

Overview and Perspectives of Syringe Services Programs in Washington State



Susan Kingston, ADAI, with contributions from staff and volunteers of syringe services programs

HIGHLIGHTS

- There are **nearly 40 syringe services programs (SSPs)** operating in urban, suburban, rural, and tribal areas across 30 counties in WA State. SSPs operate in brick-and-mortar sites; in mobile settings using vans, cars, and RVs; and through on-foot street outreach.
- SSPs **distribute essential harm reduction supplies** to people who use drugs and help them **access medical care, mental health support, and substance use disorder treatment**, often directly on site.
- As homelessness and drug smoking become more prevalent, **many SSPs are offering drug smoking supplies and/or boosting mobile outreach** to engage new participants who do not inject drugs or do not have a way to reach a fixed SSP site.
- **Inadequate funding for SSP staffing and infrastructure** restricts the number of hours that SSPs can operate and the range and frequency of services they can offer.
- Drug use stigma, local politics, and community frustration with homelessness, overdose, and public drug use put **tremendous pressure and scrutiny on SSPs**, commonly, but not exclusively, in rural areas.
- With their geographic distribution and trusted reputation with participants, **SSPs are well-positioned to develop into full-service “health hubs” for people who use drugs**. With adequate funding, SSPs could offer a range of health services in a place these individuals already trust.

INTRODUCTION

Syringe services programs (SSPs) have been operating in Washington State for over three decades. This report describes how these SSPs operate, the services they provide, the challenges they face, and their untapped potential. Information in this report was gathered by staff from the University of Washington’s Addictions, Drug & Alcohol Institute (ADAI) from interviews (using a semi-structured guide) with 38 front line SSP staff, volunteers, and department/agency administrators.¹ The perspectives of these individuals were supplemented with information from staff of the Drug User Health Team at the WA State Department of Health.

This report represents 32 syringe services programs operated by 27 organizations in 30 counties². While there are more than 32 SSPs in the state, including some operated by tribes, not all were available to participate in interviews. There are also several organizations or programs that do not consider themselves to be a public syringe services program but that do offer syringe exchange and harm reduction services to their own clients; these programs are not included in this report.

¹ ADAI produced a similar report in 2015 available here: <https://adai.uw.edu/pubs/infobriefs/SEPOverview2015.pdf>.

² An SSP with multiple sites within a county is counted as a single SSP. If an organization operates SSPs in multiple counties, the site in each county is counted as a separate SSP.

What is a syringe services program?

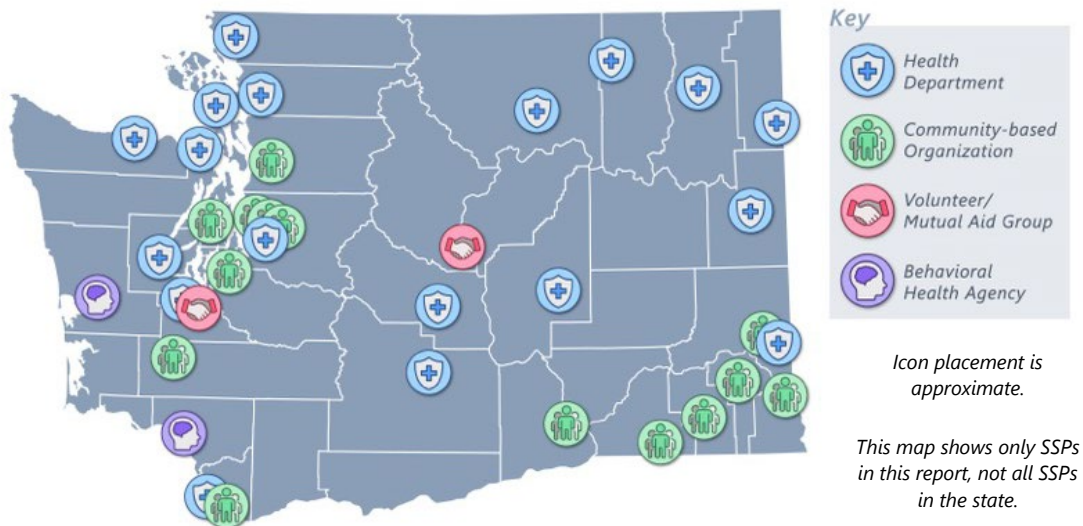
Syringe services programs are community-based public health programs that provide harm reduction and health services in nonjudgmental environments to people who use drugs, including:

- Access to sterile syringes and other safer drug use supplies
- Safe syringe disposal
- Connections to healthcare, substance use treatment, and other supports

The Department of Health (DOH) has supported SSP operations in WA State since 1992 with harm reduction supplies, limited funding for operations and case management services, and technical assistance on sexual health and infectious disease services. DOH also maintains an [online directory of WA State SSPs](#) along with information on the background, legality, evidence base, and impact of SSPs. A DOH factsheet about SSPs is in Appendix 1.

1. SSP MODELS AND SITES

The map below shows the 32 programs in this report by county and the type of organization that operates them. The majority (53%, n=17) are operated by local health departments, about a third (34%, n=11) by community-based organizations, and the remainder (13%, n=4) by volunteer/mutual aid groups or behavioral health agencies.



SSPs in WA State, by county and type of operating entity, as of December 2022.

While just over half (56%, n=18) call themselves a "syringe services program" or a "syringe/needle exchange," the remaining 44% of programs prefer to use names such as "harm reduction program," "harm reduction services program," "harm reduction health center," or "mobile outreach program" to better reflect their focus beyond just drug injection. For simplicity, this report will use the term "syringe services program" or "SSP."

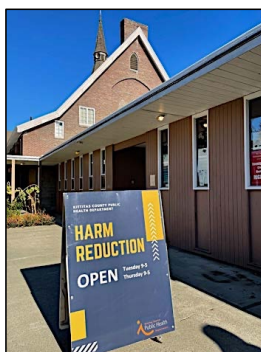
Table 1 lists the 32 SSPs included in this report, when they started, their settings, and their operating hours, which range from just 2 hours/1 day per week up to 70 hours/6-7 days per week. About one third of these SSPs, mostly in rural counties, are open only one day (2-4 hours) per week. In more populated counties, most SSPs operate at least 5 days (10-70 hours) a week. **The greatest constraint on operating hours is lack of funding.**

Table 1. SSPs represented in this report (n=32)

County	Type of organization	Established	Types of sites/settings					Days per week	Hours per week
			Inside building	Van/RV parked at regular sites	Delivery	Street/encampment outreach	Peer 1-1 outreach		
	<i>CBO=community-based organization</i>								
Asotin	CBO	2017	✓	✓				2	8
Benton	CBO	2019	✓					3	12
Chelan	volunteer-mutual aid group	2022				✓		1	4-8
Clallam	health department	2000	✓		✓	✓		5-6	20+
Clark	health department	1990	✓					3	9
	CBO	2019		✓	✓	✓		3-4	10+
Columbia	CBO	2022		✓	✓			1	varies
Cowlitz	behavioral health agency	2000	✓					1	4
Ferry	health department	2018	✓					1	2
Garfield	CBO	2022		✓	✓			1	varies
Grant	health department	2018	✓					1	2
Grays Harbor	behavioral health agency	2004		✓				1	3.5
Island	health department	2017	✓					3	9.5
Jefferson	health department	2000	✓					3	6
King	health department	1989	✓	✓	✓	✓		6	70
	CBO	2007	✓	✓	✓	✓		6	30
	CBO	2017	✓		✓	✓		4	28
	CBO	1995	✓			✓	✓	7	50
Kitsap	CBO	1997		✓	✓	✓		3	24
Kittitas	health department	2008	✓		✓	✓	✓	2	16
Lewis	CBO	2019		✓				1	3
Mason	health department	2018		✓				2	8
Okanogan	health department	2010	✓					2	8+
Pend Oreille	health department	2018	✓					1	2
Pierce	CBO	1988	✓	✓	✓	✓		4	40
Skagit	health department	2015		✓				3	16
Snohomish	CBO	1994	✓	✓	✓	✓		5	50
Spokane	health department	1989	✓					5	10
Stevens	health department	2018	✓					2	4
Thurston	health department	1993	✓	✓				3	14
	volunteer-mutual aid group	1999		✓				5	10
Walla Walla	CBO	1997	✓					5	35
Whatcom	health department	1999	✓	✓		✓		3	8
Whitman	CBO	2022		✓				1	varies
Yakima	health department	1992		✓				1	3

The SSP network includes both long-standing and newer programs that offer services in a variety of settings. Nearly half of programs (47%, n=15) have been operating for at least 20 years. Forty percent (40%, n=13) opened within the last five years (since 2017). As seen in Table 1, SSP services are provided in a variety of fixed and mobile settings. Some SSPs operate multiple sites, often a combination of fixed and mobile settings:

- 22 (69%) Indoor site
- 17 (53%) Mobile settings including delivery and street/encampment outreach
- 12 (37%) Van/RV parked at regular site(s) each week
- 1 (3%) 1-1 peer educator outreach



Examples of indoor SSPs



Examples of vehicle-based SSPs

Access to SSP services has remained stable over the past three years, even through the COVID-19 pandemic (see more in Section 6 about the impact of COVID-19). The majority of SSP staff reported they are currently operating the same number of sites and hours as they did just before the pandemic started in early 2020 (Table 2).

Table 2. Number of sites and operating hours now compared to 3 years ago

Total sites		Total hours/week	
Same as 3 years ago	27 (84%)	Same as 3 years ago	21 (66%)
Opened a mobile route	3 (9%)	More hours now	7 (22%)
Closed an indoor site	2 (6%)	Fewer hours now	3 (9%)
Closed a mobile route	2 (6%)	Not open 3 years ago	1 (3%)

Staff at nearly all SSPs in this report (94%, n=30) felt they are “likely” or “very likely” to be operating in some fashion two years from now, although **maintaining or finding new sites is a growing challenge** (see more in Section 7).

2. DISTRIBUTION OF HARM REDUCTION AND HEALTH MATERIALS

“Needs-based” and “one-for-one” syringe access policies

Historically, many SSPs provided syringes to participants with an “exchange” model, offering one new syringe for one used syringe. Years of research evidence now supports a “needs-based” model as best practice to prevent new HIV/viral hepatitis infections. In this model, [endorsed by the Centers for Disease Control and Prevention](#), participants are given the amount of syringes they need to use a new syringe for each injection, reducing vein damage and infections from re-using syringes. While returning used syringes is not required to access new syringes, it is strongly encouraged by SSPs to promote safe disposal. WA State DOH also [recommends a needs-based model](#). While most SSPs are free to shape their own policies, a small number of SSPs must adhere to operational mandates set by their county commissioners or Board of Health.

Half of the SSPs in this report (50%, n=16) consider themselves as needs-based programs, although some do cap the amount available (e.g., 50, 100 syringes). All these **programs encourage return of used syringes** by distributing sharps containers, offering home pick-up of used syringes, organizing syringe clean-ups from parks and encampments, and other strategies. Another third (38%, n=12) operate a modified one-for-one approach in which staff have the discretion to “round up” on the number of new syringes provided if some used syringes are returned.

Harm reduction and health supplies

The availability of harm reduction equipment for safer drug injection is stable and consistent across SSPs (Table 3). Other health supplies, including sexual/reproductive materials, vary by SSP based on participant demand and budget.

Table 3. Harm reduction and health supplies offered by SSPs

Drug injection	Sexual/reproductive health	Other health supplies	Overdose prevention
Alcohol wipes Tourniquets Cottons Wound care kits* Sharps containers Cookers Sterile water	Male/external condoms Female/internal condoms Lubricant Pregnancy tests Emergency contraception	At-home COVID tests Nicotine replacement PPE (e.g., masks, gloves, hand sanitizer) Over the counter medications (e.g., ibuprofen, acetaminophen, anti-diarrheal, cough drops) Vitamins (e.g., multivitamins, vitamin C)	Intramuscular naloxone Nasal naloxone Fentanyl test strips
<i>*items such as gauze, band aids, bandages, antibiotic cream</i>			

Demand for fentanyl test strips is also steady along with demand for testing strips to detect benzodiazepines and xylazine (not yet widely available for SSPs). Other high-demand items requested by participants include backpacks, gas and grocery cards, bus passes, and phone charging areas, although most SSPs do not have funding to provide these.

“Survival supplies” for people living unhoused

As the rate of homelessness escalates in all areas of the state, SSPs **report increasing demand from participants (and even individuals who do not use drugs) for supplies to meet their daily needs while living outside or in vehicles**. SSPs usually acquire these supplies from community donations, very limited funding from DOH, or staff who purchase the items themselves. These “survival supplies” provided by many SSPs include:

- Hygiene items (e.g., soap, body wipes, toothpaste, menstrual products)
- Tents and sleeping bags
- Hand/foot warmers, socks, gloves, coats
- Food, snacks, bottled water
- Flashlights, lighters
- Toilet paper
- Food for pets

Lately, we feel more like a homeless services provider than an SSP. People are experiencing more harms from living outside than from their drug use.

We have a huge increase in homelessness and need for supplies for "basic human dignity." It's becoming a real mission challenge for us. We are not resourced to be a one-stop homeless services organization.

Drug smoking supplies

All SSPs also report **unprecedented demand for safer drug smoking supplies**. The prevalence of smoking (versus injecting) drugs has increased with the recent rise of fentanyl and methamphetamine use. Most SSPs report a drop in both the number of participants and the volume of syringes provided within the last year, which may be related to changing trends in drug use and routes of administration.

We're frustrated that we're losing people to serve because we have nothing to offer those who are no longer injecting or who only smoke. We want to help!

As with syringe access policies, some SSPs can decide independently to offer smoking supplies; others require approval from organizational and/or political leadership. At the time of this report, about one third of SSPs (31%, n=10) are distributing some type of safer smoking supplies. All these SSPs must limit that distribution (e.g., frequency, amount/person) as these items are expensive and there are no public funds currently provided for smoking supplies.

About half of SSPs are interested in distributing smoking supplies but are in different phases of readiness:

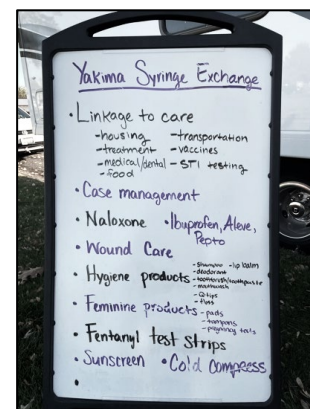
- 9 (28%) Want to distribute but waiting
- 4 (13%) Putting together a proposal now
- 4 (13%) Have approval and will start soon
- 1 (3%) Asked for approval but was denied

According to these SSPs, factors that might facilitate approval include clarity on paraphernalia laws³, funding to buy smoking supplies, and more data on distribution's impact on participant engagement. In 2022, ADAI published a [research brief on the potential public health benefits of distributing safer smoking equipment](#), the evidence supporting this intervention, and related legal issues. It also includes preliminary data from a local SSP showing the increase of new participants once it offered smoking supplies.

3. ON SITE SERVICES

Most people think harm reduction just means "stuff" like syringes and naloxone. They don't understand that services are also harm reduction.

In addition to providing harm reduction materials, **SSPs also help participants access a range of services**. All SSPs make referrals to local services. Some SSPs receive funding to provide care navigation services. Beyond referrals and linkage to care, the majority of SSPs provide some healthcare services on site.



³ Current WA State law explicitly allows public health entities (i.e., SSPs) to distribute new syringes and other drug injection equipment to prevent transmission of infectious disease. This excludes SSPs from being prosecuted under other laws that prohibit the sale or possession of drug paraphernalia. Since distribution of clean equipment to smoke or snort drugs can also reduce spread of infectious disease, the application of these laws to SSP distribution of smoking supplies remains unclear.

Health care services

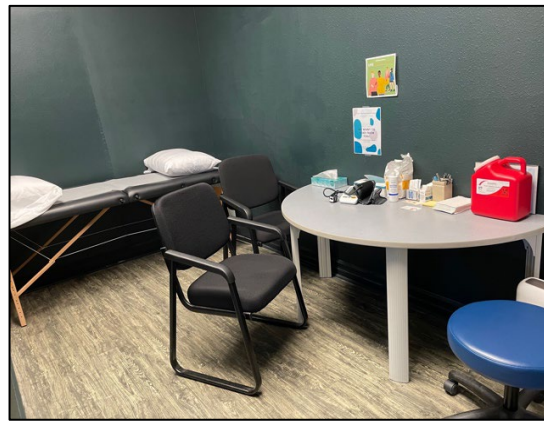
Table 4 shows the range and frequency of healthcare services available on site at SSPs. Some services were halted during the first year of COVID restrictions and are slowly returning as funding and staffing permits.

Table 4. Number of SSPs that offer onsite health services

	Always available	Sometimes available	(Re)starting soon	Used to have	Never had
HIV testing	9 (28%)	5 (16%)	11 (3%)	3 (9%)	4 (13%)
Sexually transmitted infections testing (excluding syphilis)	6 (19%)	1 (3%)	2 (6%)	2 (6%)	21 (65%)
Syphilis testing	6 (19%)	1 (3%)	2 (6%)	0	23 (72%)
Hepatitis C testing	11 (34%)	4 (13%)	1 (3%)	3 (9%)	13 (41%)
Hepatitis C treatment	2 (6%)	2 (6%)	0	0	28 (88%)
PrEP (HIV prophylaxis)	1 (3%)	2 (6%)	0	0	29 (91%)
Wound care	8 (25%)	4 (13%)	0	2 (6%)	18 (56%)
Vaccinations*	3 (9%)	7 (22%)	0	2 (6%)	20 (63%)

*examples include COVID, influenza, hepatitis A and B, Tdap (tetanus, diphtheria, pertussis), mpox, shingles

Healthcare services can be provided in both mobile settings and indoor sites (examples below).



Healthcare spaces at SSPs: a nurse station in a mobile RV and a nurse exam room in an indoor SSP.

Most SSPs are eager to provide auxiliary health services, but their capacity to do so depends largely on physical space and funding. (See more about how SSPs would like to expand their health services in Section 8.)

We desperately need money for staff so we can add services.

Substance use disorder treatment services

Because of the trust established between staff/volunteers and participants, SSPs are often the first place individuals will go to ask for substance use disorder (SUD) treatment resources. All SSPs provide referrals to SUD services, and many SSPs provide direct services onsite:

- 12 SSPs offer onsite SUD counseling and/or linkage into treatment services provided by SSP staff, a substance use disorder professional (SUDP), or recovery navigator from a partner community agency.

- 2 SSPs are operated by behavioral health agencies whose own SUDPs run the SSP and assist participants with assessments and admissions into treatment services.
- 9 SSPs provide walk-in, same day access to buprenorphine and/or naltrexone to treat opioid use disorder. Three of these SSPs also provide contingency management for those who want to reduce their stimulant use.

ADAI and SSP partners regularly survey people who use drugs to identify their needs, preferences, and use of healthcare and SUD treatment. Learn more here: <https://adai.uw.edu/cedeer/community-surveys/>.

Table 5. Number of SSPs that offer onsite SUD treatment services

	Always available	Sometimes available	Used to have	(Re)starting soon	Never had
Buprenorphine or naltrexone	8 (25%)	1 (3%)	1 (3%)	0	22 (69%)
Substance use counseling (recovery coach, counselor)	6 (19%)	0	1 (3%)	0	25 (78%)
Direct link to SUD treatment (e.g., assessments, detox admissions)	12 (38%)	0	2 (6%)	0	18 (56%)
Contingency management (approach to treat stimulant use)	3 (9%)	0	0	0	29 (91%)

Other care and support services

Table 6 shows the availability of other support services at SSPs such as care navigation and mental health counseling.

Table 6. Number of SSPs that offer onsite support services

	Always available	Sometimes available	Used to have	(Re)starting soon	Never had
Health insurance enrollment	10 (32%)	0	1 (3%)	0	21 (65%)
Care navigation	11 (34%)	1 (3%)	1 (3%)	0	19 (60%)
Case management	4 (12%)	0	0	0	28 (88%)
Mental health counseling	5 (16%)	0	0	0	27 (84%)

In 2022, ADAI published a [report on care navigation at harm reduction programs](#). It describes the role of care navigators and provides preliminary data on the type, length, and content of care navigation activities in buprenorphine programs offered by local SSPs in partnership with ADAI.

The Health Hub model

The concept of “health hubs” is gaining recognition as an innovative yet practical way to provide a range of health services “under one roof” at a place that people who use drugs already trust and frequent. SSPs aim to provide walk-in, same day access to low barrier services that could include:

- Minor wound care with triage and referral for more acute medical conditions
- Screening (and in some cases, treatment) for HIV, viral hepatitis, and sexually transmitted infections
- Referrals for primary and specialty care, including substance use disorder treatment
- Medications for substance use disorder
- Screening, care coordination, and medication management for common mental health conditions
- Drop-in emotional support and brief harm reduction counseling
- Care navigation and case management

Many more SSPs would like to provide medical, mental health, and substance use services like these (see more in Section 8) but need sufficient and sustainable funding to do so.

4. OPERATIONAL ISSUES

Staffing

Staffing capacity varies widely across SSPs, ranging from part- to full-time staff who may be paid by SSP funds or by other program funds in the agency. At local health department SSPs, especially those in rural counties, the main (and often only) person to staff the SSP may be a public health nurse who serves multiple roles at the health department (e.g., communicable disease, immunizations, direct clinical care).

While a few SSPs are run *solely* by volunteers (i.e., mutual aid organizations), 41%, (n= 13) operate without any volunteers at all. With the end of COVID restrictions, many SSPs are now rebuilding their volunteer base.

SSPs value staff and volunteers who have direct experience with drug use, and the organizations that operate SSPs have a range of policies about hiring people with drug use experience:

- 13 (41%) Hiring people with past/current drug use experience is a priority.
- 11 (34%) Agency does not have an explicit policy about past/current drug use.
- 8 (25%) Past drug use is OK and even preferable. Current use is not permitted.

All but four SSPs said they have **someone with past or current drug use experience working or volunteering at the SSP**. While this brings valuable expertise to a SSP team, it can also highlight challenges of cultivating diverse workplaces, such as equitable pay and professional opportunities.

We only hire people with lived experience. We ARE our people.

I'm a person with lived experience hired to work the SSP. But I get paid very low compared to other colleagues with college degrees who help at the SSP. I have to teach them about injecting and addiction. My experience and knowledge were enough to get me hired but not enough to get me paid equitably.

When asked about staffing, these were the challenges most often reported by SSP staff:

- 11 (34%) Pay isn't high enough to attract applicants
- 8 (25%) Number and/or quality of applicants is low
- 7 (22%) High staff turnover
- 6 (19%) Being the only person who works the SSP feels isolating/there's no support

It's hard for people to take jobs with us because our pay scale can't match the cost of living here.

I run this program by myself and it's lonely. I hold a lot myself. I wish I had colleagues for support.

Funding

Operating an SSP involves the following core expenses:

- Salaries and benefits
- Harm reduction supplies
- Other supplies (hygiene kits, office needs)
- Syringe disposal fees
- Rent, utilities, cleaning, insurance
- Vehicle fuel and maintenance

Washington State Department of Health has supported SSP operations in the state since 1992. In 2022, DOH provided approximately \$2,000,000 in supply funding to 30 SSPs. In addition to supply funding, DOH provided approximately

\$3,100,000 in funding through contracts with 17 SSPs to support operations, (e.g., staff, facilities) and case management services. DOH also provides technical assistance for sexual health and infectious disease services.

To cover the remaining costs, SSPs must seek support from other funding sources such as:

- County funds (including general, environmental health, and behavioral health funds)
- Health department internal discretionary funds
- City human services funds
- Private donations or grants
- Waste site disposal fees
- Accountable Community of Health grants
- Tribal funds

These resources are rarely sufficient, which limits the number of operating hours and services at an SSP.

Data collection

The one area in which syringe services programs vary most notably is in data collection—which data are collected and how. The majority of SSPs (especially mobile programs) record activities on paper tracking sheets to enter later into an electronic database (e.g., Excel, Smartsheet). About one third of SSPs are paperless and enter data directly online.

At a minimum, SSPs record during each shift the number of participant encounters and number of syringes distributed. Nearly half of SSPs (44%, n=14) use a unique, anonymous code to link each encounter to a specific participant. Participants who do not want a personal code can choose to use a “dummy code.” SSPs can then track the number of unduplicated participants served, repeat visits, and how SSP services are used over time.

Specific data variables are not standardized across the SSP network, but the types of data commonly collected include: participant demographics, types of drugs used, type and amount of supplies given, and referrals. About two thirds of SSPs (63%, n=20) say they choose the data they collect, although specific data elements are often determined by other entities such as funders (44%, n=14) or local leaders from their agency, Board of Health, or county commissioners (30%, n=10). Unfortunately, data required by funders and other entities often overlap poorly with each other and conflict with what SSPs really need or what participants want to willingly share.

We value data but have to balance that with the actual capacity of our staff and volunteers to collect data during busy hours and the need of some participants to stay anonymous and low interaction.

The majority of SSPs report their data to agency staff and managers, external stakeholders, and funders and/or use their data in grant writing. While a quarter of SSPs (25%, n=8) said they review their data regularly to make program adjustments, 34% (n=11) said they do not review or use the data collected, largely because the data they are asked to collect do not feel relevant to their work or staff simply do not have the time or capacity to do so.

5. EXTERNAL RELATIONSHIPS

Most SSPs reported very positive relationships with their local health department, although relationships with local boards of health or county commissioners were more mixed (Table 7).

Table 7. How would you describe your SSP's relationship with:

	Very good	OK	Bad	No relationship
Local health department	26 (81%)	5 (16%)	0	1 (3%)
Local Board of Health	4 (14%)	11 (34%)	3 (9%)	14 (44%)
General community	3 (9%)	23 (72%)	0	6 (19%)
Law enforcement	6 (19%)	16 (50%)	1 (3%)	9 (28%)
Other service providers	19 (59%)	4 (14%)	0	8 (25%)

SSPs are **proactive to maintain positive relationships and ease tensions with the local community** and law enforcement. Most SSPs reported that their local law enforcement were generally tolerant of SSP activities, while many police chiefs and individual officers publicly supported harm reduction or even made referrals to SSP services. Several SSP staff commented that being a central community resource for naloxone and overdose response training had helped improve relationships, including with law enforcement.

Poor interactions with us (the SSP) only lead to poor interactions with our participants. So we work really hard to maintain good rapport with our neighbors, even when they blame us for why everyone is homeless and using drugs. We have to rise above those feelings and stay open and friendly. It does get hard sometimes.

Normalizing naloxone trainings with everyone in the community has decreased stigma about overdose. Now people associate our SSP with naloxone, which is a positive image.

Our local Board of Health and community are divided: half love us and half hate us.

Benefits and challenges of partnerships

Many SSP staff attend regular workgroups and meetings to educate community members and service providers about harm reduction and SSP services, advocate for SSP participants, and build personal relationships. Most SSP staff report that this participation has yielded fruitful partnerships and even funding opportunities. Types of community meetings/events SSP staff report attending include:

- 14 (44%) Local opioid task force
- 12 (38%) Community events (Overdose Awareness Day, Drug Take Back Day, tabling at community events)
- 10 (31%) Substance use/behavioral health service providers
- 8 (25%) Homelessness services providers
- 7 (22%) General service providers

Despite the clear benefits of networking, several SSP staff expressed frustration that they had to invite themselves to these meetings and initiate these connections because other service providers don't typically reach out. Other common frustrations with community partnerships (with real-life examples given by SSP staff) include:

- **Being a "token" partner** (e.g., being written into grant proposals as a "partner" without even being asked).
- **Treatment agency staff don't engage well with SSP participants.** Their approach with SSP participants is often seen as either too pushy or even stigmatizing (e.g., asking participants "Would you like to get into treatment today?" or "Do you want to get clean?") or too passive (e.g., "they just sit with a stack of brochures and scroll on their phones").

- **SSP staff not being seen as equal professionals** (e.g., treatment agency wanted to “teach us about treatment” but declined our offer to train their counselors on harm reduction; condescending attitudes from clinicians that SSP staff are “just low-skill outreach workers”).
- **Distrust of researchers** (e.g., want SSP staff to help recruit for studies that staff or participants had no role in developing, never getting results back from surveys they helped administer, no financial or staffing support for the extra recruitment work).

We initiate most of our relationships with service providers. Most people don't really know what we do or don't even know we exist. So it's really up to SSPs to reach out.

I find it hard to break barriers and build partnerships beyond the behavioral health world.

When agencies say they want to “partner” with us, they don't really want our input or expertise. They just want access to our participants.

6. IMPACT OF COVID-19

No SSP closed permanently during the COVID-19 pandemic. Yet all SSPs had to change *how* they operated such as reducing hours, installing physical barriers, or limiting interactions to curbside supply drop-offs. Many SSP staff felt an emotional toll of losing genuine connection with participants due to physical distancing. At some SSPs, COVID also highlighted the division some SSP staff feel between themselves and other staff in their agencies.

The masking and physical distancing from participants sent a message that we didn't want to be close to them. That's the last message we wanted!

We never closed during COVID. Not one day. And everyone else in our organization got to work from home for two years (and still do). But we had to show up, every single day. I don't feel like we ever really got credit for that from our leadership or other non-SSP staff.

While COVID had several negative impacts on SSP operations and relationships (Table 8), SSP staff also noted some positive outcomes.

Table 8. Impacts of COVID on SSP operations and staff

Negative impacts	Positive impacts
<ul style="list-style-type: none"> • Loss of services like HIV/viral hepatitis testing. • SSP interactions became transactional, less conversational. • Professional connections and networking dissolved. • Erosion of trust and respect for public health and hostility towards public health professionals. <p><i>I have to work twice as hard now because of what COVID did to the public's perception of Public Health. I feel like I'm walking on eggshells now to keep harm reduction services operating quietly.</i></p>	<ul style="list-style-type: none"> • Streamlined data collection and made it more efficient. • Moved from a strict 1-1 exchange policy to more needs-based. • Strengthened relationship with local health department. <p><i>Before COVID, our health department never really acknowledged us. But then COVID came, and they realized how our relationships with people are actually valuable.</i></p>

7. STRENGTHS AND CHALLENGES

Strengths of SSPs

SSP staff listed multiple strengths of their programs but were especially proud of the trust they have with participants and the commitment of their staff and volunteers:

- 22 (69%) Trusted relationships with participants
- 16 (50%) Dedicated, passionate staff/volunteers
- 10 (31%) Our safe, caring, empathetic space
- 7 (22%) People who use/used drugs work here
- 7 (22%) Support of agency leadership
- 5 (16%) Number/variety of services we offer
- 5 (16%) Ability to detect and respond quickly to changing needs of participants

We help people who aren't seen or heard to feel seen and heard.

We're really proud of the way our outreach team spots drug use trends and immediately adjusts their harm reduction response.

We're really available-we go to people rather than wait for them to come in.

External challenges

Stigma about drug use and a lack of local services to address the immense needs of participants top the list of external challenges SSPs face in doing their work:

- 12 (38%) Stigma in community about drugs, people who use drugs, and services for people who use drugs
- 7 (22%) Lack of community services for referral/linkage
- 7 (22%) Overwhelming level of participant needs, especially for housing and mental health services
- 5 (16%) "Compassion burnout" of community towards homelessness and drug use
- 5 (16%) Restrictive attitudes and policies of local politicians/Board of Health
- 5 (16%) Community pressure to close/active harassment from individual community members
- 4 (13%) Misunderstanding in community and/or own agency about what SSPs do

Community frustration with homelessness has become anger against drug use and people who use drugs.

Encampment sweeps push out our participants and then they don't come back.

*The conservative climate in our county means we need to be very discreet to stay open.
But staying quiet also means we can't broadcast our successes.*

Another significant challenge faced by most SSPs is securing and keeping operating sites. High rents and gentrification are impacting the stability of fixed and mobile settings. Examples cited by SSP staff include:

- Several mobile sites may lose their regular spots in empty parking lots as the lots get slated for development.

- Some indoor sites that were once centered in neighborhoods with high drug use are now getting “boxed in” by upscale urban development which is displacing their participants or creating tensions with new neighbors.
- High housing/rent costs make it difficult for some SSPs to afford their indoor spaces and hire staff who can afford to live locally.
- City sweeps of encampments force outreach routes to shift and push participants farther from SSP services.

Internal challenges

Internally, SSPs struggle with lack of funding and their limited capacity (e.g., funding, staffing, space) to offer more services that could address the acute health and daily needs of their participants:

- 12 (38%) Not enough/unstable funding
- 11 (34%) Frustration that we can’t meet level of need
- 9 (28%) Discouraged by lower number of participants; “we aren’t helping as much as we could”
- 9 (28%) Emotional stress on staff/burnout
- 9 (28%) Not enough staff
- 8 (25%) Financial and staffing instability at our organization
- 8 (25%) Health department or Board of Health limits what we can do
- 7 (22%) Lack of physical space
- 6 (19%) Not open enough hours to meet needs
- 5 (16%) Low pay for staff
- 5 (16%) Staff turnover

Rent is crushing our budget.

Funding for harm reduction always comes last. We’re always at the bottom of the barrel.

Most of our participants have been pushed farther away, outside. We’re stuck inside our building and aren’t allowed to set up anywhere else. So people can’t get to us.

There is a lot of joy and connection in this work, but also a lot of grief, hopelessness, and worry. Being witness to all the brokenness takes its toll.

8. LEVERAGING SSP STRENGTHS TO IMPROVE HEALTH ACCESS

Syringe services programs are doing foundational public health work with very limited resources and with participants who come with multiple, complex needs. **SSPs in WA State are both an untapped and underfunded resource to provide health services to people who use drugs**, many of whom are not well-served in more traditional spaces. Increased funding investment would help leverage the expertise and capacity of SSPs to scale up their reach and impact.

Opportunities to share harm reduction expertise

Harm reduction as both philosophy and practice has recently gained wider acceptance and attention, encouraged in part by new funding emphasis from several federal agencies. During interviews, many SSP staff commented about this recent shift. Some staff saw this as an opportunity for SSPs to share their expertise with “newcomers” to harm reduction by offering training on harm reduction principles, strategies, and best practices. At the same time, many SSP staff felt wary of the motivations and consequences of this “sudden embrace” of harm reduction:

It's good that harm reduction is finally making it into the mainstream dialogue, but it feels disingenuous and discounting. Everyone says they're doing harm reduction now, mostly because funders are promoting it. But most of what people call "harm reduction" really isn't. It's diluting what harm reduction really stands for. We aren't a new trendy idea. We've been doing this work for four decades already with very little respect from the very groups who now suddenly embrace it just because there's money.

Harm reduction used to be this quiet thing we did. Now community stakeholders, housing units, everyone wants harm reduction outreach. But no one ever asks us for any training or help on how to do it.

I worry that treatment providers are now embracing harm reduction as a "strategy" just to get more people into treatment. "Getting people to do something" is not the essence of a true harm reduction philosophy.

More hours and more services for participants

When asked how they would like to grow their programs, SSP staff said they would like to increase reach and engagement, add services, and bolster operating capacity:

- 16 (50%) Add mobile component
- 12 (38%) Add more services
- 5 (16%) Add street/encampment outreach
- 4 (13%) Add more hours
- 3 (9%) Add staff

SSP staff shared the following ideas for how they would **extend their reach into communities** through mobile outreach and **add more health services** for their participants:

- *More outreach to people of color and younger communities.*
- *Create a regular mobile health unit that would provide a range of services - not just syringe exchange.*
- *Get an RV to offer more health care.*
- *Find more space to allow for "drop-in and stay" services.*
- *Get a bigger vehicle so we can have more meaningful conversations with participants.*
- *Create a "one-stop shop" of health services for participants.*
- *Add in-house wound care, vaccination, HIV/HCV testing and buprenorphine access.*
- *Find an indoor site so we can add services.*

CONCLUSION

Syringe services programs across WA State provide a broad array of highly desirable services to people who use drugs. In response to the rapid increase in fentanyl and methamphetamine use, overdoses involving these drugs, and the prevalence of drug smoking, SSPs are adapting to reach more individuals with high-demand harm reduction supplies and services. **Syringe services programs are universally and substantially underfunded to support the robust services they currently provide.** With their geographic distribution and trusted reputation with participants, **SSPs are well-positioned to develop into full-service "health hubs."** With adequate funding, SSPs could build up staffing and infrastructure to offer a range of health services in a place that people who use drugs already trust.

Citation: Kingston S. Overview and Perspectives of Syringe Services Programs in Washington State. Seattle, WA: Addictions, Drug & Alcohol Institute, Department of Psychiatry & Behavioral Sciences, School of Medicine, University of Washington, February 2023. URL: <https://adai.uw.edu/download/7650/>

This report was produced with support from the Washington State Health Care Authority, Division of Behavioral Health and Recovery (DBHR). The content was created by ADAI.

STATE DEPARTMENT OF HEALTH SUPPORTS SYRINGE SERVICES PROGRAMS

SSPs Benefit Communities and Public Health

What are Syringe Services Programs (SSPs)?

Syringe Services Programs are community-based public health programs that provide critical services in nonjudgmental environments to people who use syringes. Services include sterile injecting supplies and safe disposal, and access to healthcare, treatment, and support.



SSPs provide free sterile syringes to people who need them in order to reduce syringe re-use and sharing. SSPs also offer safe syringe disposal for used syringes. SSPs do not encourage or enable drug use.



SSPs can offer screening for infectious diseases including viral hepatitis, STDs, and HIV. SSPs can also serve as sites for vaccination against hepatitis A and B to those at greatest risk.



SSPs provide opioid overdose prevention education and distribute naloxone. People who use drugs and their loved ones are most likely to witness opioid overdose. Ensuring they have the tools to respond is essential.



SSPs provide referrals to physical and behavioral health care, including medication assisted therapy, supportive housing, and primary care.



SSPs are a critical HIV prevention intervention. Where SSPs are effectively implemented, HIV prevalence among people who inject drugs is low.



SSPs access people not engaged in traditional healthcare and establish trusting relationships in order to provide health education and risk reduction counseling.



DOH 150-123 March 2019

Washington State Department of Health has funded SSPs since 1992. The authority of public health to establish SSPs was decided in Supreme Court Case 120 Wn.2d 140 (1992) Health District v. Brockett, and SSPs legally operate under RCW 69.50.4121.

For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 711).