# Syringe Services Programs

*A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation*

DEVELOPED BY

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## Suggested Citation

# Contents

# Overview

## Background

This technical package provides evidence of the effectiveness of strategies and approaches for supporting successful planning, design, implementation, and sustainability of syringe services programs (SSPs). This document was developed by the Centers for Disease Control and Prevention's (CDC) National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention in partnership with the National Alliance of State and Territorial AIDS Directors (NASTAD). It provides a broad framework for new and existing SSPs to ensure needs-based service delivery, reduce harms related to injection drug use, and link participants to services that support their health and wellness. This was developed through a review of scientific literature as well as from the experiences and current practices of a diverse mix of SSP directors, key stakeholders, and experts in harm reduction.

Technical packages are a key components of effective public health program implementation.[1] Technical packages are designed to outline key proven interventions within a given public health program. This document was developed to highlight strategies with SSP implementation and service delivery that are known to be effective, to help users avoid the tendency of many public health programs to adapt a scattershot of interventions, some of which might have only a small impact. Technical packages are intended to be reference guides, not manuals. This document provides references and resources for more information about any topic presented so that readers can gain a deeper understanding, if desired.

## Framework

We identify five main strategies for supporting new and existing SSPs including **involving people with lived experience**; **planning, design, and implementation**; **providing core versus expanded services**; **collecting data to inform planning and evaluation;** and **ensuring program sustainability**. Each strategy includes the following key components:

- **Key Takeaways** foreshadows section content.
- **Approach** describes **how** to make the strategy work.
- **Evidence of Effectiveness in Achieving Intended Outcomes** are the expected results of putting each strategy into practice, providing evidence from the literature demonstrating the effectiveness of the strategy.
- **Voices from the Field** include perspectives and opinions from key stakeholders and current SSP providers regarding their experiences in implementing the strategy.

Table 1 outlines major strategies and approaches, which are discussed in detail in respective sections.

# Guidance for Use

This technical package is a resource for use by health departments, community-based organizations, and diverse stakeholders to guide effective SSP design, implementation, and service delivery. The technical package provides evidence that the recommended strategies and approaches are effective in achieving the expected outcomes. SSPs can choose to use (or not use) the strategies and approaches supported by the evidence of effectiveness presented. The elements of this technical package are not intended to be used as standards for making decisions to open a new program or to close an existing program. New SSPs can use the technical package to ensure effective planning, design, and implementation; existing programs can use the document to identify program operations that need improvement or identifying opportunities for program enhancement.

Because of the unique needs of people who inject drugs (PWID) as well as local and regional variation in policies, politics, and resources, this document is not intended to be used to provide standards of practice for SSP operations. Based on the current status of the evidence on SSPs and the dynamic nature of SSP implementation locally, standardized models are not described.

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## Benefits of Using this Document

This technical package is a vital steppingstone toward establishing guiding principles and strategies to design SSPs and assess performance management, program evaluation, and continuous quality improvement in the provision of intended services. By identifying evidence-based interventions and describing how programs have implemented them in a real-world setting, users are provided with the information needed to establish a successful program that engages clients, meets their comprehensive needs, and has strong stakeholder support.

## Key Terms

**1:1 exchange —** a practice of restricting syringe access by providing a participant only the number of syringes that the participant returns to the SSP for disposal (**not a recommended practice** — see *needs-based distribution*).

**Booting —** an injection practice whereby a person repeatedly plunges and adjusts the volume of substance in a syringe more than once during a single injection episode. Booting has been shown to be preventive against accidental overdose and can create a more prolonged and pleasurable drug effect. Booting is not possible with retractable syringes, which are not recommended for distribution within SSPs.

**Harm reduction —** an approach to policies, programs, or practices that aim to reduce the negative health and social impacts of substance use.

**Hepatitis C virus (HCV) —** a curable, chronic infection spread through infected blood that attacks the liver and over time can lead to cirrhosis or cancer of the liver if left untreated.

**HIV —** human immunodeficiency virus; an incurable virus spread through infected blood, semen, vaginal fluids, or breast milk that attacks the immune system. HIV is manageable with medications but is often fatal if not appropriately treated.

**Injection equipment (aka *works*) —** equipment involved in injecting drugs including cookers, cottons, water, and alcohol wipes. This equipment is typically distributed along with syringes at an SSP to prevent bloodborne disease transmission.

**Medications for treating opioid use disorder (MOUD) —** the use of medications, such as methadone, buprenorphine, or naltrexone, to treat opioid use disorder. **Previously referred to as medication-assisted treatment (MAT)**

**Naloxone (Narcan) —** a synthetic drug that rapidly reverses an opiate overdose, by blocking opiate receptors in the nervous system. Naloxone can be injected into a muscle or sprayed into the nose, depending on the packaging of the drug. It is non-addictive, safe, and can be administered with minimal training.

**Needle exchange —** another term for SSPs, less preferred by some because of its focus on needle distribution (less accurate than syringe distribution) and implication of 1:1 exchange (not a recommended practice).

**Needs-based distribution —** a syringe distribution practice that allows participants as many syringes as they say they need, regardless of how many syringes they return to the SSP for disposal. A best practice, for contrast, see *1:1 exchange.*

**Overdose —** a biological response to too much of a substance or mix of substances; can be fatal (a type of poisoning).

**People who use drugs (PWUD) —** an acronym used to refer to people who use drugs, and generally preferred as "person-first" non-stigmatizing language.

**People who inject drugs (PWID) —** an acronym used to refer to people who inject drugs and generally preferred as "person-first" non-stigmatizing language, which is not recommended.

**People with lived experience —** while this term can be used more broadly, in the SSP context, it is used to refer to a person with current or former experience of substance use, typically a PWID.

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**Pre-Exposure Prophylaxis (PrEP) —** a medication for people at high risk for HIV infection, to prevent them from acquiring HIV when exposed. This currently requires a daily oral pill, but other treatments are in development and testing, including a long-acting injectable medication.

**Retractable syringes —** syringes that are designed to be single-use only, primarily created to reduce the chance of accidental needlesticks in healthcare settings. The use of these types of syringes are discouraged for SSP distribution due to being less preferred by most PWID and coming with higher risk for overdose (see *Booting*).

**Secondary syringe exchange —** a practice through which SSP participants distribute sterile syringes and injection equipment to peers within their social and drug-using networks who cannot or will not attend SSPs; often secondary exchangers also collect used syringes for safe disposal.

**Single-use syringes —** see *Retractable syringes.*

**Syringe Services Program (SSP) —** a term for harm reduction programs where syringes and other safer injection and drug use equipment are distributed and collected for safe disposal, often with other medical and social services designed to improve the health of PWUD. Syringe services are provided free of charge.

**Substance use disorder (SUD) — a** condition defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 that refers to the loss of ability to control the use of a legal or illegal drug coupled with continued use despite negative consequences. In most cases this term is preferred over the older term *drug addiction* (https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2013.12060782).

**Syringe exchange program —** another term for SSPs, less preferred by some because of its sole focus on syringes and implication of 1:1 "exchange" (not a recommended practice).

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**Table 1.** Strategies and approaches for SSP design, implementation, and sustainability.

| STRATEGY | APPROACH |
|---|---|
| Involve people with lived experience of injection drug use, substance use disorder, homelessness, or other pervasive issues affecting the population served | • Involve PWID in all phases of program design, implementation, and evaluation<br><br>• Create meaningful engagement opportunities to encourage participant ownership of program<br><br>• Recognize the expertise of SSP participants and compensate appropriately |
| Planning, design, and implementation | • Needs-based distribution is the best approach<br><br>• Delivery model should be informed by thorough and ongoing needs assessment<br><br>• Partnerships are key to successful SSP implementation<br><br>• SSPs should link PWID to care, whenever possible and desired |
| Providing core versus expanded services | • Syringe distribution and safe disposal education are core services<br><br>• Expanded services complement core services and establish continuum of care. Broadly, these include<br><br>   – Naloxone distribution and training<br><br>   – Infectious disease screening and/or treatment, or immediate linkage to care<br><br>   – Other expanded services |
| Collecting data to inform planning, implementation, and evaluation | • SSPs should collect data on trends, needs, and overall program effectiveness<br><br>• Data collection should be sufficient to meet needs and never a barrier to service delivery |
| Ensuring program sustainability | • Foster relationships with a variety of stakeholders to increase and diversify community support, both financially and socially<br><br>• Street outreach fosters relationships with clients and neighbors when they see services being provided<br><br>• Diversify funding sources for increased program sustainability<br><br>• Create a sense of shared purpose with the community to reduce stigma for both SSPs and the communities they serve |

| STRATEGY I | Involve People with Lived Experience of the Issues Impacting Your Target Populations |
|---|---|

Syringe services programs (SSPs) were first developed by people who inject drugs, to help keep friends and community members safe and healthy. Health departments, community-based organizations, clinics, and outreach teams adopted the practice and adapted it to fit within their institutions. It is important for SSPs today begin by centering their work on people who inject drugs (PWID). The PWID SSPs serve are the most important part of an SSP and are one of the primary sources of information, guidance, and insight for program design, implementation, and evaluation. Meaningful involvement of people with lived experience in these aspects is key to program success. This approach centers PWID as fundamental partners, teachers, and decision makers as well as service recipients, which enhances program reach, strengthens partnerships, and builds trust and a sense of ownership. Former PWID who no longer inject drugs may be among PWID with relevant lived experiences, but ensuring that the needs, interests, and understanding of current PWID are well-represented is crucial. Coalition building and community consultation are key to SSP acceptance and sustainability, and should include a wide variety of community stakeholders encompass communities of people who use drugs.[2] PWID

involvement models, including secondary peer exchange as well as approaches such as PWID employment within SSPs, have significant public health benefits and present opportunities to enhance overall program effectiveness.

### KEY TAKEAWAYS

✔ Involve participants in all aspects of program design, implementation, and service delivery.

✔ Consult, empower, and provide thoughtful support to all participants.

✔ Create meaningful engagement opportunities, ranging from short-term roles to consulting, committee/board membership, paid peer distribution programs (secondary exchange), and long-term employment.

✔ Commit to learning from PWID in order to train staff on key concerns affecting participants and help shape programming to be useful, effective, and respectful of participant autonomy.

✔ Acknowledge PWID experience as an invaluable resource — ideally, SSPs will provide PWID compensation for their time.

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# Approaches

To maximize individual and public health benefits, PWID ideally should be involved in all aspects of SSP design and implementation. SSPs should recognize the immense value of participant engagement, feedback, and leadership and create opportunities for involvement in various aspects of the program. The following sections discuss key approaches for effective engagement and meaningful involvement of PWID. Each approach is discussed in the context of evidence and intended outcomes.

| APPROACH 1 | *Involve PWID in All Aspects of Program Design, Implementation, and Service Delivery* |
|---|---|

A recent CDC review of evidence-based SSP strategies indicates SSPs are most likely to be successful when the needs and concerns of the local PWID communities are addressed.[3] Participant involvement can provide important insights into local conditions, needs, and resources and is critical for program design and planning. PWID knowledge and personal experience, whether past or current, help guide resource allocation and service provision. Further, the unique expertise offered by people with relevant lived experience are invaluable from an implementation and evaluation standpoint. Ideally, SSPs should offer PWID a range of options for levels of participation.

## EVIDENCE OF EFFECTIVENESS IN ACHIEVING INTENDED OUTCOMES

**Inform program design, implementation, and service delivery**

- Peers and PWID provide unique insights into community needs and preferences; peer involvement is vital to designing programs that meet PWID needs.[4,5]

- People with lived experience can help expand SSP outreach to communities with whom the SSP might be having difficulty establishing relationships.[6,7]

- Peer involvement facilitates both core and expanded services delivery, including syringe distribution and naloxone administration.[8]

- Participant involvement informs challenges faced by specific populations and serves as a bridge to those groups. Peers who have experienced, or are experiencing, similar issues to the participant population are of particular importance. Ashford et al.[8] reported that PWID experiencing homelessness, on probation or parole and having prior mental health disorders were least likely to interact with peers, whereas PWID with human immunodeficiency virus (HIV) were most likely to interact.

**Improve individual and population health outcomes**

- Richardson et al. reported that employment was associated with over 50% reduction in risk of mortality among persons who use drugs (PWUD) with HIV.[9]

- Participants report better treatment, greater satisfaction, deeper engagement, and better health outcomes as a result of interaction with their peers.[10,11]

| APPROACH 2 | *Create Meaningful Engagement and Service Delivery Opportunities for People with Lived Experience* |
|---|---|

Meaningful PWID engagement builds peer networks and creates an environment of collaboration and knowledge sharing. It demonstrates a program's commitment to community health and well-being, utilizes PWID expertise to expand program reach, deepens staff knowledge, and has demonstrated individual and broader public health benefits such as reduced risk of disease transmission, reduced mortality, and overall improved health outcomes.[9–12]

Such involvement can create and reinforce a sense of program ownership among participants through shared decision making. Possible engagement opportunities can range from participation in feedback groups to short-term employment as well as long-term, full-time roles with the SSP, including executive leadership, serving on a community advisory board, and participating as secondary exchangers. Ideally, SSPs will pay all individuals with lived experience for their time. A

bidirectional relationship that recognizes and respects peers as professionals can be motivating for participants and beneficial for the program.

### EVIDENCE OF EFFECTIVENESS IN ACHIEVING INTENDED OUTCOMES

**Enhance trust with PWID; build community networks**

- Bardwell et al. reported that monetary compensation of PWID's time and involvement with an SSP reduced participants' perception of stigma.[13]

- Engagement of people with lived experience in service provision has been shown to foster connections to their community,[14] build confidence and empowerment, and improve wellness.[15,16]

**Encourage participant ownership through meaningful engagement**

- A recent study of PWID employed at a comprehensive harm reduction program found that participants view monetary compensation as acknowledgement of their time and skills and report increased social connection and a sense of collective purpose.[13]

- An open, welcoming environment and a range of engagement options for participants are at the heart of a successful international harm reduction program (COUNTERfit), which is managed exclusively by people with lived experience.[4]

## VOICES FROM THE FIELD

"Listen to drug users. To your participants. They are participants. They are not clients; they are definitely not patients. And as participants they should be part of your decision-making process. Have them part of your board, have them part of your decision-making. Even if it's just making sure [you are] constantly asking your participants what's working and what's not."

*– Community-Based SSP Director, Puerto Rico*

"If you want these programs and the people who run them, particularly if they're from the population served, to be leaders in this specific way, there's a lot of training and technical support, program development support that needs to happen to support them as true leaders in this work."

*– Community-Based SSP Director, California*

"I think that's part of our job in this world, to create employment opportunities and sustain people in them so they can move beyond for the next step of their lives."

*– Community-Based SSP Director, California*

"I want to be very clear that peer is not a level of a position in an organization. Peer — peer educator, being a peer drug user, post-drug user, it's a vantage point, or positioning that this person has vis-à-vis drug use, sex work, homelessness, whatever. Peer is a vantage point, not a position. I just want to make sure I take a position on this — many times peers are seen as, that's the lowest position, a peer, and then you graduate to being an outreach worker, and then a coordinator. No, ours are peer outreach workers. Like an outreach worker with a peer perspective. Hopefully, someday we'll have a peer Executive Director."

*– Community-Based SSP Director, Puerto Rico*

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## STRATEGY II | SSP Planning, Design, and Implementation

SSP planning, design, and implementation are challenging activities. Those activities are more likely to be effective if they are based on a careful assessment of the needs of the target population for syringe services and the available and needed resources of other key stakeholders in the SSP. Overly complex needs assessments can create barriers to and delays in providing timely services for PWID. Meeting the immediate needs of the PWID community should be given higher priority and balanced with ongoing needs assessment for program modification. Ideally, SSP design should be a collaborative process that is informed by individuals who use the services provided. Program design should include interventions for reducing the effects of social determinants such as racism, poverty, stigma, and trauma on individual and community health. Evidence suggests that SSPs are more successful when they are planned as community-level public health interventions and not only interventions for individual PWID.[2]

### KEY TAKEAWAYS

✔ Syringe distribution and disposal options are essential (i.e., core) SSP services; programs should look for opportunities to link PWID to care where possible and desired.

✔ Needs-based distribution is the recommended syringe distribution practice. It reduces disease transmission and unsafe injection practices and enhances PWID trust and involvement.[26,27]

✔ Ensure low-threshold access to services (i.e., maximize access in terms of number of locations, hours, etc.), ensure participant confidentiality, and minimize administrative burden (e.g., data collection).[2]

✔ Secondary syringe exchange programs increase SSP reach and effectiveness; programs should offer peer educator training whenever possible.[2]

✔ Involve participants when determining the size and type of syringes to be distributed by the program. High-quality syringes protect participants' health and improve program uptake.

✔ SSP design should accommodate the needs and concerns of the local PWID communities.[2,26]

✔ Partnerships are key to successful SSP implementation. Include diverse stakeholders in all aspects of planning, design, and implementation to ensure community understanding of SSP goals and create a sociolegal environment supportive of SSP.

✔ Offer assistance in accessing care for substance use disorders or for other physical or mental health concerns. Whenever possible, provide and/or coordinate provision of other health and social services, especially for PWID who do not receive care elsewhere.[2,26]

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# Approaches

A clear approach to achieving intended health goals is essential for overall program success. The approaches discussed in the following highlight integral components of an effective SSP and are designed to guide various aspects of program planning, design, and implementation.

| APPROACH 1 | *Needs-Based Syringe Distribution is the Best Approach* |
|---|---|

Needs-based distribution is the most effective syringe distribution model, both in terms of syringe coverage (ensuring adequate supplies are available for sterile injection) and disease prevention. It builds a culture of trust and inclusivity with the participants and values them as essential stakeholders in the decision-making process. In addition, needs-based distribution supports secondary syringe exchange, which broadens program reach and improves overall effectiveness. Although restrictive syringe distribution approaches such as 1:1 exchange may seem desirable, in fact, they are associated with increased syringe sharing and increased risk of infections among PWID and are therefore ***not*** recommended. In addition, PWID face multiple barriers to care; SSPs should strive to address such challenges and provide low-threshold access to services.

*Other things to consider*: The size and type of syringes are important from both a harm reduction and participant preference standpoint. High quality, nonretractable syringes reduce the risk of disease transmission; programs are encouraged to acquire participant feedback before syringe distribution. Providing participants with safer injection and vein care education is also recommended as this will decrease skin and soft tissue infections and other injection-related injury. Further, programs should ensure safe syringe disposal to reduce the spread of infectious disease and potential for syringe reuse within communities of people who use drugs. Disposal options should be provided onsite through portable sharps containers, and safe disposal education.

## EVIDENCE OF EFFECTIVENESS IN ACHIEVING INTENDED OUTCOMES

### Infectious disease prevention

- Kerr et al. reported an over 90% lower risk of HIV associated with unlimited syringe distribution practices.[17]

- Several studies have linked a restrictive 1:1 syringe exchange policy to the HIV epidemic among PWID in Canada in the mid-1990s.[18-20]

### Improved syringe coverage

- Bluthenthal et al. reported that syringe coverage rates (or adequate access to sterile injection supplies for each injection) were lowest for 1:1 exchange and highest for needs-based distribution policies.[21]

### Safer injection and syringe disposal

- Kral et al. found that participants of needs-based SSPs were approximately half as likely to reuse syringes than participants of SSPs with more restrictive dispensation policies.[22]

- Bluthenthal and colleagues found that increasing the numbers of syringes participants receive from SSPs does not result in increased odds of unsafe syringe disposal.[23]

- Quinn and colleagues revealed that receiving more than 30 syringes in the past 30 days was associated with a lower chance that participants disposed of syringes improperly.[24]

### Community buy-in and increased program reach

- PWID who serve as secondary exchangers can provide safer injection materials, information, and education to their peers who are not coming to SSPs.[25-27]

- Wood et al. found that a peer-run secondary exchange program reached a particularly vulnerable PWID population and was associated with nearly 3-fold increased likelihood of safe syringe disposal.[11]

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SSPs can take on a variety of designs such as a fixed site *storefront* model, a van or backpack-based mobile outreach model, or a secondary exchange model powered by participants themselves. Certain models are better suited for different environments, e.g. mobile outreach models for rural areas while others might be better suited to provide wrap-around support services. For example, offering rapid hepatitis C virus testing as part of backpack-based mobile SSP is difficult. A thorough needs assessment that includes people intending to use the services, can help determine what program model or models to employ. Needs assessments should be carried out in a periodic or ongoing way to adapt programming to changing and emerging needs. Suggested needs assessment components include, when possible:

- **Need:** PWID prevalence; infectious disease rates among communities of PWID and surrounding community, environmental factors that may influence drug use; prevalence of other comorbidities (e.g, mental illness, homelessness, hepatitis B virus, etc.)

- **PWID characteristics**: age, race/ethnicity, sex or gender identify, cultural and linguistic barriers, vulnerable populations, drug use characteristics

- **Populations with increased vulnerability**: adolescents, elderly, pregnant people, racial/ethnic and sexual minorities, individuals with comorbid mental health disorders, and people experiencing poverty or homelessness

- **Resources:** workforce and funding (available/ required)

- **Partnerships:** health departments; local, state, or national agencies; community-based organizations; substance use disorder treatment programs; elected officials; and public safety

- **Local policies, politics, and practices:** community/ political/agency support, legal barriers to SSPs

## EVIDENCE OF EFFECTIVENESS IN ACHIEVING INTENDED OUTCOMES

**Greater understanding of local PWID needs/demands**

- In their study of nearly 500 PWID from 13 SSPs in New York City, Heller et al. reported that younger and homeless PWID were at greater risk of receiving an inadequate number of syringes and concluded that partnerships with law enforcement and homeless services was key to addressing the local "syringe gap."[28]

- Multiple local factors affect participants' ability to access SSPs. Designing services by considering the local context — both local, individual-level PWID characteristics and the structural (physical and political environment) — is vital for success.[21,28,29]

**Informed SSP design and resource allocation**

- Downing et al. studied syringe distribution models in nine different US cities and reported that coalition building and community consultation were key to program acceptability and sustainability.[2]

- A peer-run, night-time SSP established in the heart of Vancouver's open drug scene reached PWID at highest risk of HIV infection and improved syringe disposal practices.[12]

- The know-your-epidemic, know-your-response philosophy has been instrumental in addressing the HIV epidemic globally — lessons learned should inform SSP needs assessment and service delivery.[30]

**Reduced health disparities and improved PWID health and well-being**

- In response to the opioid crisis, Safe Recovery — the largest SSP in Vermont — partnered with the state to offer low-threshold buprenorphine in an effort to integrate addiction treatment with the broader healthcare system. Since October 2018, over 87 participants have initiated treatment.[31]

- A nurse-led health promotion program in New Jersey[32] offers a range of reproductive and preventive treatment services in an SSP setting to reduce perinatal HIV transmission among a pregnant population at high risk.

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## APPROACH 3 | *Partnerships Are Key to Successful SSP Implementation*

Ensuring buy-in among from a wide range of stakeholders, especially public safety, can play a principal role in addressing community opposition and stigma associated with SSPs and provide important insights into considerations for long-term program sustainability. In addition, relationships with key community and local, state, and national partners are important for ensuring successful SSP planning, design, and implementation. Input from stakeholders — including local PWID communities, community-based organizations, health departments, local businesses, neighborhood residents, and public safety — offers valuable knowledge and helps identify and address major barriers at each stage of SSP design and delivery.

The resulting knowledge is vital for program planning and efficient resource allocation. (*See section V for a detailed discussion on partnerships and sustainability*).

### EVIDENCE OF EFFECTIVENESS IN ACHIEVING INTENDED OUTCOMES

**Understand local needs; identify barriers and opportunities**

- As a first step in establishing SSPs, health departments and other local partners, including existing SSPs and HIV prevention planning groups, can provide important information such as burden of HIV, HCV, HBV and possibly demographic characteristics of communities of people who inject drugs.[3]

- Partnerships with public safety, faith-based organizations, neighborhood representatives, community organizations, and business owners help identify major concerns and challenges to both design and delivery; relationships with health departments, local businesses, and medical or social services can help with delivery of expanded services.[5, 11]

- Partnerships with networks of people who have current and past drug injection experience can help establish secondary syringe exchange programs and improve the overall effectiveness of SSPs.[3, 5, 11]

**Use partnerships to address stigma and maximize health benefits**

- Public safety champions can play an important role in shifting attitudes and beliefs regarding SSPs by helping programs connect PWID to treatment, as opposed to a strict criminal legal approach.[3,18]

- Barocas et al. reported that previously incarcerated SSP participants had high risk for opioid overdose, compared with those without prior incarceration; however, they were also more likely to use naloxone for overdose prevention, highlighting the importance of buy-in from law enforcement and corrections to connect such vulnerable populations to care (*See Section III for a discussion of "core" vs "expanded" SSP services*).[19]

- Making collaboration a key strategy and establishing relationships with government, legal, medical, and other relevant stakeholders is recommended as an evidence-based, guiding principle to successfully address the opioid overdose crisis.[3]

## APPROACH 4 | *SSPs Should Link PWID to Care, Whenever Possible*

While syringe distribution and disposal are at the core of any SSP, linkage to physical and behavioral health services is important from both an infection control and a broader harm reduction standpoint. Additionally, it should be recognized that SSPs are an important resource that PWID are often referred to and valued as such.

Care linkage serves as a crucial mechanism in merging substance use disorder treatment with traditional healthcare services and establishes a continuum of care, especially for participants who are not receiving care elsewhere. Further, a coordinated care approach can help identify highly marginalized populations and help tailor services accordingly. Identifying community resources and services that are willing to work with communities of PWID can be challenging, yet ongoing effort to build these partnerships is vital to improve the health of PWID. The following services can be provided either directly by the local SSP or through a partnering agency:

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- Education about safer injection techniques, overdose prevention, viral hepatitis, HIV, and other challenges relevant to participants' health.

- Naloxone distribution and training.

- Onsite access or immediate referral or linkage to care to

  - substance use disorder treatment

  - low-threshold or onsite medication to treat opioid use disorder (MOUD)

  - HIV, viral hepatitis, and STD testing, care and treatment, including HIV PrEP (Pre-Exposure Prophylaxis)

  - basic wound care and/or advice and consultation.

- Vaccinations for hepatitis A and B viruses, human papillomavirus, influenza, pneumonia, and tetanus-diphtheria-pertussis.

- Patient navigation.

- Mental health and/or harm reduction-based counseling.

## EVIDENCE OF EFFECTIVENESS IN ACHIEVING INTENDED OUTCOMES

### Access to additional health services for PWID health and wellbeing

- SSPs provide important opportunities to link PWID to care, especially for high risk PWID with little or no access to traditional healthcare providers.[33–35]

- CDC's *Evidence-Based Strategies for Preventing Opioid Overdose* report recommends SSPs work best when appropriate care is provided for opioid use disorders (OUD) and other physical/mental health concerns.[3]

- Kidorf et al. reported that concurrent syringe exchange and substance use disorder treatment was associated with a 30% reduction in frequency of heroin use and a 20% reduction in injection drug use as well as reduced frequency of illegal activities and incarceration, compared with syringe exchange alone.[35]

- SSPs might also provide such other services as naloxone and medication-assisted therapy.

### Establishing a continuum of care

- Successful SSP support services integration models can present important opportunities for learning. For example, through an innovative pilot program, Virginia's behavioral health agency and the University of Virginia have partnered to provide HCV treatment via telemedicine at comprehensive harm reduction and opioid treatment programs.[36]

- The Access to Reproductive Care and HIV Services (ARCH) program successfully integrated reproductive and HIV care for high-risk pregnant people in five New Jersey cities and expanded over time to include hepatitis screening, immunizations, gonorrhea and chlamydia testing and treatment, and tuberculosis testing.[33]

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"We used to have a 1:1+ exchange model — We gave people 30 syringes when they came originally, regardless of how many syringes they had, and then thereafter it was 1:1 with rounding up for packaging. And then a couple of years ago, we switched over to negotiated exchange. We had to do a regulation change in order to do this — We still encourage them to return their syringes to us. But what we found is that — before what would occur is people would try to come up with ways of scamming the system to get what they need. We were encouraging people to be dishonest with us about what they needed, and then they wouldn't talk with us about other barriers or issues they were having. This was a real problem — [now] people are being much more honest with us. And not just about the syringes, but about other things. Because it's not just about that talking, but having additional communication."

*– Public Health Department SSP Coordinator, New Mexico*

"We want to literally be able to go where people are at. We do this both physically, psychologically as much as we can, emotionally, and socially as much as we can. We come from a social justice perspective to harm reduction."

*– Community-Based SSP Director, Puerto Rico*

"You don't understand harm reduction, if you're saying, 'If you don't bring me any, I won't give you any.' And some syringe exchanges here are literally like that. So there's a real lack of knowledge of how harm reduction can and will affect the HIV epidemic — or really touch on the HCV epidemic. And more importantly, what are good policies for the participants, and what are good policies to push in society so we're better to drug users?"

*– Community-Based SSP Director, Puerto Rico*

"I get that in some places the ONLY way to do syringe exchange at all is 1:1, and in those places that's definitely better than nothing. But I think as soon as there's a little window to push away from that, we all need be focused on getting away from those practices that can be so damaging — everyone has to be in that mindset that you are settling because of these constraints you can't do anything about, and the second that you're able to push, even if it's a year or two later, you have some successes, you're able to say, 'Remember before, you were skeptical, but look what I'm doing...' You have to constantly strive to follow best practices."

*– Community-Based SSP Director, Vermont*

"The first advice I would give to new programs is that they need to have at least one, and probably ideally a series of focus groups, with active drug using participants or potential participants who can offer insight into exactly what materials people want and need. I really don't think anything else will do — I don't think it's sufficient to pull together a list of local recovery coaches, or people who identify as being in recovery or having a history. I just don't think that's sufficient — Some things change really rapidly. That would be my first advice is do not even think about opening your doors before doing that — in a way that is respectful, and ideally pays people for their time and expertise."

*– Harm Reduction Practitioner, Illinois and Michigan*

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Harm reduction is a basic tenet of an SSP. A combination of core and expanded services encompasses various facets of primary and secondary prevention, reduces harm, and improves the overall health and well-being of people who inject drugs and the community as a whole. While syringe distribution and disposal are core SSP services, expanded services (see Approach 2 in this section) can complement core services by providing unique opportunities to increase access to integrated care, especially for participants without a usual source of care.

**KEY TAKEAWAYS**

✔ Syringe distribution and disposal options are core SSP services; expanded services complement core services and improve PWID health and well-being; while SSPs provide all core services, ideally and when possible, expanded services can also be provided.

✔ Syringe distribution should be needs-based; ideally, syringes should be high quality and non-retractable.

✔ Safe disposal should be offered onsite; portable sharps containers should be provided whenever possible. If neither of these disposal options is possible then education about safe home disposal should be provided.

✔ Naloxone distribution and training is a life-saving intervention demonstrated to reverse overdose and reduce mortality; naloxone should be provided directly to participants and their immediate networks whenever possible.

✔ Expanded services can act as a bridge between SSPs, Substance Use Disorder (SUD) treatment, and traditional medical care and help establish a continuum of care.

✔ Infectious disease screening/referral to treatment, education regarding safe injection practices, medication for opioid use disorder (MOUD), naloxone, and other supportive services are vital primary and secondary prevention approaches that help achieve the overall SSP purpose of reducing harms and improving the health of PWIDs.

✔ Ideally, programs will make efforts (e.g., establish partnerships and acquire funding) to offer expanded services to participants. Successful integrated care programs exist and offer valuable models for other programs.

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# Approaches

Each community has its own unique needs based on a variety of demographic, social, and clinical factors. Similarly, each SSP has a unique capacity to provide services. However, an understanding of the minimum standard of services (i.e., *core*) and any additional services that support core services (i.e., *expanded*) and help achieve overall SSP goals is essential. The approaches following discuss the importance and relevance of each set of services.

## APPROACH 1 | *Syringe Distribution and Safe Disposal are Core SSP Services*

All SSPs should ensure syringe distribution, provision of injection equipment, and safe syringe disposal options. Syringe distribution should be needs-based (see Strategy I: Approach 1 for needs-based distribution practices). In addition, size and type of syringes are relevant from both a harm reduction and participant preference standpoint. Retractable syringes carry a high risk of overdose,[37] are generally more difficult to use, and not preferred by participants.[38] High quality, non-retractable syringes reduce the risk of disease transmission; programs are encouraged to acquire feedback from the local PWID community before syringe distribution to ensure services and supplies are appropriate and meet the community need. In addition, safe syringe disposal should be offered onsite, through provision of portable sharps containers or education about safe home disposal options.

### EVIDENCE OF EFFECTIVENESS IN ACHIEVING INTENDED OUTCOMES

**Safe injection practices and reduced infectious disease transmission and injury**

- Needs-based distribution is associated with greater syringe coverage and safer injection practices;

restrictive syringe distribution increases risk of infectious disease transmission. *(See Strategy I: Approach I for needs-based distribution practices.)*

- Single-use or retractable syringes increase the chance of overdose by preventing *booting*, which titrates the dose being injected' (locking mechanism retracts the needle).[2] Programs should provide high quality, non-retractable syringes.

**Safe syringe acquisition and disposal**

- Quinn et al. reported that receiving syringes at an SSP was associated with a significantly lower odds of improper syringe disposal compared to receiving syringes from other sources.[25]

- Coffin and et al. reported that reliable, sterile syringe acquisition was associated with a seven-fold higher odds of safe disposal. The study concluded that expanding SSP sites can improve safe disposal practices and that such initiatives should target injection drug users who do not access SSPs.[38]

- Bluthenthal et al. reported that increasing the number of syringes received from SSPs does not result in increased odds of unsafe syringe disposal.[24]

## APPROACH 2 | *Expanded Services Complement Core Services and Establish Continuum of Care*

Some PWID experience multiple, often co-occurring disorders that require a broad, collaborative approach to care. Various socioeconomic and demographic factors might further limit PWID's access to care. In addition, PWID might have special treatment needs because of the type of substances used. SSPs present unique opportunities to provide and/or link PWID to care. This comprehensive, integrated care approach provides PWID with multiple health services under one roof and can act as a bridge between substance use disorder treatment and traditional healthcare. The resulting

continuum of care benefits all PWID; however, the need and impact of increased service availability is highest for PWID who do not have a usual source of care.

Ideally, SSPs will provide various screening, diagnostic, and referral services, in addition to core services, so long as they do not interfere with the provision of core services. These services may be provided directly by the SSP or indirectly through referrals to local, regional, or co-located partnering. The following is a list of services that SSPs should consider providing:

- Education about safer injection techniques, overdose prevention, viral hepatitis, HIV, and other issues relevant to the health of participants.

- Naloxone distribution and training.

- Onsite access or immediate referral or linkage to care to the following:

  - Substance use disorder (SUD) treatment. Additional resources and guidelines regarding SUD treatment for PWID can be found through the links below:

    https://findtreatment.samhsa.gov/

    https://www.samhsa.gov/medication-assisted-treatment

    https://www.cdc.gov/pwid/substance-treatment.html.

  - HIV, viral hepatitis, and STD testing, care, and treatment, including HIV PrEP (Pre-Exposure Prophylaxis). Additional information regarding testing and treatment practice guidelines are available at:

    https://www.cdc.gov/hiv/guidelines/index.html

    https://www.cdc.gov/hepatitis/abc/

    https://www.cdc.gov/pwid/disease-treatment.html.

  - Basic wound care, advice, or consultation.

- Vaccination for HAV, HBV, HPV, influenza, pneumococcal, and Tdap

- Case management

- Mental health and/or SUD counseling

- Harm reduction support groups

## EVIDENCE OF EFFECTIVENESS IN ACHIEVING INTENDED OUTCOMES

### Reduction in fatal opioid overdose

- The World Health Organization recommends that community distribution of naloxone be part of all comprehensive harm reduction programs.[40]

- Community placement of naloxone, including provision of naloxone directly to people who inject drugs, has been shown to be effective in preventing fatal opioid overdose.[3,41,4]

- Walley et al. reported reduced death rates in communities where overdose education and naloxone distribution were implemented.[43]

- Only 5–10 minutes of education are needed to train participants in effectively recognizing and responding to an overdose with the lifesaving drug naloxone.[44]

### Access to care

- PWID who regularly use an SSP are five times as likely to enter treatment for a substance use disorder and nearly three times as likely to report reducing or discontinuing injection drug use, compared with those who have never used an SSP.[45–47]

- Kidorf et al. report that SSPs can be used to increase treatment interest and enrollment and even reenrollment after discharge.[48]

- Expanded buprenorphine treatment and linkage to social services were identified as major contributors to the success of a Philadelphia SSP.[49]

## NALOXONE SAVES LIVES

✔ Naloxone is a life-saving medication that reverses opioid overdose and reduces mortality.

✔ Ideally, naloxone should be distributed directly to people who inject or otherwise use drugs.

✔ Naloxone should be free-of-charge and distributed in quantities that ensure adequate coverage within communities.

✔ Naloxone distribution should be accompanied by a short, simple training in its use and safety practices.

✔ Naloxone should be prioritized for active PWUD and their immediate networks.

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"We try to make it as easy as possible for them to get them the services they need and not create barriers."
*– Community-Based SSP Director, Utah*

"If we do SSPs right, we need to keep harm reduction at the core of it. This is about the message of empowering drug users to take care of their own health, both at the individual and the collective level. If we're not doing that, we're missing it. It's about empowerment.

"Start small, don't try to conquer the world. Do what you can, focus on strengthening process and your procedures."
*– Community-Based SSP Director, Utah*

"I would say needs-based distribution is great, but if that's going to get in your way and keep you from starting because you're scared about capacity, like, if you have to ration, you have to ration. It's more important to be doing the work than it is to be perfect."
*– Community-Based SSP Director, California*

"It's just nice to be able to offer people treatment. And with low barrier, they're also not getting discharged for poly substance use, so they really feel like we're hanging in there with them. And if they show up at 4pm for a 2pm appointment, we still see them. It's really the way it should be."
*– Community-Based SSP Director, Vermont*

"You have to look at your community and what's going on. What's the problem you need to solve? It isn't one size fits all. In one community what you really need to be working on is academic detailing for prescribers, or some way to limit the prescriptions without sudden cessation, which we're pretty convinced drives people to injection use. If you've got that problem – you might not have that much of an injection problem, you may have more of a need for support to enter drug treatment or maybe you need more testing and linkage to care services. Maybe you need telemedicine for MAT [medication-assisted treatment]. What will best serve your county?"
*– Health Department-Run SSP Director, West Virginia*

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| STRATEGY IV | Collect Data To Inform Program Planning and Evaluation |
|---|---|

Data collection is a critical aspect of program planning and evaluation. Data is important to understanding what is needed versus what is available and what is working versus what is not (i.e., program evaluation). In addition, reliable data is an important component of an effective needs assessment. **While data regarding major trends and performance indicators is helpful for planning and evaluation, data collection should neither distract from the primary mission of syringe distribution for participants nor act as a barrier to PWID participation.**

**KEY TAKEAWAYS**

✔ Data collection is essential to informing program planning and evaluation. Data should help programs better understand provided services and available resources in the context of local needs for people who inject drugs.

✔ Efforts should be made to collect reliable data on key demographics, services provided, and trends in service utilization.

✔ Data collection should be minimal and always serve a purpose. Participation in research activities should never be a requirement for participation in SSP. SSPs should strive to provide low-threshold services.

✔ Ongoing monitoring should include regular review of collected data to assess program effectiveness, with particular attention to reaching marginalized and/or highly stigmatized populations(e.g., people of color, women, and transgender persons).

## Approaches

Data can be used as a tool for improving program efficiency and overall effectiveness. Efforts that focus on collecting data related to services provided and population(s) served (e.g., number of people receiving services, demographics, etc.) provide insights into community needs and help direct efforts to address identified gaps or challenges. Data collection should be minimal to reduce participant and administrative burden and should never be a barrier to care.

| APPROACH 1 | *All SSPs Should Collect Data on Trends, Needs, and Overall Program Effectiveness* |
|---|---|

Collecting some types of data is necessary for understanding population needs and program efficacy. Minimal data collection can include the following:

- Number of people receiving services (e.g., syringes, testing, SUD treatment, etc.).

- Number of syringes/naloxone kits distributed.

- Number of individuals for whom each participant receives syringes (o collect the number of people served through each exchange interaction (i.e., secondary exchange coverage).

Minimal data collection can be supplemented with periodic efforts (e.g., annual/quarterly surveys) to capture data on additional factors such as participant demographics (e.g., age, race/ethnicity, and sex or gender identity) and emerging participant needs. Data that includes any potentially identifying information about participants should be stored in a secure, electronic database. Data may be collected either on paper forms or via mobile devices, to be transferred securely (i.e., through encryption) to the database later.

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Periodic analysis of program data can help monitor progress and identify areas of improvement.

### EVIDENCE OF EFFECTIVENESS IN ACHIEVING INTENDED OUTCOMES

**Better understanding of community needs: improved program effectiveness**

- Data can provide useful information regarding participant concerns and satisfaction and identify program strengths and areas for growth.[51]

- Both qualitative and quantitative data are useful in identifying gaps in service provision, improving program services, and developing goals and objectives.[51]

- The Works Program in Boulder, Colorado — one of the oldest SSPs in the country — worked collaboratively with other SSPs and the state health department to design a centralized data collection system. Routine information (date, location, number of syringes collected/provided) is supplemented by annual participant surveys to assess trends in drug use.[52]

**Ensuring program sustainability**

- Both routine and supplemental data (e.g., PWID at high risk for mortality or morbidity, minority populations, stigma and other barriers to SSP services) can be used to track SSP progress and justify program presence; such information might be of interest to funders, regulators, and community stakeholders.[51]

| APPROACH 2 | *Data Collection Should Be Minimal* |
| --- | --- |

Efforts to collect data should neither distract from the program's primary focus (i.e., syringe distribution) nor deter participants from seeking services. Further, participation in research or other activities should never be a requirement for SSP participation.[16] Data collection should primarily focus on gathering crucial information on trends and program effectiveness.

### EVIDENCE OF EFFECTIVENESS IN ACHIEVING INTENDED OUTCOMES

**Reduced burden of data collection**

- The World Health Organization recommends that no data collection effort should be a burden on service delivery. Minimal data can be collected during routine interaction with participants without putting extra burden on the staff or participants; mobile devices can be used to facilitate data collection.[53]

- Evidence from the Harm Reduction Coalition suggests linking an SSP to research participation is counterproductive when providing services. Any research involving PWID at an SSP should be limited to a small number of participants and captured for periodic evaluation only.[38]

**Low-threshold service delivery**

- There are multiple 'thresholds' that participants have to overcome to successfully access services, including the registration threshold (experience on arrival), the competence threshold (awareness of needs), the efficiency threshold (effectiveness of service), and the trust threshold (quality of relationship with service provider). All SSPs should strive to address each of these barriers in order to provide truly 'low-threshold' services.[54]

- Low-threshold delivery includes maximizing access (service location and hours) and ensuring anonymity and no requirements for participation in other services. SSPs in Colorado have prioritized keeping encounter-level data minimal in order to provide low-threshold access to syringe exchange, outreach, and education services.[52]

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## VOICES FROM THE FIELD

"We want people to be able to walk in and out within 60 seconds if they want — so we're really focused on making sure that any information we're collecting is worthwhile, that there's a point. We don't want people to have to feel burdened with having to give up anything extra we honestly don't need."

> – *Former Community-Based SSP Director, North Carolina*

"I think the people should keep a close accounting of the number of people they reach and the services that people are able to access. I think one thing people who don't really like needle exchange focus on [is] the exchange of needles and I always tell people that like ten percent of the program is the exchange of needles. This is just a comprehensive home a touch point."

> – *Community-Based SSP Director, Florida*

"There are so many levels of success with harm reduction. If someone says, 'I used to use heroin, and now I use marijuana,' that's a success story. 'I got into care, I got my kids back,' that's a success story. 'Since I have to be at work at 8, I've learned to get up an hour earlier so I can use and still get to work on time and not get fired.' Everything is a success story. There are so many different angles and vantage points, for the participants who are coming in. All of this is success."

> – *Public Health SSP Coordinator, Kentucky*

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# STRATEGY V | Sustainability

SSPs face several social, structural, and political barriers to implementation. Strong relationships with a variety of community partners and stakeholders are essential for ensuring overall program success and long-term sustainability. First, they address the concerns of the community and help achieve a sense of common purpose. Second, SSPs often have small, restrictive, or limited funding resources; developing strong relationships and building trust with local and regional communities and agencies plays a major role in expanding and diversifying funding sources. Sustainability of SSPs also depends on clients utilizing the program. Although following the evidence-based approaches presented in this technical package will do much to engage and attract clients, an effective outreach program is also important for both gaining community support and engaging PWID who are not using the program.

## KEY TAKEAWAYS

✔ Partnerships are key! SSPs ideally should consider partnering with jurisdictional health and social service agencies, local and regional foundations, community-based organizations, opioid coalitions, public safety, and other state entities to ensure program sustainability — both financially and socially.

✔ Fostering relationships with a variety of stakeholders is critical to addressing community concerns and ensuring diversification of funding sources.

✔ Diversifying funding sources is beneficial for program sustainability.

✔ Health department support and legal counsel can play an important role in addressing community concerns, especially around syringe disposal.

✔ An environment of shared purpose (i.e., supporting rather than punishing PWUD) ensures stakeholders work collaboratively and not independently; public safety champions can play an influential role in changing agency attitudes and gaining useful support.

✔ Outreach and community engagement can expand program reach and visibility, connect with PWID who might otherwise not come to the program, and improve community relationships.

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# Approaches

SSPs face considerable challenges to implementation, service delivery, and overall program success. Community opposition, concerns, and financial difficulties can be substantial threats to sustainability. However, such barriers can be addressed through strong partnerships and support from key stakeholders, diversifying funding, and by working together with public safety and other state or jurisdictional agencies to create a sense of shared purpose and common goals. SSPs and syringe distribution are valuable and vital even when faced with community opposition. While building support is an ongoing process, a lack of initial support should not prevent providing syringe services to PWID. Establishing a presence in the community through outreach workers or other outreach efforts can increase program visibility, educate the public about SSPs, and engage PWID who may not yet be using an SSP.

| APPROACH 1 | *Foster Relationships with a Variety of Stakeholders* |

Despite overwhelming evidence supporting the effectiveness of SSPs, programs continue to face considerable challenges. Ultimately, the success of SSPs depends on their relationships with community partners and other stakeholders. Outreach to, and partnerships with, local/regional agencies, community-based organizations, and other SSPs/harm reduction organizations are vital in addressing such community concerns as syringe disposal. It is important for programs to identify and work closely with legal counsel in order to address any legal challenges. Similarly, partnerships with researchers can be extremely beneficial and provide useful information to improve current and future services. Such research partnerships should align with the mission and vision of the SSP and ideally involve some form of compensation for participants and the program itself.

Strong partnerships with a variety of stakeholders is also important for purposes of diversifying funding sources and ensuring long-term sustainability of the program. SSPs often work with limited, restricted funding that may fund aspects of the program but not the entire SSP. Innovative partnerships with diverse stakeholders can not only open additional funding streams, services, and resources, but also help identify federal, state, local, and private grant opportunities. Most funding will stream into a specific activity, such as HIV or hepatitis C testing. Programs should make every effort to be aware of new funding opportunities that improve overall sustainability and expand services provided. A close network of supporters and stakeholders can help keep programs informed of opportunities.

Programs should also conduct outreach in the communities where they are providing services, open lines of communication with their neighbors, and work to incorporate constructive feedback into programmatic activities. Establishing an outreach presence can help inform local PWID about available services, build confidence in the program among the PWID community, and engage PWID who are not coming into the SSP. Engaging in the community also can help the program be aware of changes in where local PWID are residing, what drugs are being used in the community, and what services are most needed. In providing services and engaging with the PWID population outside of the SSP, community members can also better understand the services these programs provide and the benefits of SSPs, further building stakeholder support.

## EVIDENCE OF EFFECTIVENESS IN ACHIEVING INTENDED OUTCOMES

**Diversification of funding sources**

- Lack of local support, uncertainty around coordinating with local/state governments, and local politics have been identified as major barriers to obtaining state or public SSP funding.[55]

- The Homeless Youth Alliance (HYA) — the only grassroots harm reduction coalition designed by and for underserved youth experiencing homelessness in San Francisco — used diverse and innovative funding streams, including foundations, donations, local government, and grants for violence prevention, food insecurity and creative arts to sustain the program. In 2018, the agency received a housing contract from the city, which provided housing to many of its participants.[56]

- Creativity and diversification with funding streams can be used to provide a wide range of services at

SSPs, even in political or policy environments that are not particularly supportive.[33]

- Diverse community partnerships and funding support from private citizens and city or county sources have been cited as major contributors to the financial stability and growth of *Point Defiance* — the first publicly funded needle exchange program in the United States.[57]

**Addressing community concerns.**

- Community-acquired needlestick injuries are perceived as a vital concern by community members and politicians[25]; however, an 8-year national study revealed that only 0.0007% of the US population had sought emergency medical care for a needlestick injury acquired in the community.

- Partnerships and effective communication with law enforcement, elected officials, business leaders, public health, the medical community, PWID and family/friends, and the faith community can address a variety of community concerns.[58]

- One study analyzing SSP implementation models found coalition building and community consultation as critical steps for program sustainability.[2]

- A core component of street outreach may include cleaning up any used injection equipment from streets and parks.[59] This can help improve community relations, stakeholder support, and overall community health.

- Outreach efforts can also educate the community and cultivate support. The Chicago Recovery Alliance uses outreach to connect with PWID and other community members, businesses, churches, and other organizations, and incorporates feedback from communities served into their programs.[59]

| APPROACH 2 | *Create a Sense of Shared Purpose to Reduce Stigma* |

Attitudes and actions of public safety, including law enforcement agencies, can have substantial impact on an SSP's success. SSPs can draw on relationships established with community members, policymakers, and other stakeholders to build support among these groups. Identifying a public safety champion can be an effective strategy to change attitudes and perceptions regarding SSPs and to gain useful support.

In addition, local businesses, neighborhood residents, faith-based organizations, schools, elected officials, public safety agencies, and other individuals/agencies can have varying opinions regarding SSPs, and efforts to establish a shared goal and sense of common purpose with these groups can ensure SSP support and sustainability. Building useful partnerships with a wide range of stakeholders and creating opportunities for education and training can create consensus on the value of harm reduction programs and regarding the health of people who use drugs. The resulting environment can positively shape beliefs and attitudes, reduce stigma, and ensure the wellbeing of participants, program staff, and the population at large.

**EVIDENCE OF EFFECTIVENESS IN ACHIEVING INTENDED OUTCOMES**

**Law enforcement and public safety buy-in and support**

- Punitive law enforcement policies and attitudes can adversely impact SSP goals. Davis et al. found that both number of SSP participants and number of syringes accessed decreased after every police intervention designed to disrupt open-air drug markets in Philadelphia — importantly, SSP participation by black participants decreased twice as much as that by whites and use by males decreased twice as much as that by females, exacerbating health disparities.[60]

- Davis and Beletsky reported that a brief police training intervention that combined information about public health benefits and legality of SSPs with officer concerns about infectious diseases and occupational safety (needlesticks) resulted in improved communication and collaboration between the two institutions.[61]

- Beletsky et al. reported that trainings that combine police officers' concerns about occupational safety with public health's harm reduction goals can help improve attitudes about the benefits of syringe access and SSPs.[62]

**Collaboration with broad stakeholder groups improves health for communities of PWID**

- With proper training, understanding, and communication, public safety entities can play a major role as a public health partner by directing people found with illicit drugs to SSPs and treatment programs rather than arresting and detaining them.[3]

- The Harm Reduction Action Center (HRAC) in Denver, Colorado used local police department's support, which came in the form of a harm reduction champion from within the department, to address neighborhood concerns and successfully entered into a *Good Neighbor* agreement with the local neighborhood association. HRAC provided services in that neighborhood for 3 years.[63,64]

## VOICES FROM THE FIELD

"Another person described their local sheriff as initially threatening to jail anyone who tried to operate an SSP, but after open conversation, they realized what he wanted was transparency — open bylaws and awareness of what was really occurring at the SSP. 'I have a great relationship with him now; he's very, he's one of our biggest allies now, to be honest with you.'"
*– Community-Based SSP Director, Utah*

"It builds our credibility when we have these relationships, so I can call on these folks if we need them to back us up."
*– Former Community-Based SSP Director, Indiana*

"We've had a lot of funders send people from red and purple states to us to learn about how we hustle and do our thing. So sometimes what would be helpful with the funders if they can't do a large investment is to invest in helping new programs that are interested, and potential future groups that could be funded, to provide them with some kind of mentorship to help build up programs' capacity to hustle and to help build up programs' understanding of how to do things with very little money. They should constantly be helping programs to learn."
*– Former Community-Based SSP Director, North Carolina*

"We are authorized by law to do these things, but we live in a political and economic reality. People have to know that, and adjust accordingly. You definitely want as many advisors as possible in your planning process. Multiple agencies — that's one way to help prevent a crash and burn."
*– Health Department-Run SSP, West Virginia*

"We hired a lawyer who worked in the Attorney General's office and worked in a unit that worked on human trafficking, sex crimes, those types of things. And then he was a prosecutor with the Salt Lake County DA's office. So we're leveraging his relationships throughout the state to help mediate concerns with law enforcement, add some credibility to our program, add some protection for our staff, so that if something happens we have representation immediately. So that's been helpful."
*– Community-Based SSP Director, Utah*

"I believe very heavily in the good neighbor agreement. It's very awkward initially because you sit down with a mediator, law enforcement, some neighbors — then talk about what you're going to do and how you're going to do it. And then everybody signs off and then they allow you to just do it and implement it. I like that. Because honestly the *Good Neighbor* agreements are very nebulous but people feel heard."
*– Community-Based SSP Director, Colorado*

"My goal is to get a meeting with the residents to start to humanize the problem to be like, 'We're your neighbors! Everyone here is your neighbor.'"
*– Community-Based SSP Director, California*

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# Additional Resources

*Figure 1. Pros and cons of service delivery models*

| DELIVERY MODEL | PROS | CONS |
|---|---|---|
| **Fixed site/ Storefront** | • Fixed-site models work best in locations where PWID are gathered and allow for easier integration of or referral to ancillary support services<br><br>• Set location with predictable hours allows easier access | • Visibility can be a barrier due to concerns about stigma<br><br>• A brick-and-mortar design can be costly to maintain<br><br>• Transportation to site can be a barrier<br><br>• Fixed sites based in clinics or other healthcare settings may deter participants due to previous experiences of stigma or poor treatment |
| **Mobile Unit/ Outreach** | • Mobile Units or Outreach can reach targeted groups of people who might face transportation issues or fear stigma from accessing fixed sites<br><br>• Brings services to people rather than asking them to come to services | • Cost of unit<br><br>• Limited expanded services able to be offered with some forms of outreach<br><br>• Varying schedule can make it harder for participants to remember where and when services are available |
| **Secondary exchange/ delivery** | • Secondary exchange models deliver services for large areas and sparsely distributed PWID populations that are difficult to cover with traditional delivery models<br><br>• May reach PWID who will not go to fixed-site SSPs | • Additional considerations include training and oversight of secondary exchangers, and legal framework.<br><br>• May be more challenging to support participants to get HCV, HIV testing, other expanded services |
| **Mobile/ Backpack** | • Mobile models allow for service delivery to PWID in discreet/rural areas, populations with limited transportation access and/or areas with low PWID density | • Cost might be based on distance, resources needed (e.g., car, van, gasoline, or insurance, etc.) and frequency of visits<br><br>• Service delivery schedule is subject to weather or other unforeseen circumstances; keeping up with the delivery location and times might be challenging for participants<br><br>• May be more challenging to support participants to get HCV, HIV testing, other ancillary services |
| **Secondary Exchange, combined with Fixed or Mobile model** | • Multiple options for service delivery (both core and expanded)<br><br>• Flexibility for participants, given their current circumstances and context<br><br>• Different levels of engagement options can ensure access to comprehensive services | • Potential for increased training and support for secondary exchangers<br><br>• Maintenance of multiple service delivery models might increase program operating costs or staffing needs |

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*Figure 2. Need-based versus 1:1 exchange: Why restrictive syringe exchange is not the preferred approach?*

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## Box A-1. Designing an SSP: What to Consider?

- **Burden:** PWID prevalence; infectious disease rates among PWID

- **PWID characteristics**: age, race/ethnicity, gender, cultural and linguistic barriers, vulnerable populations, drug use characteristics

- **Vulnerable populations**: adolescents, elderly, pregnant women, comorbid mental and substance use disorders

- **Resources:** workforce, funding (available or required)

- **Partnerships:** health departments, local/state/national agencies, CBOs, MOUD programs, elected officials, law enforcement

- **Local policies, politics, and practices**

**OTHER PUBLISHED RESOURCES ON SSP PLANNING, DESIGN AND IMPLEMENTATION**

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