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NOTES FROM THE FIELD

The Impact of COVID-19 on Syringe Services Programs in the United States

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Syringe services programs (SSPs) were established in the 1980s to prevent HIV transmission among people who inject drugs (PWID) and have become a primary intervention point for other preventive and treatment services [1–4]. The COVID-19 pandemic and its associated social distancing measures have dramatically changed operations at many SSPs. The impact of these changes could halt, or even reverse, the tremendous progress made by SSPs during the HIV/AIDS epidemic [1]. At the same time, the pandemic also presents an opportunity for some SSPs to provide COVID-19 screening, linkage to testing, and policy adaptations to better serve PWID.

We conducted a rapid mixed methods assessment of SSP response to the COVID-19 pandemic in the United States (U.S.) to quantify and characterize changes in services provided by SSPs and the potential impact on PWID. Quantitative data were collected by the North American Syringe Exchange Network (NASEN), which maintains a directory of SSPs in the U.S. On March 31, 2020, NASEN emailed a short electronic survey to SSPs in the directory that asked a question about changes in SSP operations. Survey completion was voluntary and not incentivized. We analyzed data collected through April 16, 2020. Qualitative data were collected through interviews with SSP program staff and public health staff who support SSP activities in their jurisdictions. The research team conducted interviews with staff from a purposive sample of early COVID-19 hot spots including Detroit, New Orleans, New York City, Philadelphia, and Seattle. Interviewers used a semi-structured interview guide, and all participants provided informed consent. Most interviews were conducted and recorded using Zoom videoconferencing software. For this rapid, interim analysis, the qualitative data were analyzed by the interviewers for major themes. All data collected for this study pertained to programs, not individuals, thus this study did not constitute human subjects research or require review by an IRB.

Findings from Our Quantitative Survey

Among the 173 SSPs that responded to the NASEN survey, 43% reported a decrease in availability of services due to COVID-19. Many programs reported that these decreased services included medication for opioid use disorder and testing and treatment services for HIV, hepatitis C virus (HCV), and sexually transmitted infections. One-quarter (25%) of responding SSPs reported that one or more of their sites had closed due to COVID-19. Write-in responses suggested that factors related to SSP closures included staff safety, staff shortage, and instructions from administrative sponsors. SSPs also reported changing their service delivery model in response to COVID-19. Over one-half (53%) of SSPs are prepacking all supplies for participants, 20% are providing delivery services or only delivery services, and 6% are providing mail-based services. Write-in responses indicated that programs are increasing the amount of supplies provided to clients, usually 2–4 weeks' worth at a time. Over one-quarter (27%) of SSPs reported that they are screening participants for COVID-19 symptoms.

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Findings from Our Qualitative Interviews

Five key themes emerged from this interim analysis of data from qualitative interviews of SSP staff in five COVID-19 hotspots (Detroit, Philadelphia, New Orleans, New York City, and Seattle).

Programs have Adapted to Maximize the Safety of Their Staff and Participants

To reinforce social distancing practices and minimize the number of participant visits, programs have increased distribution of syringes, works, and naloxone. In some circumstances, this reflected a change in a program's syringe distribution model from one-for-one (more restrictive) to needs-based (less restrictive). One large program allows in one participant at a time in its fixed site location, is prepackaging supplies, and is limiting visits to a few minutes. Another program moved its indoor exchange activities to an outdoor space, and some programs are trying to provide food for clients. In certain jurisdictions, SSP clients can initiate buprenorphine treatment and receive prescriptions through a telemedicine hotline. Several programs have reduced staffing, and some staff have been unable to work due to their own elevated risk for complications from COVID-19. Staff are often former drug users, some of whom have serious pre-existing conditions, and many are very concerned about acquiring COVID-19. SSPs have PPE for staff, but programs reported limited supplies (e.g., staff are wearing bandanas) and nearly all are concerned about maintaining adequate supply levels.

SSP Demand Remains High

Most SSPs in our sample reported that the number of participants seeking services has declined since social distancing measures were implemented, while one small program reported a dramatic increase in participants since nearly all other nearby SSPs had closed. However, when data were available, programs reported that the number of syringes distributed had remained level or had increased due to distributing more supplies to each participant, including through secondary exchange (i.e., providing supplies to peers to distribute to others).

SSPs Remain Essential Services for PWID, But This is Not Always Recognized

Some jurisdictions have explicitly designated SSPs as essential services. SSPs in other states have continued to operate through collaborations with other essential services. Nearly all SSP staff noted that policy makers and leadership had not included SSPs in jurisdictional emergency planning and response and were not able to provide informed guidance on the expectations for SSPs. Instead, program managers have been empowered to implement changes autonomously and involve SSP staff in these decisions. Several programs have utilized guidance on best practices in the COVID-19 era from large harm reduction organizations. Multiple organizations stated they hope this experience increases the visibility of the public health importance of SSPs.

Syringe and Naloxone Distribution have been Prioritized, While HIV and HCV Testing have Declined

SSPs noted the importance of ensuring that participants have sufficient injection equipment and naloxone, and had developed protocols for distributing supplies that minimize close contact with participants. Conversely, because testing for HIV and HCV requires direct contact, nearly all programs said that testing availability had declined or been eliminated. In one city, testing staff were diverted to responding to a concurrent outbreak of hepatitis A among PWID.

SSPs can Provide COVID-19 Related Services to a Vulnerable Population

SSPs in most of the five jurisdictions we interviewed were conducting some screening for COVID-19 among their participants. Larger programs have been able to partner with organizations to implement more routinized screening, and at least one SSP was able to refer symptomatic participants to a COVID-19 testing station behind their building.

Conclusion

This rapid assessment of the response of SSPs to the COVID-19 pandemic revealed an urgent and dramatic shift in critical prevention services provided to PWID. Data were collected less than one month after most jurisdictions in the U.S. began implementing stringent social distancing guidance and stay-at-home orders. During those few weeks, approximately one-quarter of SSPs in this sample reported closing at least one site. The rapid closure of many SSPs highlights the thin margins on which many of these programs operate [5]. These closures could potentially have profound negative impacts on the health of PWID. The risk of fatal opioid overdose may increase due to decreased naloxone distribution. A reduction in sterile injection equipment available to PWID may increase risk for HIV, HCV, and other infectious consequences of injection drug use. Disruptions in the availability of HIV and HCV testing will further

increase the likelihood of ongoing transmission in communities. Additionally, SSPs often provide direct or indirect linkage to treatment for substance use disorders, and the inability of PWID to access these services further increases their risk of morbidity and mortality.

The consequences of COVID-19 among SSPs have also produced opportunities for ingenuity and have pointed a spotlight on the fortitude of these programs. Most programs that remain open have made changes to their service delivery model to minimize contact between participants and staff. Indeed, several SSPs reported distributing more syringes and naloxone than before. These interventions are aligned with current best practices for SSPs and could save lives [6, 7]. These programs indicated the desire to retain these changes after the COVID-19 response ends and use this period to experiment and demonstrate the feasibility of these new models. Finally, SSPs stressed the importance of their connections with populations with environmental and structural risk factors for serious COVID-19 sequelae, and their commitment to continuing to serve these participants. These connections present the opportunity to offer COVID-19 screening and testing, which some programs are already doing. Moreover, if a vaccine for COVID-19 is developed, SSPs may provide a critical venue for the rapid administration of vaccine to historically marginalized and hard-to-reach populations.

While SSPs are to be admired for their resiliency and ingenuity in the present COVID-19 pandemic situation, the problems presently facing SSPs must not be underestimated. Clients are likely to have great difficulty social distancing and "staying at home;" most will need to obtain drugs to avoid withdrawal and many remain homeless. Many SSPs have closed and those that remain open have greatly reduced their services, are struggling to procure sufficient PPE for staff, and have been forced to reduce testing for blood borne pathogens, a change that could lead to increasing rates of HIV and HCV among an already vulnerable population.

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