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Overview of Syringe Exchange Operations in Washington State

This report provides a descriptive overview of the 18 syringe exchange programs (SEP) that participated in the 2015 Washington State Drug Injector Health Survey. The survey was conducted in King County by Public Health – Seattle & King County and coordinated across other sites statewide by the Center for Opioid Safety Education (located within the Alcohol & Drug Abuse Institute, University of Washington), with supporting funds from the Washington State Division of Behavioral Health and Recovery.

The information in this report was gathered from staff interviews and observations conducted during visits to all 18 participating programs. This report documents the various models by which syringe exchange services are delivered and how policies, operational approaches, and funding compare across programs. It does not critique any one program's model or effectiveness. Rather, the goal of this report is to help staff, volunteers and managers of SEPs across the state learn more *about* each other and *from* each other to improve syringe exchange operations.

I. Description of Participating Syringe Exchange Programs

Eighteen syringe exchange programs from 17 counties (2 SEPs in Kitsap County) administered the health survey to their clients and were therefore included in this operations review. Thirteen of these SEPs are operated by health departments and 5 by community-based organizations (CBO) or individuals. Together, these programs provide exchange services at 23 fixed site locations and through 5 mobile/delivery programs and account for approximately 80% of total syringe exchange volume for the state.

Table 1 describes the type and location of the exchange programs that participated in the survey. While these SEPs provide the majority of syringe exchange services in WA State, there are other organizations or groups that also conduct syringe exchange. Several tribal communities conduct syringe exchange on tribal land (openly or underground) and a few grassroots/volunteer exchanges operate independently or as "secondary exchange" branches of larger exchanges. In addition, many social service providers (e.g., shelters, youth outreach programs) also exchange syringes for their clients.

Table 1. Description of participating syringe exchange programs

Syringe exchange program	Site type/location	Operated by	Established
Clallam County *Port Angeles*	inside health department	health department	2000
Clark County *Vancouver*	shares a building with another CBO	health department	1990
Cowlitz County *Kelso*	room inside drug treatment center	health department	2000
Grays Harbor County *Aberdeen*	RV parks in empty lot	health department	2004
Jefferson County *Port Townsend*	inside health department	health department	2000
King County[1] *Seattle*	- Downtown: shares building with other Public Health services - Capitol Hill: inside an HIV/AIDS CBO (during its off- hours) - van for south county delivery	health department	1989
Kitsap County *Bremerton*	inside health department	health department	1998
Ostrich Bay *Bremerton*	private residence	individual, secondary exchange	1997
Kittitas County *Ellensburg*	room inside church complex	health department	2009
Pierce County *Tacoma*	- van parks on city street corner on 14th St - van parks in health department parking lot on 38th St -van does delivery	Point Defiance AIDS Project, CBO	1988
Skagit County *Mt Vernon*	van parks at various sites in 4 towns	Phoenix Recovery, drug treatment agency	2015
Snohomish County *Everett*	-shares a building with other CBOs -van parks at various sites in 3 towns and does delivery	Pacific Treatment Alternatives, CBO	1994
Spokane County *Spokane*	inside health department	health department	1989
Thurston County *Olympia*	-shares a building with other CBOs -van does delivery	health department	1993
Walla Walla County *Walla Walla*	inside the CBO office	Blue Mountain Heart to Heart, CBO	1997
Whatcom County *Bellingham*	inside health department	health department	1999
Yakima County *Yakima*	RV parks in empty lot	health department	1992
_____ County *Eastern WA*	inside health department	health department	2010

[1] *Another known syringe exchange program based in King County declined to participate in the survey.*

II. Operating Capacity and Exchange Levels

Table 2 shows total operating capacity and levels of syringe exchange activity (2014) for participating SEPs. (Note that exchange encounters are the number of total visits made to the exchange, not the unduplicated number of clients served. Since many clients use an exchange frequently, this number reflects duplicated numbers of clients.)

Table 2. 2014 operating capacity and syringe exchange activity

Syringe exchange program	Site location	# Days open/week	Total hours/week	# Syringes exchanged	# Exchange encounters
Seattle/King	Downtown	6	22	2,831,887	22,748
	Capitol Hill	6	12		
	Delivery	3	12		
Pierce	Van site on 14th St	4	16	1,544,006	9,558
	Van site on 38th St	3	24		
	Delivery	4	24		
Clark		3	8	1,200,000	6,000
Snohomish	Outreach center	3	12-14	968,278	6,835
	Delivery	1	5*		
Thurston	Site	2	10	942,100	1,997
	Delivery	1	5.5		
Spokane		5	12	902,585	8,367
Ostrich Bay		5	15*	869,196	3,040
Grays Harbor		1	4	750,000	6,000
Cowlitz		1	3	418,155	1,748
Clallam		1	2.5	275,000	865
Whatcom		1	2.75	222,183	3,273
Skagit	Began April 2015 (see note below)				
Walla Walla		4	7.5/day, drop in +	120,019	1,457
Yakima		1	2	85,593	1,409
Kitsap		3	12	45,069	250
Jefferson		5	8/day, drop in +	42,809	350
Kittitas		1	2.5	2,633	41
____County		1	8/day, drop in +	2,000	100
TOTAL for 2014				**11,221,513 syringes**	**75,038 encounters**

Skagit County did not have a needle exchange in 2014. Phoenix Recovery began mobile exchange in Skagit County in April, 2015. In the first 14 weeks they exchanged 53,510 syringes in 237 encounters. As exchange volumes grow weekly, the program is likely to exchange at least 300,000 syringes in over 900 encounters in 2015.

** Additional delivery hours as needed.*

+ Clients can drop-in anytime during routine business hours.

Although the table above lists SEPs by the number of syringes they exchanged, syringe volume alone can be a limited and somewhat misleading way to compare SEPs with each other. Many factors impact syringe volumes such as exchange policy (i.e., 1 for 1 or unlimited distribution) and the number of hours an SEP can operate, both of which are usually limited by budget and/or the local political climate. The number of secondary exchangers, those who pick up syringes for others, varies across places and can be influenced by many factors including the setting of the exchange, hours of operation, and typical travel time. These and other factors vary across SEPs and can even differ between neighboring counties.

Syringe volume is also not a reliable indicator of how much injection drug use or demand for syringe exchange there is in a community. For example, many injectors legally purchase some or all of their syringes at pharmacies. It is also does not indicate how effectively a particular program provides syringe exchange or meets the overall need for clean syringes and other health services of its clients. The general scope or impact of a syringe exchange program can also be measured by the number of individuals it serves, its geographic reach, or the number of auxiliary support services it provides.

III. Service Models

A. Exchange Policy[2]

All programs operate on the principle "no one leaves without a clean syringe." Yet *how* syringes are distributed differs across exchanges:

- Three SEPs have a 1-for-1 policy (see side box).
- Eight SEPs have a 1-for-1 policy but generally round up by tens without a limit.
- Five SEPs have the same "round up" 1-for-1 policy but cap the total amount per exchange at either 200, 400, 500, or 1000 syringes due to budget constraints.
- One exchange uses a "discretionary distribution" model where clients can get more syringes than they bring in, although how much is up to staff discretion based on the client's regularity, size of injecting network, etc.
- One exchange has an unlimited distribution policy (i.e., "get what you need").
- Eight SEPs will give a starter/emergency pack (e.g., 2, 5, 10, or 20 syringes) to those who have no used syringes to exchange.

"We are strict 1-1 for new people but will round up for our regulars."

"We won't just give out syringes. But if someone comes in without any, we'll ask other clients if they might "kick down" a few to the person who doesn't have any. This way everyone leaves with some cleans and we adhere to our mandate to only conduct 1-for-1 exchange."

"We flex the 1-1 policy by letting clients bank syringes in their account for a rainy day. New clients can get a starter kit."

[2] There are different philosophical, public health and economic perspectives about syringe exchange policies. Some endorse a strict 1:1 policy to encourage injectors to dispose of syringes properly instead of in the trash or on the ground. This reduces accidental exposures in the community and makes them unavailable for other injectors to use. Others feel this policy is too restrictive and doesn't give injectors enough syringes to use a new sterile syringe each time they inject, which minimizes vein damage and infection. Therefore, they support a model of flexible distribution ("get what you need"). See for more details: http://dx.doi.org/10.2105%2FAJPH.2009.178467

While staff at most SEPS expressed a personal preference for a looser "get what you need" approach, their actual policy or practice has to balance multiple factors such as:

- Political environment.
- Amount of money available for syringes.
- Limits on how many syringes they can get from the Department of Health (DOH).
- How many days their budget allows them to operate. For example, a once-a-week exchange may give out more syringes in order to keep people supplied until the following week. A daily exchange might stay with 1-for-1.
- Funding mandates. For example, an SEP that receives environmental health dollars for safe syringe disposal may encourage a firmer 1-1 policy.

B. Syringes and Injection Supplies

Most syringe exchange programs stock a similar inventory of syringes and try to offer some choice, as clients need different sizes to inject different drugs or to minimize vein damage (Table 3).

Table 3. Type and size of syringes available at SEPs

Syringe type and size	How many SEPs give it out	Syringe type and size	How many SEPs give it out
Easy Touch 28 1cc	15	BD 29 1cc	1
Easy Touch 28 ½ cc	5	BD 29 ½ cc	1
Easy Touch 29/1cc	5	BD 30 1cc	1
Easy Touch 27 1cc	5	Terumo 28 1cc	1
Easy Touch 30 1cc	5	Terumo 28 ½ cc	1
BD 28 1cc	3		
BD 28 ½ cc	2		

Four SEPs accept donated syringes of various sizes from community members. Five exchanges have some type of 3cc syringe available for intramuscular injection of drugs or hormones. Other exchanges do not carry 3cc syringes due to budget limitations, lack of client demand, or concerns about promoting riskier injection practices such as muscling and femoral injecting.

All 18 syringe exchange programs distribute alcohol wipes, tourniquets, cookers, cottons, and male condoms. Other injection-related supplies are also distributed (Table 4).

Table 4. Supplies distributed at syringe exchange programs

Supply item	How many SEPs give it out	The following items were found at only one SEP (not the same SEP for all items):
alcohol wipes, tourniquets, cookers, cottons, male condoms	18	• epsom salt • potters clay for wound care • eyeglasses • empty 3oz bottles for injecting water • saline • socks • straws • twist ties (in place of paper clips)
water vials, packets	13	
lubricant	13	
personal size sharps box	13	
paper clips	10	
wound care kits	9	
hygiene supplies	9	
female condoms	8	
band aids, antibiotic cream	8	
hand sanitizer	4	
snacks, cookies	2	
bleach for cleaning own syringes	2	
latex gloves	3	

Other differences to note regarding injection equipment:

- Two-thirds of SEPs (12/18) distribute loose (not pre-bagged) quantities of injection equipment, and most of those programs allow clients to "self-serve" whatever amount of supplies they need. Four of these SEPS, however, only permit staff to handle the supplies for better inventory and infection control (with MRSA a particular concern).
- For similar infection control reasons, five SEPs package some or all of their equipment into pre-assembled ziplock kits. Three SEPS give out *only* pre-made kits to ration their limited inventory.
- Two syringe exchange programs that have no budget to distribute biohazard sharps containers improvise by collecting used, clean plastic containers (e.g., laundry detergent, milk jugs, soda bottles) from staff/volunteers to hand out to exchange clients.

C. Referrals and On-site Services

Each syringe exchange program makes referrals to local services, most frequently to drug treatment, primary health/wound care, and housing. However, not all SEPs document these referrals or do so in the same way. For example, some SEPS record referrals per client encounter while others simply tally mark referral categories throughout the exchange shift. SEPs that report their activity in the WA State SHARE database (or had previously) additionally rate each referral as high, medium, or low intensity.

Notably, staff from at least half of the SEPS reported they had stopped referring clients to particular services because exchange clients were treated poorly and/or had significant difficulty getting the actual service. Staff at nearly every SEP expressed a desire for more treatment options and lower-threshold treatment options for their clients (e.g., fewer rules, steps or time).

"Every week at least 1 client will ask for help to quit heroin. And I have to say there are no methadone slots, the bupe docs are all full, or the other options just suck. It's the only part of my job that ever gets to me-the constant frustration I carry."

"We're all trained and experienced here to do HIV testing and clients still ask for it, but the state won't give us test kits anymore. Does Scott County, Indiana teach us nothing?"

Beyond referrals, the majority of SEPS also offer some type of regular, on-site support service to clients (Table 5).

Table 5. Support services available at syringe exchange programs

On-site service	**# SEPS where available**
HIV testing (weekly, monthly, to quarterly)	11
Hepatitis C testing (weekly, monthly or quarterly)	11
Wound care	7
Case management or intake/assessment for drug treatment	7
Apple Health enrollment	6
Vaccinations	5
Substance use counseling by a Chemical Dependency Counselor	5
STD testing	3
Family planning/emergency contraception	2
No direct services available on site (i.e., referrals only)	3

Most SEPS expressed concern about dwindling funds for "essential services" like HIV and hepatitis C testing or how they would sustain or increase funding for services to meet client demand (e.g., wound care, facilitated access to drug treatment).

> *"We (syringe exchanges) are best positioned to provide services for drug injectors. The state should be giving us MORE money, not less, so we could build up these services. I think we're missing a lot of opportunities. But is that the state's fault or is it OUR fault for not being more organized and vocal about what we do?"*

IV. Overdose Education and Naloxone

Staff at all syringe exchange programs report they regularly provide overdose prevention education via face-to-face conversations with clients. Eight SEPs also distribute print information on overdose prevention and four SEPs also use video for education.

At the time of the survey, there were six syringe exchange programs distributing naloxone:

Clark (intramuscular)
Ostrich Bay (intramuscular)
King (intranasal)
Snohomish (intramuscular)
Kittitas (intranasal)
Walla Walla (intranasal)

Five of these programs regularly record information on distribution, refills, and reported reversals. Three collect little or no consistent data on their naloxone distribution efforts.

V. Data Collection

The one area in which syringe exchange programs vary most notably is in data collection—which data are collected and when and how data are collected.

A. Data Collection Approaches

Four SEPs enter data during the exchange visit directly into a computer while all other SEPs collect data on paper (lack of Internet connection can limit computer use in mobile and some fixed sites). One half of the exchanges (9/18) then enter data into the DOH SHARE database, which serves as their only database. The remaining exchanges use their own database.

Most programs record client and/or exchange activity data by individual encounter. Two exchanges, however, simply tally mark demographic and exchange activity categories throughout the shift, in which case the data are not linked to a particular encounter or individual.

"We'd love to get a better database. But we don't have the money or staff to create one. I feel like we're operating in the Dark Ages."

About one-third (7/18) of the syringe exchange programs use some method to link each encounter to a specific client which enhances their ability to track the number of unduplicated clients they serve. Four SEPs assign an anonymous unique ID number (from components like birth month, mother's initials, etc.) to each client when he/she uses the exchange for the first time. One SEP collects a client's initials at each visit and another SEP collects the full name of each client.

Several SEP staff were surprised to learn that some SEPs assign client IDs and assumed it was only smaller, rural exchanges who did so. However, the SEPs that use this client-specific approach to data collection vary in their size, use of technology, and rural/urban location.

B. Exchange Activity Data

All syringe exchange programs record the number of syringes they distribute and most SEPs record additional exchange activity data (Table 6). Most SEPs record this by individual client encounter while two SEPs simply record a running total (tally marks) during each shift.

Table 6. Encounter activity

Data	**How many SEPs record it**	**Notes:**
Syringes brought in	7	
Syringes given	18	
Client came in with 0 to exchange	1	• as worded on data collection form
Syringes collected without exchange	1	• as worded on data collection form
How many are you exchanging for?	8	• 1 SEP also asks the age and gender of each person being exchanged for.
Supplies given(type and/or amount)	14	
Referrals given (type and/or amount)	13	• 7 SEPs rate each referral as "low, medium, or high intensity" as done in the SHARE system. • 1 SEP records (Y/N) if a client has followed up on a previous referral.
# wound care kits given	7	
# condoms given	6	
# and size of sharps container given	2	
# HIV or hep C tests given	3	
Health education provided (Y/N)	1	

C. Client Information

To collect client demographics, SEPs generally following one of the following approaches:

1. Demographics at first visit

Five SEPs conduct a brief "intake" with first-time clients to collect demographic and health data. Some examples of health questions include:

- How long have you been injecting?
- Do you need help with ___? (followed by checklist of referral options)
- Do you have or have you had unprotected sex?
- Have you been vaccinated for hepatitis A or B?
- What drug do you use if you can't get your drug of choice?

2. Demographics at each encounter

The majority of SEPs collect demographics on each client each time he/she comes to the exchange, although the data collected vary by site (see tables below).

3. Demographics at set intervals

Due to its high volume of encounters, King County does not collect demographic data during exchange encounters. Instead, it surveys every client during a designated two-week period, every other year, to estimate client demographics.

D. Types of Data Collected

Tables 7a, 7b, and 7c show the range of data that is collected across the 18 exchanges and how differently that data can be framed.

Table 7a. Client demographics

Demographics Data	**How many SEPs record it**	**Notes:**
Client age	16	• 10 SEPs record by SHARE age categories (0-19, 20-29, 30+). • 6 SEPs record exact age or date of birth.
Client gender	15	• 3 SEPs do not include a transgender option. • 2 SEPs use the options "Male-Female-Other".
Race/ethnicity	14	
Residence	9	• 7 SEPs record zip code. 2 SEPs record name of town. No one tracks homelessness.
Main injecting drug/ drug of choice	7	
HIV risk (based on SHARE categories)	5	e.g., IDU, MSM, MSM/IDU, pregnant woman, heterosexual risk

Table 7b. Syringe use and sharing data

Actual questions on data forms	How many SEPs record it
How many times did you use your *last* syringe?	4
Have you shared a needle in the last 30 days?	4
Have you shared any works in the last 30 days?	3
How many times was *each* syringe used?	1
Have you reused a syringe (Y/N)?	1
How many times in the last 30 days have you shared a needle?	1
How many times in the last 30 days have you shared any works?	1

Table 7c. Health data

Actual questions on data forms	How many SEPs record it
When was your last HIV test?	3
When was your last hep C test?	3
Have you ever been tested for HIV? hep C?	2
Self-disclosed if either HIV-positive, hep C-positive, or pregnant	2
Would you like drug treatment info on this visit? (Y/N)	1
What is your level of interest in drug treatment (low, some, ready to talk)?	1

Overall, data collection was a robust topic of conversation at all site visits. Staff and volunteers regularly asked questions such as:

- *Is there something we <u>should</u> be asking?*
- *Why would you assign or use client ID numbers? Doesn't that make clients nervous?*
- *Should we be collecting the same data as everyone else?*
- *Can someone help us get a better database?*
- *We've always collected information this way. Is it relevant anymore?*

VI. Marketing and Community Relations

Due to local political opposition, only one syringe exchange program (in a rural county) purposely avoids any publicity and relies solely on word of mouth to promote its services. All other exchanges are promoted on their local health department or CBO website. Several SEPs also distribute wallet cards, posters, and fliers to advertise exchange location, hours and services. Two SEPs have their own Facebook page. Pierce County AIDS Project puts out a monthly client newsletter called "Let's Talk" to communicate health alerts, healthier injection tips, and local resources.

Staff at each syringe exchange attend regular community meetings or service provider work groups to be an ambassador for syringe exchange or to advocate on behalf of syringe exchange clients (Table 8). Two SEPs, however, limit their participation to internal health department meetings so they can operate "off the radar" in politically conservative areas.

In addition to professional networking, a handful of syringe programs regularly sponsor high-visibility "syringe pick-up" events at public parks or city blocks to promote a favorable public image of their syringe exchange.

Everyone reported positive relationships with local law enforcement with no or minimal police presence near their exchange locations. Only rarely have police engaged clients near exchange, usually due to a client's inappropriate or illegal activity. Most SEP staff reported that local police were not only tolerant of syringe exchange but were publically supportive of syringe exchange or even made referrals to exchange.

Table 8. Community networking

Type of meeting or work group	# of SEPs who attend this type regularly
Internal health department staff meetings	9
County human services/drug treatment work group	7
Networking/info sharing meetings among local CBOs	5
Local mental health/substance use provider work group	4
Health system consortium or work group	4
Local housing work group/committee	3
Citizen-based drug prevention coalition	3
Law enforcement work groups/meetings	2
Community health worker meetings	2
Local exchange providers network	1

VII. Budgets and Staffing

Most syringe exchange programs have at least two sources of financial support for their operation, one source being the contribution of injection supplies from DOH (Table 9). For one rural exchange, however, the DOH supply delivery is its only source of support; without this contribution the exchange would be forced to close.

Table 9. SEP funding sources

Funding source	How many SEPs use this source
DOH annual contribution of injection equipment	15
DOH HIV prevention funds	7
County general funds	7
County environmental health funds	5
County funds for mental health/chemical dependency	2
Health department internal discretionary funds	2
Private donations or grants	5
Waste site disposal fees	4
City human services funds	1

Of the 14 syringe exchange programs that reported budget data, 11 SEPs use some of their budget to cover SEP staff salaries at partial or full FTE (Table 10). Five SEPs use their budgets entirely for exchange supplies. Staff from these programs are paid from other budgets to perform other scopes of work (e.g.,

communicable disease, health education, public health nursing), and they simply blend needle exchange duties in with their primary job functions.

Table 10. SEP budgets and staffing

DOH supplies plus additional budget of:	How much FTE this covers	Additional notes:
$500	0	• 1 SEP receives DOH supplies only. • 1 SEP has a budget of $150,000 (that covers 0.5 FTE) but receives no DOH supplies. • 4 SEPs did not report budgets.
$20,000	0.5	
$21,219	0.5	
$44,736	0	
$50,000	0	
$76,264	0.4	
$103,341	0	
$142,000	2.0	
$200,000	1.0	
$200,000	0.8	
$330,000	3.2	
$1,077,837	5.9	

All of the SEP coordinators felt "cautiously optimistic" they will have resources to operate at current levels in 2016, assuming supplies will still be available from DOH. Coordinators from nine SEPs indicated they would likely be forced to close their exchange programs without continued support from DOH since no county or local funds are available for supplies.

At least two-thirds of SEPs also utilize volunteers to provide exchange services. Volunteers are most often students, public health/social service professionals, individuals who need to perform community service hours, and former syringe exchange clients.

VIII. Topics for Further Discussion

During the site visits, staff and volunteers spoke passionately about their work and commitment to their syringe exchange clients. They also shared their concerns about the challenges of operating exchange programs in a precarious funding environment. Changes in the public health landscape such as the Affordable Care Act and diminished HIV funding for syringe exchange have many SEP coordinators and staff asking questions such as:

- What is "best practice" for how syringe exchange services should be delivered? How well do we all follow these best practices?
- How many of us are operating on outdated approaches? How should we update our practices to reflect new funding realities and changing client needs?
- How much are our service models shaped by what's good for staff or because "that's how we've always done it"? Are clients asking for something different?
- Are there ways we could "standardize" data collection so we can better demonstrate our contributions and impact?

- Should we have a list of services that are essential for every syringe exchange, like a standard of care? Would this help push for an essential baseline of funding for these services?
- Are we using technology effectively or are we tech-phobic?

" It would be a real shame if we changed nothing after this survey."

SEP staff expressed a desire to dialogue with peers about these issues, and they offered the following ideas to strengthen conversation, collaboration, and problem-solving among exchanges:

- Promote and use the WASSP (WA Syringe Service Programs) listserv more often.
- Establish a monthly conference call for all SEP providers.
- Establish regional SEP provider network meetings for SEPs in neighboring counties.
- Organize "field visits" with each other where staff and/or volunteers work a shift at another exchange to learn and share ideas.

Syringe exchange programs are doing crucial public health work with very limited resources and with clients who come with multiple, complex needs. Theirs is often the first door through which injectors will enter to access health services or to explore drug treatment options. Given the increases in heroin use, and in some places methamphetamine use, resources to support SEP operations statewide are greatly needed. Regular assessments of syringe exchange operations and capacity such as this one would also provide important feedback for staff and managers of syringe exchange programs to ensure services and funding are keeping pace with client need.

Related report:
Results from the 2015 Washington State Drug Injector Health Survey / Susan Kingston and Caleb-Banta-Green, University of Washington Alcohol & Drug Abuse Institute, February 2016.
URL: http://adai.uw.edu/pubs/infobriefs/2015DrugInjectorHealthSurvey.pdf

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