Implementing Clinical Services within Syringe Services Programs

In addition to being at risk of fatal overdose, people who use drugs — especially those who inject substances — are at risk of experiencing soft tissue infections, endocarditis, and bloodborne infections such as HIV and hepatitis C virus (HCV).[1,2] People who use drugs may have other chronic or acute health issues that need to be addressed; however, personal and structural barriers may prevent them from engaging with traditional health care settings. These barriers might include stigmatization or discrimination by clinical providers, transportation challenges, high cost of care and lack of insurance, multiple competing needs, and challenges navigating a complex health care system.[3-5]

Syringe services programs (SSPs) deliver essential, evidence-based services to people who use drugs, including the distribution of safer drug use equipment and naloxone.[6] Data show that, through provision of these services, SSPs reduce new cases of HIV and HCV and help prevent opioid overdose deaths.[6] SSPs are increasingly expanding to implement clinical services in response to their participants' desires to access such support in one location and in a nondiscriminatory or stigmatizing way.[7] Through the National Survey of Syringe Services Programs (NSSSP), 88% of 558 SSPs reported providing at least one type of clinical service in-person in 2024, which could include vaccines; infectious disease testing, prevention, or treatment; wound care; or substance use disorder treatment.[8]

We spoke with staff members from 24 SSPs, representing different organizational types and regions across the United States, about their experiences implementing clinical services. These findings, along with other research and expert guidance, are summarized below.

THE SSP ADVANTAGE

SSPs reported 2,433,155 engagements with participants in 2024.[8] Through these encounters, they deliver low-barrier, participant-centered, and judgment-free support. Core services like overdose prevention and drug use equipment distribution are often the foundation to building relationships and trust with participants, which can increase their likelihood of engaging with other offered services like HCV care or treatment for opioid use disorder.[9,10] SSP staff described how clinical care aligns with the missions of their organizations, specifically noting how offering clinical services reflected their SSP's commitment to offering whole-person care. Additionally, staff reported that participants sometimes consider an SSP a "one-stop shop," suggesting the provision of clinical services may result in increased access and improved health outcomes for people who use drugs.[11]

> *[Our SSP team] was just talking about how important it is to incorporate these [clinical] services, how important it is to have them in addition to the [other] services that we offer, not only because [it's] easy access, low-barrier, [and] people can get to them, but also a lot of people don't go to other [service providers] because of stigma, because they don't know if that [provider's] going to be able to really fit their needs…This is something that we figure we can offer [for] whole-person health.*
>
> **—Department of public health, West region**

NSSSP NATIONAL SURVEY OF SYRINGE SERVICES PROGRAMS
NATIONAL HARM REDUCTION COALITION
RTI INTERNATIONAL
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SSP staff we spoke with described the impact of their clinical care on participants, noting things like more engagement with services, feelings of empowerment, improved health, and a better quality of life.

> *[In] just about every area that we've implemented something new has had big effects on people… they look at us as a one-stop shop kind of thing. Especially with wound care, for instance, we're seeing more people taking stock in their own health and taking care of their wounds because they have [services] available in a place that they feel safe, not judged, and have those resources. So just by proxy of us having [wound care] and being [safe and judgment-free], more people are treating those wounds, learning how to keep them from getting bad.*
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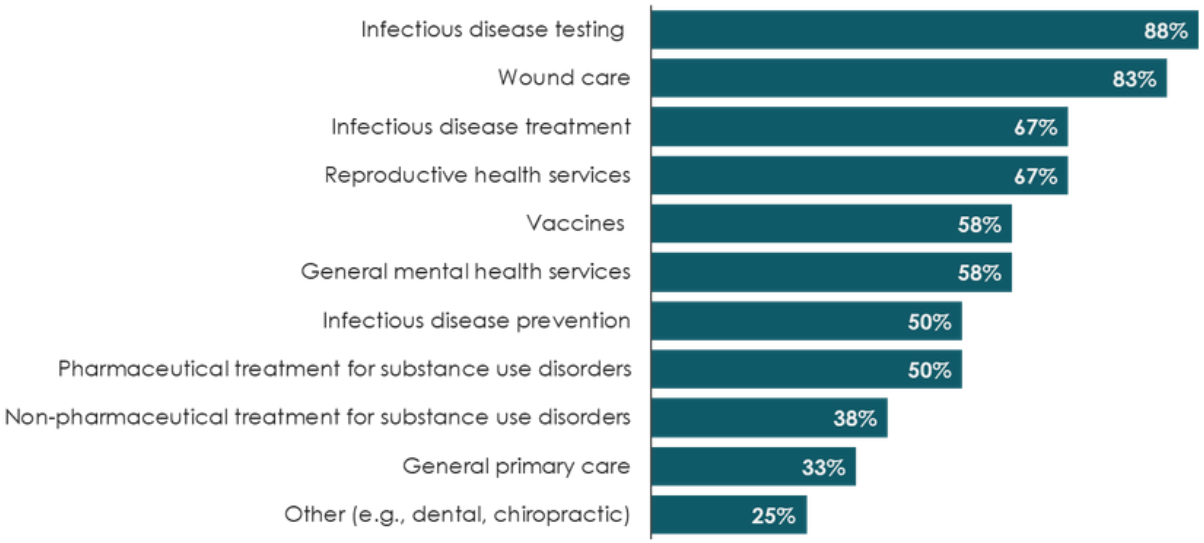
> **—Community-based organization, Northeast region**

HOW IT WORKS

The clinical services SSPs decide to implement are often based on the program's capacity and the desires and needs of their participants. Among the SSPs interviewed, infectious disease testing and treatment (e.g., for HIV and HCV) and wound care were the most commonly offered types of clinical services. Additionally, 75% of SSPs interviewed provided case management and 67% offered assistance enrolling in health insurance to increase participant engagement in clinical services **(Figure 1)**.

Figure 1. Clinical services provided by SSPs

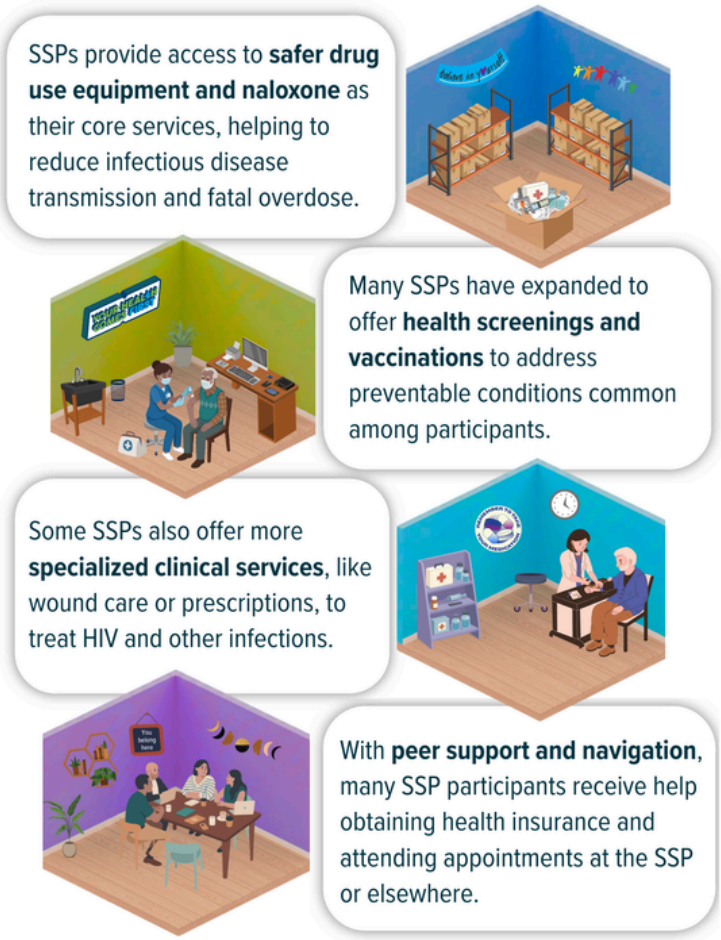


SSP staff described three main models for delivering clinical services in-person. Some SSPs leveraged more than one model depending on the clinical service. For example, an SSP may offer HIV testing using their own staff but rely on partner organizations coming to their program to offer prevention or treatment services.

- **Integrated care delivered by a partner organization.** SSPs partnered with another organization (e.g., clinic, hospital, university, public health department) to offer clinical services. This model was the most popular among interviewed SSPs, especially those operating as community-based organizations, as the partner organizations would cover most or all the costs of providing clinical services. SSPs commonly used this model to offer services like wound care, infectious disease treatment, and general primary care. Partner organization availability can impact integration of these services on site or within mobile teams and the frequency at which they are offered to participants. Additionally, each clinical service offered may require a different partner.

Smith J, Ballantyne B, Rodriguez Borja I, Erickson E, Philbrick S, Glick, S, Lambdin BH, & Patel SV (2026). Implementing Clinical Services within Syringe Services Programs. RTI International. https://doi.org/10.5281/zenodo.20044507.

- **Integrated care delivered by SSP staff.** SSPs hired or trained clinical providers (e.g., doctors, nurse practitioners, physician assistants, phlebotomists) to provide services. Other specialized staff commonly employed directly through the SSP included social workers, certified peer specialists, community health workers, addiction counselors, and medical assistants. These staff often provided infectious disease testing and non-clinical services like case management and health insurance enrollment, while clinical staff offered wound care, infectious disease treatment, medications for substance use disorder, and primary health care. As staffing clinical providers can be expensive, some SSPs hired them as contractors or found providers willing to volunteer their services; however, these options may limit the time providers are available to be on site or accompany a mobile team during core service hours. When clinical providers are fully integrated into an SSP, they can administer services more frequently and flexibly. This model was less common among interviewed SSPs and may be best for well-resourced programs.



- **Warm handoff to parent organization.** SSPs part of a broader organization that offers comprehensive health care services quickly connected participants to clinical staff. Most interviewed SSPs that used this model indicated clinical services had always been integral to their program given the focus and priorities of the parent organization. This model may be helpful to HIV/AIDS service organizations, community health clinics, or social service agencies considering establishing an SSP and aiming to ensure participants have integrated access to all services their organization offers.

The delivery model implemented may influence the extent to which clinical services are integrated with an SSP's core equipment distribution and overdose prevention offerings. Additionally, SSP staff described offering participants warm handoff referrals to other organizations for critical services they could not provide at their program.

FUNDING SOURCES

SSP staff described a variety of funding sources used to cover the cost of providing clinical services, including state and federal grants, foundation grants, and opioid settlement funds. State Opioid Response Grants and Substance Use Prevention, Treatment, and Recovery Services Block Grants distributed through the Substance Abuse and Mental Health Services Administration can help cover medications for opioid use disorder and a range of wraparound services, while funding through the Ryan White HIV/AIDS Program can support a variety of HIV services. For information about accessing opioid settlement funds, see The National Association of County & City Health Official's (NACCHO) How-to Guide.

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Many SSPs that partnered with other organizations benefited from the partner funding clinical services. Partner organizations and some SSPs billed insurance as a primary way to cover these costs. Access this free e-course from the National Harm Reduction Coalition (NHRC) for more information on health care financing for SSPs.

WHO TO ENGAGE

- **SSP participants.** SSPs used feedback from their participants (e.g., through client surveys, advisory boards) to determine which types of clinical services would be most helpful and to adapt and improve them as needed. Participants also provided feedback about other service providers they engage with, which can help SSPs decide where or where not to refer participants if they need access to a service the SSP does not provide.

> *We do point-in-time surveys…but there's also a customer service component of that. That's really where we gather the data to shape our program. That's how our program has become what it is — because of what participants have said and shared with us.*
>
> **—Department of public health, West region**

- **Community decision-makers.** Community engagement, education, and coalition-building can help ensure SSPs have the support and resources needed to provide additional services. Staff at some SSPs described using community education and involvement with local public health or substance use coalitions to build support and find providers interested in offering clinical services at their SSP or accepting warm handoffs from the SSP. NACCHO's guide on increasing capacity through education and community collaboration, NHRC's toolkit on building community-centered support, and National Overdose Prevention Network's resource library provide more information on community education and engagement strategies, community buy-in for SSPs, and coalition-building.

- **Partners with aligned values and approaches.** Partnerships often provide participants an opportunity to engage with licensed providers such as doctors, nurse practitioners, emergency medical technicians, dentists, counselors, and psychiatrists. These providers can offer some of the most-needed clinical services, including wound care, prescriptions for acute or chronic conditions, and mental health services. SSP staff frequently noted that potential partners approached them to collaborate. Ranging from individual providers to community health clinics, they had a vested interest in serving the same population and acknowledged the valuable work being done by the SSP. SSPs that needed to seek out partners prioritized organizations with similar values and providers who would offer low-barrier, participant-centered services. SSPs took time vetting such organizations, scheduling conversations or interviews and sometimes established a memorandum of understanding to formalize a partnership.

> *We were the first SSP in the state, and so we had a tremendous amount of barriers to overcome with funding and partnerships and all sorts of stuff. It just so happens that we have a local AIDS service organization in our community that is pretty like-minded, and they were an easy first partner. They don't do syringe services, but they understand it, and they're aligned with it.*
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> **—Community-based organization, South region**

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- **SSP staff with lived or living experience.** Although it was less common for SSPs to have people with lived or living experience with drug use directly provide clinical services, almost all interviewees noted the importance of having staff with this experience to support participant engagement in clinical services. Hiring people with lived or living experience may be more difficult for SSPs operated by health departments or Federally Qualified Health Centers, which more commonly require background checks or receive federal funding that require strict adherence to drug-free workplace policies. This guide contains useful information about employing and supporting people who use drugs.

CHALLENGES AND OPPORTUNITIES

Stigma. SSP staff named stigma as the reason some funders and community members did not see value in prioritizing implementation of clinical services for people who use drugs, contributing to a lack of buy-in and resources for offering these services. Staff described constantly engaging and educating community members to build support for their program and reduce stigma against their participants. They also described identifying champions from the community or partner organizations, including local health departments, who could help build support for their services.

Capacity. SSP staff consistently described insufficient funding and staffing as barriers that limit SSPs' capacity to implement and expand beyond core services.[12] Because of this, SSPs must carefully prioritize which services to provide—focusing first on core services. Most SSPs were able to expand their offerings to include clinical services by partnering with other organizations that could cover the costs of service delivery, including licensed provider's time.

Leadership buy-in. SSPs operated by departments of public health or broader service organizations may encounter hesitation from leadership, especially if they do not fully understand the value of prioritizing clinical services for people who use drugs. SSP staff noted that using participant feedback to highlight the need for specific services and external research showing the impact of people who use drugs having access to desired clinical services was an effective strategy for gaining leadership buy-in.

Organizational bureaucracy. When attempting to implement new services, SSPs may face additional and potentially challenging requirements from new policies and procedures to formalizing agreements with partner organizations. SSPs operated by departments of public health or larger service organizations may face further barriers if multiple layers of approval are needed, which can delay implementation of new services. SSP staff noted that identifying internal champions to help expedite the process and ensure leadership prioritized service implementation helped them overcome such issues.

Partner constraints. SSPs that partner with other organizations to provide clinical services may encounter constraints that impact the continuity and frequency of services provided. For example, some SSP staff mentioned scheduling conflicts with partners, issues when the primary contact or champion at a partner organization leaves, or changes to services when a partnership evolves or ends. Highlighting data on the positive impact clinical services have on people who use drugs can help promote continuity of funding and partnership engagement. Additionally, the partner organization may have participant requirements (e.g., more frequent appointments) that create barriers to services for some participants. Ongoing conversations and negotiations with partners can help address these challenges and support provision of low-barrier services.

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ADDITIONAL RESOURCES

For more information about implementing clinical services within your organization, email training@harmreduction.org.

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