SOUTH CAROLINA
HARM REDUCTION AND SYRINGE
SERVICE PROGRAMS SYMPOSIUM

2023

Harm Reduction and Syringe Service Programs in South Carolina: The Beginning of the Continuum of Care *Conference Proceedings*

Prepared by:
Jodi Manz, MSW
Clear Bell Solutions
Charleston, SC

Symposium Background

On Friday, June 9, 2023, the Prisma Health Addiction Medicine Center in Greenville, South Carolina hosted over 175 individuals from multidisciplinary backgrounds to discuss the current landscape of harm reduction services and to share ideas to foster access to these services in the state. The symposium agenda was developed by a 17-member steering committee composed of South Carolina providers, community organization leaders, and state agency representatives. The stated objectives[i] were to:

1) *Outline the evidence supporting syringe service programs (SSPs) and highlight innovative national models of comprehensive syringe service programs and harm reduction;*
2) *Discuss legal and policy issues related to operating syringe service programs in South Carolina, and describe how other states launched and expanded syringe service programs; and,*
3) *Develop a collaborative action plan for expanding syringe service programs in South Carolina.*

This white paper prepared by Jodi Manz, Clear Bell Solutions, summarizes the content delivered by expert speakers at the South Carolina Harm Reduction and Syringe Service Program.

Speakers, listed in order of appearance, provided content in support of these objectives.

- Kimberly Sue, MD, PhD, Medical Director of National Harm Reduction Coalition, presented a brief overview of the history of harm reduction and provided a review of evidence-based, research-supported harm reduction strategies. She leveraged her experience as a harm reduction and substance use disorder (SUD) treatment provider to emphasize the utility of SSPs, particularly in the face of an increasingly complex drug supply.
- Christina Dent, Founder and President of End it for Good, a Mississippi-based advocacy non-profit, applied her lens as a foster parent to share her personal learning process about the value of harm reduction services. Employing a framework that explores the concept of harm at market, substance, and consumer levels, she outlined a case for harm reduction as one response to multiple systemic issues that are contributing to the SUD crisis.
- Brianna Norton, DO, MPH, Associate Professor of Medicine at Albert Einstein College of Medicine and Medical Director of ONPoint NYC, an SSP and overdose prevention center in New York, described the innovative model that she and her colleagues use to deliver healthcare to people who use drugs (PWUD). This approach provides comprehensive care by integrating harm reduction services with infectious

disease prevention and treatment, and ultimately, connecting individuals to primary care and other resources.

- Najja Morris-Frazier and Brendan Cox provided an overview of the Law Enforcement Assisted Diversion (LEAD) program model in which PWUD are prevented from entering the criminal-legal system and are instead guided to care systems. Both speakers shared how their professional histories – Ms. Morris-Frazier, the LEAD National Support Bureau Director, working with youth who were unhoused, and Mr. Cox, the LEAD Director of Policing Strategies, serving in the Albany Police Department – informed their understanding of working with PWUD.
- Corey Davis, JD, MSPH, NREMT, Director of the Harm Reduction Legal Project at the Network for Public Health Law and Teaching Professor at the East Carolina University Brody School of Medicine, outlined the legality of harm reduction services in South Carolina via a virtual presentation. Through an examination of state statutory law and state agency policy, he clarified the legal status of syringe service programs, fentanyl test strips, and naloxone distribution in the state.
- Jon Zibbell, PhD, Research Triangle Institute (RTI), used drug seizure data collected by law enforcement to provide an analysis of how fentanyl continues to drive overdose fatalities, alone and in combination with other drugs, while noting that deaths involving heroin and prescription opioids have declined precipitously since 2016, particularly in easter and Midatlantic states. Further, he presented consumer-driven data from a community-based study in North Carolina and West Virginia that provided first-hand consumer experiences on challenges navigating an unpredictable and increasingly toxic drug supply.
- Marc Burrows, LMSW,(Challenges Inc) and A'zhane Powell, LMSW, (Fyrebird Recovery) discussed the realities of operating SSPs in South Carolina as part of a panel facilitated by Laura Pegram, MSW, MPH of the National Alliance of State and Territorial AIDS Directors. They were joined by Robert Childs, MPH, former Executive Director of the North Carolina Harm Reduction Coalition, who added his experience on engagement of communities, legislators, and organizations to move harm reduction policy forward.

Defining Harm Reduction

As a public health term with multiple, nuanced definitions, harm reduction can be challenging philosophy to conceptualize. This makes harm reduction subject to urban mythology about how legal it is, stigma about how acceptable and effective it is, and confusion as to precisely *what* it is. To level-set, Dr. Sue provided several definitions, all of which reflect overarching goals to

increase safety and decrease risk among people who use drugs and their communities. From the concise Chicago Recovery Alliance definition – "any positive change" – to the headier international definition – "policies, programs, and practices that aim to minimize negative health, social, and legal impacts associated with drug use, drug policy, and drug laws," – ultimately harm reduction seeks to promote safety among PWUD. Dr. Sue suggested that harm reduction can be simply defined as "*a wide-ranging set of practical strategies aimed at reducing negative consequences associated with drug use*." As a healthcare tool, provision of these strategies is valuable, having been shown to reduce HIV[ii] and HCV transmission[iii] and decrease healthcare costs[iv].

While SSPs are often centered as the primary component of harm reduction programs, many other services can be delivered alongside sterile syringes. These services cover a range of interventions, including provision of safer-use tools like fentanyl test strips, sterile water or citric acid packs, cooking equipment, naloxone, and education about risks/safer use. Further, many sites provide on-site HCV/HIV testing and connections to treatment for infectious disease and wound care. Recognizing a continuum of care for PWUD, many sites also offer referrals to SUD treatment; participants in harm reduction programs are five times more likely to enter treatment than those who do not or cannot access harm reduction[v]. Beyond connections and referrals, some sites also have capacity to provide medications for opioid use disorder (MOUD).

Federal and State Harm Reduction Policy

The current federal Health and Human Services (HHS) Overdose Prevention Strategy cites harm reduction as a critical component of reducing fatal and non-fatal overdoses. Implementing evidence-based strategies, including SSPs, is also among key priorities of the federal Ending the HIV Epidemic (EHE) plan, initiated in 2019 under the Trump Administration with goals of reducing new HIV infections by 75% by 2025 and 90% by 2030. Many federal agencies have expressed their strong support of harm reduction: in early 2021, the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) began allowing the use of federal dollars to purchase fentanyl test

> Rural HIV Urgency
> *South Carolina is one of seven EHE priority states with significant HIV diagnosis numbers in rural areas.*

strips[vi]. Later that year, SAMHSA announced a novel grant program that made a total of $30 million available to state, local, and tribal entities as well as community organizations and providers to deliver harm reduction services[vii]. "Getting people into treatment for substance use disorders is critical, but first, people need to survive to have that choice," said National Institute on Drug Abuse (NIDA) Director Nora D. Volkow, M.D. "Harm reduction services acknowledge this reality by aiming to meet people where they are to improve health, prevent overdoses, save lives and provide treatment options to individuals."[viii]

South Carolina law, a state determined by the CDC[ix] to be among 44 states experiencing or at risk of significant increases in HCV or HIV outbreaks due to injection drug use, permits SSPs, as explained by Davis in his presentation. In South Carolina, items like syringes and fentanyl test strips are not defined as paraphernalia. Though many states adopted language from a Drug Enforcement Administration (DEA) model paraphernalia law in the early 1980s outlawing syringes, South Carolina's paraphernalia law (SC Code of Law § 44-53-110(33)) has never included this language[x]. While Davis is not a South Carolina attorney, he indicated that he saw no reason why distributing syringes is South Carolina is would be illegal. Obtaining naloxone for harm reduction programs in South Carolina may actually be more challenging than distributing syringes in some cases, as DAODAS policy currently requires community distributors of naloxone to provide information in excess of what the law requires, including references from "a credible state or local entity." However, this is an internal policy that can be easily modified to make it easier for community groups to distribute naloxone.

Symposium Themes

Over the course of the symposium, several themes emerged from presentations, contributing to the foundation for potential action items. Taken together, these concepts informed the conversations of facilitated discussion groups[xi] and their resulting recommendations.

1) Understanding the history of drug policy contextualizes the need for harm reduction today (Sue, Dent, Zibbell). While use of drugs is not new, US policy toward PWUD has changed significantly in just the last century, growing progressively more punitive. Before the 20th

century, SUD in the United States was treated primarily as a medical issue requiring treatment. Over time, however, a series of increasingly stringent laws banned specific substances and increased penalties for their possession. . This process accelerated with the "War on Drugs" that began in the mid-1970's, which focuses on arresting and incarcerating people who use drugs, many of whom have an SUD. Today, nearly 9 out of every 10 drug arrests are for simple possession, not sales or manufacturing.

Criminalizing consumers directly is a relatively new policy approach, marking a departure from the policies of alcohol Prohibition. The 18th amendment (and resulting Volstead Act) prohibited the manufacture, sale and transportation of most alcohol. Prohibition policy, as outlined by Dent, reflected not increased regulation, but an absence thereof, which ultimately increased risks for the public. Previously regulated businesses, such as bars, which were subject to quality control, were outlawed. This created a violent underground market in which gangs gained control of production and sales, and to the production, sale and consumption of homemade alcohol, some of which was poisonous and all of which was of relatively unknown purity. The same can be seen in the contemporary drug market as a result of over a century of drug prohibition and criminalization policies: competition and supply are unregulated, leading to a host of harmful outcomes and fostering stigma that poses barriers to attempts to increase safety.

The lessons of Prohibition provide a pathway to understanding the need for harm reduction. Despite best intentions, Prohibition did not stop people from being harmed by alcohol. Ironically, the repeal of Prohibition enabled the creation of a regulated, legal, and much safer market and eliminated the violence caused by rival gangs fighting for a share of the illicit market. Regulation to monitor potency and purity, restrict purchase age, limit driving under the influence, and control where drinking is legal are all examples of policies designed to reduce the harms of alcohol.

An unregulated underground drug market is inherently a more dangerous drug market. Because consumers are at the whims of unregulated sellers, they cannot make demands nor educated choices in an unregulated market. This is clear with the proliferation of fentanyl.

Despite many drug users reporting that they do not enjoy the effects of fentanyl and prefer less-potent opioids like heroin, they are limited to a supply based on market availability.

2) The drug supply is evolving to become more toxic (Sue, Dent, Davis, Zibbell). The modern opioid epidemic has come in waves, beginning with prescription opioids falsely marketed by pharmaceutical companies in the mid 1990s as being less addictive. When legal changes were made to reduce supply of these prescription drugs, many people who had developed an opioid use disorder switched to the illicit market, and heroin overdoses began a precipitous rise in 2010. Fentanyl began to enter the opioid supply around 2013, and by 2016, it was the chief driver of fatal overdoses. As of 2022, well over two-thirds[xii] of fatal overdoses involve fentanyl.

Using 2014-2019 drug seizure data from the Drug Enforcement Administration's National Forensic Laboratory Information System (NFLIS) as a proxy for the nation's drug supply, a market shift appears in 2014. As heroin and prescription opioid seizures decreased, fentanyl seizures increased – as did deaths – indicating that highly potent fentanyl had "usurped" the rest of the opioid market. Using NFLIS data, Zibbell showed that fentanyl supply numbers aligned to overdose fatalities closely, both alone and in combination with other drugs[xiii]. An incident rate ratio analysis (assessing exposure to a substance and an attendant incident) of drug seizures and mortality provided by Zibbell showed that for every one fentanyl seizure, there was a correlating 3% increase in deaths. While stimulants are increasingly implicated in overdose deaths, fentanyl is in most of the drug supply and remains the driver of mortality.

Xylazine, a veterinary anesthetic recently designated an emerging national threat, has been detected in most states, including South Carolina. Southern states have seen an outsized impact, experiencing a 193% increase in seizures and a 1,127% increase in xylazine's presence in overdose deaths[xiv]. Xylazine increases the sedation effect of fentanyl, making it particularly toxic when mixed into the fentanyl supply.

3) An increasingly toxic drug supply is driving not just overdoses, but infection risk, intensifying the need for harm reduction services (Sue, Davis, Zibbell). Fentanyl effects are different from heroin: more sedative, less euphoric, and considerably shorter. This leads to higher injection frequency and with it, more risk. These frequent injections are not, however, in and of themselves, the primary risk for transmission of infectious disease like HCV, HIV, and endocarditis – Davis emphasized that it's the *sharing* of syringes that poses the risk factor. Syringe sharing, however, is extremely common[xv], and infectious disease has risen alongside injection drug use. For example, Zibbell described a 400% increase in HCV infections among young people (18-29 years old) in central Appalachia between 2004-2014 that paralleled a 622% increase in treatment admissions for opioid injection[xvi]. Syringe sharing has also led to infectious disease clusters in rural areas: over 200 cases of HIV (and many co-occurring cases of HCV) in rural Scott County, Indiana, in 2015, and 85 cases of HIV in Kanawha County, West Virginia between 2019-2021.

> Increases in stimulant use are directly related to the ubiquity of fentanyl (and now, xylazine)
> *The sedative effect reduces ability to engage in daily life: working, driving, finding housing, and monitoring personal safety becomes challenging. As a result, many report using stimulants to counter this.*

Increased injection frequency is likewise contributing to a xylazine-related emerging crisis of injection-related wounds and soft tissue infections. Though injection-related abscesses and bacterial infections resulting from used, often dull syringes are not new, the high injection frequency of fentanyl increases incidence. Xylazine within the supply is further causing a new type of wound that is not infectious, is not at the site of injection, and is slow to heal.

4) Effective harm reduction services and strategies are necessary to respond to the challenges brought by the evolving supply (Sue, Norton, Davis). The increased risks of overdose, infection, and wounds brought by the unregulated and increasingly dangerous drug supply pose an urgency to ensuring the health of PWUD. This requires increasing access to harm reduction and expanding services to address prevention and treatment along a continuum of care for SUD and infectious disease.

A unique partnership in New York is doing just that. Montefiore Health System's academic medical center partnered with the New York Harm Reduction Educators (NYHRE), a

community-based harm reduction organization, to provide an integrated approach to drug user health services. This model brings HCV treatment as well as HIV prevention, wound care, low-barrier buprenorphine, and re-entry into primary care and HIV care to individuals who are already seeking harm reduction services. Norton, a provider at the program, emphasized that any improvement in drug use (e.g., from daily to social use) is seen as a success in this environment, and abstinence is not a determining factor in ongoing care. The program had 118 patients in its first three months seeking care for a variety of conditions, including HCV treatment.

Entry into HCV treatment requires only a positive HCV test. Participants can do group or individual treatment, and they receive gift card incentives for weekly visits. Medication is available daily at the clinic or via two-week take-home supply. Once treatment is completed, patients can access reinfection interventions with an HCV navigator. Appointments are never necessary. Nearly all treatment is covered by Medicaid, and funds from New York City's Innovative HCV Elimination grant and New York State's AIDS Institute supplement other needs. Most patients who initiated HCV treatment in this program were cured.

5) Law enforcement can take a harm reduction approach to public safety (Dent, Morris-Frazier and Cox). In many communities, law enforcement has embraced SSPs because provision of sterile syringes increases their safety by reducing their risk from accidental needle sticks. In addition, since people who use SSPs are five times more likely to access substance use treatment, they are less likely to engage in interactions with law enforcement. Beyond this, law enforcement is also taking a direct and active role in reducing the systemic harms of criminalization often encountered by PWUD.

The Law Enforcement Assisted Diversion (LEAD) program, which currently has nearly 80 sites around the country, including two in South Carolina, asks a fundamental question: "What if jail and prosecution were a last resort, not a primary strategy?" Rather than arrests for drug-related offenses, LEAD directs PWUD to case management to access the services they need, like housing, food, clothing, and employment supports. Described by Morris-Frazier as a pre-court program and by Cox as "not an extension of the legal system," LEAD is a tool to avoid

criminalization of SUD altogether. This represents a departure from how SUD has been typically handled in the past, and evidence is showing that it produces savings while reducing burdens on the criminal legal system. Further, LEAD reduces harms to officers who, by the nature of their work, experience secondary trauma and violence.

Individuals are referred into LEAD in various ways: by officers who make referrals instead of arrests, proactive social contact referrals by anyone within the criminal legal system, or community referral. Any referral gives PWUD access to case managers to work alongside individuals, providing coordinated care without requiring abstinence. LEAD programs are collaboratively governed by a Policy Coordinating group composed of local entities with an interest in reducing systemic harm. This may include representatives from police or sheriff's offices, mayors or municipal leadership, health and behavioral health departments, and other stakeholders. This intentional power sharing ensures that LEAD programs can remain sustainable and able to grow.

6) State governments have been key partners in implementation of harm reduction policy (Davis, Norton, Childs). Accessibility to harm reduction services is largely determined by the policy environment in which an individual lives. States have multiple levers to impact this environment, including regulations on providers and facilities, differences in paraphernalia laws, and budgets to fund (or not fund) services.

As discussed above, South Carolina law allows for but does not expressly authorize SSPs, as the state's paraphernalia law is not restrictive of syringes. Other states, however, have needed to take explicit steps to authorize SSPs, as they were otherwise prohibited by state law. Kentucky authorized SSPs in 2015, and Tennessee followed in 2017; both states had adopted paraphernalia laws based on the 1979 DEA model law and therefore had to create exemptions from it. South Carolina can encourage SSPs by spreading the word that they are not prohibited, and by funding organizations that distribute sterile syringes.

States as Messengers

New York's Department of Health released a Build a Safety Plan flier that provides tips to avoid overdose and infectious disease transmission, as well as information on how to find SSPs and SUD treatment.

Collaborative Action Plan: Recommendations to Move Forward

Solutions and innovations were embedded in every component of the agenda; the speaker sessions, the panel discussion, and the facilitated breakout groups all yielded suggestions for actionable steps that could make harm reduction services more accessible in South Carolina. Strategies listed below, many of which were raised by multiple participants in different contexts, represent collective ideas that were shared throughout the symposium.

South Carolina SSP Development, Implementation, and Service Delivery

- *Maximize personal networks.* Utilize the skills of friends and colleagues for challenging administrative tasks like grant writing, budget management, and supply procurement.
- *Learn about and apply for opioid abatement funds.* Harm reduction is a South Carolina core strategy, and both Guaranteed Political Subdivision (local) and Discretionary funds should be considered as resources for SSP establishment and operational costs.
- *Ensure compliance with all local, state, and federal laws.* While SSPs are legal in South Carolina, other regulations and laws may impact services. Review policy guidance and regulations to avoid pitfalls, and reach out to attorneys or agencies with questions.
- *Gather data to validate current and future funding needs.* Data can be helpful in making the case for harm reduction interventions. Where doing so won't negatively impact services, collect meaningful data that can be used to make the case to policymakers and funders.

SC SSP Spotlight: Challenges Inc, Greenville

Establishment: Marc Burrows, an LMSW with lived experience from Greenville, started Challenges, Inc – the first SSP in the state – in 2016, handing out syringes, condoms, and other supplies from his car trunk. Over time, and with some grant funding, Challenges Inc has grown into a volunteer-run thriving mobile unit serving the region at set times and locations throughout each week. The mobile unit provides syringes and other sterile supplies, fentanyl test strips, naloxone, condoms, sharps containers, and rapid HCV/HIV testing with immediate referral to treatment.

Challenges: Funding, particularly ongoing funding for staffing

Successes: Grant funding purchased a mobile van that allows services to be delivered throughout the region; 100k+ syringes dispensed each year, over 50k total naloxone doses dispensed, and a reported 743 overdose reversals.

Commented [CD1]: Requiring unnecessary data is actually a huge problem for small harm reduction orgs. Yes, meaningful data should be collected, but not at the expense of services (you do not need to have someone fill out a questionnaire every time they come to the SSP, nor should you). We definitely do not need to quantify everything. NASEM just held a two day meeting on this topic.

- *Consider community composition and needs.* Programs should consider how social determinants, local drug markets, and gender or racial implications may impact participants and should tailor services and locations accordingly.
- *Include PWUD to help direct harm reduction programs and services.* People who use drugs are subject matter experts in supply and usage patterns, and practice inclusion of PWUD aligns to the CDC's guidance on Participant Input on Harm Reduction Programs.
- *Educate participants on xylazine and other emerging risks.* SSPs are among the first to learn about emerging drugs/additives and should share that knowledge to reduce risk (existing resources from North Carolina, Prevention Point Pittsburgh, and Chicago available).
- *Integrate drug checking.* Community drug checking is urgently needed to test for new and emerging substances like xylazine and can help communities to quickly forecast risk.
- *Allow secondary syringe exchange.* Encourage participants to pass along sterile supplies to non-participants to expand SSP reach, and provide safe syringe disposal guidance.
- *Modify South Carolina paraphernalia statue so that it does not include smoking equipment (e.g., pipes, stems) used for safer smoking of controlled substances*.
- *Source options for consistent supplies.* Leverage state resources and buyer's clubs like the Remedy Alliance for naloxone and NASEN for other SSP supplies.
- *Foster intentional relationships among clinical resources, community organizations, and law enforcement*. Partnering across systems grows SSP capacity and reach while cultivating

SC SSP Spotlight: Fyrebird Recovery, Horry and Loris Counties

Establishment: A'zhane Powell, an LMSW in Myrtle Beach, created Fyrebird in 2022 in response to a lack of harm reduction programs in the region. Without a source of start-up funding, she started with a supply of donated syringes and an open car trunk at a local bus stop after months of working to get municipal leaders on board. Fyrebird trusted program consumers to direct equipment provision, adding cookers, filters, and other supplies based on their feedback. The makeshift SSP unit has evolved into a thriving site and now has some grant funds to support things like a peer sustained library, case management, and connections to low barrier treatment.

Major challenges: 90+% of participants report having HCV but no treatment access. Obtaining naloxone remains a challenge despite need – last year, Fyrebird distributed 1000+ doses, and in just one month this year, they distributed 400+doses to about 300 people.

Major successes: In just one month this year, Fyrebird distributed 400+ doses of naloxone to about 300 people. Fyrebird also has a 25-member drug user union, 5 of whom are on staff. Fyrebird has also received opioid abatement funds from SC Opioid Recovery Fund.

knowledge in communities and among professionals. Law enforcement should be trained on the legality of SSPs and the importance of not interfering with SSP participants, and can be made aware of SSP hours, locations, and supplies in order to mitigate concerns before they potentially impact services.

Clinical Service Delivery and Integration

- *Leverage changes to state Medicaid policy to expand capacity.* South Carolina Medicaid's most recent prior authorization form for HCV care removes fields for both individual abstinence requirements and provider type.
- *Foster HCV treatment champions within health systems.* Encourage health system leadership, including hospitals and safety net providers, to dedicate even a few clinical slots for HCV treatment, and create a platform for champions to share successes and challenges.
- *Bring infectious disease care and SSP services together.* South Carolina's academic medical centers should consider opportunities to partner with SSPs for integrated care models. SSPs will be central for HCV elimination and addressing the HIV epidemic in South Carolina.
- *Develop mobile services to reduce transportation and stigma barriers.* Mobile SSPs and SUD treatment expand access and, if coordinated, create an initial step toward integration. Over time, programs can add other services (and permanent space).

Systems and Policy Change

- *Establish a platform for interagency data interoperability.* Timely data across systems helps to assess needs, analyze outcomes, and target resources. Consider a platform to collect and maintain relevant data to efficiently develop policy and programs, and ensure that SSPs are sufficiently resourced to collect and report the data.
- *Clarify existing statute on residue.* Current statute could be improved by using clear language to confirm that residual amounts in injection equipment are not criminalized.
- *Expand retail sales of syringes.* Remove or modify current statute that permits only pharmacies to sell syringes to expand availability of sterile supplies.
- *Introduce statutory and budgetary language to encourage and explicitly fund SSPs*. Policy guidance and consistent funding would help SSPs navigate service provision.

- *Reduce barriers to community naloxone distribution.* Review and revise the DAODAS protocol to allow fewer or different requirements to become a Community Distributor.
- *Evaluate existing LEAD sites in South Carolina for outcomes.* Program evaluations have indicated savings to public systems. Programs in Lancaster and Chester counties can provide local evidence of savings for future state investment or federal grants.
- *Engage groups with similar interests, even those with different motives.* A coalition that represents different interests can contribute to a singularly focused policy strategy.
- *Create cross-agency engagement specific to drug user health in South Carolina.* Convene all relevant state agencies to focus on improving health through harm reduction, integrated care infrastructure, and provider supports and reimbursement.

Messaging and Growing Community Support

- *Emphasize that harm reduction is more than syringe exchange*. Using facts and data, make clear the multitude of services offered and how they benefit individuals and communities.
- *Leverage any increase in newfound understanding of SUD as a chronic behavioral health condition*. This includes growing acceptance of the need for naloxone and MOUD.
- *Use less loaded language*. Terms like "place of respite" and "infectious disease elimination" convey the goals of harm reduction while deemphasizing stigmatized concepts.
- *Cultivate advocates within communities*. Work with champions within professions or community groups to help them translate harm reduction among their peers.
- *Advocate alongside PWUD who may not have experience in policy settings.* As Powell said on the SSP panel, "I can open the doors, and then let's go through those together."
- *Appeal to faith communities.* While culture varies by congregation, houses of worship are seen as a safe haven by many, and this status confers opportunity. In addition, clergy are respected members of the community and often carry weight with the policymakers.
- *Clarify messaging on fentanyl in cannabis.* To ensure that messaging is factual and focused on real harms, rely on simple data: no analysis has found fentanyl in cannabis.
- *Highlight humanization and acknowledge that people seek out SSP services because they are trying to care for themselves and their loved ones.* Prioritizing safety is unto itself accountability, and the use of SSPs reflects a desire to be safer and healthier.

Future Planning

As the first large-scale event in the state focused on building readiness and capacity for harm reduction, this symposium was historic for South Carolina. Planning partners are considering options to hold similar gatherings in the future to continue collective learning, organizing, and strategizing. With the creation of a second SSP in South Carolina, the timing was right for Challenges Inc and Fyrebird Recovery to come together and form a statewide coalition. The South Carolina Harm Reduction Coalition was newly reformed in 2023 with a new board and new members and seeks to build on this momentum into expanded statewide advocacy and public education for harm reduction and drug-user health policies. The SCHRC Board of Directors includes Marc Burrows, Azhane Powell, Rollie Martinson, and Rachel Kaplan and there currently exists an active Political Affairs Committee that meets regularly to discuss drug policy issues. Their Mission is to encourage and motivate the implementation of harm reduction interventions, public health strategies, drug policy transformation, and justice reform in South Carolina by means of leadership, advocacy, resource and policy development, and education. Their Vision is a community where people who use drugs have the necessary tools to stay safe and a society where people are not criminalized based on the drugs they choose to consume. People can visit www.southcarolinahrc.org to receive a monthly newsletter and learn how to get involved with SCHRC.

Commented [KK2]: Marc Burrows

Sponsored and/or provided CME for the conference

Conference Convenors

Marc Burrows, MSW, LMSW
Katiey Kitzmiller
Alain Litwin, MD, MPH
Claire Stam, PhD, MPA, MBA
Margie Stevens, PhD, CRC

Steering Committee

Maurice Adair – AID Upstate
Linda Brown – DAODAS
Marc Burrows – Challenges, Inc.
Michael Crouch – Prisma Health Addiction Medicine Center
Katiey Kitzmiller – Prisma Health Addiction Medicine Center
Alain Litwin – Prisma Health Addiction Medicine Center, University of South Carolina School of Medicine-Greenville, and Clemson Center for Addiction and Mental Health Research
Becky Maddox – Phoenix Center
Jodi Manz – Clear Bell Solutions
Rollie Martinson – Community Education Group
Zoie Miller – Greenville Shape Coalition
Quang Pham – Inova Health System
Ericka Pursley - Catawba Nation
Daniel Raymond – National Viral Hepatitis Roundtable
Tina Skinner – SC DHEC
Margie Stevens – Prisma Health Addiction Medicine Center and University of South Carolina School of Medicine-Greenville
Claire Stam – Prisma Health Addiction Medicine Center
Kenric Ware – South College School of Pharmacy

Endnotes and Resources

[i] The activities of the symposium were approved for the University of South Carolina School of Medicine-Greenville (USCSOMG) Continuing Medical Education (ACCME) for physicians, nurse practitioners, physician assistants, and pharmacists, as well as for continuing education through AHEC for General AHEC Credit, Nursing, Counselor/Therapist, Social Workers, EMS, and Law Enforcement.

[ii] Aspinall EJ, Nambiar D, Goldberg DJ, et al. Are needle and syringe programmes associated with a reduction in HIV transmission among people who inject drugs: a systematic review and meta-analysis. *Int J Epidemiol*. 2014;43(1):235-248. doi:10.1093/ije/dyt243

[iii] Platt L, Minozzi S, Reed J, et al. Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs. *Cochrane Database Syst Rev*. 2017;9(9):CD012021. Published 2017 Sep 18. doi:10.1002/14651858.CD012021.pub2

[iv] Stephen C Ijioma, PharmD, BA1*, Vasco M Pontinha, MPharm, MA1, David A Holdford, PhD, MS, BSPharm1, Norman V Carroll, PhD, MS, BSPharm1, Cost-effectiveness of syringe service programs, medications for opioid use disorder, and combination programs in hepatitis C harm reduction among opioid injection drug users: a public payer perspective using a decision tree; J Manag Care Spec Pharm, 2021 Feb;27(2):137-146. https://doi.org/10.18553/jmcp.2021.27.2.137

[v] Hagan H, McGough JP, Thiede H, Hopkins S, Duchin J, Alexander ER. Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. *J Subst Abuse Treat*. 2000;19(3):247-252. doi:10.1016/s0740-5472(00)00104-5; https://pubmed.ncbi.nlm.nih.gov/11027894/

[vi] Centers for Disease Control and Prevention; Press Release: Federal Grantees May Now Use Funds to Purchase Fentanyl Test Strips; https://www.cdc.gov/media/releases/2021/p0407-Fentanyl-Test-Strips.html

[vii] Substance Abuse and Mental Health Services Administration; Harm Reduction Grant Program Notice of Funding Opportunity, 2021-22; https://www.samhsa.gov/grants/grant-announcements/sp-22-001

[viii] NIDA. NIH launches harm reduction research network to prevent overdose fatalities. National Institute on Drug Abuse website. https://nida.nih.gov/news-events/news-releases/2022/12/nih-launches-harm-reduction-research-network-to-prevent-overdose-fatalities. December 16, 2022 Accessed April 5, 2024.

[ix] Centers for Disease Control and Prevention; Determination of Need for Syringe Services Programs; Jurisdictions Determined to be Experiencing or At-risk of Significant Increases in Hepatitis Infection or an HIV Outbreak Due to Injection Drug Use Following CDC Consultation; https://www.cdc.gov/ssp/determination-of-need-for-ssp.html

[x] This published brief was prepared by the presenter and includes further detail and legal analysis of SSPs in South Carolina. Network for Public Heath Law, Fact Sheet: Legality of Syringe Access Programs in South Carolina. https://www.networkforphl.org/wp-content/uploads/2022/02/Fact-Sheet-Legality-of-SSPs-in-SC-2.pdf

[xi] Symposium participants joined one of three hour-long facilitated discussion breakout groups following the delivery of presentations. Groups included: Comprehensive Care Delivered in Syringe Service Programs, facilitated by Lillie Armstrong and Brianna Norton; Systems, Policies, and Implementation facilitated by Robert Childs and Jodi Manz; and Community Readiness, Messaging, and Narratives, facilitated by Margie Stevens and Laura Pegram

[xii] Centers for Disease Control and Prevention, National Center for Health Statistics; National Vital Statistics System; Provisional Drug Overdose Death Counts; https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[xiii] Zibbell presented data showing that, in 2013, heroin-involved deaths *without fentanyl* accounted for 32.2% of overdose fatalities, but by 2019 heroin-involved deaths dropped to 10.6% as fentanyl deaths accounted for 80% of all overdose fatalities. Declining trends are present for other drugs: prescription opioid overdoses without fentanyl composed 13.7% of fatalities in 2013 but dropped to 3.7% by 2019. Cocaine-involved deaths without fentanyl likewise reduced in the same period from 10.3% to 3.7%.Taken together, these trends provide evidence that further establishes the opioid epidemic as a national crisis whose deadly arc for more than two decades has been facilitated by a profound transformation of America's illicit opioid supply.

[xiv] US Department of Justice, Drug Enforcement Administration; The Growing Threat of Xylazine and it's Mixture with Illicit Drugs – DEA Joint Intelligence Report, October 2022. https://www.dea.gov/sites/default/files/2022-12/The%20Growing%20Threat%20of%20Xylazine%20and%20its%20Mixture%20with%20Illicit%20Drugs.pdf

[xv] Bartholomew TS, Feaster DJ, Patel H, Forrest DW, Tookes HE. Reduction in injection risk behaviors after implementation of a syringe services program, Miami, Florida. *J Subst Abuse Treat*. 2021;127:108344. doi:10.1016/j.jsat.2021.108344; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8221088/

[xvi] Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, May 8, 2015/64(17);453-458; Increases in Hepatitis C Virus Infection Related to Injection Drug Use Among Persons Aged <30 Years – Kentucky, Tennessee, Virginia, and West Virginia, 2006-2012; https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6417a2.htm

Acknowledgements: The symposium, as well as this companion document, were funded by Prisma Health Addiction Medicine Center. Content in this paper does not necessarily represent the views or opinions of associated sponsors of the event.