Health & Human Services and Public Safety Committee

Thursday, March 4, 2021, 6:00 PM
Remote Meeting

Councilor Tae Chong, District 3, Chair
Councilor Belinda Ray, District 1
Councilor Mark Dion, District 5

1. Announcements

a. Zoom Information:

You are invited to a Zoom webinar.
When: Mar 4, 2021 06:00 PM Eastern Time (US and Canada)
Topic: Remote HHS and Public Safety Workshop

Please click the link below to join the webinar:
https://zoom.us/j/94117150602?pwd=L1dIcEl5LzNvVTJ1TUI4c1l4cEl4dz09
Passcode: 349187
Or iPhone one-tap :
US: +13017158592,,94117150602#,,,,*349187# or +13126266799,,94117150602#,,,,*349187#
Or Telephone:
Dial(for higher quality, dial a number based on your current location):
US: +1 301 715 8592 or +1 312 626 6799 or +1 929 205 6099 or +1 253 215 8782 or +1 346 248 7799 or +1 669 900 6833
Webinar ID: 941 1715 0602
Passcode: 349187
International numbers available:https://zoom.us/u/abz7Jczsq4

2. Needle Exchange Program

a. Documents

3. Next Meeting: March 9, 2021

NOTE: Since there are no action items on the agenda, there will be no opportunity for public comment at this meeting. Please feel free to send comments to members of the committee on any issue at any time via email. Councilors email addresses are available on the city website: www.portlandmaine.gov

The meeting can be watched online via livestream: www.portlandmaine.gov/livestream

Keep up to date with the new shelter design and planning process at the City's website

www.portlandmaine.gov/shelterplanning

Health & Human Services and Public Safety Committee Workshop
March 4th, 2021

Panelist Information

Gordon Smith, Director of Opioid Response:
Gordon H. Smith, Esq. was appointed by Governor Janet Mills as Director of Opioid Response in January 2019. He is responsible for coordinating and directing Maine's response to the opioid crisis, including prescriber education and reduction of opioid prescribing, prevention and treatment of substance use disorder, and harm reduction strategies. He stepped down as the Executive Vice President (EVP) of the Maine Medical Association in January 2019, where he had served as its EVP since September 1993 and where he began as General Counsel in 1981. He graduated from the University of Maine with the highest distinction in 1973 and from the Boston College Law School, magna cum laude, in 1976. He is a past Chairman of the American Society of State Medical Association Counsel, a nation-wide group of 140 attorneys representing medical associations. Mr. Smith has also served as Chairman of the American Medical Association/State Medical Society Litigation Center, the Maine Health Data Organization and the Advocacy Resource Center of the American Medical Association. He is a former board member and chair of Quality Counts, a former board member of the Daniel Hanley Center for Health Leadership, and the Maine Association of Area Agencies on Aging. Mr. Smith is a frequent lecturer to medical groups on various medical legal subjects.

Bob Fowler, Director of Public Health, City of Portland:
Bob Fowler joined the City of Portland as its Director of Public Health in August, 2020. Most of Bob's career has been in leadership roles within the social services nonprofit sector, most recently as Executive Director of Milestone Recovery, a nonprofit organization whose focus is serving those experiencing homelessness and substance use disorders. He served as a member of the Maine Legislative Task Force to Address the Opioid Crisis in 2017, and as a member of the Maine Opiate Collaborative in 2016. He holds Master's Degrees in Public Policy & Management from the University of Southern Maine's Muskie School of Public Service, and in Social Welfare from the University at Albany in New York.

Bridget Rauscher, Chronic Disease Prevention Program Manager, City of Portland:
Bridget Rauscher has been with the Public Health Division, proudly serving the City of Portland since 2010, working as a Disease Intervention Specialist at the India Street Public Health Center before becoming the Substance Use Prevention Program Coordinator in 2016, where she created the Mobile Medical Outreach Project. In 2019, Bridget became the Division's Chronic Disease Prevention Program Manager. Prior to joining the Division, Bridget worked as a Medical Case Manager with Frannie Peabody Center, a non-profit AIDS Service Organization in Southern

Maine. In 2019, Bridget was appointed to the Board of Directors for Milestone Recovery and is currently working on her Masters Degree in Public Policy & Management at the University of Southern Maine's Muskie School of Public Service.

Robert Wassick, Training and Safety Administrator, Portland Public Works:
In October of 2014, Bob retired from the Fire Department as Deputy Chief after 31 years. In November 2014 he became the Safety and Training Administrator for the City Department of Public works. In 2019, Bob was added to Parks, Recreation and Facilities staff in Safety and Training. In addition, Bob is a licensed EMT and CDL driver

Ethan Hipple, Director of Parks, Rec and Facilities, City of Portland:
Ethan Hipple has served with the City of Portland since 2016. He first served as the Recreation Division Director, then Parks Division Director, and now the Director of the Parks, Recreation, and Facilities Department. He serves on the boards of the Portland Parks Conservancy and One Longfellow Square music venue. Prior to working for the City of Portland, Ethan directed the Parks and Recreation Department in Wolfeboro, New Hampshire, directed the SCA NH Conservation Corps (an AmeriCorps program), and managed youth volunteer conservation programs for the Student Conservation Association. His focus in his position as Director of Parks, Rec and Facilities is to create opportunities for Portlanders of all backgrounds to enjoy the outdoors and create community through recreation programs and meaningful cultural experiences.

Whitney Parrish (she/her), Director of Advocacy and Communications of Health Equity Alliance (HEAL):
Whitney Parrish (she/her) is the Director of Advocacy and Communications of Health Equity Alliance (HEAL) a harm reduction, LGBTQ+, and HIV/AIDS service providing organization located in northern, Down East, and Mid Coast Maine. Formerly the Down East AIDS Network, HEAL was founded in the late 1980's to support Mainers who are HIV-positive in rural Down East Maine. HEAL has since expanded to offer harm reduction services by operating 7 syringe services program locations and advocating with and for people who use drugs through systemic public health and criminal legal systems transformation in Maine policy making.

Whitney is the former Policy and Programs Director of the Maine Women's Lobby and currently serves as Policy and Communications Coordinator for the Maine Prisoner Advocacy Coalition. She moved back to where she grew up in central Maine with her daughter Aurora, though she called Portland home for many years.

City of Portland, Maine
Health & Human Services Department
Kristen Dow, Director

Public Health Division
Bob Fowler, M.PPM., LCSW

MEMORANDUM

To: Members of the Health & Human Services & Public Safety Committee

From: Bob Fowler, Director of Public Health
Bridget Rauscher, Chronic Disease Prevention Program Manager

Date: March 4, 2021

Re: Staff Response to Council Questions and Packet Requests for Committee Workshop

Packet Requests from HHS & PS Committee Members

Councilor Ray:

1. **Sharps map for Portland**

   Can be found here, as well as in the committee packet.

2. **List of syringe exchanges by location in Maine**

   Can be found here as well as in the committee packet.

3. **For the Portland Needle Exchange: Numbers of needles distributed and collected historically, by year, in a chart for easy comparison with a breakdown of how many needles were collected from sharps boxes vs. from clients (past 3-5 years if possible)**

Year	Collected by NEP	Distributed by NEP	Collected from Community Sharps Boxes/Public Spaces*
2016	158,942	152,997	874
2017	174,089	187,937	1634
2018	180,532	205,740	2230
2019	221,303	257,177	4008
2020	225,980	370,740	6242

*Data would need to be sorted month by month to determine numbers in community sharps boxes and in public spaces. This can be done, but would require additional time.

4. **A copy of the Governor's order lifting the 1:1 requirement for needle exchanges**

   Executive Order 27 FY19/20 can be found here. An amendment to this order from 2/24/21 can be found here, under ORDERS B. They also can be found in the committee packet.

5. **A list of our panelists/speakers for this meeting with brief bios**

   Please see the list of panelists in the packet.

6. **Information on any bills currently before the legislature pertaining to needle exchange programs, their purposes, and whether or not they have the support of the State CDC**

   Per Lauren Gauthier of Maine CDC:
   "As far as I'm aware, there are not any bills specific to syringe service programs before legislature this year."

7. **Lists of questions submitted in advance by committee members or other councilors.**

   Please see below.

Councilor Dion:

1. **Information about the rates of local hospitalization for endocarditis and hepatitis C might be of use as indirect evidence of the use of contaminated needles among SUD patients.**

   Have requested this information from MMC via our medical director. Specifically, have requested information on hospital admissions for IV drug use infections month over month for the past 24 months. We have not yet received those data.

Questions for Needle Exchange Workshop from HHS & PS Committee Members

Councilor Ray:

Understanding Basic Operations

1. **Could you provide us with an org chart for the NEP? I'd like to see the structure as it exists now, as well as the structure as it existed before the pandemic. It would be helpful to have these two org charts on one page if possible. I don't need names of people in positions – just positions and whether or not they are filled or vacant.**

   Please find this information here, as well as in the committee packet.

2. **I'd like the same type of information for the volunteer program at the NEP: the current number of volunteers working with the program as well as the number of volunteers prior to the pandemic.**

Volunteers Pre-Pandemic	Volunteers Currently
Active: 5	Active: 3 (4 beginning 3/8/21)
Inactive: 2-4	Inactive: 3

3. **Could you please break down the duties performed by staff employed by the City of Portland vs. duties/hours performed by volunteers?**

   Staff engage in a wide variety of duties related to the Needle Exchange Program, which operates at 103 India Street Monday-Friday from 9am-4pm. At present, staff are responsible for the ordering and distribution of all supplies, including Narcan. Distribution includes both distribution to clients as well as packaging and preparing

supplies for volunteers. Additionally, staff are responsible for the ever-changing inventory of all supplies as well as for the accurate record keeping and reporting of each Exchange.

In addition to exchanges which occur at our India Street location, exchanges also occur on an outreach basis. Staff are currently providing outreach services for four hours each week. Due to the less private nature of outreach exchanges as well as prevention efforts related to COVID-19, outreach interactions are typically shorter than exchanges happening at India Street, with less specific information collected from each client. During an exchange at our India Street location, staff take the opportunity to talk with clients about the following: housing status, time of last HIV/HCV test with results, substances currently being used, syringe reuse/sharing practices, and Narcan use. Many of these questions are in an effort to supply relevant referrals and/or information related to the answers.

Volunteers presently offer five hours/week of outreach exchanges. Volunteers are responsible for requesting and maintaining their supplies from NEP as well as recording and reporting on a weekly basis the number of exchanges they complete, including numbers of needles collected and distributed, and tracking Narcan distributed. Volunteers are additionally responsible for bringing the biohazard waste they collect during outreach exchanges to 103 India Street for proper disposal. On an as needed basis volunteers are asked to attend NEP meetings.

Finally, could you please list the hours of the India Street location and the hours and locations for mobile outreach? Again, please break them down so we can compare current hours/locations with hours/locations prior to the pandemic.

Outreach is most consistently offered at our established location at the corner of Oxford and Elm Streets, where clients know NEP staff or volunteers will be present. Since January, staff have increased outreach to include encampments, which takes place on Thursday mornings from 10am-12pm.

India Street Present	India Street Pre-Pandemic	Outreach Present	Outreach Pre-Pandemic through 1/2021
Monday 9am-4pm	Monday 9am-4pm	Monday 8-9am	Monday - No Outreach
Tuesday 9am-4pm	Tuesday 9am-4pm	Tuesday 8-9am & 4-5pm	Tuesday 8-9am & 4-5pm
Wednesday 9am-4pm	Wednesday 9am-4pm	Wednesday - No Outreach	Wednesday 8-9am
Thursday 9am-4pm	Thursday 9am-4pm	Thursday 8-9am, 10am-12pm & 2-3pm	Thursday 8-9am & 4-5pm
Friday 9am-4pm	Friday 9am-4pm	Friday 8-9am	Friday 8-9am
Saturday - CLOSED	Saturday - CLOSED	Saturday - No Outreach	Saturday 8-9am
Sunday - CLOSED	Sunday - CLOSED	Sunday 8-9am	Sunday 8-9am

4. **How large are the sharps boxes we have around town? How many needles can each hold? How often are they emptied?**

   Sharps boxes are 1.5 quarts and will typically hold about 30-40 syringes (depending on what else might have been placed in the boxes, how the needles are positioned, and so on). Boxes are emptied weekly by staff from the Department of Public Works.

1:1 Exchange Policy

1. **The City of Portland is currently following a 1:1-plus policy. It has some exceptions to the 1:1 policy when clients can receive a kit of 10 clean syringes. How long are 10 syringes expected to last an individual? I understand there is no single answer to this question, but what can you give me for a range? How slowly or quickly might an individual use 10 clean syringes if there is no reuse of needles?**

   We encourage NEP clients to use a new syringe and new supplies for each injection. Individual practice, access to veins, frequency/infrequency of use, substance(s) used, and other factors all contribute to this number and it is often different and personal to each individual. NEP staff have recently been collecting data from clients about needle use practices and will use this information to inform planning efforts going forward. There is no established limit to the number of visits a client can make to the Exchange on a daily or weekly basis.

2. **I saw the data that suggested 80% of clients surveyed had not reused syringes, but that 20% had, with 17% reusing themselves and 3% reusing through sharing. I know that 182 clients were surveyed. How many clients do we have? How were clients surveyed? And how reliable is this self-reporting considered to be?**

   The answer to the question about the number of NEP clients is multi-layered. There are in excess of 3,600 clients who are enrolled in the program though historically a fraction of this number are seen on an annual basis.

   Starting on 2/4/21 clients engaging in exchanges at India Street have been surveyed as to their use patterns. Since that time 204 unique individuals have been surveyed. As of 3/2/21:

   - 78% of clients surveyed report not sharing or reusing a needle
   - 18.4% report reusing needs
   - 3.6% report sharing needles with others

   This self-reporting data is likely as reliable as any other self reporting information any of us participate in. It is likely that there may be some "scaling" of information provided by individuals due to the very real phenomena of stigma and shame. Staff are sensitive to this fact and attempt to ask these questions in a non-shaming manner while conveying to clients that their responses are anonymous and being used in an effort to improve delivery of services.

3. **Do we have any data about how many times a syringe is used/shared before it is exchanged? If so, please share that data.**

   Please see item above.

4. **How did the State of Maine come to its 1:1 rule for exchanges? Was there a specific determination that a 1:1 policy is the most beneficial? If so, what data supported that conclusion at the time?**

   Per Lauren Gauthier from Maine CDC:
   "I can't find any communication around the history of the 1:1 exchange rules since the policy began in the 90s so it's hard to find that information. There's no one in our office at that time that can highlight the origin of the rule. We can only speculate that it was best practices at the time when the one-to-one rule was created."

5. **Is there any difference between Maine CDC guidance on this issue and National CDC guidance? I don't see a 1:1 policy endorsed at the federal level. Am I missing it? For that matter, does the Maine CDC endorse a 1:1 policy as a best practice?**

   Per Lauren Gauthier from Maine CDC:
   "Current rules at Maine CDC state the 1:1 policy. However, under Executive Order 27 the State has removed the 1:1 policy and allowed SSP programs to go to a needs-based approach in keeping with CDC's *Interim Guidance for Syringe Service Programs* while under the State of Civil Emergency. Maine CDC and DHHS leadership are reviewing all rules under EO 27 and feedback from community advocates on which provisions of EO 27 might remain after the pandemic is over and that includes the 1:1 policy.

   I have also included the attached guidance from CDC regarding effective strategies and approaches for SSP implementation as well as the fact sheet of their support of needs-based distribution that was released in December."

6. **A 2020 CDC publication titled, "Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation" recommends needs based delivery services for syringe services programs. I know that City of Portland staff are reviewing policies at this time. Is this document part of that review? As stated in the executive summary, it "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)."**

   Yes, this is among the documents that is a part of the literature review and is informing that process. The literature review is ongoing by staff at this time with additional focus directed on particular topic areas of focus (such as determining whether there is a relationship between particular needle distribution policies with overdose rates, bloodborne infection rates, and community needle waste, to name some.

Councilor Dion:

1. **Does the City have the legal authority to adopt a distribution model that is inconsistent with the "one to one" model authorized by DHHS?**
   From Jen Thompson in the City's Legal Department:
   In general, possession of "hypodermic apparatus" and "trafficking in hypodermic" apparatus are not permitted unless someone is authorized under State criminal and civil statutes. One of the exceptions to the general prohibition on trafficking in or furnishing hypodermic apparatus is when a person is doing so in connection with a needle exchange program certified by the State. See 17-A M.R.S. 1110 & 22 M.R.S. 2383-B(2)(F). As such, it is

certification under the State regulations promulgated by the Maine Bureau of Health that permits our needle exchange employees and volunteers to possess and provide hypodermic apparatus to clients of the needle exchange.

The State statute authorizing certified needle exchange programs is relatively sparse in terms of program requirements. See 22 M.R.S. 1341. The bulk of the substantive requirements for NEPs are contained in the state regulations, attached below. Those state regulations include several "operating requirements" including the 1:1 exchange rule. The language of the requirement around 1:1 is as follows:

> "Programs must adhere to a strict one-for-one syringe exchange distribution policy and shall not distribute syringes without receiving a used syringe in return. An exception must be made for a new enrollee who has no needles for the initial exchange."

As we've discussed, in March 2020, the Governor relaxed the usual 1:1 requirement by way of an executive order (attached) in response to COVID-19. That executive order authorized needle exchange programs to deviate from the usual 1:1 requirement - though it did not mandate that they do so.

So, in answer to this question from Councilor Dion: Any NEP, including the NEP operated by the City, may adopt a distribution model that does not comply with the 1:1 requirement quoted above <u>for as long as the Governor's Executive Order remains in effect.</u> In the absence of changes to the State regulations governing NEPs in the usual course, when the executive order expires, NEPs will be required to return to the 1:1 distribution requirement. In other words: the City's NEP can temporarily relax its 1:1 policy even more than it already has if it chooses. However, barring a change to the state regulations, when the state of emergency expires, those temporary changes will need to be curtailed and 1:1 reinstated consistent with State law.

2. **The rationale for needle exchange programs is to facilitate the use of a sterile needle and syringe for each injection and thereby reduce transmission of HIV, hepatitis C (HCV), hepatitis B (HBV), and other pathogens. If that is so, then one likely indicator of the program's efficacy would be to assess the rates for acute HVC, HBV and endocarditis at MeMed. Can we acquire local medical data for such an analysis.**

We have requested information from MMC related to trends in bloodborne infections related to IV drug use for the past 24 months but have not received these data. That said, it should be cautioned that there are many individuals in Portland who inject drugs and do not receive services from NEP and thus a causal link between inpatient admissions for these bloodborne

infections and NEP policies would be difficult to establish. Among the areas being researched through the literature review being undertaken by Portland Public Health staff is an assessment of the availability of controlled studies which could better answer this question.

3. **What is the nature and portfolio of "services" that we are referring needle exchange program clients for participation or admission? Does this pool of providers include entities that provide medication assisted treatment? What is the referral rate of exchange clients? What is their rate of admission to these services?**

   Needle Exchange Program clients are referred to services based upon either a self-reported or requested need, or at the suggestion of the staff member who is working with them during their exchange. These services include, but are not limited to the following: Substance Use Treatment (detox, MAT, counseling services), Recovery Services, Primary Care, Urgent Care and/or Mobile Medical Outreach Program, Housing, Food, Social Services/General Assistance, STD clinic for either comprehensive testing or strictly HIV/HCV testing, Reproductive Health Services, Patient Navigator. Clients are also offered Narcan at each visit and are offered additional education on overdose response if necessary. The NEP, by design, is an anonymous program and does not provide formal case management services, thus there is not a mechanism to follow up on referrals made. That said, referral to treatment, recovery, and other services is an important function of the program. These referral services have been further enhanced in recent months with the addition of a Patient Navigator which has increased the opportunity for collection of more specific referral data.

4. **How does the exchange program define the recovery process? Where does the exchange see itself in a SUD plan of care matrix?**

   We embrace the working definition from the federal Substance Abuse and Mental Health Services Administration, namely "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential". The Portland Needle Exchange Program embraces the philosophy of harm reduction by "meeting clients where they're at", striving to welcome and serve them without judgment, ultimately with the goal of supporting individuals to achieve their optimal health and well-being. The Portland NEP, as with syringe service programs generally, strives to reduce mortality and morbidity of those the program serves (through linkage to other services and provision of naloxone, to name some), as well as to improve the community more broadly.

5. **What are the parameters of our mobile outreach strategy? Does it entail more than setting up a table at Oxford and Elm Streets or do we flex our outreach to homeless**

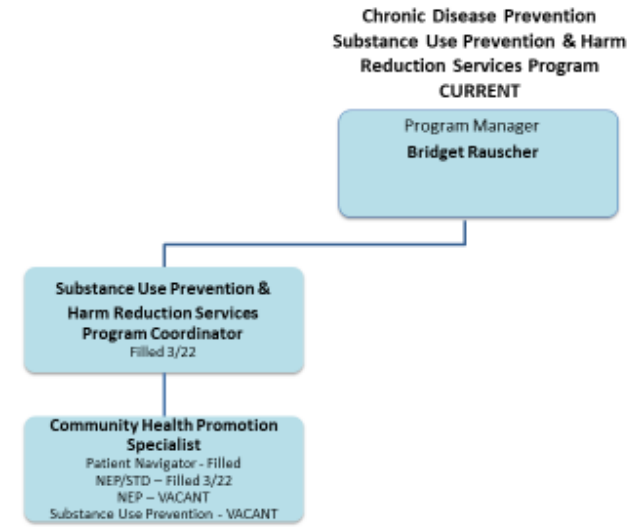
encampments or other sites in the city where those with substance use disorder may congregate?

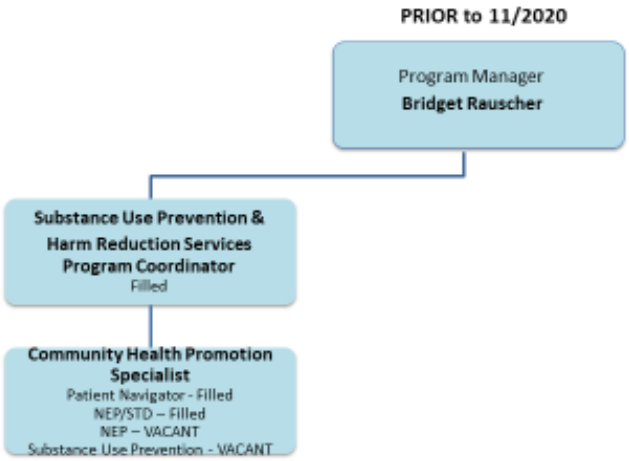
NEP outreach services are well established in the community. At present, we offer seven hours/week of outreach at our certified outreach location. At the start of 2021, we expanded our outreach to include encampments (an additional two hours/week). In response to a recent identified need to support unsheltered individuals who need to quarantine or isolate due to COVID-19 and have been referred to the state-established Quarantine Shelter, NEP established a mail-order protocol to support these individuals to remain in quarantine. City staff are presently working with MaineHousing and Preble Street staff to consider further expansion of this service in light of the most recent update to Governor Mills' Executive Order 27.

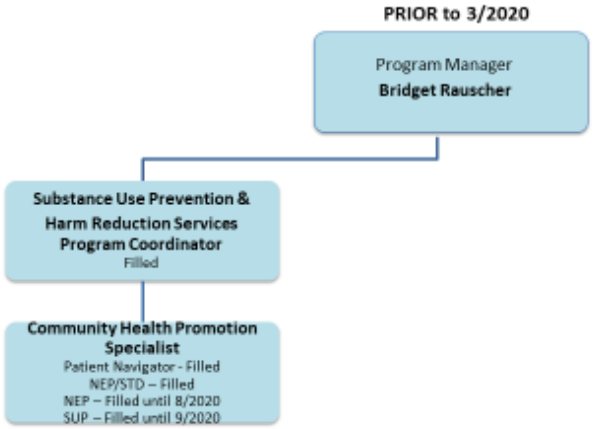
It is important to note that all of these exceptions to a formal 1:1 exchange policy and operations outside of Portland are temporary and tied to Maine's State of Emergency as authorized under Governor Mills' executive order.

6. **What steps do we take, beyond sharp drop boxes to insure public confidence in the safety of common spaces from the health risks posed by discarded needles?**

Several years ago, in collaboration with Public Works, the Public Health Division implemented a safety campaign for safe retrieval and disposal of syringes. This campaign provided community members with a phone line to report improperly discarded needles, as well as a PSA encouraging them not to pick up the needle. In 2015, Park Rangers and other Parks staff began seeing an increase in discarded needles and incorporated collecting these needles into their work. With the implementation of SeeClickFix, community members were able to begin reporting needle waste with more immediate resolution. At this time Public Works staff, Occupational Health & Safety staff, and Public Health staff share the weekday responsibility of responding to these reports. On weekends and/or holidays, these reports are forwarded to the Portland Fire Department.


Chronic Disease Prevention
Substance Use Prevention & Harm Reduction Services Program
CURRENT
Program Manager
Bridget Rauscher
Substance Use Prevention & Harm Reduction Services Program Coordinator
Filled 3/22
Community Health Promotion Specialist
Patient Navigator - Filled
NEP/STD – Filled 3/22
NEP – VACANT
Substance Use Prevention - VACANT


PRIOR to 11/2020
Program Manager
Bridget Rauscher
Substance Use Prevention & Harm Reduction Services Program Coordinator
Filled
Community Health Promotion Specialist
Patient Navigator - Filled
NEP/STD – Filled
NEP – VACANT
Substance Use Prevention - VACANT


PRIOR to 3/2020
Program Manager
Bridget Rauscher
Substance Use Prevention & Harm Reduction Services Program Coordinator
Filled
Community Health Promotion Specialist
Patient Navigator - Filled
NEP/STD – Filled
NEP – Filled until 8/2020
SUP – Filled until 9/2020

Needs-Based Distribution at Syringe Services Programs

CDC supports a needs-based approach to syringe distribution.

Needs-based syringe distribution provides people who inject drugs (PWID) access to the number of syringes they need to ensure that a new, sterile syringe is available for each injection. A needs-based approach **provides sterile syringes with no restrictions, including no requirement to return used syringes**.

CDC supports the needs-based approach to syringe distribution, as the evidence shows that this is the best practice for reducing new HIV and viral hepatitis infections.[1,2,3] Restrictive syringe access policies are associated with higher injection risk behaviors and higher rates of HIV and other bloodborne infections.

In contrast, under the most restrictive approach to syringe distribution, syringe services programs (SSPs) clients must return used syringes and can get only as many new syringes as used ones returned.

SSPs that use a needs-based approach reduce their clients' risk of transmitting hepatitis C, HIV, and other infectious diseases.

SSPs help prevent bloodborne infections related to injection drug use.

People injecting drugs should use one sterile syringe (including a needle) for each injection to prevent bloodborne infections like hepatitis C and HIV. This means that a never-used, sterile syringe is used for each injection.

Without reliable access to syringes, PWID remain at risk for contracting infectious diseases.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Syringe services programs (SSPs) are community-based programs that:

provide access to sterile needles and syringes

facilitate safe disposal of used syringes

provide referrals to substance use disorder treatment

Most SSPs provide linkage to substance use disorder treatment [4, 5] and have been found to improve people who inject drugs (PWID) enrollment and retention in these treatment programs.[6, 7, 8, 9]

SSPs can further the impact of a needs-based approach to syringe delivery and increase sterile syringe coverage in the community by providing additional sterile syringes to clients to distribute to their peers who do not or cannot use SSPs.

Increasing the number of syringes among PWID through distribution by peers helps to reach the goal of providing a sterile syringe for each injection.[10]

PWID can play an important role in supporting safer injection-related behaviors among their peers.[11] SSPs with a needs-based approach to syringe delivery do not increase syringe litter; they promote the safe disposal of used syringes by providing sharps containers, drop boxes, community clean-ups, and other methods of controlling syringe litter.[2, 12]

Resources

1 Kerr et al. Syringe sharing and HIV incidence among injection drug users and increased access to sterile syringes. AJPH 2010: https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2009.178467.

2 Bluthenthal et al. Higher syringe coverage is associated with lower odds of HIV risk and does not increase unsafe syringe disposal among syringe exchange program clients. DAD 2007: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2562866/.

3 Mascolini. Widening Needle Distribution Cuts New HIV Cases in Baltimore. 9th IAS Conference on HIV Science (IAS 2017), July 23– 26, 2017, Paris: https://www.ias2017.org/.

4 Bramson et al. State laws, syringe exchange, and HIV among persons who inject drugs in the United States: History and effectiveness. J Public Health Policy 2015: https://www.ncbi.nlm.nih.gov/pubmed/25590514.

5 Des Jarlais et al. Syringe Service Programs for Persons Who Inject Drugs in Urban, Suburban, and Rural Areas — United States, 2013. MMWR Weekly 2015: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6448a3.htm.

6 Hagan et al. Reduced injection frequency and increased entry and retention in drug treatment associated with needle exchange participation in Seattle drug injectors. J Substance Abuse Treatment 2000: https://www.ncbi.nlm.nih.gov/pubmed/11027894.

7 Heimer. Can syringe exchange serve as a conduit to substance abuse treatment? J Substance Abuse Treatment 1998: https://www.ncbi.nlm.nih.gov/pubmed/9633030.

8 Strathdee et al. Needle-exchange attendance and health care utilization promote entry into detoxification. J UH 1999: https://www.ncbi.nlm.nih.gov/pubmed/10609594.

9 Scott County, IN data. Unpublished.

10 Blumenthal et al. Recommended best practices for effective syringe exchange programs in the United States: Results of a consensus meeting. New York City Department of Health and Mental Hygiene 2010: https://www.rti.org/publication/recommended-best-practices-effective-syringe-exchange-programs-united-states

11 Snead et al. Secondary Syringe Exchange Among Injection Drug Users. J Urban Health 2003: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3456273/.

12 de Montigny et al. Assessing a drop box programme: A spatial analysis of discarded needles. Int J Drug Policy 2010: https://www.sciencedirect.com/science/article/pii/S0955395909001108.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Syringe Service Programs

Tri-County CommUnity Recovery website: www.tcmhs.org	1155 Lisbon Street Lewiston, ME 04240	(207) 783-9141
Portland Needle Exchange Website: www.portlandmaine.gov	103 India Street Portland, ME 04101	(207) 756-8024
Down East AIDS Network & the Health Equity Alliance Website: www.mainehealthequity.org	5 Long Lane #1 Ellsworth, ME 04605	(207) 667-3506
Health Reach Harm Reduction Website: www.mainegeneral.org	9 Green Street, Augusta, ME 04330 - and - Thayer Center for Health 149 North Street, Terrace Level, Waterville, ME 04901	(207) 621-3770
Down East AIDS Network & the Health Equity Alliance Website: www.mainehealthequity.org	304 Hancock St, Suite 3B Bangor, ME 04401	(207) 990-3626
Down East AIDS Network & the Health Equity Alliance Website: www.mainehealthequity.org	147 Waldo Ave, Belfast, ME 04915	(207) 249-8916
Down East AIDS Network & the Health Equity Alliance Website: www.mainehealthequity.org	10 Barker St., Calais, ME 04619	(207) 610-4351
Down East AIDS Network & the Health Equity Alliance Website: www.mainehealthequity.org	7 VIP Road Machias, ME 04654	(207) 255-5849

Maine Access Points website: www.maineaccesspoints.org	Waterfront Pier, Calais, ME 04619	(207) 370-1042
Maine Access Points website: www.maineaccesspoints.org	Intersection of Weaver Drive & Heritage Crossing Sanford, ME 04073	(207) 370-4782

OFFICE OF
THE GOVERNOR

NO. 27 FY 19/20
DATE March 30, 2020

AN ORDER REGARDING STATE CERTIFIED HYPODERMIC APPARATUS EXCHANGE PROGRAMS

WHEREAS, I proclaimed a state of emergency on March 15, 2020 to authorize the use of emergency powers in order to expand and expedite the State's response to the many different effects of COVID-19; and

WHEREAS, the spread and identification of additional cases of COVID-19 in Maine is likely to continue and taking proactive steps to prevent a substantial risk to public health and safety is paramount; and

WHEREAS, the escalating COVID-19 public health emergency will present substantial barriers to the clients of the state certified syringe exchanges receiving the services of the exchanges; and

WHEREAS, the sharing of hypodermic apparatus, especially needles, leads to the spread of disease including possibly COVID-19; and

WHEREAS, the establishment and operation of needle exchanges is a proven and effective harm reduction strategy; and

WHEREAS, the provisions of this Order are necessary for the exchanges to continue their operation; and

WHEREAS, 37-B M.R.S. §742(1)(C)(1) and §834 authorize a governor during a state of emergency to suspend the enforcement of certain laws if strict compliance therewith would in any way prevent, hinder or delay necessary action in coping with the emergency;

NOW, THEREFORE, I, Janet T. Mills, Governor of the State of Maine, pursuant to 37-B M.R.S. Ch. 13, including but not limited to the provisions referenced above, do hereby Order as follows:

I. ORDERS

The provisions of 22 M.R.S. §1341 and DHHS Rule 10-144, Chapter 252 are suspended for certified hypodermic apparatus (needle) exchange programs to the extent necessary to permit the following:

A. The 1-to-1 needle exchange limit is temporarily suspended;

B. Physical contact with clients shall be avoided where possible and when clients are physically present social-distancing and appropriate medical protocols shall be followed;

C. Such certified programs may operate in a location other than that authorized in their current certification so long as the location is in the same municipality, the State is notified of the duration, and there is proper needle disposal;

D. Hours of operation may be expanded or contracted without approval of the State so long as the State is notified; and

E. Supplies may be provided by U.S. mail service to the extent permitted by federal law.

II. GUIDANCE

The Maine Center for Disease Control and Prevention shall issue guidance for law enforcement regarding enforcement of 17-A M.R.S. §1110-1111 during this period of emergency.

III. EFFECTIVE DATE

This Order is effective March 30, 2020 and shall remain in effect until amended, rescinded or the State of Civil Emergency to Protect Public Health is terminated, whichever happens first.

Janet T. Mills
Governor

Office of
The Governor

No. 33 FY 20/21
DATE February 24, 2021

AN ORDER AMENDING EXECUTIVE ORDERS
16 FY 19/20, 21 FY 19/20, 27 FY 19/20, AND 36 FY 19/20

WHEREAS, I proclaimed a state of emergency on March 15, 2020, and renewed that state of emergency most recently on February 17, 2021, to authorize the use of emergency powers in order to expand and expedite the State's response to the serious health and safety risks of the highly contagious COVID-19 virus; and

WHEREAS, it is necessary and appropriate to amend dates and other provisions in various Executive Orders issued in 2020 to ensure their continuing effectiveness through 2021; and

WHEREAS, the Governor's emergency powers expressly include the authority suspend the enforcement of statutes pursuant to 37-B M.R.S. §§ 742(l)(C)(l) & 834, to adjust timeframes and deadlines imposed by law pursuant to 37-B M.R.S. § 742(l)(C)(13)(a), and to modify or suspend the enforcement of requirements for professional or occupational licensing or registration by any agency, board, or commission pursuant to 37-B M.R.S. § 742(l)(C)(13)(c);

NOW, THEREFORE, I, Janet T. Mills, Governor of the State of Maine, pursuant to 37-B M.R.S. Ch. 13, including but not limited to the authority referenced above, and Me. Const. Article V, Pt. 1, § 1 and § 12, do hereby Order as follows:

I. **ORDERS**

A. To protect the public by ensuring that physicians, physician assistants, and nurses are qualified and properly licensed, Section I(E) of Executive Order 16 FY 19/20 is hereby repealed, and all physician, physician assistant, or nurse licenses issued by the Board of Licensure in Medicine, the Board of Osteopathic Licensure, or the State Board of Nursing that were scheduled to expire during the declared state of civil emergency but were extended pursuant to executive order shall expire on March 31,

2021 unless renewed prior to that date. All other provisions of Executive Order 16 FY 19/20 remain in effect.

B. To ensure the on-going effectiveness of needle exchange programs, Section (1)(C) of Executive Order 27 FY 19/20 is repealed and replaced with the following:

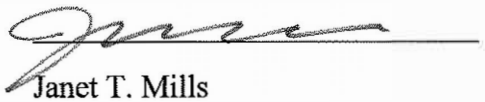
> Such certified programs may operate in a location other than that authorized in their current certification so long as the location is in the same county, the State is notified of the duration, and there is proper needle disposal;

C. To ensure the continuing effectiveness of pertinent provisions of Executive Order 36 FY 19/20, Section I(C) of Executive Order 36 FY 19/20 is hereby amended to replace the reference to the year 2020 with 2021.

D. To ensure the 2021 elver fishing season proceeds in an orderly fashion and the economic benefits of that season are realized to the maximum extent practicable, Sections (II)(A)-(H) in Executive Order 21 FY 19/20 are hereby amended to replace all references to the year 2020 with 2021. All other provisions of Executive Order 21 FY 19/20 remain in effect.

II. EFFECTIVE DATE

The effective date of this Order is February 24, 2021.



Janet T. Mills

Governor

Syringe Services Programs

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

DEVELOPED BY

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2020

Acknowledgments

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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.

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.

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).

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 • Create meaningful engagement opportunities to encourage participant ownership of program • Recognize the expertise of SSP participants and compensate appropriately
Planning, design, and implementation	• Needs-based distribution is the best approach • Delivery model should be informed by thorough and ongoing needs assessment • Partnerships are key to successful SSP implementation • SSPs should link PWID to care, whenever possible and desired
Providing core versus expanded services	• Syringe distribution and safe disposal education are core services • Expanded services complement core services and establish continuum of care. Broadly, these include – Naloxone distribution and training – Infectious disease screening and/or treatment, or immediate linkage to care – Other expanded services
Collecting data to inform planning, implementation, and evaluation	• SSPs should collect data on trends, needs, and overall program effectiveness • 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 • Street outreach fosters relationships with clients and neighbors when they see services being provided • Diversify funding sources for increased program sustainability • 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.

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*

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]

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]

APPROACH 2 *Delivery Model Should Be Informed by Thorough Needs Assessment*

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.

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:

- 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]

VOICES FROM THE FIELD

"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*

STRATEGY III Core versus Expanded Services

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.

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.

VOICES FROM THE FIELD

"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*

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.

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]

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*

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.

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.'"

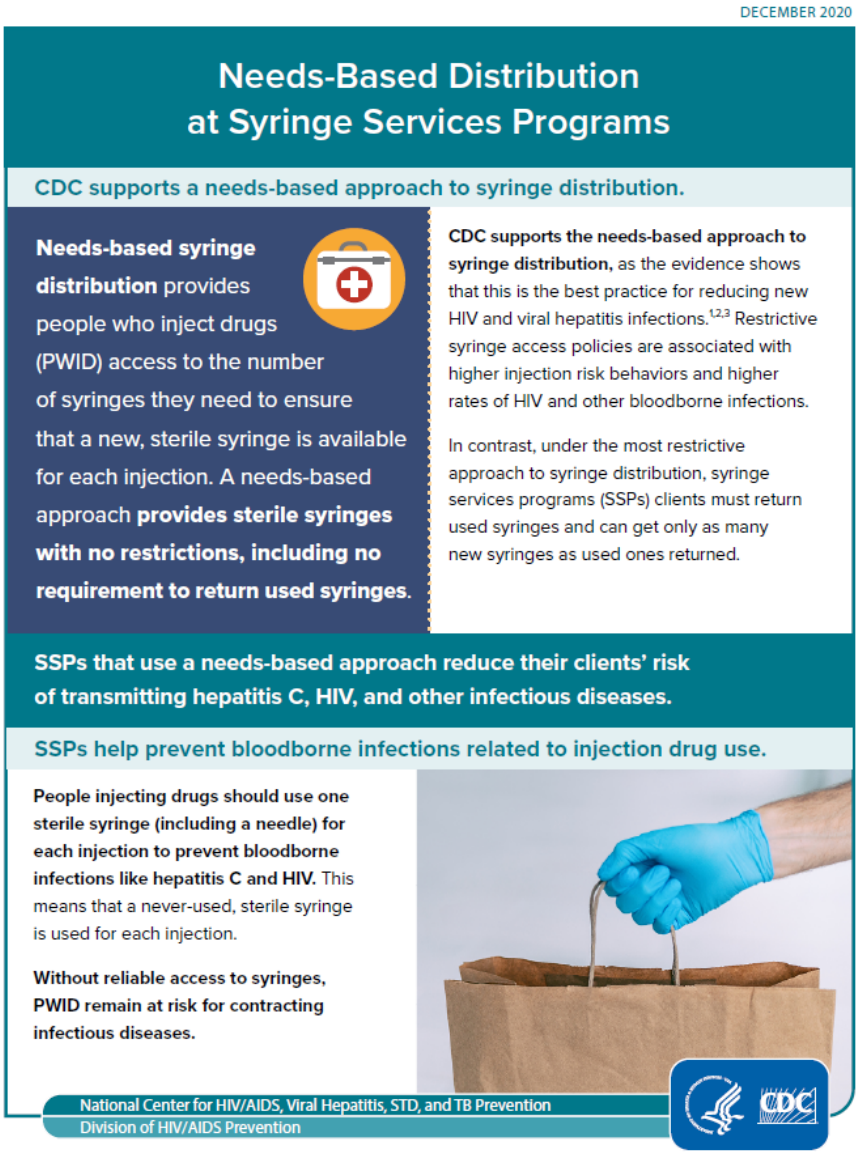
– *Community-Based SSP Director, California*

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 • Set location with predictable hours allows easier access	• Visibility can be a barrier due to concerns about stigma • A brick-and-mortar design can be costly to maintain • Transportation to site can be a barrier • 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 • Brings services to people rather than asking them to come to services	• Cost of unit • Limited expanded services able to be offered with some forms of outreach • 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 • May reach PWID who will not go to fixed-site SSPs	• Additional considerations include training and oversight of secondary exchangers, and legal framework. • 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 • Service delivery schedule is subject to weather or other unforeseen circumstances; keeping up with the delivery location and times might be challenging for participants • 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) • Flexibility for participants, given their current circumstances and context • Different levels of engagement options can ensure access to comprehensive services	• Potential for increased training and support for secondary exchangers • Maintenance of multiple service delivery models might increase program operating costs or staffing needs

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



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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5. New York City Department of Health and Mental Hygiene. Recommended Best Practices for Effective Syringe Exchange Programs in the United States. https://harmreduction.org/wp-content/uploads/2012/01/NYC-SAP-Consensus-Statement.pdf
6. Harm Reduction Coalition. Guide to Developing and Managing Syringe Access Programs, www.harmreduction.org
7. National Governor's Association. State Approaches to Addressing the Infectious Disease Consequences of the Opioid Epidemic. https://www.nga.org/wp-content/uploads/2019/05/NGA-Brief-State-Approaches-to-Addressing-Infectious-Disease-May-2019-002.pdf
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9. Centers for Disease Control and Prevention. Persons Who Inject Drugs. https://www.cdc.gov/pwid/disease-prevention.html
10. Open Society Foundations. Harm Reduction at Work: A Guide for Organizations Employing People Who Use Drugs. https://www.opensocietyfoundations.org/uploads/170e646d-bcc0-4370-96d7-7cf2822a1869/work-harmreduction-20110314.pdf
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Public Health
Prevent. Promote. Protect.
Portland Public Health Division
City of Portland, Health and Human Services Department

Community Sharps Container Map

City of Portland

Detailed Information:

Bayside Community Garden: Chestnut St. Container is behind Oxford St. Shelter.

Bayside Trail: Container located on the trail behind Trader Joe's.

Bramhall Fire Station: 784 Congress St. Containers are inside the station.

Congress Square Park: Congress St. Container attached to light pole.

East End Beach: Attached to Big Belly trash can at entrance to the beach.

Deering Oaks Park: Containers are located throughout the park:

- At the bridge, attached to Big Belly trash can
- At the Mellen St. entrance, attached to Big Belly trash can
- In the Rose Garden between State St. and High St., attached to light pole.
- At the porta-potty enclosure near Deering Ave.

Florence House: 190 Valley St. Containers are in common area bathrooms.

Harbor View Park: Tyng St. Container attached to Big Belly trash can.

India St. Pubic Health Center: 103 India St. The Needle Exchange Program is open Monday - Friday 9:00am - 4:30pm. Containers are also inside exam rooms.

Logan Place: 52 Frederic St. Containers are in medical areas and common area bathrooms.

Munjoy Hill Fire Station: 134 Congress St. Containers are inside the station.

Oxford St. Shelter: 203 Oxford St. Containers are in the courtyard.

Peppermint Park: Cumberland Ave. and Smith St. Container attached to Big Belly trash can.

Preble St. Resource Center: 5 Portland St. Containers are in day room bathrooms.

Stone Street Playground: Oxford St.and Stone St. Container attached to Big Belly trash can.

Western Prom: Container attached to Big Belly trash can.

Portland Maine | Yes. Google's good here.

Kristen Dow <kjd@portlandmaine.gov>

Re: Needle Exchange - Please share this comment with the HHS Committee

1 message

Kristen Dow <kjd@portlandmaine.gov> Tue, Mar 2, 2021 at 2:34 PM
To: Anne Pringle <oldmayor@maine.rr.com>
Cc: "Hipple, Ethan" <EHIPPLE@portlandmaine.gov>, "Marshall, Alex" <amarshall@portlandmaine.gov>, Adam Harr <ash@portlandmaine.gov>

Thank you, Anne. We will add your communication to the packet materials for Thursday's HHS & PS Committee workshop on this subject matter.

Kristen

Kristen Dow
Director of Health & Human Services
City of Portland
389 Congress Street
Portland, ME 04101
207-874-8633

On Tue, Mar 2, 2021 at 1:45 PM Anne Pringle <oldmayor@maine.rr.com> wrote:

> Councilors,
>
> I am writing to express support for the City retaining and reinforcing its policy of 1-for-1 needle exchanges, despite the criticism.
>
> For many years, unfortunately, Deering Oaks has been one of the "hot spots" for drug use and discarded needles. Parks staff installed a number of disposal boxes about four years years ago, hoping they would be used and reduce the risk to the public using the park. But I am told by Parks staff that the majority of used needles were found on the ground, discarded where the person shot up rather than walked over to the disposal boxes. We thought that perhaps more disposal boxes would address this behavior,
>
> So, when the situation got worse about two years ago, we did a walk-about with Parks managers and rangers to discuss locations for more boxes. I specifically asked if the 1-for-1 protocol was being followed and was assured that it was, because that is what the Needle Exchange staff told Parks staff. Now it appears from the recent program audit that that was not the case, which what we had long suspected. In my view, this is a misguided way for former needle exchange staff to operate a harm reduction program.
>
> That some shelter clients have 100 needles in their their possession indicates to me that they may be they selling their excess "free" exchange needles to support their addiction. Certainly not "harm reduction".
>
> Finally, when the huge influx of homeless people gravitated to Deering Oaks last summer, after Preble Street closed its food service operation and day room, there was

an **exponential** surge in the number of discarded needle, especially at the Edwards Lot, where they congregated (without masks and social distancing). The number of discarded needles went from something like 30-40 per **month** to hundreds per **week**! Deering Oaks had become an open-air shooting gallery. From my car, I personally witnessed a person injecting drugs in the neck of someone else. And a Rwandan genocide survivor, watching a baseball game, was run over and killed by a driver who likely bought and ingested drugs bought in the park.

Over time, diligent efforts by Kristen Dow's staff and community partners worked to address this problem in Deering Oaks, as well as focused enforcement by the police.

As we all know, drug abuse and addiction is a very serious problem. As one city resident, I am proud that the City is standing firm in the face of criticism from people whose actions may not be helping the situation, but actually causing more harm to those they serve. Having to go back to the City for 1-for-1 needle exchanges provides the opportunity for engagement and counseling. Providing multiple needles to active drug users is a missed opportunity for regular engagement and may well enable, rather than reduce, dangerous behavior.

Anne Pringle

West End

Portland Maine Yes. Google's good here.

Adam Harr <ash@portlandmaine.gov>

Re: Letter for the Members of the Health and Human Services Committee

Kristen Dow <kjd@portlandmaine.gov> Wed, Mar 3, 2021 at 7:51 PM
To: mariegray263@aol.com
Cc: Adam Harr <ash@portlandmaine.gov>

Thank you, Marie. We will add your communication to the packet materials for Thursday's HHS & PS Committee workshop on this subject matter.

Sincerely,
Kristen

On Wed, Mar 3, 2021 at 5:44 PM <mariegray263@aol.com> wrote:

Kristen, would you please forward this letter to the members of the Health and Human Services Committee for their consideration. I have also pasted it onto this email.
Thank you very much.

263 State Street
Portland, Maine 04101

March 3, 2021

Members of the Health and Human Services Committee of the Portland City Council
Portland, Maine
Dear Councilors:

I am writing in support of requiring individuals who are assisted by the Portland Needle Exchange return a needle in order to obtain a fresh one. As a long time resident of the Parkside neighborhood and an avid walker, the issue of randomly discarded needled is major concern. Unfortunately, it is almost impossible to take a walk through the neighborhood and not see several discarded needles. .Also, discarded needles are routinely reported on *FixItPortland.*

Of special concern is the number of discarded needles left in Deering Oaks. In our densely populated neighborhood, with little or no private yard space, this wonderful public park serves as our community back yard for individuals and families. For me, randomly discarded needles violates what I have called, *The Twelve Year old Rule",* namely:

A**ny** ***12 year old in the City of Portland should be able to safely use any of Portland's public parks at 2:30 in the afternoon***.

The activities last summer in the Edwards lot of Deering Oaks violated this rule to a degree that was previously unimaginable.

I think we can all agree that discarded needles are unsafe for everyone. Requiring a user to return a needle in order to obtain a fresh one is a reasonable condition.

Thank you for your consideration.

Very truly yours,
Marie L. Gray

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Kristen Dow
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City of Portland
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Portland, ME 04101
207-874-8633