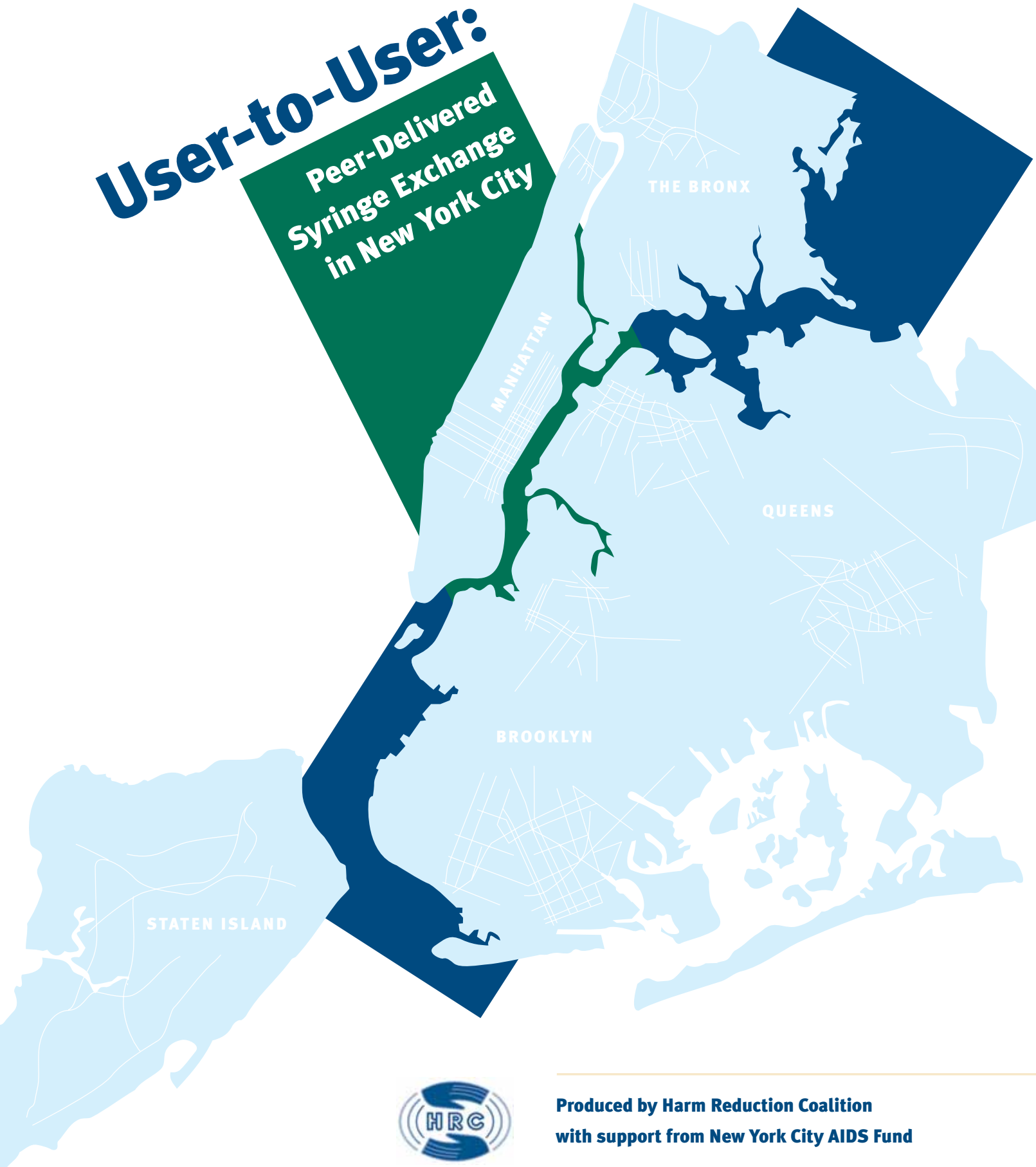
User-to-User:

Peer-Delivered Syringe Exchange in New York City



Produced by Harm Reduction Coalition
with support from New York City AIDS Fund

Emily Winkelstein, MSW

Produced by Harm Reduction Coalition
with support from New York City AIDS Fund

Emily Winkelstein, MSW

Edited by Maria "Sam" Josepher and Daniel Raymond

HRC would like to acknowledge PDSE workers and syringe access program staff for their contributions to this report, and for their ongoing commitment to protecting and improving the lives of drug users. Thank you.

Harm Reduction Coalition
www.harmreduction.org

East Coast:
22 West 27th Street, 5th Floor
New York, NY 10001
tel: 212.213.6376
fax: 212.213.6582
hrc@harmreduction.org

West Coast:
1440 Broadway, Suite 510
Oakland, CA 94612
tel: 510.444.6969
fax: 510.444.6977
hrcwest@harmreduction.org

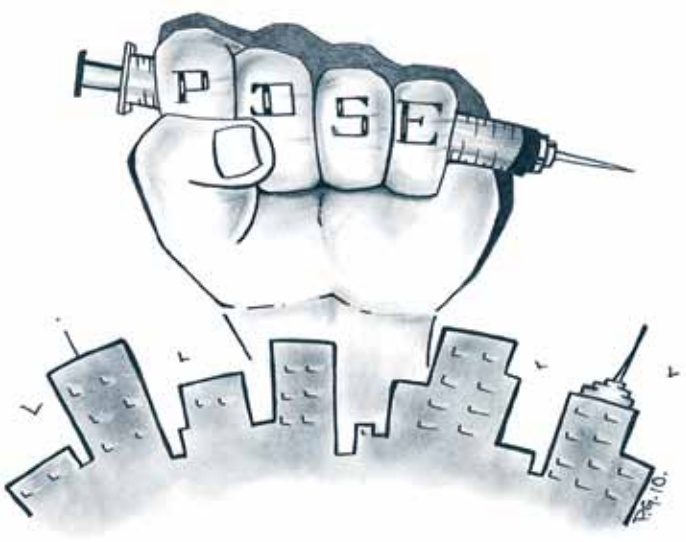
The Harm Reduction Coalition is a national advocacy and capacity-building organization that promotes the health and dignity of individuals and communities impacted by drug use. HRC advances policies and programs that help people address the adverse effects of drug use including overdose, HIV, hepatitis C, addiction, and incarceration. We recognize that the structures of social inequality impact the lives and options of affected communities differently, and work to uphold every individual's right to health and well-being, as well as in their competence to protect themselves, their loved ones, and their communities.

Executive Summary and Recommendations

Peer-Delivered Syringe Exchange (PDSE) is an essential model for preventing HIV and hepatitis C among injection drug users (IDUs). PDSE expands syringe access coverage to the most marginalized and "high-risk" IDUs, while increasing the cultural competency of syringe exchange programs (SEPs) and expanding professional development opportunities for people with histories of drug use.

New York City has one of the highest concentrations of SEPs in the nation, yet it has been estimated that less than 5% of heroin injections use sterile syringes[1]. Eliminating HIV and hepatitis C transmission among IDUs requires investments in innovative syringe access models such as PDSE. To realize the full potential of PDSE, policies must be developed that prioritize sterile syringe access over invasive data collection and align programmatic and regulatory requirements with the needs of drug users.

The PDSE model demonstrates that IDUs can not only be effective agents for syringe distribution, but can also disseminate accurate risk reduction and prevention information, develop meaningful relationships with clients, and promote linkages to additional services and interventions.



In addition, PDSE shows great potential for engaging traditionally "harder to reach" drug injector populations such as transgender persons, women, sex workers and youth. PDSE workers provide SEPs with a unique and vital connection to evolving drug trends such as shifts in community norms, law enforcement practices, overdose rates and injection practices. PDSE workers express a strong sense of value and reward at the opportunity to "give back" to their communities, engage their peers around health promotion, and build their own professional capacity.

The PDSE model implemented in New York can be extended and enhanced. PDSE workers would benefit from increased training and professional development, along with cross-agency planning and coordination of outreach efforts. SEPs should seek to strengthen support and supervision of PDSE workers in order to better integrate them into their agencies and draw upon their experiences and insights for further program development. The PDSE model should expand to develop a lower-threshold tier to authorize more IDUs to participate and to include other social service providers that reach people who inject drugs under the program's auspices.

The following report offers recommendations under two scenarios for maximizing effectiveness of PDSE in NYC. One scenario suggests improvements to the existing PDSE program, while the second proposes a lower-threshold model that reduces requirements for participation and expands program reach to any IDU wishing to participate. These changes, coupled with sufficient and sustained investments in PDSE, have the potential to radically change the face of syringe access in New York City.

RECOMMENDATIONS:

1. **Revise local and state policies to remove restrictions on secondary syringe access and encourage needs-based syringe distribution polices.**

   PDSE provides an opportunity to reassess traditional syringe distribution models. PDSE has been successful in demonstrating that needs-based distribution can occur safely and that participants can remain attentive to proper syringe disposal. Expanding this model to fixed SEPs and ESAP and removing restrictions placed on syringe quantities will be valuable. Further, deregulation of syringes would increase the number of sterile syringes in the community, a valuable step toward decreasing risk of disease transmission.

2. **Challenge drug-related stigma for improved integration of PDSE workers into broader agency culture.**

   Research demonstrates that drug use is among the most highly stigmatized behaviors and that the impact of stigma often remains despite changes in drug use. Harm reduction programs are not exempt from imposing stigma. SEPs must be vigilant in confronting drug-related stigma in their policies and relationships in order to support PDSE workers, as well as other staff and clients. Inclusion of PDSE workers in staff meetings and increased PDSE worker involvement in decision-making processes relevant to PDSE and overall SEP development should be considered. SEPs can better harness the skills and expertise of PDSE workers, as well as the specialized knowledge gained in their role conducting PDSE. Education and training on drug-related stigma should be provided for all SEP staff.

3. **Prioritize PDSE worker recruitment, particularly among individuals with strong social networks in communities of highest need, including women, youth, transgender persons and sex workers.**

   Consult community expertise for guidance in recruitment strategies and train PDSE workers to tailor messages in order to maximize the engagement of target communities.

4. **Increase professional development opportunities and training for peers.**

   To maximize effectiveness and stability of the PDSE program, workers must have access to increased training opportunities in areas such as HIV/AIDS, hepatitis C, overdose prevention, outreach methods, basic wound care, conflict resolution and drug use management/self care. SEPs have a responsibility to provide adequate skills building training and individual support to PDSE workers. Guidance and standardized training protocols that increase skills without raising the threshold for program involvement should be developed. Supervisors should work with PDSE workers to identify areas of greatest need. Guidance on performing administrative tasks and professional development assistance, such as resume writing, should be made available.

   PDSE workers bring a high-level of unique skills and experience. They increase the cultural competence of SEPs and offer valuable insight into current drug trends and patterns, the importance of which should not be underestimated or undervalued. Compensation for PDSE should be competitive and reevaluated as responsibility and experience/skill-level increases. Providing transportation costs for PDSE workers must also be taken into account.

5 **Remain attentive to the drug use management needs of workers.**

Burnout prevention and self-care skills development provide mechanisms for discussing the relationship between drug use and PDSE activities. Workers must be informed that they will be supported fully if they wish to make changes to their drug use and that these changes will not alone impact job stability.

6 **Develop systems to maximize communication and coordination between PDSE workers.**

Increased coordination will ensure maximum productivity of PDSE, help to avoid over-saturation of certain areas or communities, and address service gaps in areas that continue to have little-to-no sterile syringe access. This can be achieved through community mapping and increasing communication between participating SEPs. The monthly PDSE Worker Network meetings, an important step toward improving communication between PDSE workers, should be supported and sustained.

7 **Utilize innovative technology to develop more efficient and accurate data tracking systems for peers to use in a variety of settings.**

Minimize the use of paper tracking forms and data transfer. Data collection should be simplified to include only essential information. Adjust evaluation processes and measures to reflect the value of relationship-building and the quality of interactions in addition to transaction data and demographics.

8 **Expand safe disposal options for PDSE workers and participants. Promote safe disposal of syringes and education about disposal options, but remove any requirements that PDSE workers collect used injection equipment for return to the SEP.**

Policies must recognize the full range of strategies employed by IDUs to safely dispose of injection equipment. In addition, they must recognize that PDSE workers are placed at unnecessary and increased risk of infection by needle stick and harassment by law enforcement when asked to handle and transport used syringes.

Individual fit-packs and sharps containers should be made available along with education on alternative safe disposal options and needle stick injury. Policies should promote the expanded use of disposal kiosks in a wide range of locations.

9 **Utilize formal identification means (such as ID cards) to identify peer workers and ensure their recognition by law enforcement.**

Fear of law enforcement is a significant deterrent for IDUs to accessing sterile syringes. Formal and consistent means of identification of PDSE workers is essential in allowing workers to do their jobs without fear of harassment. Law enforcement must receive education and training on PDSE as well as syringe exchange broadly as an essential prevention tool that promotes greater individual and community health, including greater safety for officers.

10 **Integrate PDSE (or a variation on PDSE) into the service menu of related non-SEP providers that maintain contact with large networks of IDUs.**

PDSE was introduced as a means of tapping into IDU social networks. Any setting that works with IDUs should be eligible to implement PDSE, including AIDS service organizations, substance abuse treatment programs, community health centers and related social service providers. Expanding PDSE training and authorization to both professional staff and clients of these organizations would increase access to both sterile syringes and ancillary services. Compensation tied to PDSE would be waived for professional service workers and additional costs to organizations would be minimal.

RECOMMENDATIONS FOR EXPANDING THE PDSE PROGRAM:

Although PDSE is an effective strategy for expanding syringe access, the current model has retained certain aspects of conventional SEP delivery that restrict productivity and have the potential to perpetuate a problematic hierarchy among workers in SEPs.

The following will outline an alternative PDSE model that incorporates a tiered structure into the existing framework and introduces a lower threshold variation of PDSE. This structure aims to maximize the reach of PDSE, increase the number of sterile syringes getting to IDUs and fully develop the skills of PDSE workers.

Tier 1: Low-threshold PDSE

PDSE was borne out of the acknowledgement that IDUs were obtaining syringes from SEPs for secondary distribution to their peers. Thus far, PDSE has utilized only a handful of IDUs with the most expansive social networks who possess the time and motivation to meet SEP administrative and attendance requirements and distribution quotas. By lowering the threshold for participation in PDSE, SEPs could harness the efforts of a much greater proportion of IDUs while giving legitimacy to transactions that are likely already to be occurring. Ideally, any IDU who would like to distribute syringes to another injector should be authorized to do so.

Low-threshold PDSE would be an *unpaid voluntary* program that provides any IDU enrolled at an SEP an opportunity to become authorized as a PDSE volunteer to distribute syringes within their social networks. The program would not impose hourly commitments or distribution quotas. Participants in the lower-threshold PDSE program would not receive compensation; however, they would receive authorization to disseminate sterile syringes within their social networks.

Policies can be developed to formalize a very brief, on-site training and enrollment protocol to cover basic safety information including needle stick prevention and response. Participation in PDSE should be made available upon enrollment at the SEP, as well as any time thereafter. The addition of this tier will require few additional resources aside from staff time and injection supplies necessary to meet expanded coverage needs.

Reducing requirements for detailed transaction data may be necessary to ensure that the maximum number of IDUs are receiving sterile injection equipment. Given the great opportunity to prevent the transmission of infectious disease through this program, it would be unethical and negligent to allow data collection requirements to trump the health and safety of program beneficiaries. It would not, however, be unreasonable to require that low-threshold PDSE members report whether they are obtaining sterile syringes for themselves alone, or for other IDUs (and if so, approximately how many). Low threshold PDSE members would not be asked to collect contaminated syringes for disposal at the SEP.

The success of this model ultimately requires increased access to safe disposal options, ID cards, increased education to law enforcement and expansion of needs-based syringe distribution policies. SEPs would also be able to use the lower-threshold PDSE tier to identify and recruit possible candidates for the higher-threshold PDSE model that will prioritize worker development, described in the section below.

Tier 2: Higher-threshold PDSE

For those workers interested in investing a greater level of involvement in the PDSE program and the SEP, the existing PDSE model will remain in place, taking into account all of the above-stated recommendations.

Individuals recruited for this higher-threshold, second tier of PDSE will be required to meet program requirements similar to those currently in place, including reporting to the SEP on a regular basis, meeting distribution quotas, collecting more detailed transaction data, and participating in SEP activities as directed. In turn, they will also gain from greater skills-development opportunities and will receive monetary compensation for their participation.

User-to-User: Peer-Delivered Syringe Exchange in New York City

This report provides an overview of New York State's Peer-Delivered Syringe Exchange (PDSE) model for syringe access. We will evaluate the ways in which PDSE functions in New York City and present some early lessons learned. Our goal is to emphasize the valuable role that PDSE can play nationwide in: reducing transmission of infectious diseases such as HIV and hepatitis C among injection drug users (IDUs), increasing cultural competence of syringe exchange programs (SEPs) and legitimizing health-promotion behaviors among drug users.

Using qualitative and quantitative means—including focus groups, individual interviews and surveys with PDSE workers, program administrators, Health Department officials and other experts and researchers on syringe access—this report aims to define successful program characteristics, outline PDSE program variations, delineate strengths and challenges of high-functioning PDSE programs, and make recommendations for successful and innovative PDSE implementation in New York State and beyond.

PDSE workers conduct a neighborhood clean-up of improperly discarded syringes.

Courtesy of Washington Heights Corner Project
www.cornerproject.org

Introduction

Syringe exchange has made a significant impact on the trajectory of the HIV/AIDS epidemic in New York City with research demonstrating both prevalence and incidence of HIV among injection drug users (IDUs) dropping by roughly 75% since the late 1980s and early 1990s. Recent data estimates prevalence at 13–15% and incidence at 1/100[2].

However, significant challenges remain to be addressed. Several studies collectively highlight geographical gaps and racial/ethnic disparities in on-going HIV transmission among IDUs and their sex partners due to critical limitations in current syringe exchange coverage.[3 4 5 6]

A 2006 survey found that 28% of IDUs had not obtained any syringes from syringe exchange programs (SEPs) in the past 12 months, and 14% of IDUs had not acquired any syringes from sterile sources (SEPs, medical providers, pharmacies, etc.) in the previous year.[7] Syringe source varied significantly by neighborhood, with IDUs in certain Brooklyn neighborhoods least likely to obtain syringes exclusively from sterile sources. Results from cross-sectional surveys of IDUs in Harlem and the Bronx in 2001 and 2002 found that between 43.2% and 66.2% reported SEPs as the syringe source for their most recent injection, with 10-15% purchasing their most recent syringe from the street[8]. Earlier data from a large sample of IDUs entering a detoxification program found that the proportion who reported using a syringe exchange program in the past six months never exceeded 50% during the first decade of legal syringe exchange in New York[9]. This study also found significant racial/ethnic disparities in HIV prevalence among IDUs, with

African Americans most likely to be HIV-positive, followed by Latino IDUs.[10]

Although recent key developments have begun to address some of these gaps and disparities, new strategies and investments will be necessary in making further progress on syringe access and HIV prevention in the city. In part due to political support from the mayor and health commissioner, syringe exchange has experienced a renaissance in New York City during this decade with the advent of new program launches for the first time since the mid-'90s. Additionally, many SEPs are re-assessing traditional one-for-one exchange policies in favor of needs-based distribution in direct response to research evaluating the impact of syringe coverage and distribution models on IDU risk behaviors. New services addressing a broader range of drug user health issues that intersect with HIV/AIDS—including hepatitis C, overdose, and access to buprenorphine treatment—are increasingly being integrated into the standard package of care that IDUs receive at community-based syringe access programs. These developments coincide with concerted efforts by drug user advocacy networks and a much needed yet insufficient infusion of additional public funding from the city and the state after several years of stagnant syringe exchange budgets.

Finally, new syringe access models–most notably the Expanded Syringe Access Demonstration Program (ESAP) and Peer-Delivered Syringe Exchange (PDSE)—have broadened the repertoire of strategies and interventions through which to engage more IDUs and distribute more syringes.

Since 2001, ESAP has allowed registered pharmacies and licensed health care facilities and health professionals to furnish syringes to IDUs without a prescription. PDSE, launched as a pilot in 2007, trains and authorizes SEP clients to conduct syringe exchange with members of their social networks and other contacts. ESAP and PDSE provide new avenues and innovative solutions to syringe access for IDUs in areas underserved by traditional syringe exchange. They ease historical constraints that have curtailed the growth of syringe access such as community and political un-acceptance, limited resources and funding, and regulatory burden. While each form of syringe access has its own strengths and limitations, the robust mix of models now available effectively multiplies opportunities for IDUs to obtain sterile syringes. Organizations and service providers can select and adapt the model best suited to their needs and the needs of the IDUs they serve.

While new programs and additional city and state funding have resulted in a resurgence over the past few years in both total numbers of syringes distributed and numbers of syringe exchange/community-based ESAP transactions, the absolute

Secondary Syringe Exchange (SSE)

Secondary Syringe Exchange (SSE) is the commonly acknowledged name assigned to the practice wherein injection drug users (IDUs) obtain syringes at SEPs and re-distribute them among their friends, family, social networks and communities (sometimes also referred to as Satellite Syringe Exchange). Many studies point to the value of secondary syringe exchange as an important tool for HIV prevention.[12 13 14 15] SSE is a broad term encompassing a range of both formal and informal arrangements wherein syringes are furnished by one IDU to another; this can include regular distribution among injection partners or established social networks of injectors wherein there is a "designated exchanger" as well as loose affiliations wherein syringes are sold, traded, loaned or otherwise provided on an as-needed basis.

Despite legal barriers to widespread authorization of SSE, research indicates that distribution of syringes among IDUs is common practice, and even encouraged by many SEPs. A nationwide survey of SEPs found that approximately 90% of programs encourage secondary exchange and that the vast majority of IDUs supply sterile syringes to each other.[16] In a California research study, 75% of SEP clients reported engaging in SSE. Studies also document that SSE has been successful in expanding the number of sterile syringes in circulation.[17] A research study in Chicago found that 22% of 40,000 syringe exchange visits involved secondary exchange and that the secondary transactions accounted for over half of all syringes exchanged at the program.[18]

SSE is a particularly strong model for expanding syringes to the most vulnerable and marginalized IDUs, including those who are unwilling or unable to access SEPs. In addition, SSE taps into the valuable skills of drug users, empowering and validating users as experts and role-models. Although well-acknowledged as a risk-reduction intervention that has naturally evolved from drug user norms, formal SSE has yet to be fully embraced by many health departments and governing bodies. Continuing shifts in syringe access policy from one-for-one exchange to a needs-based distribution policy may lead to wider employment and official acceptance of SSE as an effective strategy.

volume of syringes distributed by New York City SEPs and community-based ESAP providers still falls well below its historical peak of 3,000,000 per year reported in 2000. The variance may be attributable in part to a shift towards syringe purchases from pharmacies following the introduction of ESAP, and an aging and perhaps declining IDU population. However, available estimates suggest that current levels of syringe coverage by SEPs for heroin injectors in New York City amounts to only 2 syringes for every 100 injections.[11]

In New York City, PDSE offers a promising opportunity to expand syringe access and increase the number of syringes utilized by IDUs. PDSE is especially pertinent for reaching those IDUs unwilling or unable to access syringes from traditional or existing sources.

Three distinct variations in PDSE have evolved as a result of resourceful implementation of PDSE by individual SEPs—each somewhat tailored to best meet the needs of their client base: 1) peer delivery within existing social networks, 2) peer delivery at stationary outreach sites, and 3) peer home-delivery service.

Background

In the early 2000s, SEP data revealed a pattern wherein a noticeable cohort of syringe exchange clients were receiving significantly large quantities of syringes—more than could possibly meet one individual injector's needs. These syringes were most likely being obtained for secondary distribution. In light of the ongoing challenges to expand syringe coverage and fill gaps in access throughout NYC, New York State Department of Health AIDS Institute (AI) introduced PDSE as a means of formalizing secondary syringe exchange (SSE) throughout New York State.

PDSE formalized limited SSE by allowing SEPs to authorize and train a select number of SEP clients to conduct syringe access services among their peer networks and within their communities.

A PDSE worker facilitates an activity at the First Annual Conference on Peer-Delivered Syringe Exchange held in New York City in April 2010.

There are currently 10 SEPs participating in the PDSE program in New York City with additional programs upstate in Ithaca, Johnson City and Buffalo. The number of individual PDSE workers per program range widely across programs, usually fluctuating to account for changes in lifestyle, new employment, or geographic relocation among other resons.

With assistance from the New York City Department of Health and Mental Hygiene (NYC DOHMH) and AI, the Harm Reduction Coalition supported PDSE workers in the organization of the first statewide conference on PDSE in April 2010. The one-day conference gathered over 100 participating PDSE workers, drug users interested in learning more about PDSE, program staff, health department officials and advocates. PDSE workers developed programming including panels and interactive sessions on topics such as worker safety, outreach, training, workplace issues, and analysis of relevant laws and policies. In addition, the conference served as a platform to launch a regular PDSE Worker Networking Group hosted by NYC DOHMH. The Networking Group continues to meet monthly to discuss issues pertinent to PDSE workers, coordinate activities and training, and serves as a clearinghouse for support, advocacy and ongoing professional development.

General Program Characteristics

Generally, PDSE workers are not required to have formal training prior to their engagement and participation in the program. Workers are recruited based on their connections to IDU social networks, knowledge of the community and their ability to meet program requirements (syringe transactions,

meetings or trainings, complete documentation and other administrative duties, communicate with the SEP, etc). PDSE workers are required to attend a one-time, comprehensive training at AI that trains to receive instruction on general program regulations and safety issues, standards of conduct, needle-stick prevention and response, engagement with law enforcement, relevant statutes related to syringe access and possession. Individual agencies can elect to provide additional training to PDSE workers prior to and during their participation with the program. Once workers have been trained to conduct PDSE, their parent agency is responsible for providing them with identification that designates their status as a PDSE worker as well as all of the supplies necessary to both distribute sterile syringes and collect used syringes from individuals in their social networks and communities.

Collection of used syringes happens largely at the discretion of the individual SEPs and PDSE workers. Fear of harassment from law enforcement, reluctance of PDSE recipients to carry used equipment, insufficient sharps disposal bins, and SEP policies restricting PDSE collection due to safety concerns all hinder collection of contaminated syringes. In cases where workers are unable to provide disposal for used syringes, they are trained to offer education about proper disposal options.

PDSE workers are able to enroll new clients into the SEP and issue SEP ID cards to clients (both new clients, as well as enrolled individuals who may have misplaced their SEP cards). Workers must complete some documentation of the transactions and are expected to maintain contact with their supervisors on a regular basis (as determined with the program). In addition, there is an expectation that workers will provide PDSE recipients with education and referrals to the parent SEP or other necessary services. In order to provide vital linkages between SEPs, community services and PDSE clients, many programs have customized referral cards or documents that PDSE workers carry for distribution.

PDSE workers receive financial compensation in the form of a modest stipend for a predetermined number of hours and in some cases, travel reimbursement (determined by SEP programs individually). Payment schedules and amounts are left to the discretion of individual programs to arrange with PDSE workers. Although general program guidelines are issued by the State, there is no "standard operating protocol" for SEPs participating in the PDSE program. Subsequently, each SEP operates their PDSE worker program somewhat differently, tailoring the program based on the needs of its injecting community, the PDSE workers and agency resources.

Overview of PDSE Program Variations

There have been three primary methods of PDSE operationalized in New York City. Each of these methods bring unique strengths and challenges to maximizing expansion of syringe coverage and can be easily adapted and improved to meet the needs of a particular community or network. This analysis will isolate the primary methods that are used to target particular subgroups of IDUs, acknowledging that, in practice, there is often overlap across approaches and the populations reached.

PDSE via Social Networks

PDSE in social networks is the most straightforward practice of PDSE. In this model, PDSE workers collect syringes and other safer injection supplies from an SEP for distribution within their communities and social networks. Workers deliver syringes to injection partners, friends, and family as well as to strangers and other connections that are established through word-of-mouth. This method of PDSE is the least structured in that workers define when and where they work. In order to prevent worker burnout and protect the safety of everyone involved, it is necessary for workers to define personal boundaries regarding exchange practices.

PDSE workers are recruited for this model based on an established role within their social network of users, either as an already "designated exchanger" or a trusted member of the community. Transactions may occur at any time of day or night, based on parameters generally set by the workers themselves. PDSE workers are required to log transaction details based on policies established by their SEP as

information collected is not standardized across programs. Syringe recipients contact PDSE workers via personal contact information including cell phones, home or work addresses, incidentally in the street or at established meeting areas.

Our data suggests that this method of PDSE has a greater capacity to reach people who have traditionally been disconnected from SEPs and is effective at acquiring new SEP enrollments. In addition, data reveals that this method of PDSE also yields a high number of syringes received per client although not necessarily per transaction.

This method of PDSE is particularly important for alleviating the following common barriers to engagement with traditional SEP models:

Stigma: IDUs may be unwilling to visit SEPs due to social stigma and fear of being identified publicly as an IDU. PDSE workers are able to establish trust, build individual relationships with clients, and conduct lower-threshold transactions with increased privacy and discretion. This can be particularly effective for engaging individuals with higher social/community status.

Fear of Law Enforcement: It is well documented that IDUs avoid areas where there is perceived risk of identification by law enforcement, including SEPs. Despite efforts to reduce police harassment of SEP clients, fear of surveillance remains a strong deterrent especially for individuals on probation or parole, or those with outstanding warrants or otherwise unresolved legal issues. This PDSE model offers greater discretion for syringe transactions.

> ***One reason why this is vital is that fact that not everyone can go to the average needle exchange. There are some people who are afraid, and for some it's too far away... other instances, people are afraid of police harassment... that seems to be the major reason why a lot of people are afraid.***
>
> **—PDSE Worker**

SEP location: SEPs may be difficult to reach or their location may be distant or inconvenient. PDSE workers are in the community and can conduct transactions nearly anywhere.

Insufficient or Inconsistent Transportation: Costs associated with travel to and from the SEP, inadequate public transportation, and lack of other personal means of transportation create barriers to SEP engagement. These issues can be addressed by PDSE because workers bring syringe access services into the community and work more directly with IDUs.

SEP hours of operation: SEPs may only be open during certain hours and are often unavailable nights and/or weekends. Although PDSE workers may be encouraged to establish boundaries for personal safety and burnout prevention, they are more likely and able to set flexible hours that make syringe transactions available and accessible to IDUs outside of conventional hours.

Drug lifestyle: It is not uncommon for persons wishing to abstain from or limit their drug use to discard or dispose of excess syringes in their possession in an effort to reduce temptation. However, if they decide to resume use, it may not occur at a time that is convenient to visit a SEP, or there can be shame associated with the decision to use again. Also, certain drugs such as cocaine and methamphetamine may lead to increased use of syringes. Refurnishing syringe supply via PDSE may be easier and more accessible.

Demographics: Research suggests that transgender people, women, African-Americans, foreign-born individuals and people over the age of 43 are less likely to access sterile syringes from SEPs. By recruiting workers that match these demographics, PDSE may alleviate traditional barriers associated with gender, race/ethnicity, age or immigration status.

PDSE via Stationary Outreach Sites

In this model of PDSE, workers are dispatched by the SEP to fixed locations during set days and times allowing SEPs to expand the reach of their outreach services beyond traditional catchment areas and adapt to shifting drug trends. Standard SEP outreach routes or "walkabouts" must conduct syringe exchange at designated sites at approved times. Since PDSE allows for syringe exchange to take place at any time and in almost any location throughout the State (with certain exceptions, such as Housing Authority property), SEPs can use PDSE workers to increase access to transient injecting communities and areas with little to no service coverage. This model is generally used to supplement existing SEP outreach, not replace it.

PDSE workers and staff on street-based outreach.

Courtesy of Washington Heights Corner Project
www.cornerproject.org

Stationary PDSE outreach is easier to manage from an administrative standpoint, can be safer for PDSE workers and minimizes the pressure placed on individual workers to define boundaries regarding distribution hours. However, this model also limits transaction privacy and may create tension between PDSE workers and SEP staff if they are performing the same functions for different compensation and benefits.

Stationary PDSE sites are most often established in close proximity to methadone programs, parks and housing projects, as well as other high activity areas known to PDSE workers. Stationary PDSE may also include service on a mobile unit. Site locations may be identified by the SEP or by the PDSE worker, although SEP approval may be required to change sites.

SEP staff may accompany PDSE workers at stationary sites, providing educational information, referrals and support. In a number of programs, PDSE workers fulfill their entire hourly commitment at stationary sites; however this does not seem to deter the workers from also conducting SEP transactions within their social networks.

This method of PDSE tends to alleviate certain common barriers to engagement associated with traditional SEP models:

Shifts in injection communities/SEP location: Areas with a higher concentration of IDUs may shift periodically based on the location of drug markets, police presence, gentrification, or seasonally, among other reasons. The process of amending outreach routes for waivered SEPs can be time consuming and may be unnecessary for temporary shifts whereas PDSE sites can be identified based on current injection trends and modified as needed.

Reaching sub-groups of injectors: Certain sub-groups of injectors such as sex workers, new injectors, and IDUs of a certain racial/ethnic background may be more difficult to reach via traditional SEP methods because of trust and cultural issues. PDSE workers who are members of the sub-groups will be able to identify the most effective and safe outreach locations and times, are more familiar with cultural norms and can blend into the community thereby alleviating stigma associated with syringe access from designated SEP outreach sites.

PDSE via Delivery Service

The PDSE via Delivery Service is another innovative model that enlists PDSE workers to engage in an on-call syringe delivery service. Delivery requests for syringes are called into either the program or the

individual PDSE worker, and workers are dispatched to locations for syringe collection and delivery. PDSE workers may fulfill their entire hourly commitment conducting delivery. However, these PDSE workers may still also conduct SEP transactions within their social networks on their own time.

Syringe delivery has been effective in reaching drug users who live in single room occupancy hotels with workers visiting several units in one stop. While this method seems to attract fewer new SEP enrollments, data from one program that uses PDSE almost exclusively for delivery suggests that they are able to deliver more syringes per client as well as per encounter and are able to achieve higher collection rates of used syringes.

This method of PDSE is particularly effective in alleviating the following common barriers to engagement associated with traditional SEP models:

Disability (including illness/disease, injury and mental illness): Physical and/or mental disabilities are commonly reported as a deterrents for accessing SEPs. The delivery method ensures that persons with disabilities can still access sterile syringes.

Caregiver responsibilities: For individuals who are caregivers of children or the elderly, it may be more difficult to leave the home to visit an SEP. Delivery from PDSE workers provides a discreet and convenient way to ensure access to sterile syringes.

Drug lifestyle: Certain drugs such as cocaine and methamphetamine may lead to increased use of syringes or paranoia. It may be easier to refurnish sterile syringe supply via delivery. In addition, activities associated with drug use can lead to complicated relationships with other drug users and may lead people to avoid SEPs. Delivery offers an additional level of privacy.

Stigma: Individuals unwilling to visit established SEP sites due to social stigma and fear of being identified publicly as an IDU can be reached through the delivery method because of the increased levels of worker-client trust, and the added levels of privacy and discretion. This can be of particular relevance to individuals with a perceived higher social/community status.

Strengths

The introduction of PDSE has been invaluable to expanding syringe access in New York City. Aggregate data collected from the 9 NYC SEPs that had implemented PDSE at the time of this report indicate that between March 2009 and March 2010, PDSE was responsible for nearly one-third of all syringes distributed. Program data also indicates that just over half of all new program enrollments during this period were a result of PDSE. From a broad syringe access perspective, PDSE is also contributing to a shift that emphasizes needs-based syringe access models rather than traditional one-for-one-based models.

Data suggests that women and transgendered people benefit significantly from PDSE, as well as African Americans and persons over 40—all subgroups that have been identified as "harder-to-reach" by traditional SEP models. Qualitative reports from PDSE workers indicate that a large percentage of their recipient bases are professionals and "functional users" (doctors, lawyers, etc.) as well as people on methadone, undocumented persons, and sex workers. This suggests that PDSE's low-threshold approach to syringe access—with an emphasis on trust and individual relationships between PDSE workers and syringe recipients—has been successful in overcoming some of the traditional barriers.

> ***A lot of times during the first initial [contact] there's so much more information that we have to give and so many more services that we have to provide to the client that that's when they really—you know, they come in. They didn't know that we did OD prevention, they didn't know that we did STD testing, HIV/AIDS testing—so sometimes that first contact is really your initial [opportunity] to gettin' people in a community involved in other services...meeting people where they're at.***
>
> **—PDSE Worker**

The capacity to increase the number of sterile syringes accessed by IDUs is especially promising given that PDSE has only been a fully operational program for roughly three years.

PDSE workers on-call for syringe delivery.

Linkages to Service

The high proportion of new program enrollments generated via PDSE suggests that more IDUs are being connected to services as a result of this initiative. Workers report that much of early relationship and trust building is built on discussions about general SEP services such as HIV prevention (condom distribution), benefits assistance and case management services—introducing syringe availability only after an initial rapport is established. Although tracking mechanisms have not been set up at this time, it can be assumed that a proportion of PDSE recipients take advantage of the additional SEP services provided based on PDSE interactions.

PDSE workers report assisting their clients with a variety of services such as case management, prevention education, referrals and general support, supporting the assertion that IDUs are benefiting from this program through much more than sterile syringes alone. For example, several PDSE workers in our focus groups and interviews reported escorting their clients to medical visits and drug treatment programs as well as to get testing for HIV and hepatitis C. PDSE workers also report that being able to build stronger, authentic relationships with clients over time allow them an extra advantage in counseling their clients; they gain insight into the day-to-day status of clients' overall health and well-being and are therefore better positioned to help their PDSE clients identify needs during periods of greater instability. In turn, PDSE workers are able to provide their SEPs with vital information about the community, including changes in drug patterns, overdose trends, law enforcement issues and other concerns that could affect client needs.

Unique Program Reach

PDSE is successful in reaching IDUs in a way that traditional programs have not been able to for several reasons.

- PDSE offers the unique convenience of bringing syringes directly to the areas and communities when and where people are injecting drugs.
- PDSE has the capacity to increase the privacy of transactions therefore alleviating many concerns that IDU status will be revealed.
- PDSE utilizes the unique skills and experiences of PDSE workers and this is, in many ways, the cornerstone of PDSE's success.

Given not only the illicit nature of injecting drugs, but also the social stigma associated with the activity, IDUs often learn quickly to exercise a degree of caution before extending trust with regards to their drug use. Given their own personal relationships to drug use and

We get integrated into the [user] community—which is a risky thing. We need to have a boundary for ourselves and be careful not to get caught up in the mix…but the thing is, that we're accessible…and get the trust, and lack of suspicion. So things that wouldn't normally come out in a professional setting…when they come to us, it comes out in conversation.

—PDSE Worker

We can relate to certain things that's going on—we don't come in judging, we don't come in with stigmas, labels, and things like that.

—PDSE Worker

drug using communities, PDSE workers are often able to earn the trust of SEP clients more quickly.

PDSE workers' unique cultural competency cannot be underestimated in allowing for a deeper relationship with clients. They also bring a certain "street savvy" that lends itself to easily setting boundaries, informally engaging in conversations about sensitive topics and making transactions as safe, quick and convenient as possible.

PDSE workers in the field.

Courtesy of Washington Heights Corner Project
www.cornerproject.org

Benefit to PDSE Workers

Consistent with the well-documented experience of HIV prevention peer delivered services,[19] [20] PDSE workers benefit significantly from their participation in the PDSE program, its training and supportive services. In addition to receiving financial incentive in the form of a stipend, workers receive training on HIV and HCV prevention, overdose prevention and response, safer injection strategies, motivational interviewing and counseling skills, among other areas. They also gain valuable mentoring and professional development by participating in regular supervision, developing communication skills, and performing administrative tasks. For some workers, PDSE may be the first engagement with a traditional work environment that they've been afforded in some time.

Most importantly, PDSE workers are provided the opportunity to engage with their own communities as ambassadors for the SEP, offering a valuable service within their social networks. The significance of this role on the self-esteem building of PDSE workers should not be underestimated. For many drug users, the communities in which they get (or got) high become a surrogate family—especially given the isolation from traditional family that is common among many people who are heavily involved in drug-using culture. PDSE allows workers an alternative way to engage with their peers—an especially valuable aspect for workers wishing to make changes to their drug use. Overall PDSE workers report great satisfaction and personal reward for contributing to the health and well being of their communities, as well as earning a new level of respect from their peers for their service.

It's a beautiful thing. Many of us can give back... if we've done harm in the neighborhood, and our lives are beginning to take on some change, and we're out here now, doing what we're doing—believe me, a lot of people give us respect. Also, it's a way of us reconciling the past. Because it gives back to the community...and users get that.

—PDSE Worker

It's like that family-like thing of being an IV drug user. Even though it's a bad thing...it could be a good thing.

—PDSE Worker

Challenges

While PDSE has been well-received by programs, workers and clients alike and clearly increases syringe access, it is critical to the improvement and strengthening of the program to carefully review aspects of the program that pose challenges and concerns. Analysis of PDSE is complicated by the variations across programs and individual workers. Nonetheless, this report offers a basis for discussion and for establishing more concrete guidelines to ensure program growth and development.

- As outlined, program data suggests that certain subgroups of traditionally "harder to reach" IDUs are benefiting from PDSE. However, data also suggests that overall syringe coverage is remaining relatively stagnant, while methods of access are shifting. It is possible, therefore, that people who had been accessing sterile syringes primarily from SEP sites have begun obtaining syringes from PDSE (or other sources) because it is more convenient or otherwise lower threshold.

  Programmatic limitations such as the few number of PDSE workers relative to the vast geographic areas to be covered and insufficient coordination of PDSE across participating programs, offer possible explanation for the findings.

- There is the need for a general coordinating body that can identify service gaps and improve inter-agency communication. For example, PDSE workers have reported conducting stationary delivery in one location (i.e. a park) only to find out that another SEP had also stationed PDSE workers in the same area. Conversely, other areas may not have any PDSE coverage. Further development of the recently structured PDSE Worker Network may be able to alleviate some of these issues. Information sharing of PDSE sites and locations as well as centralized mapping of PDSE coverage would be valuable.

- An accurate quantitative representation of PDSE's success is also limited by the lack of sufficient and simple universal reporting and data tracking systems. Historically, data collection has not taken priority over syringe distribution and collection, as it should not in PDSE either. Given PDSE's low-threshold and discreet approach, data collection and logging of transactions is challenging. To address this issue and meet reporting standards, some workers and programs have creatively modified enrollment and transaction forms to include only essential demographic or transaction information, thereby simplifying data collection.

  Also, since data collected on paper must later be manually entered into a database, there is room for error or even loss of transaction forms. Handheld electronic devices or other creative solutions may be helpful toward increasing the reliability of data while also encouraging consistency across programs. To the extent possible, further reductions in the amount of information collected at individual transactions may lead to more syringes being delivered.

- Direct supervision of PDSE workers can be challenging because work is generally completed off-site with little to no contact with other staff or supervisors and clients may not be in a position to offer feedback to the SEP. In addition, most paid PDSE hours are spent in the field, with minimal time spent on-site at SEPs. Appropriate supervision of PDSE workers is important to ensure that workers

It was like 4 of us in a 5 block area…sometimes we need to have better communication to know who's serving or who's working what areas.

—PDSE Worker

The program is very much needed—and the numbers state that. But—there's not a lot of money to support [the PDSE program]…there's a lot of people who don't know what [PDSE] does and how beneficial it is to the community …the first line of contact for a lot of issues, not just the syringes. When it comes down to it—a peer does the job, but…some people look down on the peers because of their past, their background or the communities they come from. But…very few people can reach the communities that we reach. But if we're so important…why…I mean, who's better to get paid to do the job than us?

—PDSE Worker

A map indicates locations where PDSE is conducted.

are receiving proper training and support, to offer assistance in setting boundaries if needed, and to provide an outlet for feedback.

PDSE workers also have different levels of experience with professional supervision. The independent nature of PDSE requires a high level of worker autonomy and in turn, a great deal of trust on behalf of supervisors. This trust, however, is mediated by the pervasiveness of drug-related stigma. Active drug use, changes in drug use, shifts between periods of stability and instability, worker involvement with the criminal justice system and engagement in higher-risk behaviors that could impact on job performance all pose unique challenges to supervising PDSE workers and point to the need for supervision that allows for honest and open dialogue about drug use and the best ways to support individual workers.

- The PDSE work environment cannot be controlled in the same way as a fixed site, requiring added security and safety measures to be established. Several PDSE workers reported the need for an emergency hotline or similar resource in case of police harassment or threats to personal safety while conducting PDSE.
- One of the greatest challenges to successful and productive PDSE has been lack of worker integration into SEPs. Although SEPs value the PDSE program itself, there seems to be a disconnect in their investment in and professional development of individual PDSE workers.

  PDSE workers perceive that their high level of skill, knowledge and innovation, as well as their overall contribution to PDSE success, is taken for granted. This has an impact on the confidence and self-worth of PDSE workers, contributes to burnout and diminished job interest, and has the potential to perpetuate stigma-related harms. Specific concerns have been raised in three primary areas: 1) perceived status of PDSE workers within their agencies, 2) professional development opportunities and additional training needs, and 3) insufficient compensation for services.

Agency Priority

Our analysis reveals that many PDSE workers experience a hierarchy between PDSE workers and non-PDSE SEP staff. This may suggest that SEPs are struggling to adequately incorporate PDSE workers into broader agency culture. Many PDSE workers reported feeling isolated from staff at their agencies as well as from broader staff culture. PDSE workers largely attribute the separation to differences in personal backgrounds—in particular, to their experience with drug use or differences in past employment and educational opportunities.

PDSE workers expressed feelings of frustration for doing many of the same tasks as non-PDSE staff (including case managers, SEP staff and medical staff) without proper recognition and/or inclusion in agency decision-making. Exclusion of PDSE workers from SEP staff meetings is common and seems to play a critical role in promoting feelings of segregation among PDSE workers. For workers, this separation is directly linked to a failure among SEPs to legitimize the essential and unique role that PDSE workers play in engaging new clients, delivering vital services and

> ***They need to change the name from peer delivery to peer case management—that's what we really are—we're doing their jobs; every time they have meetings, they don't like the peers to come to their meetings. They don't invite us—they're separate. I'm an employee now—I get paid on the books and I'm not allowed to come.***
>
> **—PDSE Worker**
>
> ***It's a difference between staff & peers and it really shouldn't be because a lot of times we're doing the same work and in some cases, more work—but sometimes I can't blame the agency, sometimes it's the staff themselves…there is an emphasis on "you are a peer"… but a peer is part-time staff, so what's the difference between "peer staff" and "staff staff"?***
>
> **—PDSE Worker**

establishing trust in the community. Although PDSE workers do report that their agencies place priority on PDSE at a *program level,* the majority of workers did not feel that this commitment is being translated to the *individual worker level*. With few exceptions, workers felt that they were treated differently (i.e. poorly) due to their status as PDSE workers.

Professional Development and Training

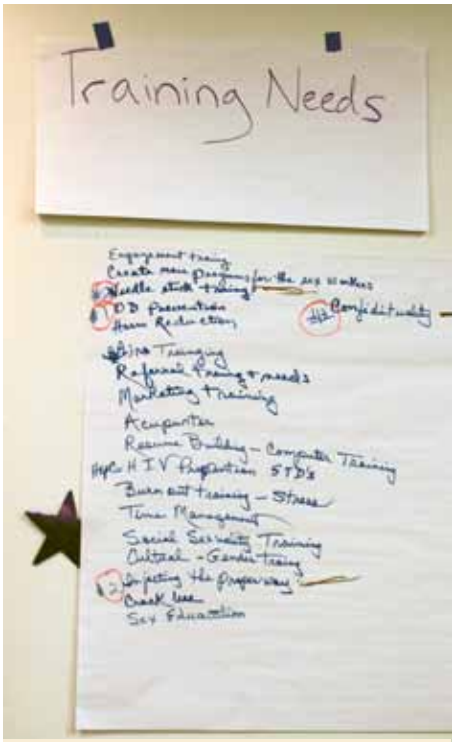
PDSE workers reported dissatisfaction with ongoing professional development and training opportunities at their agencies. Aside from the initial AIDS Institute training that is mandatory for all PDSE workers and addresses a broad range of essential issues (PDSE guidelines and regulations, legal statutes relevant to syringe access, basic needle stick protocol, etc.), training opportunities for PDSE workers vary greatly between agencies.

A sentiment echoed during data collection for this report—the need for additional training—was also highlighted by attendees at the PDSE Conference held in April 2010. Training topics that were most consistently requested include: overdose prevention, confidentiality, safer injection, referrals/case management basics, personal safety, and conflict resolution.

PDSE workers point to a contradiction between the programmatic emphasis on PDSE providing or connecting clients with ancillary services and insufficient training and support to further develop these skills. It is noteworthy, however, that despite a reported lack of training, PDSE workers consistently report providing a high level of ancillary services and referrals in their interactions with clients.

PDSE may provide a way for drug users who have little to no recent formal job experience to reconnect with a professional work environment, making it that much more important for them to receive adequate support and training in administrative or other job duties. As evidenced in successful HIV prevention peer programs, PDSE could provide a valuable stepping stone for drug users interested in advancing their careers and building their resumes. However, whether due to insufficient resources or other reasons, professional development and job promotion of PDSE workers seems to occur infrequently.

One program reported the recent promotion of a PDSE worker to full-time SEP staff, noting that although there was a need to provide administrative support, the worker's high skill in working with clients more than balanced the scales. This, however, seems to be an isolated case and the perception among several PDSE workers was that agencies would rather keep PDSE workers in their current role than promote them to staff despite their qualifications for full-time staff positions. Workers attribute this, again, to their status as current or former drug users and their proficiency at street-level work.



A list of training needs brainstormed at the First Annual Conference on Peer-Delivered Syringe Exchange held in New York City in April 2010.

[PDSE] is a good program, and it shouldn't be stopped... but, if I go, my clients go....the numbers go down. They [the SEP] don't give a relationship with us...it's not about the money, cause I would have cut it off, I could get a truck driving job. I like what I'm doing, but it's not being recognized.

—PDSE Worker

Compensation

There are three primary concerns related to compensation for PDSE workers: 1) competitive wages, 2) conflicts with public benefits and 3) transportation reimbursement.

PDSE workers receive approximately $70–$100 per week (varying by program) as compensation for their work and may or may not receive reimbursement for transportation costs.

- Despite performing tasks and duties similar to other SEP workers, wages and compensation for PDSE workers are rarely competitive with traditional non-PDSE syringe exchange program workers. Work conditions for PDSE may involve higher-risk situations, working outdoors in inclement weather and negotiating complicated circumstances with law enforcement and other community members. In addition, many PDSE workers are "on-call" at all hours and may be working outside of conventional schedules and hours. For these reasons, compensation for PDSE workers may be insufficient at the current level.

> ***We bring a lot of case management with us…when I first started I had clients come to my apartment, I had to stop that…because it would get so much. It was so many of them…but they had to have privacy…and we'd find a restaurant, but that costs money…we don't have money…I would pay out of my pocket.***
>
> **—PDSE Worker**

- Due to IRS regulations, most PDSE workers are maintained on payroll at their agencies. PDSE workers report that this poses challenges to receiving public assistance such as SSI and SSDI. This would not be a concern if PDSE wages were enough to provide a living wage; however, at present the risk of losing their benefits poses serious threats to sustained employment under the PDSE program. In the past, systems whereby PDSE workers were paid as consultants were favorable.
- Transportation can be a costly expense for workers to pick up and transport supplies to various neighborhoods. Workers report using a significant portion of their income from PDSE to cover their transportation costs. At the PDSE conference, upstate workers who serve geographically distant locations report the use of personal transportation and gas to be costly.

Other Common Concerns

Access to Ancillary Services

Several commonly raised concerns about implementation of PDSE seem to go largely unfounded based on the experience in New York City. Critics of PDSE have raised concerns that the program denies clients the benefit of ancillary services and referral to treatment that may result from visiting the SEP. However, PDSE links many people who are otherwise totally disconnected from care to syringe access services as well as education, support and referrals to both the parent SEP and other providers. Clients who may switch from accessing syringes at the SEP to PDSE services are aware of the SEP ancillary services and can access them whenever they need. Further, PDSE's emphasis on the quality of interactions between workers and clients, as well as the ability of PDSE workers to build trust and strong relationships, means that if and when individuals are interested in additional services, they will already be connected to a worker they trust who can bridge them to the appropriate service.

Law Enforcement

Since PDSE was introduced, there have been concerns over potential legal issues and interactions with law enforcement among health officials, workers, SEPs, and clients. Although there have been isolated incidents, PDSE workers overall have been successful in negotiating interactions with law enforcement and do not generally report this as a primary concern.

While fear of law enforcement among clients of PDSE services is of major concern and speaks directly to the need for PDSE services, workers reported minimal harassment from law enforcement and when interactions do occur, they are able to defuse the situation, explaining their role as an authorized representative of the SEP and AI. One worker reported that upon starting PDSE, he initiated a meeting with the police commander in his neighborhood in order to explain his role as a PDSE worker and avoid potential conflicts. Continued education of law enforcement about the mutual benefits of syringe access as well as on-going training of PDSE workers is important.

Syringe Disposal

Safe disposal of syringes is another important concern for any syringe exchange initiative. Many PDSE programs have de-emphasized the collection of used syringes because of the obvious difficulty of transporting sharps containers full of contaminated syringes while working and traveling back to the SEP.

Sharps containers and "fit-packs" (small sharps containers for disposal of approximately 10 syringes) are made available to clients and PDSE workers stress the importance of proper disposal with their clients and provide comprehensive education about a variety of disposal options including SEPs, disposal kiosks, hospitals or even with the use of rigid plastic containers as a last resort (detergent bottles, etc). Across the board, programs and PDSE workers agree that collection should not be a priority for PDSE.

Workers report that because many syringe transactions occur in the street, clients are reluctant to carry used syringes with them for fear of interactions with law enforcement. Disposal requirements could deter clients from using PDSE at all, which would cut them off from both sterile syringes and disposal education and resources. Increasing availability of alternative disposal options, such as additional disposal mailboxes/kiosks would serve to complement PDSE and likely increase return rates.

> ***I encourage [returns] but in real life, if I give you 10, I'm not gonna ask you to walk up on me and give me 10 when I know you walking on the street… the police might lock you up for that. So honestly, if you come to me and you've got 1, or you've got 2, I'm gonna give you 10. I'm not gonna see you locked up. But, you're still gonna hear, "Try and bring me more back" or "What did you do with the other 8…did you dispose of them properly?"***
>
> **—PDSE Worker**

Analysis

Research has proven that syringe exchange programs are effective at reducing rates of HIV and HCV infection, as well as connecting drug users with treatment and health care services. We also know that drug users would rather use sterile injection equipment than reuse their own or another IDU's equipment. Despite a relatively robust syringe exchange community in New York City, research on syringe coverage rates clearly indicate that current standard models of syringe delivery are insufficient for meeting daily injection needs and ensuring that IDUs have new, sterile injection equipment for each injection or meeting the needs of IDUs who have little to no access to sterile syringes. While fear of possible identification as an injection drug user and the stigma associated with drug use is a significant factor in deterring certain populations of IDUs from accessing sterile syringe sources despite even the high concentration of resources, the current gap in services is about much more than stigma alone.

Community resistance, fueled by the war on drugs, criminal justice approaches to drug use and insufficient education about drugs and drug use, contributes to the adverse climate in which syringe exchange programs must fight for their existence.

Despite the promise of new federal funding streams and a stated need for greater HIV and HCV prevention efforts,[21] SEPs are increasingly forced to work around budget cuts and devote valuable resources

toward advocacy to maintain their limited funding. In addition, alternative funding sources often mandate meeting excessive deliverable requirements, increased regulation/limits and emphasis on ancillary services as opposed to syringe exchange.

Political support for syringe exchange remains tenuous and often conditional, thereby preventing expansion to the point where it can be most effective—unhindered syringe access for anyone who needs it. Many programs experience implementing services based on the needs of funders and regulators, as opposed to the actual needs of their drug using clients. This dynamic and the political reluctance to deregulate syringe access, informs the essential need for SEPs to develop innovative strategies to effectively reach more IDUs.

A PDSE worker presenting on outreach strategies for a panel at the First Annual Conference on Peer-Delivered Syringe Exchange held in New York City in April 2010.

Our research supports a widespread understanding that secondary syringe exchange (SSE) is an essential component for expanding syringe coverage and reaching IDUs otherwise unlikely to access SEPs. IDUs have the greatest access to members of their own communities and can easily be trained to conduct syringe exchange safely and efficiently. Despite the fact that the practice of IDUs furnishing each other with sterile injection equipment through SSE is hardly a new concept, the creation of systems and official support that legitimize this act can be. PDSE is one such promising step in the right direction.

PDSE workers have proven to be an invaluable asset in expanding the quality and reach of service coverage. PDSE workers bring an essential knowledge of street and IDU culture, have the necessary skills to conduct transactions in sometimes unconventional settings, and have the ability to build trust with clients. With adequate support, workers can communicate accurate prevention and health promotion messages to their peers in an informal and accessible way, thereby contributing to a positive shift in injection behaviors and norms. Further, PDSE workers are often driven by a strong personal commitment to the work that clients respond favorably to.

Despite challenges, PDSE has helped to increase syringe coverage and target the most marginalized IDUs and has the capacity to radically change the face of syringe access in New York City (and beyond). To maximize PDSE's full potential, lower-threshold opportunities for participation in the program can be explored, tapping into the natural momentum of IDU behaviors and norms. Significant resources must also be invested to address key issues such as worker support and status, program efficiency and resource expansion.

ENDNOTES

1 Tempalski B et al. Correlates of syringe coverage for heroin injection in 35 large metropolitan areas in the US in which heroin is the dominant injected drug. Int J Drug Policy. 2008 Apr;19 Suppl 1:S47-58.

2 Des Jarlais DC et al. Reductions in hepatitis C virus and HIV infections among injection drug users in New York City, 1990–2001. AIDS. 2005 Oct;19 Suppl 3:S20-5.

3 Finkelstein R, Vogel A. (2000). Towards a comprehensive plan for syringe exchange in New York City. New York Academy of Medicine.

4 Des Jarlais, Don C., Arasteh, Kamyar, Hagan, Holly, McKnight, Courtney, Perlman, David C., Friedman, Samuel R. Persistence and Change in Disparities in HIV Infection Among Injection Drug Users in New York City After Large-Scale Syringe Exchange Programs. Am J Public Health 2009 99: S445-451

5 Valente et al. (2001) Needle Exchange Participation, Effectiveness, and Policy: Syringe Relay, Gender, and the Paradox of Public Health. Journal of Urban Health. Vol. 78 (2).

6 Riehman, K., Alex, K., Anderson, R., Flynn, N., Bluthenthal, R., (2004). Sexual Relationships, Secondary Exchange, and Gender Differences in HIV Risk Among Drug Injectors. Journal of Urban Health, Vol. 81 (2).

7 Use of Syringes from Sterile Sources Varies by Neighborhood of Residence in New York City. NYC Department of Health and Mental Hygiene; National Development and Research Institutes. 2008.

8 Deren S et al. Impact of expanding syringe access in New York on sources of syringes for injection drug users in Harlem and the Bronx, NYC, USA. Intl J of Drug Policy. 2003; 14:373-9.

9 Des Jarlais DC et al. "Informed altruism" and "partner restriction" in the reduction of HIV infection in injecting drug users entering detoxification treatment in New York City, 1990–2001. J Acquir Immune Defic Syndr. 2004 Feb 1;35(2):158-66.

10 Ibid.

11 Tempalski B et al. Correlates of syringe coverage for heroin injection in 35 large metropolitan areas in the US in which heroin is the dominant injected drug. Int J Drug Policy. 2008 Apr;19 Suppl 1:S47-58.

12 Snead, J., Moher, D., Lorvick, J., Garcia, B., Thawley, R., Kegeles, S., Edlin, B., (2003). Secondary Syringe Exchange Among Injection Drug Users. Journal of Urban Health Vol. 80 (2).

13 Murphy, S., Kelley, M., Lune, H. (2004). The Health Benefits of Secondary Syringe Exchange. Journal of Drug Issues. Vol. 34 (2)

14 Bryant, J Hopwood, M. Secondary exchange of sterile injecting equipment in a high distribution environment: A mixed method analysis in south east Sydney, Australia. The International journal on drug policy 1 July 2009 (volume 20 issue 4 Pages 324-328 DOI: 10.1016/j.drugpo.2008.06.006)

15 Grund, Jean-Paul C, et al, "Reaching the Unreached: Targeting Hidden IDU Populations with Clean Needles via Known User Groups." *Journal of Psychoactive Drugs*. Jan-March 1992; 24(1): pp. 41-47.

16 Centers for Disease Control and Prevention. (2010). *MMWR weekly:* Syringe Exchange Programs—United States, 2008. Retrieved February 2, 2011, from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5945a4.htm

17 Lorvick J, Bluthenthal RN, Scott A, Gilbert ML, Riehman KS, Anderson RL, Flynn NM, Kral AH. Secondary syringe exchange among users of 23 California syringe exchange programs. Subst Use Misuse. 2006;41:865–82.

18 Huo et al. (2005). Drug Use and HIV Risk Practices of Secondary and Primary Needle Exchange Users. AIDS Education and Prevention. Vol. 17(2).

19 Weeks MR, Li J, Dickson-Gomez J, Convey M, Martinez M, Radda K, Clair S. Outcomes of a peer HIV prevention program with injection drug and crack users: the Risk Avoidance Partnership. Subst Use Misuse. 2009;44:253–281. doi: 10.1080/10826080802347677.

20 Guarino H, Deren S, Mino M, Kang SY, Shedlin MG. Training drug treatment patients to conduct peer-based HIV outreach: an ethnographic perspective on peers' experiences. Subst Use Misuse. 2010 Feb;45(3):414-36.

21 National HIV/AIDS Strategy

Design: Worksight.com

Harm Reduction Coalition
www.harmreduction.org

East Coast:
22 West 27th Street, 5th Floor
New York, NY 10001
tel: 212.213.6376
fax: 212.213.6582
hrc@harmreduction.org

West Coast:
1440 Broadway, Suite 510
Oakland, CA 94612
tel: 510.444.6969
fax: 510.444.6977
hrcwest@harmreduction.org