs from November 2007 to November 2011.[6]

- 2,160 (22%) of the SAP participants have been successfully admitted to drug treatment through the DOH, DHSTS Medical Assistance Treatment Initiative (MATI) program from April 20, 2009 to November 2011.

- 843,585 (49%) of the 1,708,332 sterile syringes distributed have been returned since November 27, 2009.

- There has been a steady increase in the return rate of syringes in 2011 (54% in 3rd quarter) as a result of strengthening compliance. Table 1 details the return rate for each of the five SAP sites during the most recent quarter (3rd quarter of 2011) and the Figure highlights the increased return rate overall during CY2011.

Table 1. Syringe return rates for 3rd quarter, 2011

	SYRINGES OUT	**SYRINGES IN**	**RETURN RATE**
Atlantic City	43,063	20,527	48%
Camden	131,562	72,293	55%
Jersey City	16,819	7,672	46%
Newark	44,536	29,407	66%
Paterson	59,206	30718	52%
Overall	**295,186**	**160,617**	**54%**

[6] A target goal for participant enrollment was never established at the onset of this program by intention.

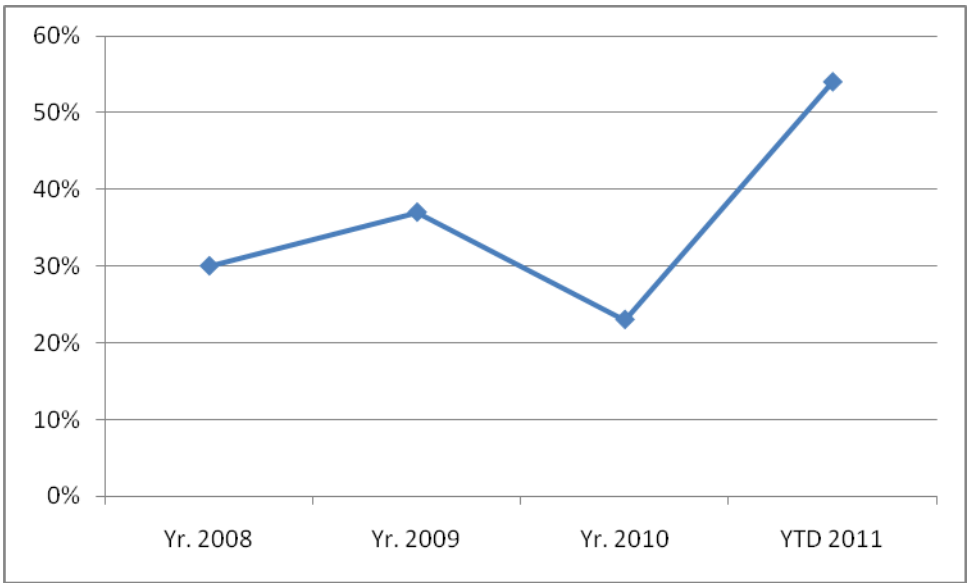

Table 2. SAP Exchange Rate Trend from January 2008 - December 2011

- An estimated 1,570 non-SAP participant IDUs received clean syringes and needles through secondary exchangers (exchanges on behalf of IDUs not enrolled in the SAP) from November 27, 2007 to November 2011.[7]

- From January 16, 2010 to November 2011, 59 pregnant SAP participants were linked to prenatal care and/or drug treatment. The SAPs provided on-site pregnancy testing to 337 female IDUs of child bearing age; of those tested, 23 women were pregnant. An additional nine female IDUs who knew they were pregnant were referred to prenatal care and drug treatment (84 women total). One out of treatment pregnant HIV positive woman was successfully linked to HIV care, prenatal care and drug treatment (refer to table in Attachment 4). The DMHAS Supportive Housing Program also reported that 11 pregnant women were able to obtain prenatal care and gave birth to healthy infants.

- 825 SAP participants were provided on-site HIV testing from November 27, 2007 to November 2011; 14 either tested positive or were positive and not in treatment. All 14 HIV positive individuals were linked to care.

- 423 SAP participants were referred for HCV testing from November 2007 to April 2011. An additional 658 participants were tested for HCV, 477 participants were tested on-site and 181 were HCV tested through the UMDNJ Evaluation Project from April 7, 2011 to November 2011. The on-site testing is part of a comprehensive medical component addressing HIV, sexually transmitted diseases (STD), viral hepatitis, immunizations, pregnancy and harm reduction.

[7] Participant self-report.

- Through the DMHAS Supportive Housing Program, there have been 126 successful housing placements from April 20, 2009 to November 2011, 35 in Atlantic City and 91 in Camden. Twenty-three of these referrals were generated by the SAPs. Additionally, 12 families have either been reunited or are in the process of being reunited with their children.

Recommendations and rationale:

1. **Continue SAPs as permitted by P.L. 2006, c. 99.**

   This demonstration program has served a hard-to-reach and at-risk population, successfully helping IDUs reduce their chance of contracting and spreading HIV, HBV, and HCV through the use of unsterile needles. Through its educational component, a large percentage of participants have also been admitted into drug treatment programs.

2. **Continue to conduct and support outreach efforts.**

   SAPs should continue to conduct outreach efforts into their catchment areas to increase the enrollment. The programs are operating with limited resources and expanded outreach may not be possible within the limits of current budgetary constraints. However, consideration should be given to directing any new non-State funding, such as private grants, to outreach efforts to realize the full potential of SAPs. In fact, Section 4 of the Operational Guidelines found in the appendix of the regulations states:

   > *"Access and Outreach. SEPs may use a broad range of points of access in order to reach and provide services to as diverse a group as possible. SEP Participants shall be treated in a manner that promotes enrollment, participation and retention." Note: Syringe Access Program (SAP) and Syringe Exchange Program (SEP) are used interchangeably.*

3. **Subject to available funding, expand existing screening, treatment and outreach services to SAP participants.**

   Expansion of the Access to Reproductive Care and HIV Services Nursing Program (ARCH) to cover all SAP hours would eliminate missed opportunities for early intervention, ultimately resulting in a further reduction in the cost for health care services (Attachment 4). This would require additional federal funds to support costs incurred due to added hours of service.

   ARCH nurses are performing a critical role with SAP sites by providing outreach to the high risk IDU population. Without the SAP sites, the ARCH nurse program would be a less effective use of resources. Medical staff is generally expensive, but used cost-effectively here because they serve out of treatment IDUs at the SAP. The

types of screening and treatment they provide would not be needed to the same degree by other populations.

The ARCH program is also collaborating with the NJDOH Vaccine for Children (VFC) program to provide federally funded adult vaccines. All five sites are approved or in the process of being approved by the VFC program to have access to vaccines.

4. **Subject to available funding, expand SAP services to include on-site mental health counseling hours.**

   Mental health assessment, including evaluation for cognitive impairment, depression, anxiety and post-traumatic stress disorder, would assist SAPs in making the proper linkage to treatment and would expedite the treatment process. Professional mental health counseling will also assist in the coordination of care among multiple providers (drug treatment and psychotherapy) and assessment for potential for violence including crisis evaluation if indicated. Counseling and motivational interviewing by a mental health professional are invaluable tools to move an SAP participant along the stages of change at their own pace, leading to improved long term outcomes.

5. **Increase collaboration with local health departments for the provision of public health services, subject to available funding, including influenza vaccinations and TB testing and treatment, as appropriate for SAP participants.**

   Currently, there is much variation between SAP sites and degree of collaboration with respective local health department:

   Atlantic City: The relationship is described as supportive by local SAP staff. The local health department provides two staff persons for 10 hours per week to support the SAP.

   Camden: The local health department provided some influenza vaccine.

   Jersey City: The SAP received left over influenza vaccine from the local health department.

   Newark: The local health officer is receiving the SAP Weekly Report.

   Paterson: The local health department provided on-site tuberculin skin testing training.

6. **Increase collaboration with the Division of Mental Health and Addiction Services (DMHAS) to improve Access to Substance Abuse Treatment for SAP participants.**

Currently, the mobile medication units and office-based programs prioritize the provision of pharmacological treatment for individuals referred by the SAP and have given priority admission status to pregnant women and those individuals who are homeless or at-risk for homelessness. Moving forward, the Medication Assisted Treatment Initiative (MATI) contract sites will ensure priority admissions to those individuals who provide documentation that they are HIV positive.

DHSTS is in discussion with DMHAS to include HIV in the MATI eligibility criteria. (Attachment 5). The MATI eligibility criteria include a requirement to prevent dual enrollment and medication overdose. This "30-day out of treatment" requirement prohibits an individual from being admitted to the MATI. DMHAS agrees that this requirement may be overridden should the treatment agency provide DMHAS detailed information to demonstrate that an individual meets all other MATI program eligibility, and can ensure the individual is not enrolled in any other MATI program.

DMHAS will work to ensure that each MATI-contract agency provides its local SAP with a written waiting list management plan that will allow the SAP to understand the process and assist its participants in following through with the waiting list protocol.

As background, P.L. 2006, c. 99, the Bloodborne Disease Harm Reduction Act (BDHRA), appropriated $10,000,000 from the General Fund to the Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) for both in-patient and out-patient substance abuse treatment services. According to DMHAS this is an annual appropriation.

DMHAS currently has contracts with six agencies to provide 200 clients at each agency with mobile medication services and/or office-based services (150 methadone clients and 50 suboxone clients per agency).

As of April 2011, DMHAS' New Jersey Substance Abuse Monitoring System (NJSAMS) reported the total number of cumulative MATI client admissions for the six sites was 3,287, while the total number of SAP participants admitted to treatment was 1,621. Statewide, 50.4% of MATI admissions have been SAP participants. It must be noted that out of the six MATI sites, four programs are sited in cities that operate a SAP (Atlantic City, Camden, Newark and Paterson). The other two MATI locations are Trenton and Plainfield.

DMHAS currently holds a bi-monthly consortium meeting in each of six cities where the MATI exists. The objective of the consortium meeting is to address any issue or concern related to the MATI. The consortium is comprised of individuals at the local level whose interest is in improving the quality of life and accessing quality treatment services for those individuals who have an opiate addiction. The local SAP programs are invited to these meetings and attend on a regular basis. DHSTS was included as a part of this consortium; however, staff was not authorized to participate. New leadership at DHSTS now permits and encourages this essential participation to

ensure ongoing cooperation, coordination and collaboration focusing on SAP participants.

Currently, two out of six of the MATI-contract agencies keep an internal waiting list for those seeking treatment into this initiative. Camden has a waiting list of 48 consumers of which 12 are referrals from the local SAP. Atlantic City has a waiting list of 14 consumers clients with two being referrals from the local SAP.

DMHAS has contracts with two programs in Camden and Atlantic Counties to create a capacity for 63 subsidized supportive housing slots, with 31 units in Camden and 32 units in Atlantic City. As of April 2011, all housing units were filled. Clinical treatment services have been offered to all those residing in the housing units, but participation has not been mandatory. To date, a total of 107 individuals have received both services and housing in Camden and Atlantic Counties. In Atlantic County, the units are occupied by 14 single adults and 18 families. A total of 58 individuals are receiving services, including 1 spouse and 25 dependent children. In Camden, housing units are occupied by 19 single adults and 12 families. A total of 49 individuals are receiving services, including 1 spouse and 17 dependent children.

7. **Subject to available funding, enhance syringe return by installing disposal kiosks or "drop boxes" at sites such as HIV prevention programs, drop-in centers, community health centers, hospitals, substance abuse programs, pharmacies and local boards of health.**

   Puncture resistant medical waste containers should be strategically placed and accessible to IDUs and law enforcement. It is also probable that others who use injectable medications, such as diabetics, would utilize drop boxes as a safe disposal resource.

   Currently in New Jersey, there are guidelines available on safe syringe disposal for home generated medical waste. Home generators include individuals with diabetes or those who use other injectable medications. Home generators of medical waste may account for the use of up to 700,000 sharps (i.e. needles) daily in New Jersey.[8]

   Further, in the restrooms of the Garden State Parkway and New Jersey Turnpike are medical waste containers for medical sharps. Inquiry to the Turnpike Authority revealed that these medical waste containers were placed in the restrooms as a risk management measure. Implementation of this recommendation would take the Turnpike Authority initiative to the next level and address another community of generators.

   As an example, Massachusetts' first needle exchange site was established in 1994. The state has prioritized sharps disposal. Massachusetts Department of Public Health (MDPH), Office of HIV/AIDS has placed 40 sharps disposal kiosks across the state

[8] http://www.nj.gov/health/eoh/phss/syringe.pdf

since 2007 (when the sale of syringes was deregulated). From December 2007-December 2010, these sites collected more than 1.2 million used sharps. The kiosks are located at HIV prevention programs, drop-in centers, community health centers, hospitals, substance abuse programs, pharmacies and local boards of health. [9]

8. **Improve relationships with law enforcement.**

As the administering entity, the DOH should work with the Office of the Attorney General to support relationships with local law enforcement to foster a better understanding of the goals, operations and functions of SAPs in designated communities. This should be supported by follow-up and/or periodic education and training sessions to provide up-to-date information to law enforcement personnel.

The DOH consulted with the Office of the Attorney General (AG) during the SAP's initial stages and with a shared understanding that the goal of the SAPs is to prevent the sharing of needles and consequently disease transmission. In addition, both entities recognized the importance of having the municipal governing bodies endorse the program and recommend continuing the requirement that a municipal ordinance is necessary prior to implementation of an SAP.

In the five municipalities that currently have an SAP, the civilian authority overseeing the municipal police department has essentially established a policy by which the department and its sworn officers abide. The police officers who encounter the SAP participants, for the most part, work for the municipality that endorsed the program.

The administrative rules requiring a municipal ordinance authorizing the operation of an SAP, at N.J.A.C. 8:63-2.1, legitimize the presence of the SAP in the town (Attachment 6). In addition, in Atlantic City, a Prosecutor's Directive dated March 17, 2008, was issued to the Atlantic County Chiefs of Police regarding the syringe access program participants (Attachment 7). Seeking directives of this nature from each participating body could save law enforcement time and dollars.

An additional recommendation is to promote improvement in the return rate and possible methods to identify the needles used by SAP participants. At recent SAP Quarterly Meetings, the SAP staff has been advised that encouraging and providing education to increase the return of syringes is an important aspect of their function. This aspect was not stressed in past years. Recent second quarter 2011 numbers show improvement; but single use syringes were dismissed as a solution since they do not necessarily prevent sharing and can be cost prohibitive. Dispersing syringes with labels and/or serial numbers is an option to assist with the tracking of the needles, although increased costs will result from requiring this identification method. However, it will provide for easy identification and tracking of SAP needles in the event that improper disposal takes place.

[9] The MDPH website has information on site locations (whether funded by MDPH or not) and how to properly dispose of used sharps. http://www.mass.gov/eohhs/docs/dph/aids/needles-syringes-disposal.pdf

DHSTS strives to improve and enhance relationships with law enforcement and recommends that if future changes allow expansion beyond six municipalities that the Attorney General consider issuing a directive or guidelines for law enforcement and training on the SAP program to ensure that officers understand the law, do not arrest participants inappropriately, and do not interfere with the SAPs themselves.

DHSTS recommends increased access to law enforcement to facilitate partnerships with SAPs. A primary goal of the access is law enforcement risk reduction training and what SAPs can do to assist law enforcement. DHSTS will work with the AG's Office to secure a meeting with county prosecutors and the Chiefs of Police Association.

Recently the Edward J. Bloustein School of Planning and Public Policy, Rutgers University, along with the NJ Drug Policy Alliance undertook an effort to provide an educational intervention for Newark law enforcement personnel to improve their knowledge of harm reduction and SAPs. This training was conducted for 147 officers at roll call in 12 roll call presentations covering all shifts. Based on survey results, 87% of officers strongly agreed that the training was valuable. The officers were provided with puncture proof gloves and sharps containers. These items were greatly appreciated by the officers.

This educational training was also provided in Paterson as a day long presentation for 30 Paterson Policy Academy Officers. They too were provided puncture proof gloves and sharps containers. This may be an opportunity in participating municipalities for educational interventions. Future training of law enforcement should be done by current or former New Jersey police officers.

It is noteworthy to state that training is currently planned for non-SAP towns as requested by specific towns that have determined a need.

9. **Continue financial support for primary care and public health services.**

Consistent with the Act, SAPs currently receive no State funding. SAPs should continue with local collaborations to secure private and municipal funding.

Initially, no federal funding was used for these demonstration projects due to a ban on the use of federal funding for syringe access programs until late 2009, when the federal funding ban was lifted. The total for 2010 CDC funds used during this time period was $600,000. The result was that the SAPs were able to expand their hours of operation to five days per week at four locations. In December, 2011 the federal ban on using federal funds for SAPs was reinstated, and no additional funds have been provided.

In CY2011, the SAPs each received $30,000 for a total of $150,000. Since fall 2009, CDC funds totaling $250,000 annually funded each demonstration project site in the amount of $50,000 to support the "Access to Reproductive Care and HIV Services Nursing Program" (ARCH), which targets women of childbearing age and serves as a gateway for the other clients of the demonstration program who need primary care intervention. Also, in 2010, the demonstration project sites each received $8,000 for limited vaccine purchase, for a total of $40,000. Beginning in 2011 and into 2012, each ARCH program received $100,000 annually.

10. **Improve Data Collection.**

DHSTS will continue working to improve data collection systems.

The University of Medicine and Dentistry of New Jersey (UMDNJ) was initially awarded funding by the DHSTS to collect data and evaluate the SAPs. The Department is currently working with Rutgers University on improving the web-based data system. In addition, DHSTS tracks aggregate data manually which is now referred to as the "SAP Weekly Update" providing a reasonable frame of reference for some of the critical data elements, such as drug treatment referrals.

In September 2010, the decision was made to pursue a web-based system. The Rutgers Information Technology Department Head designed and launched the new data system in February 2011. The SAPs were able to input data starting from January 1, 2011, thus allowing for a complete calendar year of reporting. The system was designed for real time data entry, with DHSTS having access to each of the sites allowing for accurate reporting and monitoring. Keeping the required data elements simple and to a minimum has provided DHSTS with trouble-free development and implementation of this system. All of the SAPs were involved in the creation of the database and have provided technical comments to improve functionality of the database.

11. **In light of P.L. 2011, c. 183, which permits limited pharmacy sales of syringes and needles without a prescription, conduct legislative review of P.L. 2006, c.99, to evaluate the impact of the new legislation on the SAPs.**

P.L. 2006, c. 99, combines the strategy of syringe exchange in up to six municipalities with access and referral to health care services, including mental health and substance abuse, housing assistance, career employment-related counseling and education counseling. Since the establishment of the Syringe Access Program Demonstration Pilot, participants have benefitted from this comprehensive approach. As noted in this Report, the Department supported and facilitated referral services that focused on the need for attention to women's services in the SAPs through the Access to Reproductive Care and HIV Services Nursing Program (ARCH). ARCH nurses are performing a necessary role with the SAP sites by providing outreach to the high risk IDU population. ARCH provides health screening and early

intervention linkages, pregnancy testing and linkages to prenatal care, reproductive counseling for women of child bearing age, wound care, safe injection practices, safe sex education, nutritional counseling and overdose prevention.

A recently enacted law, P.L. 2011, c. 183, removes existing barriers to sterile syringe acquisition by allowing pharmacy availability of nonprescription syringes and may expand access. However, the cost of OTC syringe sales will be borne by the consumers purchasing syringes over-the-counter. Further evaluation will be necessary to determine the effectiveness of maintaining the current structured syringe exchange program after full implementation of P.L. 2011, c. 183 and the impact of the availability of nonprescription syringes have been realized.

The availability of safe and clean needles helps prevent transmission of HIV/AIDS, with each case prevented saving a lifetime treatment cost of over $600,000. OTC access to syringes provides yet another way for all New Jerseyans to acquire clean syringes and avoid transmission. As background, some states have a requirement imposed by regulation, while others have requirements imposed by statute. There are a range of possibilities among states, from no regulation at all on OTC sales to 10 syringes with a prescription (Attachment 8).

The availability of safe and clean needles is particularly important for women of child bearing age. NJ born HIV pediatric exposures between the years of 1993-1999 resulted in 354 infected babies, whereas in 2011 we had only 2 babies known to have been infected. There is a public health rationale to continue to support programs which prevent and/or reduce transmission of HIV/AIDS and prevent mother to baby transmission to protect our most vulnerable population.

The Department supports the distribution of materials related to the safe disposal of hypodermic syringes or needles as well as substance abuse treatment information. This is an important component of the SAPs. The availability of materials recommended to be distributed with syringes pursuant to the OTC law is a useful and cost-effective way of assuring that individuals continue to receive access to information and education concerning services and referral options.