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Syringe Services Program Resource Guide

Introduction

Individuals with substance use disorder (SUD) who inject drugs suffer from multiple medical complications, not the least being the risk of blood-borne disease such as HIV, hepatitis and MRSA. The human and economic costs of these complications defy description. Syringe Services Programs (SSPs), sometimes referred to as "needle exchange programs," represent a key strategy to mitigate these risks. They are proven and effective community-based programs that provide a range of services that include vaccinations, testing, connection to medical care and substance use treatment, and access to and disposal of sterile syringes and injection equipment.

Studies clearly show that rather than encouraging IV drug use, these programs reduce the risk of HIV and hepatitis transmission and improve the likelihood users will stop injecting drugs. These programs do not result in an increase in crime. Instead, they result in fewer syringes and needles in public places like parks and sidewalks, and save lives by reducing the risk of accidental overdose.

In 2019, the High Country Health and Wellness Center, a component of the Harney County Health Department, designed, created and implemented a SSP in rural Harney County. The program has proven extremely successful and can serve as a model for other communities seeking harm reduction strategies in Eastern Oregon.

The state of Oregon and Eastern Oregon CCO recognize the value of SSPs. Jolene Cawlfield, FNP, former Director of the Harney County Health Department, has generously shared her experiences building the Harney County SSP in the following document.

EOCCO has created this toolkit to assist Eastern Oregon communities and providers who are interested in starting their own SSP. We hope our communities find it helpful.

Questions about the toolkit can be emailed to EOCCOmetrics@modahealth.com.

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You may ask, "Why start a Syringe Service Program (SSP)?" This data from HIV Alliance will demonstrate the importance of starting an SSP.

- 36% of all AIDS cases reported in the US are directly or indirectly associated with Intravenous Drug Use (IDU)
- The reuse and sharing of blood-contaminated injection equipment and drugs also play substantial roles in the transmission of Human Immunodeficiency Virus (HIV), Hepatitis B (HBV), Hepatitis C (HCV) and other blood-borne infections
- The Centers for Disease Control and Prevention (CDC) has stated a public health goal that 100% of all injections will be performed with a sterile syringe. This remains the most effective way to limit HIV transmission associated with IDU.
- SSPs reduce the circulation of contaminated syringes among people who inject drugs (PWID). Educating participants about the safe disposal of used syringes helps ensure tainted syringes are safely destroyed. This keeps potentially contaminated needles out of public areas.

Step 1: Program planning

Assess community need

This phase includes interviewing local providers serving PWID, looking at infectious disease trends and determine the number of syringes purchased at local pharmacies by people who didn't have a prescription for an injectable drug. Data on drug and overdose can be found online at the following locations:

ESSENCE: https://www.oregon.gov/oha/essence.com

Prescription Drug Monitoring Program: https://www.oregon.gov/oha/PDMP.com

Vital Records: https://www.oregon.gov/oha/vitalrecords.com

Medical examiner records: https://www.oregon.gov/osp/med.com

Information gleaned from local Emergency Medical Service Providers about Naloxone rescue.

Discussion with local law enforcement and community watch groups to see if they are finding discarded used syringes in the community. This indicates the need for safe disposal of syringes.

Compile a list of key stakeholders in the community

This may include law enforcement officers, staff at housing organizations, substance use resources, local physical and behavioral health providers, addicts in recovery, and more. We contacted each of our stakeholders in person or by phone to invite them to community information meetings and briefly educated them about SSPs [Appendix A]. Jude Leahy, MPH, OHA Adult Viral Hepatitis Prevention Coordinator, led a training at the initial meeting to educate attendees on this topic. Though we only had nine people show up, I was advised by OHA staff that this was a good indicator that there was minimal resistance in the community to the SSP.

Create an advisory committee

This committee may include many of the key stakeholders identified in the previous step. It is vital to form this committee early on so they can be a part of the planning process. There should be a variety of disciplines on the advisory committee, including a lead organization staff person, health officer, local primary care provider, tribe member, recovering addict, mental health provider, faith community member, and law enforcement. Peers and PWID provide important insights into local conditions, needs and resources. This is critical for program design and planning.

Attend relevant workshops

It is essential for those who establish and work in this program to have a basic understanding of trauma informed care, inherent bias and harm reduction principles.

- Trauma-Informed Care (TIC) is an approach that recognizes the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life.
- Inherent bias is present in each of us as we live life. We are affected by our country of origin, political beliefs, family of origin's beliefs and norms, religious beliefs, personal experiences, and more. A concerted effort to be aware of our potential biases when dealing with others is essential. It is important that we avoid statements to our syringe service clients that indicate our own values or judgments. They need to feel welcome and accepted, just as they are.
- Harm reduction is based on accepting people where they are and helping them make healthy decisions within their ability at the time.

Create a vision, mission or motto to communicate the goals and perspective of your program

Harney County Syringe Service Program motto:

Give our clients a taste of respect to create an appetite for recovery

Step 2: Decide program components

At a minimum, a successful SSP should:

- Have documented policies and procedures to ensure your team achieves and maintains program fidelity [Appendix B]. These may need to be tailored to your program's specific needs.
- Provide free sterile syringes
- Facilitate safe disposal of used syringes
- Offer education and additional supportive community resources such as referral to treatment, if desired, and options for rapid HIV and HCV screening. These will be tailored to what is available in your community.

The framework behind SSPs focus on risk prevention through a healthy environment, harm prevention, and harm containment. HCV, HIV, poverty and other social issues are part of multiple epidemics that can co-occur and interact at the level of cause, response and interaction. Understanding all of the intersecting pieces of drug use is essential to providing compassionate comprehensive care. As such, it may be helpful to include resources beyond just needle exchange to your clients to help improve their overall wellbeing. Some examples of additional services are:

- Minimizing toxic stress by providing referrals to food banks and programs
- Promote housing resources to help prevent homelessness
- Offer other harm reduction services such as:
    - Naloxone distribution
    - Condoms
    - STI testing and treatment
    - Medically assisted treatment for drug addiction
    - Substance use disorder counseling
    - Prescribing buprenorphine
    - HIV/HCV screening and treatment

It is also critical to involve your organization's staff in program planning, as there will likely be staff that may not be in support of the SSP. We had staff who were concerned about the impact the SSP would have in our office. All questions and concerns by staff were taken into account when making decisions about how the program would be implemented. Staff was educated on the SSP policies and procedures and given additional safety trainings on blood-borne pathogens and other topics [Appendix C, Appendix D, Appendix E, Appendix F, Appendix G, Appendix H]. We found an outside source to come in and do de-escalation training. The staff decided that the last hour and a half on Fridays would be the best time to hold the syringe exchange because there are typically fewer clients in our building at that time.

Step 3: Identify barriers to success

Financial barriers

Financial resources can be a barrier to the implementation of this program. Some of the help we received came from tapping into available HCV and HIV prevention mini-grants from OHA. Each county has a different burden as far as opioid use and abuse goes, and available resources are dependent upon that. Some counties will qualify for the Prescription Drug Overdose Program Grant through the injury and violence prevention program at OHA. Staff time has not been covered completely by these grants but our county has made a commitment to cover that cost. Participation in the Direct Relief program has been a huge help. We have also been able to get free syringes, Naloxone, diet supplements and personal care items for our SSP clients through them.

Public health interns and volunteers can be a source of staffing to get a program started. We were able to get the assistance of a public health bachelor's program intern from Utah, who happened to have family in our area. She was a big help with all aspects of the program. She was able to concentrate all of her time and talent on the development of the program policies and documents, which allowed us to implement the program more quickly. As with the development of any new program, this takes concentrated effort at the beginning of the planning phase. VISTA volunteers would also be a source of personnel assistance. Health Department employees have limited capacity to promote the program, so we also recommend recruiting volunteers or add more staff to assist with advertising and outreach.

Social barriers

SSPs are likely to receive opposition from members of the community who may not be familiar with these programs. Initially, the Harney County SSP team was hesitant to advertise heavily because it did not know what to expect as far as public concern around the program. We notified local pharmacies about our program so that they could talk about the program with PWIDs who purchased syringes.

After launching the program, one of our county commissioners received phone calls opposing the syringe program and asking if county funds were being used to buy these needles. Since we had received them through a grant and through the Direct Relief program, she was able to say no. However, program planners should be prepared to address public concerns about funding sources for these services. Members in your community may also express concerns that SSPs "promote" injection drug use or other stigmatized practices. These concerns can be addressed by sharing information on SSP efficacy to reduce disease and infectious transmission. Presenting recent data on HIV and HCV rates among PWIDs may also help to demonstrate the need for syringe service and harm reduction programs.

To be successful, it will also be necessary to gain a certain level of trust from the IDU population. Fear of judgement, prosecution by law enforcement or simply a lack of knowledge on how SSPs function can have a major impact on whether PWIDs seek your services. Your program planning team should be prepared for a slow start to your program. Once clients see that your team can be trusted, they are likely to promote your services to others in their community through word of

mouth. In the meantime, you can gain credibility as a valuable resource by asking those connected to the substance-using community such as Peer Support Specialists to advertise your SSP.

Step 4: Implement program components

Marketing will be a key step to getting a new SSP up and running. It is important to distribute information widely, particularly in places where PWIDs frequent, while keeping the messaging simple and straightforward.

Our team displayed and distributed posters with card inserts and pamphlets [Appendix I] in each of our health department exam rooms and bathrooms. We gave posters to the other rural health clinic in town and a hospital to display in their bathrooms and exam rooms as they saw fit. The posters were also placed in the county library bathrooms, a grocery store bathroom, post offices, fairground bathrooms, smoke shop and marijuana shop advertisement boards, and the local laundromat. We attempted to put up posters at bottle return sites, park bathrooms, the local tribal health center, gas station bathrooms and other businesses but were declined.

We also made sure to continue advertising the program even after it was launched. Six months into the program, we started a Facebook page and began advertising through it. We wrote an article in the local newspaper about the program and included a photo of our outdoor sharps disposal bin, offering it to anyone in the community to use who had sharps of any sort to dispose of. Despite our advertisement efforts, word of mouth from satisfied clients is likely to be your best form of marketing.

Once the SSP was up and running on a weekly basis, we made sure we had the proper forms to track services provided [Appendices J & K]. We offered syringes, sharps containers, condoms, Naloxone training and distribution, HCV/HIV rapid point of care tests (obtained with assistance from OHA), and Hepatitis vaccination. We also provided a range of educational resources including referrals to a PCP and/or addiction treatment options, safer injection brochures, OHA application assistance, brochures promoting the Warmline, other local resource brochures, and most importantly hope and respect through harm reduction.

Initially, we would give each new client 100 syringes and one small sharps container that holds approximately 100 syringes. Then, when they would return a full sharps container to us, we would issue them a 1:1 exchange. When new clients show up, we ask about their injection practices and give them enough syringes and sharps containers for a full month of use.

The Harney County SSP team chose to host the SSP at the health department on a weekly basis. However, your organization should do what makes the most sense for your community. For example, some SSPs choose to offer their services via a mobile van clinic. This allows the SSP team to bring their offerings to potential clients. It may also remove certain barriers such as transportation or lack of knowledge about the program. Your program planning should take the advantages and disadvantages of different program settings into account to ensure that your potential clients' unique needs will be met.

As your program grows, you may identify certain services or components that you would like to incorporate. The Harney County SSP staff saw a clear need for overdose and antidote education. Five months after launching the program, we held an overdose and Naloxone awareness event with Julia Pinsky, founder of Naloxone education and distribution organization Max's Mission. This event gained us access to free Naloxone, which we distributed through the SSP. We have also recently received Naloxone through the Direct Relief program and from Moda Health.

We have since continued to expand our support of Naloxone and overdose prevention. We have distributed Naloxone to library staff, law enforcement officers and public transportation employees. Naloxone can be prescribed by pharmacists for all patients who receive recurring opioid refills. The Naloxone administration training requirements have been abolished (see HB 4124 and 3440). https://www.oregon.gov/pharmacy/Pages/Naloxone-Prescribing.aspx Naloxone comes in a variety of forms such as nasal spray https://www.youtube.com/watch?v=LmxZkNW7VKM. We also dispense Evzio injectable Naloxone obtained through Direct Relief https://www.youtube.com/watch?v=-B_ZO_MUGBE. Our SSP staff makes sure our clients are educated about the Good Samaritan Law, which protects a person with drug paraphernalia on them from prosecution if they witness an overdose and call 911.

Step 5: Track your results

It is crucial to track the results of your program. This data may be required for some grant funding opportunities. It is also a great way to demonstrate SSP efficacy and growth in the future.
The first day of our syringe exchange was May 3, 2019. Although nobody showed up the first two days, our first customer walked in on May 17, 2019. Since then, we have distributed 15,600 clean syringes, 78 sharps containers ranging in size from 1 quart to 3 gallons, and have disposed of an estimated 15,000 syringes. We have issued several thousand condoms, performed rapid HCV and HIV tests, given Hepatitis vaccines, had one referral to SUD treatment, three to primary care, and one to a reproductive health provider.

Step 6: Identify next steps

Determine how your SSP can continue growing to serve your clients' needs. Some possible directions are:

- Initiate new social media platforms. Set up accounts on Instagram, Twitter, Tik Tok, etc.
- Launch a wound care program. People who inject drugs are prone to methicillin resistant staff aureus infections that can result in abscesses. Wound care provision and education could further reduce the morbidity of SSP clients.
- Begin an HCV case management program. This program would link HCV-infected clients with appropriate medical care and support, including treatment resources, education and referral to social services.
- Provide drug injection works and wound treatment supplies along with syringes. This can include ties, alcohol wipes, cotton filters and spoons.

- Strategic planning. It would be helpful to increase access to care for mental health and/or substance use disorder counseling. Another tool could be a peer facilitated harm reduction support group.

Conclusion

We aren't going to save the world with this work, but we may be able to prevent one person from contracting HCV or HIV. Not only can these programs make a difference in one person's life, they can also drastically impact healthcare costs.

- If we can prevent one person from being infected with HCV, we can save $75,000 in healthcare costs
- If we can prevent one person from contracting HIV, we can save $400,000 to $1 million. Not to mention the cost savings of preventing abscesses, cellulitis, sepsis, endocarditis, congenital HCV and HIV, and more.
- The CDC estimates $24.7 million in lost productivity costs annually for HCV infected individuals
- For each opioid poisoning that we prevent through the distribution of Naloxone, we can save $4,006 in direct costs and another $33,267 in indirect costs.

Much of this material came from:

- Oregon Syringe Services Manual, Expanding Harm Reduction & Syringe Exchange Service Programming Capacity in Oregon Planning & Resource Manual https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/HarmReduction/SSPManual/Oregon-SSP-Manual-Printable.pdf
- San Francisco Department of Public Health Syringe Access and Disposal Program Policies and Guidelines
- CDC guidance

Appendix A. Community Information Meeting Agenda

[ORGANIZATION NAME] Syringe Service Program

Stakeholders Meeting

[DATE]

[TIME]

Type of Meeting: Stakeholders Meeting - Syringe Exchange Program

Meeting Facilitator: [PROJECT MANAGER]

I. Syringe Service Program (SSP) Background Presentation
   a. What is the community need for this program (opioid use rates, HCV/HIV rates, etc.)?
   b. What benefits would an SSP provide?

II. SSP Components (syringes, information on community resources, testing, vaccines, etc.)

III. Create an Advisory Committee

IV. Identify Shared Objectives with Law Enforcement

V. Public Comments

VI. Adjournment

Attendee List:

Appendix B. General Policies and Procedures

[ORGANIZATION NAME]

Policies and Procedures

Syringe Service Program

Protocol number:	
Effective date:	
Approved by:	
Signature/Date:	

PROGRAM PRINCIPLES

1. The outreach will be sensitive to both the client and community; soliciting and incorporating feedback from communities served by the outreach.
2. An individual's progress toward recovery includes making **any** positive change (as they define it for themselves).
3. Respectful operation of the outreach includes being non-condemning and non-confrontational while stressing personal responsibility in harm reduction.
4. Harm-reducing prevention messaging will always be constructive and geared to the needs and interests of the person using the services (e.g., "Doing it like this can reduce harm in this way" vs. "Don't do this...").
5. Women and men injecting drugs are more knowledgeable in how they can reduce their own risks.
6. Community outreach will be as safe as possible to the women and men working the reach the people and communities we served.
7. Getting as much contaminated drug injection equipment off the street as possible and replacing it with clean drug injection equipment is part of all effective syringe exchange programs.
8. Evaluate the effectiveness and impact of our harm reduction outreach work must be ongoing and must direct our efforts; and
9. We are committed to discovering and implementing effective Harm Reduction.

ACTIVITIES AND GOALS

Cultivating community education and support

Making a strong connection in the communities we serve is a major activity prior to and during our harm reduction outreach efforts. [ORGANIZATION NAME] makes every attempt to incorporate feedback from communities served and community stakeholders in our program. We accomplish this by seeking out and meeting with people injecting drugs, other community members and businesses, churches and other community organizations. In these meetings, we provide information on:

1. Description of the Harm Reduction Program.
2. Evidence gathered, to date, about Harm Reduction through syringe exchange.
3. Our plans or activities for harm reduction outreach through syringe exchange.
4. Any other topic related to the integration of substance use, addiction, recovery and HIV/Hepatitis disease.

The outreach

[ORGANIZATION NAME] harm reduction outreach does the following:

1. Provides materials for and discussion about reducing sexual and injection risks of HIV and Hepatitis infection.
2. Exchanges used needles/syringes and/or detachable needles for sterile syringes on a one-for-one basis.
3. Provides discussion about and voluntary and anonymous referral to treatment of alcohol and other drug problems, medical care, and other risk reduction services of a person's choosing.
4. Conducts evaluation regarding the effectiveness of our services to determine harm reduction utilization, demographics, and harm histories.
5. Accesses and builds relationships between drug users and outreach workers.
6. Offers services that lead to positive change.

Program goals

[ORGANIZATION NAME] has chosen harm reduction outreach with syringe exchange as a direct service activity. We believe harm reduction outreach is a crucial part of an effective comprehensive plan to prevent HIV and Hepatitis transmission among injection drug users. The goals of our harm reduction outreach with syringe exchange are to:

1. Reduce incidence of contaminated (dirty) injections and unsafe sexual encounters.
2. Increase knowledge about risks of HIV infection and Hepatitis to injectors, their sexual partners, and their children.
3. Reduce discarded drug injection equipment in communities served

4. Increase availability of materials for reducing risky sexual behavior.
5. Increase discussion about, referral to, and enrollment in drug treatment, healthcare, etc.
6. Reduce risky activity among persons using drugs, their sexual partners, their children and those in their community.
7. Increase knowledge of the program's effectiveness as a harm reduction opportunity our community.

RESEARCH AND EVALUATION

[ORGANIZATION NAME] considers evaluation of the impact and efficacy of its operations to be an ongoing and essential part of providing services. We want to take every opportunity within our resources to determine if what we are doing is valuable, in what ways, and what we can do to improve our work.

Current and projected research will include at a minimum:

1. Analysis of data gathered by on-site surveys for evaluation of harm reduction behavior changes.
2. Demographic information regarding program use and users.
3. Analysis of harm reduction available research.
4. Analysis of hospital admission data regarding injection-related abscesses, and hepatitis B.

OUTREACH AND INTERVENTION

1. All information about persons who inquire about our services, who request our services, and who seek our services will be handled with the highest degree of confidentiality (refer to current confidentiality and HIPAA policies).
2. The relationship between an outreach worker (staff or volunteer) and a client shall be governed by the guidelines listed in this Procedures manual. See Non-dual Relationships with Clients for those guidelines and the definition of "client".
3. Clients can seek harm reduction services without sharing their identities.
4. All services, supplies, brochures, educational materials, and interventions will use the harm reduction and risk reduction model.
5. [ORGANIZATION NAME] outreach workers may offer Needle Exchange services.
6. [ORGANIZATION NAME] clinical staff may offer clinical advice to our clients as covered in the [ORGANIZATION NAME] Communicable Disease standing orders.
7. HIV tests that are given during outreach will follow appropriate Policies & Procedures for HIV Counseling and Testing. These policies/procedures will be reviewed and available to all staff who perform testing, as well for persons who want to review our practice

8. Outreach and intervention services will operate in accordance with the laws of Oregon and any other jurisdictions that may apply.
9. All staff and volunteers participating in [ORGANIZATION NAME] outreach programs must attend appropriate trainings.
10. All volunteers must be qualified and on the active list of volunteers for [ORGANIZATION NAME] to continue to participate in outreach programs and undergo a criminal background/LEDS check.
11. Outreach staff and volunteers shall not represent the program to media without prior clearance from the program manager.
12. In the course of outreach activities, outreach staff and volunteers will work to not identify clients as IDU or MSM (men having sex with other men) to other people in the outreach area.

OUTREACH AND INTERVENTION POLICIES & PROCEDURES

The site:

1. Our sites for harm reduction outreach with syringe exchange will be selected with sensitivity to both the client and the community. The sites will be stable. That is, once selected, the sites and times of operations will remain reasonably consistent.
2. The consistency in site and time is essential to reaching and earning the support of injection drug users. In addition, because word of mouth is the primary means of advertising, consistency facilitates accuracy of shared messages.
3. Site selection with community input is extremely important because the costs of moving the site are high in terms of lost users and failed confidence.
4. Site will be assessed for safety, as well as appropriateness, as covered in training. The program will not use parks or schools for needle exchange distribution.
5. Staff will visit new locations prior to performing outreach and assess for potential outreach.

General and personal safety

1. **Two or more workers:** Outreach will only be conducted with at least two SSP staff members on site ([ORGANIZATION NAME] staff, volunteers, etc.).
2. **Assessing the setting and situation:** SSP staff/volunteers will assess each new setting and situation before entering it. This includes:
    a. **Assessing a Client:** All SSP staff/volunteers shall assess whether a client is safe and appropriate before approaching him/her. This will be discussed in training prior to the volunteer entering the field.
    b. **Leaving the Situation or Area:** SSP staff/volunteers will leave anytime the interaction with a client(s) or the overall situation feels unsafe.
3. **Cell phone:** SSP staff/volunteers will always carry a cell phone during office hours. The cell phone number will be left with the front office staff at [ORGANIZATION NAME]. The phone will remain on at all times.
4. **Checking-out and checking-in:** SSP staff/volunteers will check out at the front office before leaving for outreach. This will include noting a clear return time on the check-out form. A designated staff member will be responsible for contacting the person if they do not arrive on time. If they are unreachable, 911 will be called.

5. **Refusing services:** Each SSP staff/volunteer is responsible for setting their boundaries ahead of time and knowing how they will turn down a client. Only clients over 18 years of age can use the service. Staff/volunteers must comply with the [ORGANIZATION NAME] Nondiscrimination Policy.
6. **Terminating HIV testing with a client:** SSP staff/volunteer may terminate a testing session for safety of the client, counselor, outreach worker, or other persons.
7. **Personal safety devices:** SSP staff/volunteer will have the option of carrying a personal alarm (pull-string sound alarm) during outreach.
    a. **No weapons:** SSP staff/volunteers are not allowed to carry or possess weapons of any kind (gun, knife, stun gun) during outreach.
8. **Needle stick safety:** No SSP staff/volunteer will touch used needles. Clients will deposit their own needles into a sharps container or return their used needles in a closed sharps container. All volunteers will be trained in needle stick prevention.
9. **Emergency:** All SSP staff/volunteers will know the emergency number (911), as well as contact numbers at [ORGANIZATION NAME] or have them programmed into their personal/agency cell phone. For all emergency situations, or if at any time the outreach worker feels unsafe, they will be encouraged to call 911.
10. **Incident report:** All staff/volunteers will fill out an incident report form in accordance with [ORGANIZATION NAME] policy.

Types of interventions that we do offer:

Note: All of our services are based on the principles of Harm Reduction/Risk Reduction (as defined by the Harm Reduction Coalition).

1. **Information sharing:** Facts about HIV, Hepatitis, risk reduction, harm reduction
2. **Needle exchange:** Needle exchange and disposal
3. **Supplies:** Safer sex and safer injection (harm reduction) supplies
4. **Sharps containers** (and sharps containers/needle disposal)
5. **Counseling and skill building:** Improve client's self-perception of risk for HIV/Hepatitis/STDs, support attempts that the client has already made, offer skills building and insights into risk reduction, negotiate realistic plan for reducing risk.
6. **Referrals which include but are not limited to:** HIV testing, HIV care, STD screening, follow-up, and treatment, Hepatitis A & B vaccinations, Needle Exchange services, Hepatitis C testing and treatment, Drug and Alcohol Detoxification, Drug and Alcohol treatment, Medical treatment, Mental Health Services, and other basic social services
7. **HIV counseling & testing services**
8. **Educational brochures and promotional materials**

Types of interventions that we DO NOT offer:

1. **Medical advice:** Volunteers do not offer or give medical advice to clients. Nursing staff may answer questions, as needed, and refer client to a clinic or an emergency room

Needle exchange services:

1. **Age limit:** No client under the age of 18 may receive new needles from our program unless allowed in accordance with Oregon State law. Clients under the age of 18 can access all other services.
2. **Needles:** Staff/volunteers will never handle used needles. The individuals bringing syringes into exchange are responsible for placing them directly into our puncture-proof sharps container. If a syringe falls on the ground or otherwise does not make it into the sharps container, SSP staff/volunteers will ask the person who brought it to place it in the sharps container. When a sharps container is full to the line indicated on its side, it should be closed with the attached lid and put in a safe, out-of-the-way place. It is never reopened or reused after this point and should be placed in the nearest biohazard container.
3. **Counting needles:** Staff/volunteers will never handle used needles. Clients will estimate the number of used needles they are exchanging. If a client has no needles to exchange, they may take a starter pack (a bag with safer-injection and harm reduction supplies).
4. **Needle stick response:** All staff and volunteers who are participating in IDU Outreach and needle exchange will receive training and a copy of [ORGANIZATION NAME] Needle Stick Protocol.

Listed below are the two state laws that affect the operations of Oregon State syringe exchange programs:

- Senate Bill 846 Section 1 Line 27 (3) Drug paraphernalia does not include hypodermic syringes or needles
- ORS 1997 Hypodermic Devices 475.805 Providing hypodermic device to minor prohibited; exception
    1) No person shall sell or give a hypodermic device to a minor unless the minor demonstrates a lawful need therefore by authorization of a physician, parent or legal guardian or by other means acceptable to the seller or donor.
    2) As used in this, "hypodermic device" means a hypodermic needle or syringe or medication packaged in a hypodermic syringe or any instrument adapted for the subcutaneous injection of a controlled substance as defined in ORS 475.005. [1983 c.738]

Personal boundaries:

To protect the outreach workers, as well as clients and potential clients, outreach workers should:

1. Identify oneself as an outreach worker immediately after approaching or being approached by a client.
2. Deflect come-ons and immediately share with the client that staff and volunteers are on agency time and are there to provide services.
3. Wear identifying clothing or outreach bag so clients can learn to recognize outreach workers as being on agency time and available to provide services.
4. Not accept gifts from anyone during outreach.
5. Will be prohibited from spending personal time at outreach sites.

Confidentiality:

1. Staff/volunteers will sign and comply with the [ORGANIZATION NAME] Confidentiality Policy.
2. Staff/volunteers will comply with the [ORGANIZATION NAME] HIPAA Policy.
3. Staff/volunteers will not share information about a client to law enforcement, other service agencies, other clients, or anyone else unless there is a release form signed by the client or it is required by law. All information requests will go through the Privacy Officer at the County.

Non-dual relationships with clients:

1. Many people will be approached during outreach. Those who access our services (HIV CTRS or harm/risk reduction counseling) are considered clients.
2. People in corrections, detention and treatment centers where we provide testing services or prevention/education are considered clients.
3. Minors in any group presentations are considered clients.
4. People getting supplies, event information and general information (and other interactions that are not classified as harm/risk reduction counseling) are not considered a client.
5. It is our goal to be dedicated to the well-being of clients. Staff and volunteers must recognize the potential vulnerability of clients, as well as potential power imbalance in the county-client relationship.
6. To protect the welfare of the client, staff/volunteers of [ORGANIZATION NAME] cannot have a dual relationship with clients for at least three (3) months after the client last sought services at [ORGANIZATION NAME] program where the staff/volunteer worked and performed services for the client.
7. “Dual relationships" are defined as any relationship, separate, and in addition to, the one established by a client's access and use of [ORGANIZATION NAME] services.
8. In order to assist in avoiding the possibility of client confusion about multiple relationships after a client has received services, staff and volunteers should be counseled to avoid intentional personal contact with clients. Any personal, off duty contact, where the staff/volunteer worked and performed services for the client outside of the [ORGANIZATION NAME] Outreach program should be approved by the [ORGANIZATION NAME] Program Manager.

Volunteers:

1. **Criminal History Checks:** These checks are part of the screening process for volunteers.
2. **Training/Qualification:** SSP volunteers must qualify by being trained in HIV Prevention & Harm Reduction and Street Outreach. SSP volunteers will also be trained in blood-borne pathogens prevention and needle stick prevention. Volunteers may be trained by other agencies but must be signed off by [ORGANIZATION NAME] staff and/or the Nursing Supervisor before being on the Active list of volunteers.
3. **Active list:** Volunteers must be on the [ORGANIZATION NAME] list of active volunteers in to provide HIV prevention services to clients. HIV program staff and the Nursing Supervisor have copies of the active list of volunteers.
4. **Warrant:** A staff volunteer cannot participate in outreach or provide services in the field if they have a warrant out for their arrest.

5. **Background:** A staff volunteer cannot participate in outreach or provide services in the field if they has been convicted of sexual assault, sex with a minor, or any other charges that may create a real or perceived threat to a client or the program. This decision will be made by the [ORGANIZATION NAME] Program Manager.
6. **Alcohol/Drugs:** Volunteers will not report for assignment under the influence of alcohol or drugs. Volunteers cannot use alcohol or drugs during outreach or when providing services for [ORGANIZATION NAME]. Volunteers will not possess, distribute or sell alcohol or drugs when providing services for [ORGANIZATION NAME] (or at the same locations where SSP services were provided within the same 24-hour period).
7. **Vaccinations:** Volunteers will be encouraged to have both a current TB test and to be vaccinated against Hepatitis B (within the first 10 days of work on site). A waiver must be signed if the person refuses.
8. **Guests:** Guests are not allowed unless they are from another agency providing HIV or harm reduction services or are invited by [ORGANIZATION NAME] outreach staff. All guests must be cleared through the Program Manager first.
9. **Possession of cash:** Volunteers shall have no more than $20 (each) in their personal possession during any outreach services.

Not identifying clients to those in the area:

1. SSP staff/volunteers should try to diminish the chances of identifying clients as IDU (drug users) or other high-risk behaviors to anyone in the outreach area, including the general public.

SSP site workflow:

1. **Greeting clients:** Staff/Volunteer greets person coming to the outreach and has them fill out survey/research information, as needed.
2. **First visit:** Coded identifier taken, along with appropriate harm-reduction interaction. On the first visit, the client will receive a start-up bag, 10 syringes, along with hygiene supplies, sharp boxes, and other harm-reduction items. Each client will be given a card to show at each exchange or will have a code that helps us track number of encounters.
3. **Engagement process:** Staff/volunteer respectfully engages person, informs them of the range of topics/options for positive change available on-site, and determines their interests in accessing any of these options (HIV Testing, Hepatitis B/C Testing, Rapid HIV Testing, Hepatitis A/B Vaccine options, condoms, hygiene supplies, etc.).
4. **Reducing sexual risks:** Staff/volunteer offers printed information and discussion on use of any of the materials offered or other means of reducing sexual risks of HIV/Hepatitis and other STDs.
5. **Departing clients:** Staff/volunteer thanks client for visiting the site.
6. **Follow-up visits:** During follow-up visits, staff/volunteer allow one-to-one needle exchanges, with flexibility for people acting as proxy.

Appendix C. Policies & Procedures – Accidental Needle Sticks

Syringe Service Program P&Ps: Accidental Needle Sticks		
J Tag references: § References:	Policy type:	Policy number:
Effective and Revision Date(s):		

Policy purpose: The purposes of this policy are to clearly outline the immediate steps that should be taken if an employee is exposed to an accidental needle stick.

Policy statement: [ORGANIZATION NAME], particularly with the Syringe Service Program, has a high regard for the health and safety of its employees. Sometimes, incidents arise when employees or others come across an occupational hazard that might also create a situation in which employee or other individuals may be at risk to the exposure of blood-borne pathogens through accidental needle stick.

Policy scope: This policy is informational and procedural in nature.

Policy body: Accidental needle sticks

Prevention of accidental needle sticks: The incidence of accidental needle sticks can be prevented and/or greatly reduced by several procedures, which include:

1. Proper sharps disposal
2. Never recapping needles
3. The provision and use of PPE (personal protection equipment)
4. Staff education on the risks of transmission
5. Staff education on the techniques and methods

Immediate first-aid procedures: In the event of an accidental needle stick, the following actions should be taken immediately by the employee. If the employee needs help in performing these tasks, they shall ask a supervisor or co-worker to assist. PPE should be worn and all efforts to minimize additional exposure or contamination should be exercised. The immediate steps are:

1. Wash need sticks and cuts with soap and water.
2. Flush splashes to the nose, mouth or skin with water.
3. Irrigate eyes with clean water, saline or sterile irrigates.
4. Report the incident to your supervisor or provider on duty.
5. Immediately seek medical treatment.

If you have questions about appropriate medical treatment for occupational exposures, 24-hour assistance is available from the Clinicians' Post Exposure Prophylaxis Hotline (PEPline) at **888-448-4911.**

1. **Diagnostic testing and prophylaxis treatment guidelines:** The clinic follows all recommendations of the CDC for the management of accidental exposure to blood-borne pathogens. The following publications, or a similar publication, will be used if needed for a written reference:

    a. Updated U.S. Public Health Service Guideline for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis, MMR Recommendations and Reports, Volume 54, Number RR-9 (Found at http://www.cdc.gov/mmwr/PDF/rr/ff5409.pdf.
    b. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV and HIV and Recommendations for Postexposure Prophylaxis, MMWR Recommendations and Reports, Volume 50, Number RR-11 (found at http://cdc.gov/mmwr/PDF/rr/rr5011.pdf.

2. **Subsequent testing and treatment:** The subsequent ordering of diagnostic testing shall be the direct responsibility of the clinic administrator, or in the absence of the clinic administrator, the direct responsibility of the supervising healthcare provider. The clinic may refer additional treatment of the exposed individual to a specialty healthcare provider.

Specific procedures: As described within the body of the policy, if applicable.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document name	Location

Appendix D. Sharps Injury Log

SHARPS INJURY LOG

Use this document to record sharps-related injuries.

[ORGANIZATION NAME]

Date of injury	Case number	Type of sharp	Brand name	Where injury occurred	How injury occurred

OSHA's Bloodborne Pathogens Standard, 1910,1030, requires an employer to establish and maintain a sharps injury log for recording all percutaneous injuries in a facility occurring from contaminated sharps. This log and the injury-and-illness log required by 29 CFR 1904 must be retained by the employer. This log should include all sharps injuries that occur in a calendar year. The log must be retained for five (5) years after the last recorded case and must ensure the confidentiality of affected employees.

Appendix E. Policies & Procedures – Blood Borne Pathogens Exposure Control

Syringe Service Program P&Ps: Blood Borne Pathogens – Exposure Control		
J Tag references: § References:	Policy type:	Policy number:
Effective and Revision Date(s):		

Policy purpose: The purposes of this policy are to clearly outline the immediate steps that should be taken if an employee is exposed to blood-borne pathogens and biohazardous in the workplace.

Policy statement: The Syringe Service Program, in connection with [ORGANIZATION NAME], has a high regard for the health and safety of its employees and, in particularly, in those incidents when those occupational hazards might also create a situation in which employees may be at risk of exposure of blood-borne pathogens. The intent is to safeguard employees from occupational hazards in compliance with federal and state laws and regulations.

Policy scope: The policy is informational, procedural and regulatory in nature.

Policy body: Blood-Borne Pathogen Exposure Control.

1. **Exposure control administration:** The clinic administrator shall be responsible for:

    a. Identifying the exposure risk of an employee by job description
    b. Notifying the clinic employees of potential exposure risks and safeguards and providing training on exposure control
    c. Providing proper labeling of bio-hazardous materials and storage areas
    d. Providing Personal Protection Equipment
    e. Maintaining a cleaning schedule
    f. Offering free of charge Hepatitis B vaccination to all employees at risk of exposure
    g. Providing post-exposure examination and follow-up including a medical record outlining the treatment
    h. Maintaining records of exposure incidents and other documentation, as needed
    i. Conducting a post-exposure evaluation of exposure incident

2. **Biohazardous materials**: Biohazardous materials, as defined by OSHA, include:

    a. Human blood
    b. Semen
    c. Vaginal secretions
    d. Cerebrospinal fluid
    e. Synovial fluid
    f. Plural fluid
    g. Pericardial fluid
    h. Amniotic fluid
    i. Saliva
    j. Other body fluids that are contaminated with blood or situations that are impossible to differentiate between fluids

3. **Personal protection equipment (PPE):** The clinic shall supply and make available appropriate PPE, such as gloves, masks, gowns or facial protection as needed to prevent or limit exposure to bio-hazards during the performance of job tasks.

4. **Prevention of accidental needle sticks: The** incidence of accidental needle sticks can be prevented and/or greatly reduced by several simple procedures, which include:

    a. Proper sharps disposal
    b. Never recapping needles
    c. The provision and use of PPE (personal protection equipment)
    d. Staff education on the risks of transmission
    e. Staff education on the techniques and methods

5. **Immediate first-aid procedures:** In the event of an accidental needle stick or other biohazard exposure, the following actions should be taken immediately by the employee. If the employee needs help in performing these tasks, he or she shall ask a supervisor or co-worker to assist. PPE should be worn and all efforts to minimize additional exposure or contamination should be exercised. The immediate steps should include:

    a. Wash needle sticks and cuts with soap and water
    b. Flush splashes to the nose, mouth or skin with water
    c. Irrigate eyes with clean water, saline or sterile irrigates
    d. Report the incident to your supervisor
    e. Immediately seek medical treatment
    f. If you have questions about appropriate medical treatment for occupational exposures, 24-hour assistance is available from the Clinicians' Post Exposure Prophylaxis Hotline. (PEPline) at **888-448-4911**

6. **Diagnostic testing and prophylaxis treatment guidelines:** The clinic follows all recommendations of the CDC for the management of accidental exposure to blood-borne pathogens. The following publications, or a similar publication, will be used if needed for as a written reference:

Updated U.S. Public Health Service Guideline for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis, MMWR Recommendations and Reports, Volume 54, Number RR-11 (found at www.cdc.gov/mmwr/PDF/rr/rr5011.pdf)

Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis, MMWR Recommendations and Reports, Volume 50, RR-11 (found at www.cdc.gov/mmwr/PDF/rr/rr-5011.pdf)

7. **Subsequent testing and treatment:** The subsequent ordering of diagnostic testing and treatment shall be the direct responsibility of the clinic administrator, or in the absence of the clinic administrator, the direct responsibility of the supervising healthcare provider. The clinic may refer additional treatment of the exposed individual to a specialty healthcare provider.

Specific procedures:

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document name	Location

Appendix F. Policies & Procedures - Medical Waste Handling & Disposal

Syringe Service Program P&Ps: Medical Waste Handling and Disposal		
J Tag references: § References:	Policy type:	Policy number:
Effective and Revision Date(s):		

Policy purpose: The purpose of this policy is to provide information about the disposal of bio-hazardous and medical waste.

Policy statement: [ORGANIZATION NAME], particularly with the Syringe Service Program, is committed to the appropriate disposal of potentially infectious or bio-hazardous waste (Regulated Medical Waste) in accordance with federal, state, and local laws.

Policy scope: This policy is informational, procedural, and regulatory in nature.

Policy body: Medical Waste Handling and Disposal.

1. **Trash receptacles:** All trash receptacles in patient care areas shall be equipped with lids.
2. **Red bags:** Regulated Medical Waste (soft waste) shall be discarded into containers with closable puncture-proof, leak-resistance red bags.

    a. Receptacles for medical waste which are in patient treatment areas shall be equipped with lids.
    b. Medical waste shall be removed from the patient care or treatment area as soon after the performance of a procedure as is practical and placed in the secondary storage area.
    c. Secondary containers for medical waste shall be in areas with secure access away from patient care areas. The containers are marked as bio-hazardous waste.
    d. Red bags and other waste containers are provided through the service vendor under agreement.

3. **Sharps containers:** Contaminated needles are discarded in closable, puncture-resistant, leak-resistance containers which are labeled as bio-hazardous. The containers are emptied or replaced when the manufacturer-placed indicator is reached. Containers shall be placed at an appropriate height and be out of the reach of children. Containers should be mounted

4. and secured. Containers shall be dated if the state regulations require them to be discarded based on duration of use and not full status.
5. **PPE and disposable items:** Providers and clinical staff shall use PPE, as needed, to protect themselves from exposure to contaminated equipment and exposure to body fluids. Contaminated PPE (gloves masks and gowns) and disposable laundry items (gowns, drapes and sheets) shall be discarded in red bags.

6. **Disposal of Biohazardous waste:** The off-site disposal of Regulated Medical Waste is performed under a service with a third-party which is compliant with federal, state and local laws pertaining to medical waste management. The clinic's agreement for waste disposal is currently with Stericycle. The agreement covers the disposal of sharps and red bag waste. The service provider makes routine, scheduled pick-ups of regulated medical waste and is available as needed for additional services.

Specific procedures:

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document name	Location

Appendix G. Policies & Procedures – Naloxone Training

Syringe Service Program P&Ps: Opiate Overdose & Naloxone Training		
J Tag references: § References:	Policy type:	Policy number:
Effective and Revision Date(s):		

Policy purpose: The purposes of this policy are to clearly outline the immediate steps that should be taken if an employee comes across an individual experiencing an opiate overdose.

Policy statement: The Syringe Service Program in connection with [ORGANIZATION NAME] has a high regard for the health and safety of its employees.

Policy scope: This policy is informational, procedural, & regulatory in nature.

Policy body: Opiate Overdose Treatment: Naloxone Training Protocol.

1. **Signs and symptoms of opiate overdose:** The signs and symptoms of opiate overdose include:

    a. Unresponsiveness to yelling or stimulation, like rubbing your knuckles up and down the person's sternum, or breast bone (also called a sternum rub). [This symptom effectively draws the line between overdosing and being high but not overdosing.]
    b. Slow, shallow or no breathing
    c. Pulse (heartbeat) is slow, erratic or not there at all
    d. Turning pale, blue or grey (especially lips and fingernails)
    e. Snoring/gurgling/choking sounds
    f. Body very limp
    g. Vomiting

2. **Opiate overdose treatment overview:**

    a. Check for a response
    b. Call 911
    c. Start chest compressions
    d. Administer naloxon

e. Resume chest compressions with rescue breathing if the person has not yet started breathing
f. Conduct follow-up – administer a second dose of naloxone if no response after 3 minutes and resume chest compressions with rescue breathing.
g. If naloxone is administered, provide details to emergency medical services

3. **Responding to an opiate overdose:**

    a. Check for responsiveness
        i. Yell
        ii. Give a sternum rub. Make a fist and rake your knuckles hard up and down the front of the person's sternum (breast bone). This is sometimes enough to wake the person up.
        iii. Check for breathing. See if the person's chest rises and falls and put your ear near the person's face to listen and feel for breaths.
        iv. If the person does not respond or is not breathing, proceed with the steps listed below.

    b. Call 911. If you must leave the person, put the person in the recovery position*
        i. State that someone is unconscious due to suspected overdose and indicate if the person is not breathing. (If you call police or 911 to get help for someone having a drug overdose, Oregon's Good Samaritan Law protects you from being arrested or prosecuted for drug-related charges or probation or parole violations based on information provided to emergency responders.)
        ii. Give the address and location
        iii. Be aware that complications may arise in overdose cases. Naloxone only works on opiates, and the person may have overdosed on something else, e.g., alcohol or benzodiazepines. Emergency medical services are critical.
        iv. *Recovery position:
            1. Roll the person over slightly on the person's side
            2. Bend the top knee
            3. Put the person's top hand under the person's head to support it.
            4. This position should keep the person from rolling onto their stomach or back, so the person does not choke if they vomit.

    c. (A) Start chest compressions with rescue breathing (CPR)
        i. Place heel of one hand over center of person's chest
        ii. Place the other hand on top of first hand, keeping elbows straight with shoulders directly above hands.
        iii. Use body weight to push straight down, at least 2 inches, at rate of 100 compressions per minute.
        iv. Give 2 breaths for every 30 compressions
        v. CPR should be performed for 5 rounds (2 breaths for every 30 compressions), or for approximately 2 minutes, before reassessing.

OR

d. (B) If overdose is witnessed, i.e., you see the person stop breathing, or you are sure it is overdose due to personal knowledge of the person or situation, you have the option to start rescue breathing. Be aware when you call 911 that they may instruct you to perform CPR as well.
    i. Check the person's airway for obstructions and remove any obstructions that can be seen
    ii. Tilt the person's forehead back and lift chin
    iii. Pinch the person's nose and give normal breaths – not quick and not overly powerful breaths
    iv. Give one breath every five seconds
    v. Continue rescue breathing for approximately 30 seconds

4. **Administer naloxone**: If the patient has been receiving opioids, giving them naloxone may result in temporary withdrawal symptoms. This response can include abrupt waking up, vomiting, diarrhea, sweating and agitated behavior. While these symptoms can be dramatic and unpleasant, they are not life threatening and will only last until the naloxone has worn off. See details about specific naloxone products, below.

a. If your naloxone kit is a syringe set up to be given as a nasal (nose) spray:
    i. Pull or pry off both top and bottom covers on the syringe
    ii. Pry off the cap of the naloxone capsule
    iii. Grip the clear plastic wings
    iv. Screw the naloxone cartridge into the barrel of syringe
    v. Insert white cone into nostril; give a short vigorous push on the end of the naloxone cartridge to spray naloxone into the nose; one half of the cartridge goes into each nostril
    vi. If minimal or no response in 3 minutes, then give a second dose

b. If your naloxone kit is NARCAN Nasal Spray:
    i. Peel back the package to remove the device
    ii. Hold the nozzle between two fingers
    iii. Place the tip of the nozzle in either nostril until your fingers touch the bottom of the patient's nose
    iv. Press the plunger firmly with thumb to release the does into the patient's nose
    v. If minimal or no response in 3 minutes, then give a second dose

c. If your naloxone kit is a syringe set up to be given as an injection into a muscle (intramuscular):
    i. Remove cap of the naloxone vial
    ii. Draw up 1ml of naloxone into a syringe. (Ideally, the needle size for an injection into the muscle is 1 to 1.5 inches long and 25-gauge width)
    iii. If available, clean the area with an alcohol wipe before you inject
    iv. Inject into muscle in the upper arm, thigh, or buttocks
    v. Insert the needle at a 90-degree angle to the skin and push in plunger
    vi. If minimal or no response in 3 minutes, then give a second dose
d. If your naloxone kit is an Evzio injectable device:
    i. Remove Evzio from outer case
    ii. Pull off the red safety guard
    iii. Place back end against middle of the thigh, through the clothing
    iv. Press firmly and hold in place for 5 seconds
    v. If minimal or no response in 2 to 3 minutes, administer second dose

5. Conduct follow-up

a. Naloxone takes several minutes to kick in and wears off in 30-45 minutes. The person may go back into overdose after the naloxone wears off.
b. It is recommended that you watch the person for at least an hour or until emergency medical services arrive, in case the person goes back into overdose.
c. You may need to give the person more naloxone. Give a second dose if the person does not respond after 3 minutes.
d. If an overdose victim revives, keep the person calm. Tell the person that drugs are still in their system and that the naloxone ears off in 30-45 minutes. Recommend that the person seek medical attention and assist them, if necessary.
e. Do not let the person use more opiates. The naloxone will block them, and the person could overdose again after the naloxone wears off.

Specific procedures:

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document name	Location

Appendix H. Policies & Procedures – Safety Guidelines

Syringe Service Program P&Ps: Safety Guidelines		
J Tag references: § References:	**Policy type:** Safety Guidelines	**Policy number:**
Effective and Revision Date(s):		

Policy purpose: General Safety Procedures.

Policy statement: The Syringe Service Program in connection with [ORGANIZATION NAME] has a high regard for the health and safety of its employees.

Policy scope: This policy is informational, procedural, & regulatory in nature.

Policy body: Programs should consider the following recommendations (Harm Reduction Coalition, 2010; Multnomah County Health Department, 2012):

- Ensure multiple staff are present during hours of operation
- Handle syringe transactions one person at a time
- If necessary, staff should remind participants not to crowd the exchange area
- Ensure all staff and volunteers wear closed-toe and closed-heel shoes. Clothing that covers legs and arms may be recommended, as well.
- Never give clients rides, money or any other goods
- Use caution when disclosing personal information
- If a client becomes upset or angry, use active listening to de-escalate the situation
- If a client becomes violent or hostile, shut down the exchange site and contact the program manager and the police
- Avoid bringing valuable possessions to the site or lock them in a safe place
- Keep a cell phone on you
- Conduct operations in spaces that are free of clutter and have adequate lighting
- Ensure the following items are always accessible:
    - First aid kit
    - Fire extinguisher
    - Naloxone kits, if possible

- Materials to be used in the event of a sharps spill
- Puncture-resistant utility gloves
- Tongs
- Bleach

Specific procedures:

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document name	Location

Appendix I. Marketing Poster

[ORGANIZATION NAME]

SYRINGE SERVICE PROGRAM

ANONYMOUS & CONFIDENTIAL

[DAYS/TIMES]

Questions? Call us:

[PHONE]

[ADDRESS]

Use a syringe
Once & only once

What we offer free of charge:

- Safe disposal of used syringes/containers
- Clean syringes & sharps containers
- Confidential testing of HIV & Hepatitis C – optional
- Linkage to treatment – optional
- Education
- Naloxone
- Condoms

Appendix J. Client Form

SYRINGE SERVICE PROGRAM
CLIENT FORM

Date: _____ Age: _____ Sex:_____ First Initial:_____

Would you like HIV and Hep C testing? Yes or No

Test results: _____

Would you like a counseling referral? Yes or No
Referred to: _____

Would you like a referral for primary care? Yes or No
Referred to: _____

Have you received Hepatitis A and B vaccine? Yes or No

Have you witnessed an overdose? Yes or No

Overdose instruction: _____

Naloxone instruction: _____

Harm Reduction training: _____

Syringes issued: _____

Sharps containers issued: _____

Condoms issued: _____

Syringes received: _____

Sharps containers received: _____

Syringe Service Program: Sharps Log

Date of Exchange: ___________________ Age/Sex: ________________________
Syringes In: _______________________ # Syringes Out: _________________
Sharps Containers In: __________ # Sharps Containers Out: _______
Referrals: ____

Date of Exchange: ___________________ Age/Sex: ________________________
Syringes In: ______________________ # Syringes Out: __________________
Sharps Containers In: __________ # Sharps Containers Out: _______
Referrals: ____

Date of Exchange: ___________________ Age/Sex: ________________________
Syringes In: ______________________ # Syringes Out: __________________
Sharps Containers In: __________ # Sharps Containers Out: _______
Referrals: ____

Date of Exchange: ___________________ Age/Sex: ________________________
Syringes In: _______________________ # Syringes Out: _________________
Sharps Containers In: __________ # Sharps Containers Out: _______
Referrals: ____

Date of Exchange: ___________________ Age/Sex: ________________________
Syringes In: ______________________ # Syringes Out: __________________
Sharps Containers In: __________ # Sharps Containers Out: _______
Referrals: ____

Date of Exchange: ___________________ Age/Sex: ________________________
Syringes In: ______________________ # Syringes Out: __________________
Sharps Containers In: __________ # Sharps Containers Out: _______
Referrals: ____

Date of Exchange: ___________________ Age/Sex: ________________________
Syringes In: ______________________ # Syringes Out: __________________
Sharps Containers In: __________ # Sharps Containers Out: _______
Referrals: ____

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