Harm Reduction Subcommittee

Syringe Service Program Survey Results

Executive Summary

Key Takeaways

- In late May and early June 2021, syringe service programs (SSPs) in Ohio were surveyed about various aspects their programming and barriers.
- Of the 90 individual respondents who were involved in running a harm reduction program, only 34 reported their program as being an SSP (distributing sterile syringes).
- Offering **hepatitis C virus (HCV) testing** continues to be a large challenge for SSPs, with the leading barriers being staffing and lack of funding. One third of responding SSPs stated no HCV testing was offered.
- A one-for-one syringe exchange model was the most common service model reported by SSPs in this sample, **despite not being recommended by the CDC.** A needs-based model is considered best-practice.
- The leading **administrative barriers** SSPs face were reported as data collection, followed by data reporting.

Background

Syringe services programs (SSPs) are community-based prevention programs that can provide a range of services, including linkage to substance use disorder treatment; access to and disposal of sterile syringes and injection equipment; other harm reduction supplies like naloxone; and vaccination, testing, and linkage to care and treatment for infectious diseases (CDC, 2019) [2-3]. SSPs continue to struggle in Ohio despite evidence that SSPs protect the public and first responders, save lives, reduce the impact of drug use on the community, and help those experiencing substance use disorder get the support needed to regain health (CDC, 2019). According to a preliminary report, 2020 had the highest number of unintentional overdoses deaths in Ohio history (5,018 as of July 6, 2021).[1]

Because SSPs are a highly effective way to help prevent harm and death from drug use, the Ohio Overdose Prevention Network's (Ohio OPN) Harm Reduction Subcommittee (HRSC) Syringe Service Program Workgroup developed a survey to learn more about SSPs in Ohio. Ohio OPN is an action group of the Ohio Injury Prevention Partnership (OIPP), and the HRSC aims to promote harm reduction practices and policies. The SSP Survey was sent out with another survey about the sustainability of harm reduction services; participants could answer both surveys.

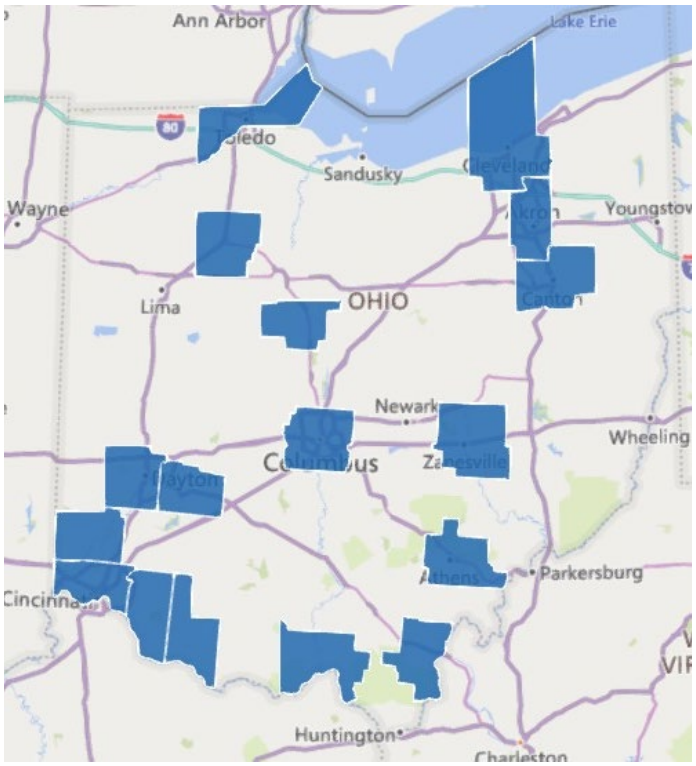
Methods

On May 24th, 2021, the survey was sent to members of Ohio OPN, Project DAWN programs, and other known harm reduction contacts via REDCap. Recipients were encouraged to share the link with those who might not have received it from the state contact lists. Anyone involved in running a harm reduction program in Ohio was eligible to participate, and responses were anonymous unless an email was volunteered at the end of the survey. The survey closed June 4th, 2021. Only respondents who indicated distributing sterile syringes were presented with the SSP Survey and were included in this analysis.

Results

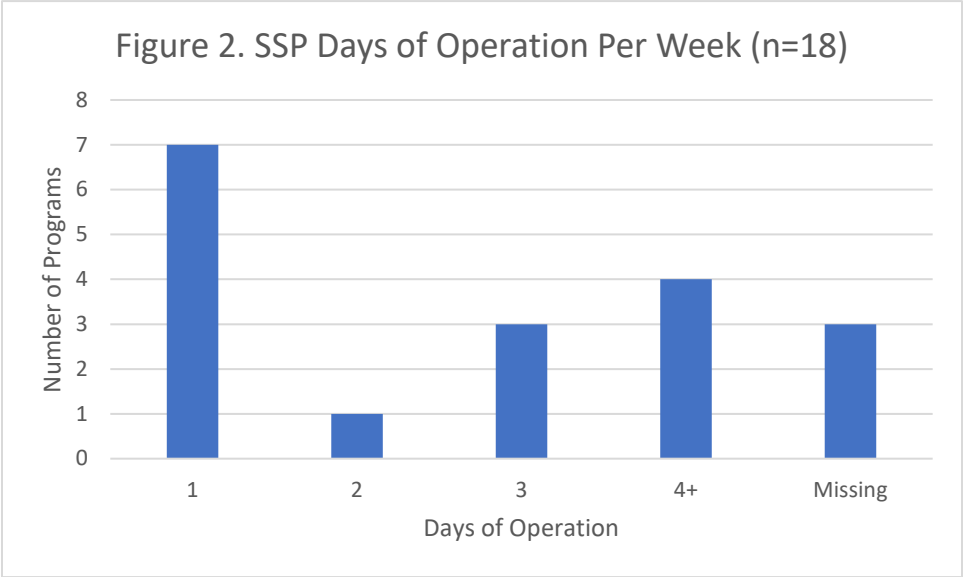
The SSP Survey received completed responses from 34 individuals representing 18 unique (unduplicated) SSPs in Ohio. Programs were based out of 17 counties in Ohio (Figure 1).

Figure 1. Counties of Responding SSPs



SSP Operation Schedule

Of the 18 responding programs, 39% reported operating their SSP one day a week while 44% operated 2 or more days a week (Figure 2).



Services Provided via SSPs

When asked about services provided, 100% of SSPs (n=18) reported naloxone is offered, followed by 94.4% offering linkage to care and 83.3% offering Fentanyl Test Strips, among other services (Table 1).

While each SSP offers services in a different capacity, listed in the table below are basic descriptions of these services. In no way does the below description completely encompass what might be available through the SSPs who responded that these services were provided.

Table 1. SSP Services Provided (n=18)

Survey results		Description of services
Naloxone	100.0%	Naloxone (commonly known as NARCAN®) is a medication that can reverse an overdose caused by an opioid drug (heroin, illicit fentanyl, or prescription pain medications). When administered during an overdose, naloxone blocks the effects of opioids on the brain and quickly restores breathing. (ODH, 2021)[4]
Sterile Syringes	100.0%	Sterile syringes, or needles, are used to inject substances and come in a variety of gauges and sizes.
Linkage to care (referrals)	94.4%	Linkage to care allows clients to be provided alternate care that might not be available through a certain agency or program (i.e., a warm hand-off to HIV treatment)
Fentanyl test strips (FTS)	83.3%	FTS can be used to determine if drugs have been mixed or cut with fentanyl, providing people who use drugs and communities with important information about fentanyl in the illicit drug supply so they can take steps to reduce their risk of overdose. (CDC,2021)[6]
STI/HIV/Hepatitis prevention services	77.8%	Sexually transmitted infection prevention aims to reduce the prevalence of STIs by interrupting their transmission through utilizing education and providing resources like condoms. (CDC, 2021)[5]
Basic resources	66.7%	Basic resources could include assistance with food, housing, transportation, personal hygiene, etc.
Peer support services	61.1%	Peer support workers are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. (SAMHSA, 2021)[7]
Safe smoking kits	22.2%	Safe smoking supplies provide safe and sterile supplies to people who use drugs (i.e., clean smoking pipe, plastic hose, alcohol swabs, foils, etc.)
Safe snorting kits	16.7%	Safe snorting supplies provide safe and sterile supplies to people who use drugs (i.e., clean straws and occasionally an object like a razor blade which could be used to chop and break up large particles before using)
Other resources	22.2%	Below are the other resources that respondents noted within the SSP survey results: • *Wound care.* • *Snacks, water, sterile water, antibiotic ointment, alcohol pads, cottons/filters, tourniquets, cookers, pregnancy tests.* • *Drug treatment, social service, health and mental health referrals; Distribution of condoms and lube; offer pregnancy tests; assist with Medicaid enrollment; Wound care; information on gambling addiction.*

Syringe Transaction Model

Participants were asked about the type of syringe transaction model their program offered (Table 2). Of the responding SSPs (n=18), the most reported model was one-for-one exchange (44.4%), followed by exchange (27.8%), and needs-based (11.1%), with 16.7% not offering a response. Below is a basic description of the traditional service models for SSPs as well as the Center for Disease Control and Prevention (CDC) recommendation and guidance.

Table 2. Syringe Transaction Model (n=18)

Survey Results		Description of Services
One-for-one	44.4%	Sterile syringes are provided in exchange for the same number of used syringes. According to the CDC, a one-for-one model is defined as *"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)."* [8]
Exchange	27.8%	Sterile syringes are provided in exchange for any number of used syringes. According to the CDC, an exchange model is defined as *"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)."* [8]
Needs-based	16.7%	Sterile syringes are provided based on need, not requiring the return of used syringes. According to the CDC, a needs-based model is defined as *"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)."* [8]

Testing Services

Human immunodeficiency virus (HIV) and Hepatitis C (HCV):

Offering HIV and HCV testing services through SSPs is proven to be effective in decreasing the prevalence of blood-borne pathogens and other infectious diseases as well as increase treatment rates (CDC, 2021.)[3] Respondents were asked about testing services provided. Almost 28% of participants responded that HIV testing (Table 3) is available at every shift. On the other hand, the next highest reported testing frequencies were no HIV testing offered at all and testing less than once a week (16.7% for each).

Respondents were also asked about HCV testing. One third of participants reported that HCV testing (Table 4) is not available at all (33.3%). Only 16.7% of programs offered HCV testing at every shift, while 33.3% offered it between less than once a week to more than once a week (but not every shift)."

Table 3. HIV Testing Frequency (n=18)

No testing	16.7%
Less than once/week	16.7%
Once/week	11.1%
More than once/week	11.1%
Every shift	27.8%
No Response	16.7%

Table 4. HCV Testing Frequency (n=18)

No testing	33.3%
Less than once/week	11.1%
Once/week	11.1%
More than once/week	11.1%
Every shift	16.7%
No Response	16.7%

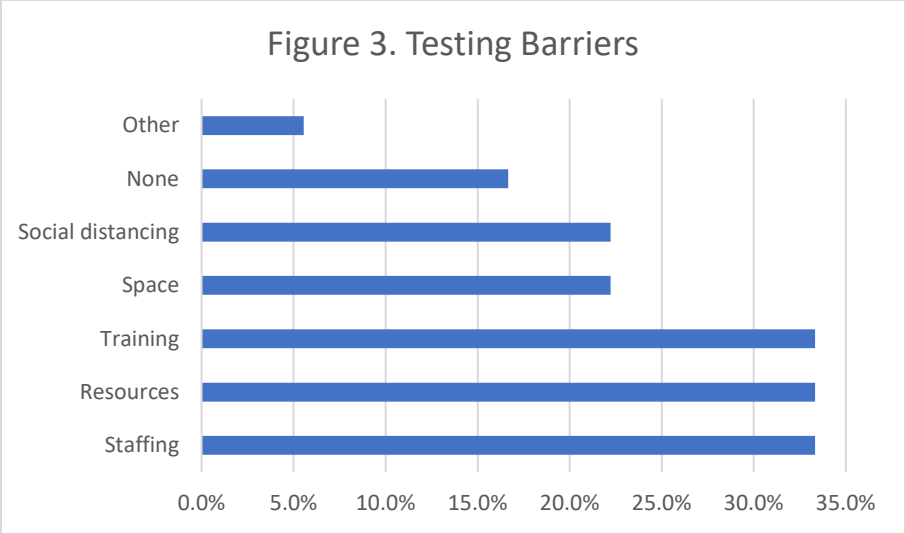
Some respondents also left comments regarding offering testing services, below are comments that offered more insight as to why testing services were or were not offered:

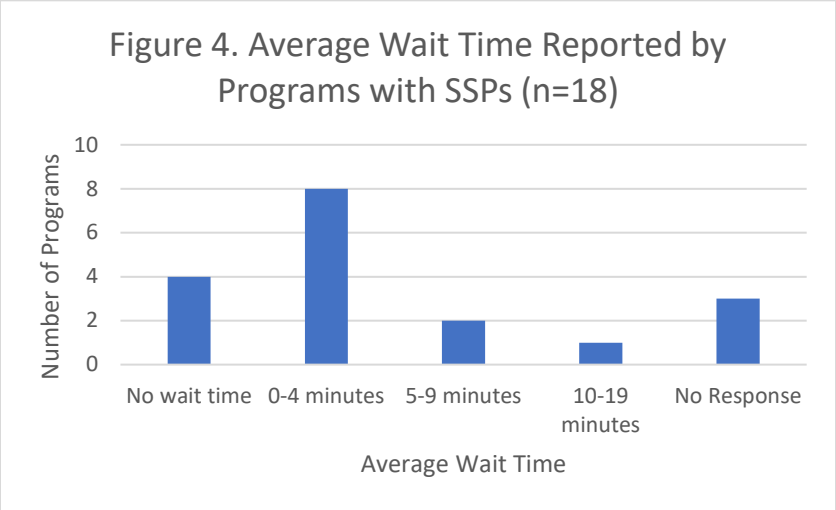
- *We have the capability to [provide testing], but not the funding to purchase test kits.*
- *We did offer [testing] at every shift but we currently do not have HCV kits.*
- *HCV testing is not being conducted at this time due to COVID. We are working on a set up so that we can conclude with testing safely.*

Barriers and Challenges

Testing barriers

Respondents were asked about barriers to HIV and HCV testing (Figure 3) and the leading barriers were staffing, resources, and training (33.3% for each), followed by space and social distancing (22.2% for each).



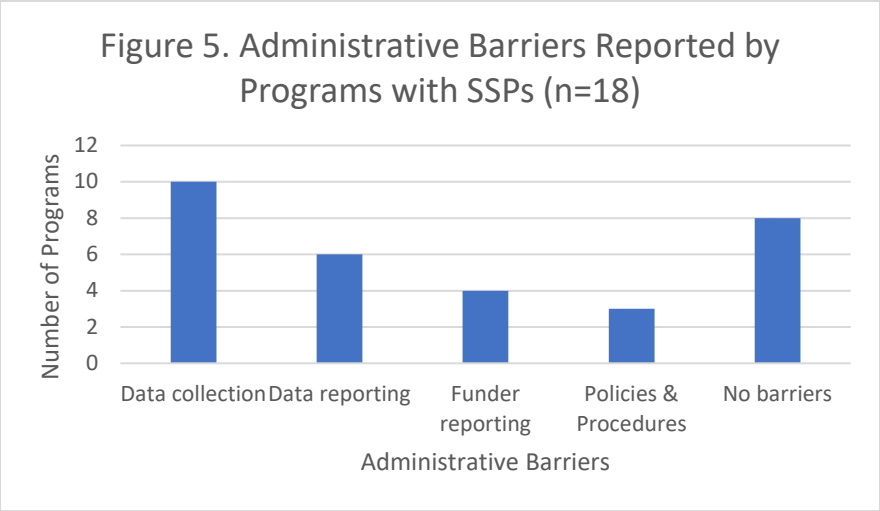


Client wait time

Respondents were asked about average wait time that clients face (time from when participant arrives at program location to when they interact with services) (Figure 4) and 44% of programs reported a wait time of 0-4 minutes, followed by no wait time (22.2%).

Administrative Barriers

Lastly, respondents reported on administrative barriers (Figure 5). Of the barriers, data collection was identified as the largest barrier (55.6%), followed by no barriers (44.4%), and data reporting (33.3%).



Funding

As part of the sustainability of harm reduction services survey, respondents were asked how their program obtains or purchases sterile syringes. The 18 responding SSPs reported obtaining syringes from a variety of sources (Table 5). The leading three funding sources were the Ohio Department of Health (ODH) GRF Harm Reduction Surge Materials funds, donations, and organizational general funds (all reported by 27.8% of programs).

Table 5. Purchasing Sterile Syringes for Distribution (n=18)	
ODH GRF Harm Reduction Surge Materials funds	27.8%
Donations	27.8%
Your organization's general funds	27.8%
County Mental Health and Addiction Recovery (MHAR) or Alcohol, Drug Addiction and Mental Health (ADAMH) board	22.2%
Buyers clubs (e.g., NASEN, DanceSafe)	22.2%
Local/county foundation	16.7%
Other organizations within community/other funding	11.1%
Crowd sourcing and mutual aid (e.g., social media resource sharing, transfers from other programs)	5.6%
Fundraising events	0.00%
NEXT Distro	0.00%
Missing	0.00%

Additional Feedback

The end of the survey offered a chance for participants to provide additional thoughts. Two SSP respondents provided the following feedback.

- *"Funding for syringes is currently our largest hurdle. Since we cannot purchase syringes with federal grant funds, we must write grants to other funders. While the number of SSPs in Ohio and the nation have increased, this also means that the funders are more competitive and often exclude governmental operations. Having a secured and sustainable path for syringe purchasing is essential for the continuation of the program."*
- *"Making IM (Intramuscular) naloxone available to Project DAWN, recognition of SSP and harm reduction programs as medically necessary services potentially fundable through other state funding channels like Medicaid."*

Limitations

The results should be considered with some limitations in mind. First, the sample may not be representative of all syringe service programs in Ohio. Many programs were managed by local health departments (LHDs), which have different experiences compared to other agency types like non-profit, grass-root, and "underground" programs. The latter were likely underrepresented due to not being on state contact lists and because of perceived confidentiality concerns. The HRSC tried to address this by making the survey anonymous unless participants volunteered an email address, and by encouraging sharing of the survey to better reach unknown programs.

In addition, because the survey was open to anyone involved in running an SSP, some individual respondents (n=34) worked for the same program. Because some questions would be more meaningful when considered by unique programs, responses that were highly likely to be from the same organization were combined and unduplicated (resulting in n=18). Responses were only combined if 1) they had matching organizational email domains OR 2) the agency type was a LHD, and that county only had one LHD. If participants did not volunteer an email or fall into the second category, it is possible they were incorrectly considered unique programs. However, results did not vary greatly between these two datasets.

Conclusion

The syringe service programs in the survey sample reported a range of services offered, challenges and barriers, and experiences. Every program reported providing naloxone via the SSP but other services like testing services (HIV and HCV) were somewhat lacking. The respondents report the structure of Ohio SSPs were mostly a one-for-one exchange, which is not best practice. This could be due to lack of community or leadership buy-in for an exchange type like needs-based. In addition, one conclusion is that of the 100 respondents who completed this survey, less than a third of those were from programs who operate an SSP, pointing to how few SSPs there are in Ohio. Lastly, results show that many programs rely on less sustainable funding sources like donations, which was reported as often as ODH Harm Reduction funds and agency general funds.

Reference List

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