

Vermont Opioid Use Harm Reduction Evaluation

FINAL REPORT
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Prepared by
Pacific Institute for Research and Evaluation

Acknowledgments

This report was prepared by the Pacific Institute for Research and Evaluation (PIRE) for the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP). Authors are Jessica Edwards and Vanessa Berman. Other team members reviewed the report and provided valuable suggestions, as well as contributed to the evaluation's overall development and implementation, including project consultant Abby Rudolph and PIRE colleagues Amy Livingston and Bob Flewelling.

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Executive Summary

The State of Vermont, Department of Health (VDH), Division of Alcohol and Drug Abuse Programs (ADAP) contracted the Pacific Institute for Research and Evaluation (PIRE) to conduct the Vermont Opioid Use Harm Reduction Evaluation, from June 1, 2018 to November 30, 2019. The evaluation was part of Vermont's *Prescription Drug Overdose Prevention for States* grant from the U.S. Centers for Disease Control and Prevention (CDC). This report summarizes the evaluation's findings and addresses the three project aims outlined below.

The primary objective of the evaluation was to conduct interviews with persons who misuse opioids and live in or access Syringe Services Program (SSP) services in three target counties (Franklin, Rutland, and Windham) in Vermont, to address the following project aims:

- 1: Assess current harm reduction services and strategies that are being used to lower the risk of opioid overdose and infectious disease transmission;
- 2: Assess gaps in knowledge and use of services and behavioral strategies that can lower the risk of opioid overdose and infectious disease transmission; and
- 3: Identify content and formats for effectively communicating health messages from the Department of Health and other agencies to populations at risk for opioid-related overdose and infectious disease transmission.

The distribution of the evaluation's 80 participants was generally equal across the target counties: Franklin (N=26), Rutland (N=27), and Windham (N=27). The sample included 69 individuals who reported using opioids in the past 30 days and 11 who reported using opioids previously but not in the past 30 days. The sample's composition reflected the evaluation's effort to elicit diverse perspectives on opioid-related risks, including recent experiences related to abstinence from opioid misuse and initial stages of being in recovery.

The report is organized into the following major sections: Introduction; Methods; Findings; and Recommendations.

Methods

Formative Interviews with Stakeholders

To prepare for the participant interviews, PIRE conducted 14 formative qualitative interviews with stakeholders (i.e., stakeholder interviews) between August and October 2018. The interviews were with individuals (e.g., state and community agency staff) whose work equips them with key knowledge and perspectives on opioid-related overdose and infectious disease transmission, harm reduction strategies, and

substance use disorder treatment. This stakeholder input was used to inform the development of the participant interview questions and participant recruitment strategies.

Community Outreach and Participant Recruitment

Additional community outreach was an important next step in the project's participant recruitment efforts. PIRE's interviewer was invited to attend community meetings in each of the three target counties to share information about the project and gather ideas for recruitment specific to each county. Using suggestions obtained from these community meetings and from stakeholder interviews, PIRE contacted locations in each county that could be potential sites for recruitment efforts for the participant interviews (e.g., libraries, substance use disorder treatment centers, community lunches, drop-in centers, homeless services providers, Community Action and recovery centers), in addition to Syringe Services Programs. Flyers and small handout cards were displayed, and contained general information about the project, including eligibility criteria and incentive information. Those interested were directed to call or text the interviewer at a local phone number to learn more about the project and to be screened for eligibility.

Participant eligibility criteria included being age 18 or older, living in or receiving SSP services in one of the three target counties, and having used illicit opioids (heroin or intentional use of fentanyl) or misused prescribed opioids (including buprenorphine and methadone) within the past 30 days. Use within the past 30 days, often a standard measure of current substance use, was used as an indicator of current or recent opioid use. In order to gain diverse perspectives on opioid-related risks, and recovery, the project sought to include up to 12 additional participants who had used opioids previously but not within 30 days prior to the interview.

Data Collection

Each participant's data collection session involved a questionnaire and an in-depth interview. The interview guide included a range of topics corresponding to the evaluation's aims. The questionnaire focused on collecting complementary quantitative data, including demographics, use of SSP and other services, and drug use and overdose experiences. On average, the data collection sessions took 1 to 1.5 hours to complete.

Data collection occurred in a private space at various locations, including SSPs, substance use disorder treatment centers, recovery centers, local libraries, or other settings of participants' choice. At the end of the session, participants received \$30 cash for their time and participation and were offered naloxone and information about various community resources. These evaluation activities, as well as the formative interviews conducted with stakeholders, were reviewed by the Vermont Agency of Human

Services' Institutional Review Board (IRB) and determined not to meet the definition of human subjects research.

Data Analysis

Interviews were transcribed and subsequently analyzed using the qualitative software package Dedoose. Themes were identified within and across interviews by creating codes corresponding to specific substantive topics in the data. Coded data were reviewed to identify quotes that illustrate the themes. One evaluation team member had primary responsibility for coding the interviews. This team member and the interviewer reviewed the codes and themes together on an ongoing basis to ensure that they were reflective of the data and consistent with the information expressed during the interviews. Quantitative data were analyzed using SPSS. The quantitative results presented in this report focus on the questionnaire data for the 69 participants in the sample who reported using opioids in the past 30 days (i.e., these main quantitative analyses excluded participants identified as those who had formerly used opioids) since understanding current overdose risks and harm reduction practices was the main goal of the evaluation and many of the questions in the questionnaire applied to current opioid use. The qualitative findings draw on the full sample of 80 participants. Although some interview questions were applicable, or tailored, to participants based on their current opioid use status, all participants could provide insights on many of the issues addressed in the interview regardless of their current opioid use status. Therefore, we sought to maximize the insights, experiences, and perspectives available to inform the evaluation by including all participants' data.

Findings

Description of Sample

For the quantitative data presented in the report, the sample (N=69) consists mainly of individuals in the 25-54 age range, with 25-34-year-olds constituting 37.7%. An additional half of participants were in the 34-44 and 45-54 age groups, in equal proportions. Over half (56.5%) of participants identified as male and 42.0% as female. Most (91.3%) participants identified as White, followed by 10.1% of the sample identifying as Native American/American Indian. Forty-six percent of participants reported their highest level of education as being a high school graduate or having received their GED, with an additional 27.5% reporting at least some college education. Thirty-seven percent of participants reported that they were currently working full or part time, including self-employment, while 27.5% of participants were not employed and were looking for work. One-fifth of the sample reported currently receiving Social Security/Social Security Disability Insurance benefits and an additional 21.7% was applying or waiting on a decision on their application for these benefits. Notably, 38.2% of the sample reported that they were currently homeless, meaning they slept outside or

in a shelter, with an additional 22.1% responding that that were “staying at someone else’s place.”

Context of Opioid Use

Most commonly, participants explained that their opioid use initiation arose from an injury, disease, or medical procedure that led to an opioid being prescribed by a medical professional for pain. Examples included car crashes, work-related injuries, C-sections, cancer, wisdom teeth removal, and injuries sustained while serving in the military.

Past 30-Day Substance Use

Heroin was the most commonly used opioid among the sample. On the questionnaire, 69.6% of the participants reporting using it in the past 30 days. More than half of the sample (55.1%) reported using fentanyl (either intentional or unintentional) during this period. Following opioids, the most commonly used substances were marijuana (66.7%), crack (60.9%), and powder cocaine (49.3%).

Knowledge of and Engagement in Harm Reduction Behaviors

Overall, participants expressed a high level of knowledge and engagement in behaviors and services related to reducing the risk of opioid-related overdose and infectious disease transmission. This included a solid understanding of the importance of going slow to test a new batch of drugs, keeping naloxone on hand, and taking care not to use drugs alone as protective measures against fatal overdose. The majority of participants were also particularly insistent that they are always careful to use new injection supplies.

Infectious Disease Acquisition and Transmission Prevention Strategies

In response to the questionnaire, 77.4% of participants who had injected drugs in the past 90 days responded that, in that period, they had never used injection supplies that had already been used by someone else. Consistent with this, during the interviews, participants tended to be uniform and emphatic in describing the safety precautions they took with their injection practices. Among those participants who did use injection supplies after someone had already used them, they indicated the following reasons for doing so: not having access to clean supplies at the time; feeling that they knew the person they were sharing with and not being worried about disease transmission; or being too focused on getting high and, therefore, not prioritizing using new supplies.

Syringe Services Program Utilization

Use of harm reduction services was high as indicated by almost three-fourths of the sample reporting on the questionnaire that they have ever used an SSP, with nearly half of these individuals using an SSP at least once per month. However, awareness of the

SSP mobile van in Franklin County was essentially absent among participants, with only one individual indicating knowledge of the van.

Among the participants who reported on the questionnaire using the SSPs, they primarily did so for access to free safer injection supplies. In addition, two-thirds detailed picking up naloxone there, and more than half of participants reported going to SSPs for information and education and to get safer sex supplies. Many participants who used SSP services reported that they pick up supplies for their peers, either intentionally as part of a pre-existing plan, or they pass out the supplies they had picked up for themselves to their peers while they are using drugs together.

Participants discussed the barriers they face when trying to access SSPs. Limited hours and transportation challenges were the primary barriers mentioned by participants, in addition to embarrassment from being seen and general stigma associated with accessing harm reduction services associated with drug use.

Comments Regarding Safe Consumption Sites

Although safe consumption sites were not a topic included in the interview guide or mentioned by the interviewer, approximately 10 percent of participants brought them up as an important harm reduction strategy for both the individuals who are using, and also as a way to keep used injection supplies out of the community.

Experiences with Medication Assisted Treatment

On the questionnaire, nearly two-thirds of the participants reported currently receiving medication assisted treatment (MAT). During the interviews, most participants on MAT described it as having eliminated or significantly reduced their opioid use. Participants explained that being on MAT helps them both physically and mentally. This included addressing physical pain for some individuals and avoiding the sickness and worry that would arise from not having access to opioids.

Participants mentioned a few main challenges to engaging and staying in MAT. These included differing views among participants regarding what type of MAT policies are most beneficial (i.e., a harm reduction-oriented approach versus an approach with penalties for any illicit use or missed programming), daily attendance requirement for dosing, and transportation.

Participants frequently mentioned that they continued to use opioids while on MAT and noted a few reasons for doing so. Some believed their dose was not adequate to keep them from getting sick. Some described missing doses due to transportation or other barriers, which resulted in them using illicitly to keep from going into withdrawal.

Meeting individuals' MAT needs sometimes aligned with whether the program was a hub versus a spoke. Some participants who were in a hub felt like they needed strict

oversight and daily dosing, while others preferred to be in a spoke, particularly due to not having to attend as frequently. Participants mentioned lack of transportation and employment as the main reasons for preferring a spoke to a hub. Participants who received their MAT from a hub and were required to attend daily for dosing reported that accessing the clinic each day was a hardship, especially if they needed to rely on other people to drive them. These transportation challenges often resulted in illicit use, which would further delay their ability to receive take-home doses in the future. Transportation was also frequently mentioned as a challenge for accessing treatment services by individuals who live in rural areas and are not able to access the bus.

Housing Instability as a Barrier to Harm Reduction Services and Strategies

Participants conveyed how homelessness and unstable housing contribute to riskier behaviors and loss of hope for recovery. They described not being able to focus on themselves, what they enjoy, their family, or their recovery when they do not have safe spaces to live. They described needing the stability of a home and the hope for a better future before they are able to focus on stopping or reducing their drug use. Problems such as affordability, quality, and accessibility for individuals who are currently using drugs or had poor rental history due to previous drug use were mentioned as the main barriers to housing.

Experiences with Overdose and Accessing and Using Naloxone

Half of the participants reported on the questionnaire that they had overdosed one or more times in their lifetime. Among those who had ever overdosed, more than 40% had overdosed within the past 12 months. The vast majority (84.1%) of participants had ever witnessed an overdose. In addition, over half of the sample responded either “likely” or “very likely” to describe their perceived risk of dying from an overdose.

Participants described naloxone as being readily available and accessible. Almost three-fourths of participants reported keeping naloxone on hand at least sometimes, while less than one-third reported doing so always. Further, more than one-fourth of participants responded that they never keep naloxone on hand.

Many participants described reluctance around using naloxone, with it often being used as a last resort because it causes instant withdrawal and destroys a person’s high.

Attitudes Related to Calling 911 for an Overdose

Participants described a range of responses that can occur in the event of an overdose, sometimes with multiple actions being taken before resorting to calling 911 and involving authorities. Participants described attempting to wake the person who has overdosed by putting cold water on them, slapping or otherwise trying to rouse them, and/or administering naloxone. Participants were aware there is a desire among some to avoid a naloxone reversal if possible, and some participants also described that a peer administering naloxone is preferable to calling 911.

Awareness of and Views on Vermont's Good Samaritan Law

Prominent among the sample was a lack of awareness of Vermont's Good Samaritan Law and often a vague awareness of the law among those who had heard about it. Further, participants commonly expressed the belief that there is a general lack of awareness of the law's existence among their peers. Some felt that knowing about the law would increase one's willingness to call 911 in the event of an overdose, while others felt mistrust about the law and were still concerned about potential consequences if 911 were called.

Harm Reduction Messaging: Participants' Suggestions for Content of Messages and Methods of Communication

Participants provided suggestions for content for health messages for individuals at risk for opioid overdose and what they thought would be effective approaches for communicating those messages. Participants indicated the importance of disseminating information on the location and hours of SSPs, in addition to the types of services offered there and that all services are anonymous and free. Participants also felt it was important to share the rationale behind these programs (disease and overdose prevention and treatment connection) in order to build community support and reduce stigma. Other recommended content included overdose risk and prevention; the protections offered by the Good Samaritan Law; behavior changes that could reduce overdose risk; unintentional consequences of drug use, including trauma to family or friends who witness an overdose or lose a loved one to overdose; and general information on available resources accessible in the community.

Word of mouth among peers or by health and human service professionals was the most common suggestion for effectively communicating these messages. Participants suggested that these encounters take place at locations frequented by individuals at risk for overdose, such as SSPs, substance use disorder treatment centers, and locations where people receive economic and health services.

Recommendations

Based on participants' direct suggestions and other findings from the evaluation, the following recommendations are offered. We have intentionally not attempted to prioritize or rate these recommendations. Such considerations will need to be part of a broader discussion among policy makers, program staff, and stakeholders – one for which we expect these findings can make a useful contribution.

- Increase awareness and utilization of harm reduction programming, including:
 - Increase awareness of SSPs
 - Expand the hours of operation at SSPs
 - Address stigma in order to increase SSP utilization

- Expand services at pharmacies (e.g., sell syringes, offer naloxone without a prescription)
- Integrate harm reduction services such as syringe distribution into other programming (e.g., MAT providers and recovery centers)
- Increase MAT engagement and retention, including:
 - Expand dosing hours at hub programs
 - Increase spoke providers, or increase awareness of providers, especially in rural areas
 - Increase awareness of shortened wait times for MAT to correct misconceptions
 - Provide child care during dosing hours and meetings with clinicians
 - Integrate other harm reduction services, such as safer injection supplies and naloxone, into the existing MAT structure
 - Review policies surrounding marijuana use
- Improve access to residential programming, including detox programs, such as faster access to treatment and longer treatment stays, if needed
- Promote use of naloxone among individuals who are at risk and among the broader community
- Tend to the basic human needs of individuals, including housing, education, employment, and social connection
- Increase awareness of and trust in the Good Samaritan Law
- Consider the evaluation's implications and recommendations for messaging and services, including:
 - Address conflicting feelings about harm reduction strategies
 - Attend to stigma when raising awareness of harm reduction services
 - Leverage and build on individuals' commitment to act in an overdose situation
 - Address resistance to naloxone administration
 - Support being prepared and managing panic during overdoses
 - Address trauma of witnessing overdoses

1. Introduction

The State of Vermont, Department of Health (VDH), Division of Alcohol and Drug Abuse Programs (ADAP) contracted the Pacific Institute for Research and Evaluation (PIRE) to conduct the Vermont Opioid Use Harm Reduction Evaluation, from June 1, 2018 to November 30, 2019. The evaluation was part of Vermont's *Prescription Drug Overdose Prevention for States* grant from the U.S. Centers for Disease Control and Prevention (CDC). This report summarizes the evaluation's findings and addresses the three project aims outlined below.

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The report is organized into the following major sections: Introduction; Methods; Findings; and Recommendations.

2. Methods

2a. Formative Interviews with Stakeholders

To prepare for the participant interviews, PIRE conducted 14 formative qualitative interviews with stakeholders (i.e., stakeholder interviews) between August and October

2018.¹ The interviews were with individuals (e.g., state and community agency staff) whose work equips them with key knowledge and perspectives on opioid-related overdose and infectious disease transmission, harm reduction strategies, and substance use disorder treatment. Some of the stakeholders interviewed were, by design, individuals who formerly misused opioids themselves. This stakeholder input was used to inform the development of the participant interview questions and participant recruitment strategies.

2b. Community Outreach and Participant Recruitment

Additional community outreach was an important next step in the project's participant recruitment efforts. Through collaborations with the local Substance Abuse Prevention Consultants in each of the three target counties, PIRE's interviewer was invited to attend community meetings, such as the Project VISION meeting and the Rutland Community Collaborative meeting in Rutland County; the Community Partnership meeting and MAT Neighborhood meeting in Franklin County; and the Consortium on Substance Use (COSU) meeting in Windham County. These meetings provided opportunities to share information about the project and gather ideas for recruitment specific to each county. Using suggestions obtained from these community meetings and from stakeholder interviews, PIRE contacted locations in each county that could be potential sites for recruitment efforts for the participant interviews (e.g., libraries, substance use disorder treatment centers, community lunches, drop-in centers, homeless services providers, Community Action and recovery centers), in addition to Syringe Services Programs. Flyers and small handout cards were displayed, and contained general information about the project, including eligibility criteria and incentive information. Those interested were directed to call or text the interviewer at a local phone number to learn more about the project and to be screened for eligibility.

Participant eligibility criteria included being age 18 or older, living in or receiving SSP services in one of the three target counties, and having used illicit opioids (heroin or intentional use of fentanyl) or misused prescribed opioids (including buprenorphine and methadone) within the past 30 days. Use within the past 30 days, often a standard measure of current substance use, was used as an indicator of current or recent opioid use. In order to gain diverse perspectives on opioid-related risks, and recovery, the project sought to include up to 12 additional participants from the three target counties who had used opioids previously but not within 30 days prior to the interview. Interview appointments were scheduled for times and locations convenient for the participant. The interviewer was also available for drop-in (non-scheduled) interviews at the SSPs, recovery centers, drop-in centers, and substance use disorder treatment centers at times coordinated in advance with the interview locations.

¹ The stakeholder interviews were summarized in the following report available from the Vermont Department of Health Vermont: Opioid Use Harm Reduction Evaluation Stakeholder Interview Report, October 30, 2018.

2c. Data Collection

Each participant's data collection session involved a quantitative questionnaire and an in-depth interview. Figure 1 displays the interview topics. The questionnaire focused on collecting complementary quantitative data, including demographics, use of SSP and other services, and drug use and overdose experiences. On average, the data collection sessions took 1 to 1.5 hours to complete. Prior to beginning each interview, the interviewer provided an overview of the project and explained the purpose of the interview and why we were interested in participants' input. The interviewer explained that the interview was voluntary, that neither individuals' names nor other identifying information would be connected with their individual responses in reports of

the data. Participants were also informed that, with their permission, the interview would be audio-recorded for project purposes only. The interviewer used an iPad to administer the questionnaire to participants verbally and collect their responses electronically. Following the brief questionnaire, the rest of the session focused on the interview. The semi-structured design of the interview allowed the interviewer to discuss topics raised by participants, in addition to asking the predetermined questions in the interview guide.

Data collection occurred in a private space at various locations, including SSPs, substance use disorder treatment centers, recovery centers, local libraries, or other settings of participants' choice. At the end of the session, participants received \$30 cash for their time and participation and were offered naloxone and information about various community resources. These evaluation activities, as well as the formative interviews conducted with stakeholders, were reviewed by the Vermont Agency of Human Services' Institutional Review Board (IRB) and determined not to meet the definition of human subjects research.

Figure 1.

Participant Interview Topics

- Drug use history and progression
- Services and supports needed by individuals who use opioids
- Experience with SSPs (including use of naloxone, fentanyl test strips), medication assisted treatment (MAT), and other services
- Hepatitis C and HIV knowledge and beliefs
- Behavioral harm reduction strategies
- Overdose experiences
- Access to naloxone
- Awareness of and views on Vermont's Good Samaritan Law
- Parenting
- Participants' suggestions for health messages

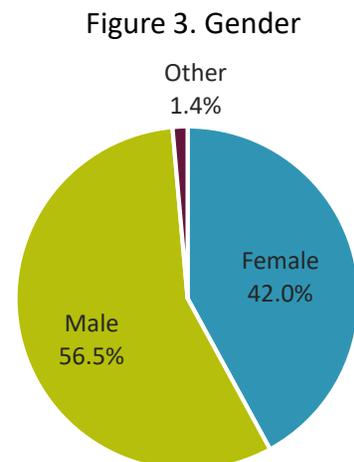
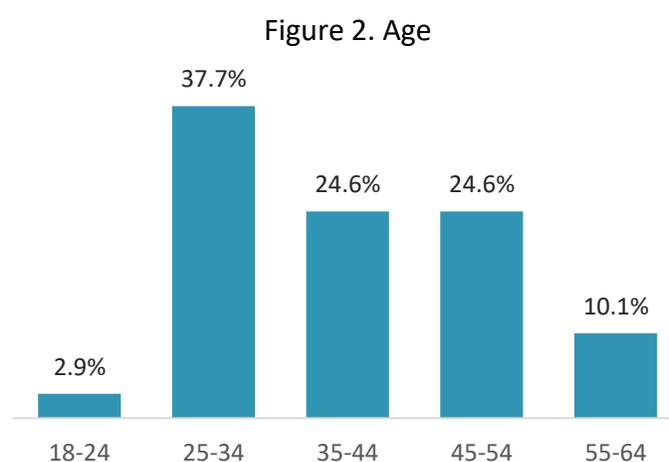
2d. Data Analysis

Interviews were transcribed and subsequently analyzed using the qualitative software package Dedoose. Themes were identified within and across interviews by creating codes corresponding to specific substantive topics in the data. Coded data were reviewed to identify quotes that illustrate the themes. One evaluation team member had primary responsibility for coding the interviews. This team member and the interviewer reviewed the codes and themes together on an ongoing basis to ensure that they were reflective of the data and consistent with the information expressed during the interviews. Quantitative data were analyzed using SPSS. The quantitative results presented in this report focus on the questionnaire data for the 69 participants in the sample who reported using opioids in the past 30 days (i.e., these main quantitative analyses excluded participants identified as those who had formerly used opioids) since understanding current overdose risks and harm reduction practices was the main goal of the evaluation and many of the questions in the questionnaire applied to current opioid use. The qualitative findings draw on the full sample of 80 participants. Although some interview questions were applicable, or tailored, to participants based on their current opioid use status, all participants could provide insights on many of the issues addressed in the interview regardless of their current opioid use status. Therefore, we sought to maximize the insights, experiences, and perspectives available to inform the evaluation by including all participants' data.

3. Findings

3a. Description of Sample

For the quantitative data presented in the report,² the sample (N=69) consists mainly of individuals in the 25-54 age range, with 25-34-year-olds constituting 37.7%. An additional half of participants were in the 34-44 and 45-54 age groups, in equal



² Due to rounding, some totals presented in the report do not equal 100%.

proportions. Over half (56.5%) of participants identified as male and 42.0% as female. Most (91.3%) participants identified as White, followed by 10.1% of the sample identifying as Native American/American Indian. Forty-six percent of participants reported their highest level of education as being a high school graduate or having received their GED, with an additional 27.5% reporting at least some college education. Thirty-seven percent of participants reported that they were currently working full or part time, including self-employment, while 27.5% of participants were not employed and were looking for work. One-fifth of the sample reported currently receiving Social Security/Social Security Disability Insurance benefits and an additional 21.7% was applying or waiting on a decision on their application for these benefits. Notably, 39.1% of the sample reported that they were currently homeless, meaning they slept outside or in a shelter, with an additional 22.1% responding that that were “staying at someone else’s place.” Given the evaluation’s interest in identifying effective communication methods, the questionnaire also asked about participants’ cell phone and internet access. Seventy-one percent of participants reported having a reliable cell phone and 81.2% reported having reliable access to the internet.

Figure 4. Years of Education

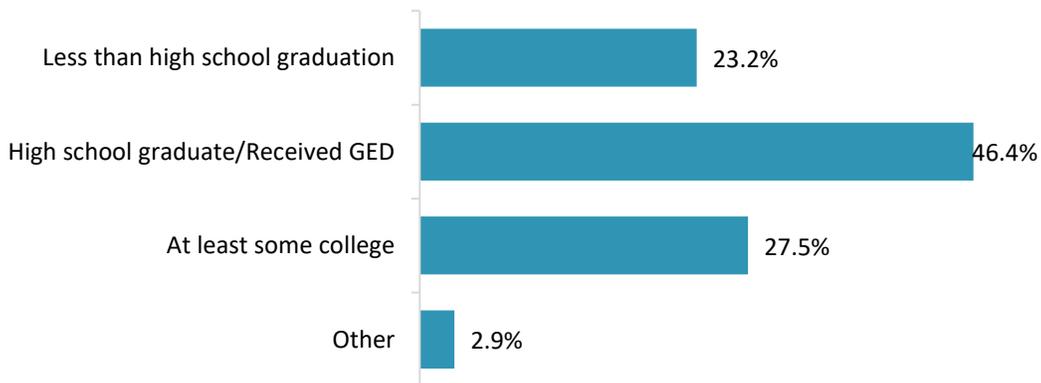
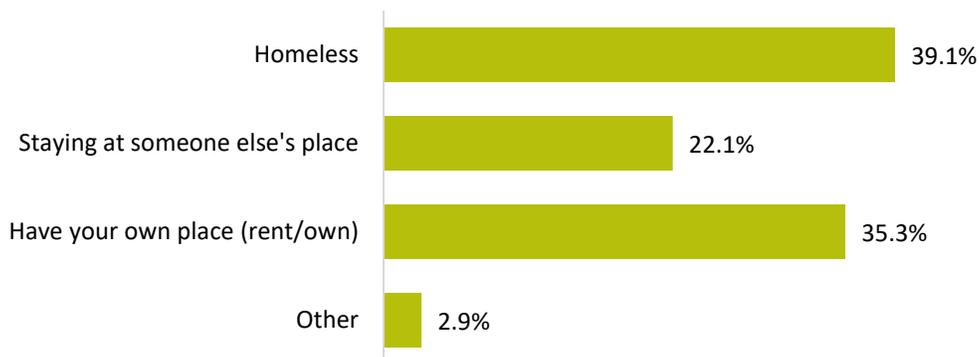


Figure 5. Housing Status



3b. Context of Opioid Use

For context, at the beginning of the interviews, participants were asked to describe how and when their opioid misuse started. Forty-three percent of the 80 participants who were interviewed explained that their initiation arose from an injury, disease, or medical procedure that led to an opioid being prescribed by a medical professional for pain. Examples included car crashes, work-related injuries, C-sections, cancer, wisdom teeth removal, and injuries sustained while serving in the military. Half of these individuals attributed their illicit opioid use to their medical provider terminating their opioid prescriptions.

- “It started with, I had some major operations and I was issued high doses of oxycodone and fentanyl for pain management for a long period of time. Then overnight they were just taken away from me. So, I spent four months getting clean. I did it myself. I couldn’t get into a rehab program. I had to manage it myself and essentially do it cold turkey, which it took me a very long time to do and then once I was clean, I was clean for two and a half years and then I got back into seeing a pain management specialist at the same hospital that issued me the medications prior and after four months of seeing them they wanted to put me back on pain meds, which they did and they kept me on those pain meds for four months. Of course your tolerance goes right back up to where it was and once they saw that happening after four months of being issued narcotics, they said that they didn’t want to do it anymore, they pulled my meds away from me and at that point in time I had gone to school, enrolled in college, and I was trying to better myself and so it was a very tough position for me ... so I in turn started getting the same medications on the street and then what happened was is I couldn’t afford the prescription medication on the street, it was cheaper going to the heroin and that’s what I did.”
- “It was rough. I’ve never been so sick in my life...I went to a detox facility for nine days trying to get off the fentanyl and I mean I was taking 100 micrograms, or whatever they are, every two days plus the percs, so when I detoxed off that with nothing it was awful and I can honestly say for about six months I didn’t feel—I felt like I was a body with no head like I did not feel right for a long time...I had never experienced anything like coming off fentanyl, ever....I can’t even believe I’m alive today because you don’t think of that you know? My doctor never said ‘Oh, be careful because you know’...you know I put it on my skin for the longest time and you know you hear people say ‘Oh, you know, and then one thing leads to another and before you know you’re a full-fledged drug addict.’”

One-fifth of interviewees described using opioids to numb emotional trauma, either from their childhood and/or from an incident as an adult. Self-medicating mental health struggles and trauma was a theme that came up often during the interviews.

- “I had an accident where a friend of mine was killed and then so I kind of started using to like numb that type of thing and then it just kind of progressed from there where you know it started out with like Percocet and then it went to oxycontin and then when they took the oxycontin away really they boosted this epidemic themselves. Then I went to that [heroin] and it was just kind of a struggle ever since and now it’s more just to feel normal. So, yeah, I don’t get the high or the like—it’s not fun for me to do it, it’s just to be normal.”
- “I’m to this point and like I said heroin is the lesser of two evils for me. It’s like, ‘Do I stay in pain or do I use?’....I just had the whole world just fall on me and so I just I went back because it’s an easier way to go, you know backwards than it is forwards, just to go back to use again, because it’s like an old friend that’s always there and I can always reach back and grab it.... So, it’s like I just keep having these things, like, fortify my use, I keep getting reasons to look back and just say, you know, alright, it’s just easier to use and put a blanket over my eyes, a blindfold you could say.”

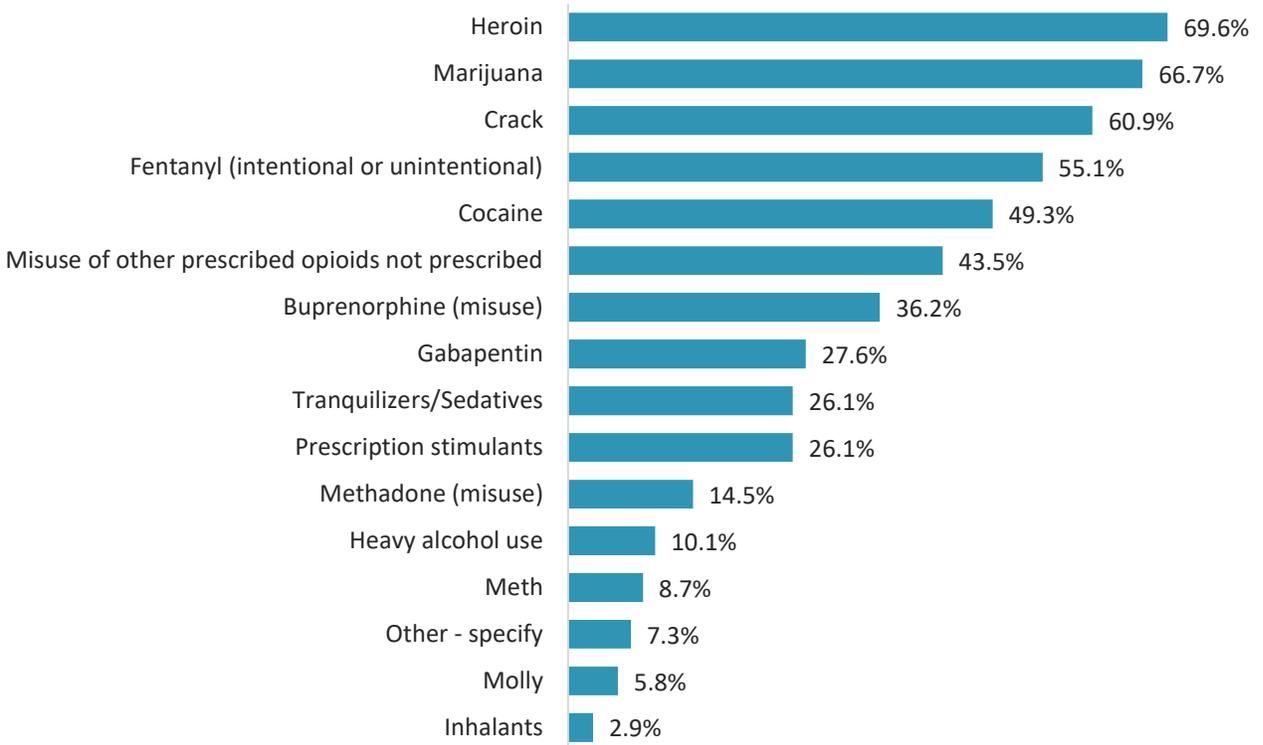
Participants also described the normalcy of drug use when they grew up with parents or around other adults using drugs. Among participants that didn’t identify a particular reason for initiation, as described above, they described the desire to feel good and to get a euphoric high.

Some participants mentioned that their opioid use began with heroin and/or injecting, although most participants started using opioids by taking pills (orally or snorting) and progressed to injecting heroin. The primary reason for this transition was cost (i.e., getting “more bang for your buck”), the ability to use less when injecting, and the difficulty in accessing pills.

3c. Past 30-Day Substance Use

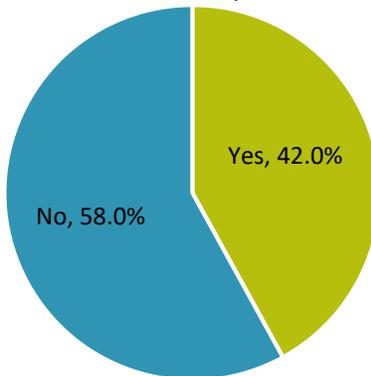
As discussed in the Methods sections, by the project’s design, all participants included in the report’s analyses had used opioids in the 30 days prior to the interview (i.e., current use). As shown in Figure 6, heroin was the most commonly used opioid among the sample, with 69.6% of the participants reporting its use in the past 30 days. More than half of the sample (55.1%) reported using fentanyl (either intentional or unintentional) during this period. Thirty-six percent of participants reported illicit use of buprenorphine, while 14.5% of the sample reported illicit methadone use in the past 30 days. Forty-four percent of participants had misused other prescription opioids. Following opioids, the most commonly used substances were marijuana (66.7%), crack (60.9%), and powder cocaine (49.3%). Figure 7 shows that 42.0% of the sample used all of these particular substances in the past 30 days – opioids, cocaine, and marijuana.

Figure 6. Past 30 Day Substance Use



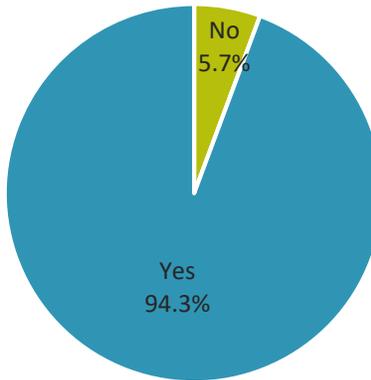
Note. Heavy alcohol use was defined in the questionnaire as 15 or more drinks per week for men and 8 or more drinks per week for women.

Figure 7. Used Opioids, Cocaine, and Marijuana in the Past 30 Days



Most participants (91.3%) reported having ever injected drugs, with 73.9% having done so in the past 30 days. Among those who had injected in the past 90 days, 94.3% reported having injected an opioid to get high (Figure 8).

Figure 8. Injected Any Illicit Opioid or Prescription Opioid Non-Medically or to Get High in the Past 90 Days



As noted, use of stimulants was high among participants. The quantitative data show that crack cocaine use was more prevalent than powder cocaine use in the past 30 days among participants. In the interviews, some participants described having a preference between the two types, while others reported that they would use whichever they could get:

- “They’re both the same price. They’re both easy to get, but it seems like over the...last couple of years now, it seems like now everybody has moved away from doing the coke snorting to now everybody and their brother now is smoking crack.”
- “...it’s kind of like whichever one I can get.”

There was some awareness that crack and powder cocaine could be laced with fentanyl. One participant noted:

“There has been more talk now that it’s been advertised on TV and stuff where people are still getting to be a little bit more worried about getting the fentanyl overdoses....all the fentanyl overdoses, well, now they’re lacing it where it could be in your coke or it could be in your crack or now it could be in your marijuana.”

Simultaneous use also differed among participants, with some preferring to do opioids and stimulants at the same time (“speedballing”), while others preferred to do them sequentially, or others not to combine them at all.

- “Usually I’ll use crack and then the opioids to kind of calm everything down.”

- “I kind of went back to like heroin. So you need heroin to function and then, like, when you smoke crack, it sucks the opiates right out of your body, coke or crack or whatever. So, by the time, say, you smoke a lot or whatever you’re fucking dope sick, you’re in withdrawals. It totally—it’s so dumb. And then and or you use the dope to come down off the crack or because your body is feeling it because the coke has sucked it all out of your body.”
- “I’m not going to say that I haven’t used both at the same time, but less frequently, you know what I mean, because of the fact I feel like if I’m upping myself so high and then all of a sudden, I go down like I’m looking at either a heart attack or you know what I mean? When you start mixing combinations of drugs, it’s as deadly as it is being heroin alone...you know what I mean? So that’s always stuck in my head, like, you know there could be fentanyl in this, but what’s in the cocaine? I don’t know. So, I started mixing things. I might make a concoction that’s going to make my heart go boom and that’s not something I wanted to do.”

Some participants felt that stimulant use was a way to prevent or reverse an overdose.

The old way of dealing with a heroin overdose was a shot of cocaine because it just speeds back up the heart rate and breathing rate and I will tell you it does work. And another thing people do is they’ll blow crack smoke in someone’s mouth when they’re starting to go down to try to speed them back up again.”

Some participants reported an increase in their stimulant use once they started on a methadone program:

- “I was on a lot of methadone. They were like overdosing me with methadone when I first went there. I was passing out at the wheel. I couldn’t even drive home. It’s crazy. I was on 90 milligrams, so I was just so sedated. So, to keep yourself awake on methadone, a lot of people go back to using coke and that’s what I did, just smoking crack like crazy.”
- “I’ve noticed that being on methadone I use crack a lot more, though.... I think that methadone kind of makes you sleepy and sluggish. It [crack] also makes you want to eat everything...makes you more alert and...”
- “It [crack use] actually came into play when I started my methadone, which was weird. I stopped using heroin and I just really, really badly craved uppers. I don’t know why, but I did and then when I stopped doing methadone, the crack urge sort of went away.”

3d. Behavioral Harm Reduction Strategies

A key focus of the project was to learn about behavioral strategies individuals use to reduce their risk of opioid overdose. As the quotes below convey, several of the strategies are interrelated. In particular, participants routinely mentioned the importance of not using alone, keeping naloxone on hand, and testing the quality and intensity of the drug by starting out slow, as “you can always do more” from there but you cannot take away or go back from the amount of drug you have already consumed. A specific example of “starting slow” was by sniffing or snorting rather than injecting the drug.

Figure 9.

Behavioral Harm Reduction Strategies

- Don't use alone and have naloxone on hand
- Start slow
- Buy from the same person over time/know who you are buying from and test it
- Assess for fentanyl
- Use marijuana to deter opioid use

“...a lot of people nowadays are carrying Narcan. I mean I think a lot of us are really sick of losing friends. That's a huge one.”

- “I guess I usually let people know when I'm going to go use if I'm going by myself or whatever, to check up on me in a little bit and my friends are usually really good about that and I do the same for them. I make sure I always have at least four Narcans on me.”
- “Try not to use by yourself. Always have somebody around. Always have Narcan on hand and most people in this area are really good about that. There's usually somebody within the group that will have Narcan, so.”
- “...you always let somebody go first and then you don't do that much. Those are just the rules...It could save your life, so it's important to do.”
- “If I don't know what it is, and it's something new that I'm trying, I'll do very, very little and see how it kind of does and then because you can always kind of add, but you can't take away.”
- “Yeah, sometimes I'll snort instead of inject because I don't know [about the quality of the drug].”

- “Usually if I get some, the first time I will either sniff it or I will just do half a ticket or less than half a ticket...”

Another strategy several participants mentioned was making it a point to know the person they get their drugs from or buying their drugs from the same person over time. With this familiarity, the person is more likely to be trusted to provide a quality product and might provide a caution against a particularly strong batch. Participants still described “starting slow” and testing the drugs obtained from these contacts:

- “...so the guy I get it through I can get a pretty good idea of what the quality is, so I know like how much to do. But then there is times he’ll be like this stuff is pretty good, so you know take it easy. You get the warning that’s when you’re like alright, so, you know, maybe have a [Naloxone] standing by and don’t go doing no half gram shots right off the bat, just take it easy because you can always do more, you can’t extract it back out as easy.”
- “...I try to deal with the same people all the time...Typically, if I’m getting it from a new person or if it’s a new product, I’ll start with just one bag and see how it affects me, that type of thing... see how hard it hits me, see if, you know, if it turns my stomach, things to that effect. But I typically try to stay with the same people because a lot of people also will cut things with some crazy stuff to increase their product and their money.”

Assessing for the presence of fentanyl was a specific type of testing that several participants described undertaking before they used their drugs. For some, this included using fentanyl test strips, but participants also explained that fentanyl could be detected by tasting the drug and discerning fentanyl’s sweet taste from heroin’s bitter one. In the questionnaire, 21.7% of participants reported having used fentanyl test strips previously (and would so again), with an additional 56.5% indicating that they had never used the test strips but would if they had access to them (Figure 10). Among participants who indicated that they would not use fentanyl test strips if they had access to them, their reasoning was due either to their perceived low risk of fentanyl exposure or their desire not to waste drugs. Participants who primarily used illicit suboxone felt that the risk of fentanyl contamination was low and therefore did not feel the test strips were necessary. Participants also expressed concern that using the fentanyl test strips required too much of their drugs for the test and they did not want to use their supply in this way.

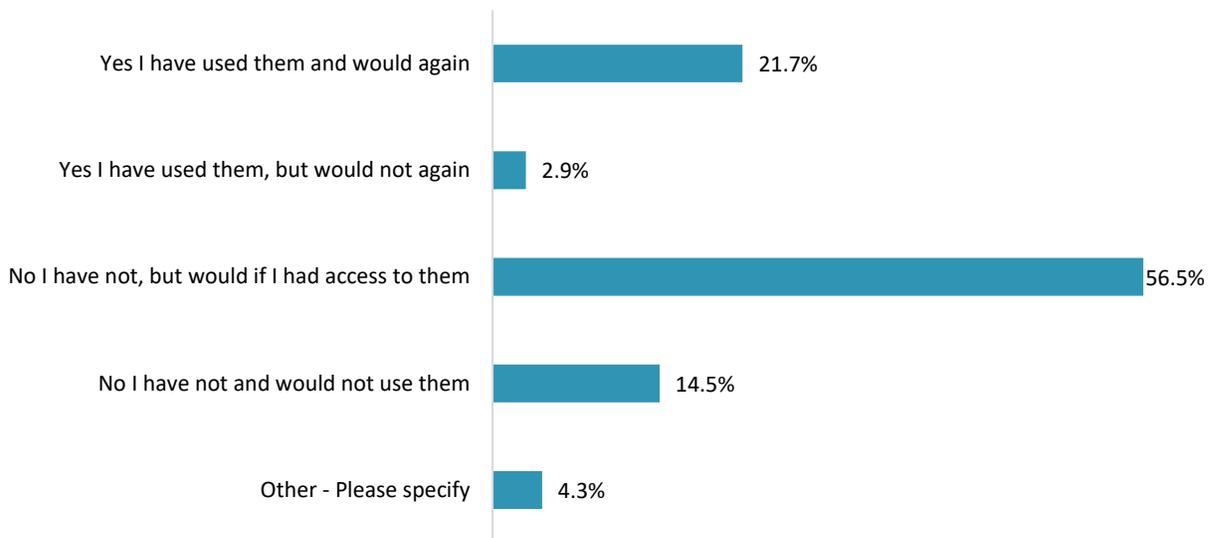
Although less frequently than mentioning tasting, participants also noted that paying attention to the color of the drug was another way to determine whether they thought fentanyl was present in their drug.

- “Well, you ask and if you don’t know, you’ve got to look at it yourself. You’ve got to know what you’re looking for because fentanyl really has kind of a sweet taste,

or no taste...you can...taste it, the color, you've just got to be cautious. Some people just don't care, so."

- "I mean I don't know really, but I feel like fentanyl is sweet, dope is bitter. If it's white colored normally it's got fentanyl in it, or something of the sort and you know the word around town about stamps... which ones are bad, which ones are strong, this and that."
- "Yeah, the sweetness of it..fentanyl is very sweet tasting. Heroin is very bitter....when I'm pushing air out of my syringe...I squirt some in my mouth so I can taste it."

Figure 10. Use of Fentanyl Test Strips



Participants described these strategies when asked specifically about steps they take to protect against overdose. In addition, during the interview discussions, some participants described marijuana use as a harm reduction strategy in that it helps deter or reduce their opioid use:

- "...the weed kind of helps deter me."
- "...people say it's a gateway drug. I think it's like a lock on the door drug because I'll think about using and get a lot of thoughts in my head, and I can sit down and smoke and relax and not think about it..."

Further, several participants discussed using illicitly-obtained buprenorphine to manage their opioid use and withdrawal symptoms:

- "I've done bupe on the street before and it worked for me. I didn't think about getting high."

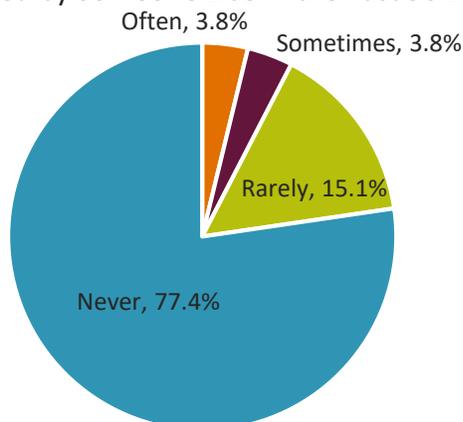
- “I mean, it took like two weeks, but I just started taking street bupe, until I got into the clinic...I think for most people it’s just you don’t want to be sick and you do whatever it takes to not be sick.”
- “I’ve got to go buy it from the drug dealer, basically, back to some of my own ways, and I don’t like to do it, but I kind of have to until I can find a doctor who will sit down and listen to me and actually help me.”

3e. Infectious Disease Acquisition and Transmission Prevention Strategies

In response to the questionnaire, 77.4% of participants who had injected drugs in the past 90 days responded that, in that period, they had never used injection supplies that had already been used by someone else (Figure 11). Consistent with this, during the interviews, participants tended to be uniform and emphatic in describing the safety precautions they took with their injection practices, as illustrated by the quotes below. Among those participants who did use injection supplies after someone had already used them, they indicated the following reasons for doing so: not having access to clean supplies at the time; feeling that they knew the person they were sharing with and not being worried about disease transmission; or being too focused on getting high and, therefore, not prioritizing using new supplies.

“...most people try to use clean supplies. Like, there’s not a lot of people I know that just trade needles around like it’s not a big deal. I think that’s more of a stereotype that junkies get.”

Figure 11. Used Injection Supplies That Had Already Been Used by Someone Else in the Past 90 Days



- “Well, I use a clean needle every time no matter what. I will never reuse a rig, never. I’ve always been really firm on that because I don’t want to get any of that shit and, you know, I always wash my cookers or spoons, whatever. Like I said, I’ll reuse the same tourniquet a bunch of times because you can still use shit from that. I won’t share cottons, I won’t share needles, I won’t do none of that, like none of it whatsoever. I just will not do it. I’d rather sniff a bag or not do it at all if I didn’t have a clean rig, but, yeah, I’m very good about that.”
- “I use a new syringe every time and have my own stuff. I don’t ever share or do anything with anybody.”
- “...if I can’t get something clean, I’d rather just snort or smoke it.”

Although participants generally felt comfortable with their hepatitis C and HIV transmission knowledge, a few participants expressed the belief that they could give themselves hep C by reusing their own injection supplies.

3f. Use of Syringe Services Programs

Another central objective of the evaluation was to assess use and barriers to use of Syringe Services Programs in the three target counties. There is one Syringe Services Program (SSP) in each of the target counties: VT CARES Mobile Van in Franklin county, which operates there once per week by appointment; VT CARES SSP in Rutland county, which operates every Wednesday 9:00am – 3:00pm; and the AIDS Project of Southern VT SSP in Windham county, which operates every Tuesday 10:00am – 2:00pm. Services offered at these harm reduction agencies include the availability of: safer injection supplies, safer sex supplies, fentanyl test strips (in Rutland and Franklin counties), HIV/HCV testing, and referrals to treatment and other services.

Awareness of the program

Of the 26 participants in Franklin county, only one was aware of the SSP mobile van. Awareness of the SSPs in Rutland and Windham counties was generally high. As illustrated by the following quote, participants there tended to indicate that they and their peers knew about the programs, even if they did not use their services: “Everybody I know knows about it, but then there’s people that choose not to want to come down here.” Participants depicted a tension in balancing individuals’ concerns about anonymity when using an SSP and the importance of advertising the program to ensure people know it is there. Participants explained that some people’s apprehension to use an SSP may be reduced by letting them know that the services are anonymous and that the locations are discreet. However, participants also noted that in order for people to know about the SSPs, it is important to advertise them. The following quotes exemplify this challenge observed by participants:

- “I think the fact that they make them aware that it’s all anonymous, you know what I mean? It’s not like you’re named in there and that’s one thing I do like about them, not having anything on the doors. Because then people don’t have to think when you walk through a door, that’s what you’re going in there for. So that does work that way. But also, you know, you should have a little bit more advertisement to, like, to know that it’s there. So, it’s a Catch-22 kind of thing.”
- “I realize that these places are supposed to be anonymous or whatever...but can’t you publish where these places are like in the newspaper or places that people read...people don’t know it’s there.”
- “I knew they had one here somewhere...Yeah, they could do a little bit more advertising.”
- “It’s kind of hard to find.”

Participants’ use of SSPs

Seventy-four percent of participants reported having ever used an SSP, with one of these participants noting that they had done so only for the purpose of getting supplies for friends (Figure 12). Among those who have ever used an SSP, 35.3% reported that they visit an SSP at least once per month and an additional 11.8% indicated that they go at least once per week (Figure 13). One-fourth reported visiting an SSP at least once every six months. The “Other” responses for this question tended to explain that the participant just recently visited an SSP for the first time or had used an SSP previously but does not currently.

Figure 12. Ever Used a Syringe Service Program

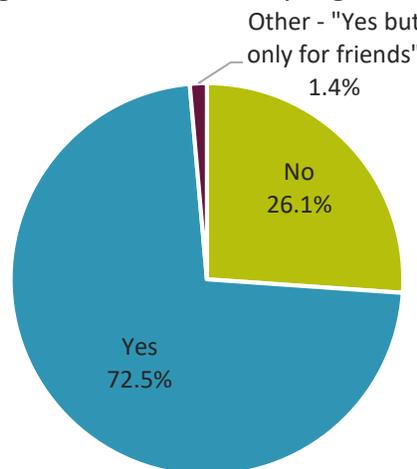
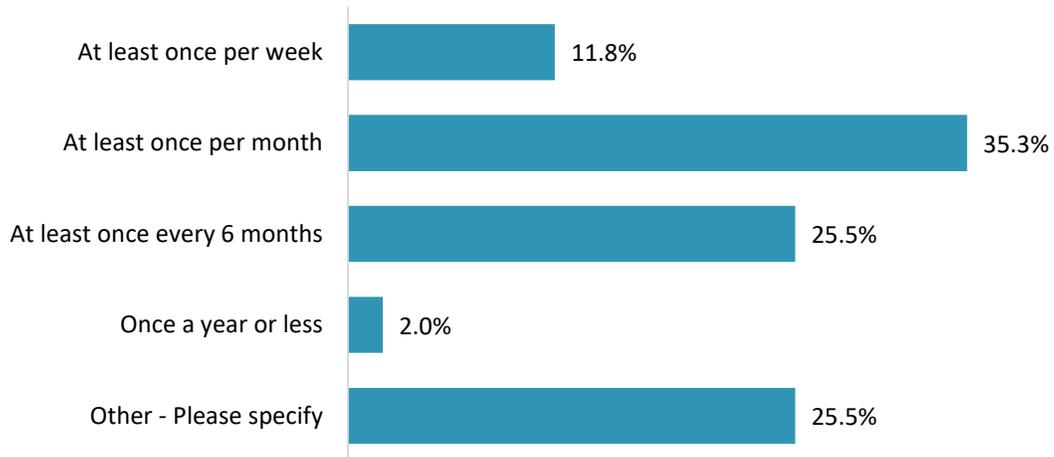


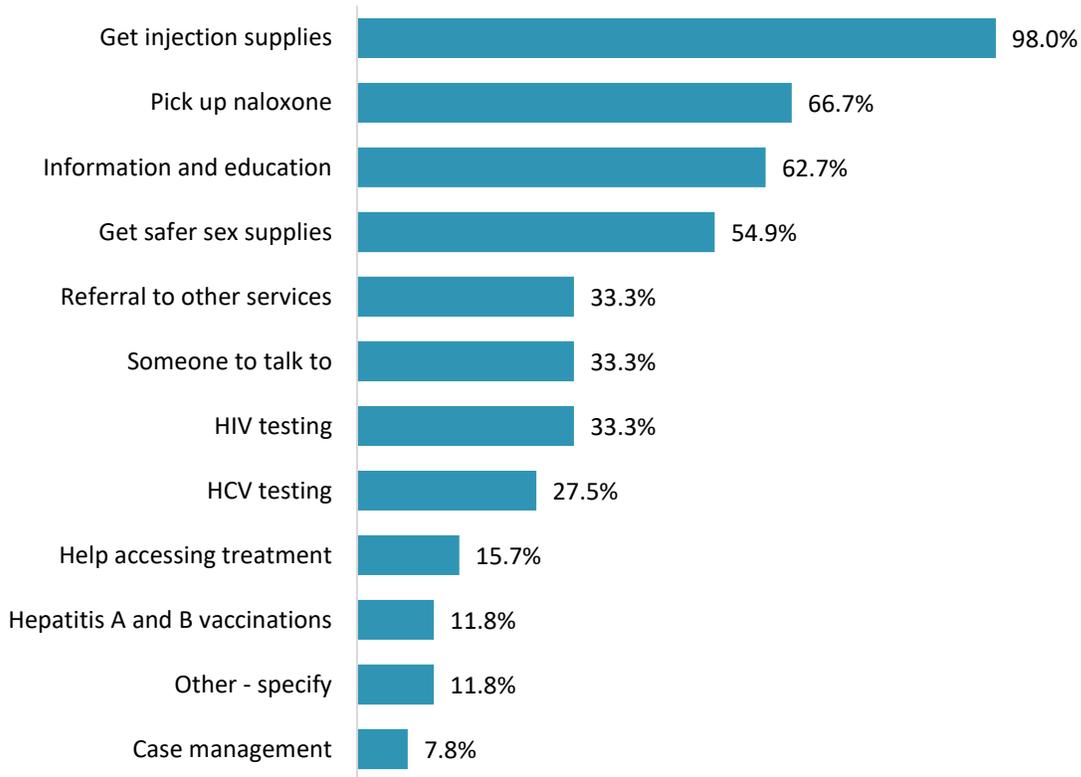
Figure 13. Frequency of Visiting a Syringe Service Program among Those Who Have Ever Used an SSP



Reasons for and benefits of using the program

Figure 14 displays the services participants reported having ever used at an SSP. In the questionnaire, the interviewer asked the participant to indicate whether or not they had ever received a series of different SSP services. Representing the most commonly reported service, almost all participants (98.0%) who had used an SSP reported getting injection supplies from the program. Picking up naloxone was the second most frequently reported service, with two-thirds of the participants who had ever used an SSP indicating this. Obtaining information and education and safer sex supplies were other relatively common services. In contrast, case management, hepatitis A and B vaccinations, and help accessing treatment were among the less commonly reported services. Examples of “Other” services participants mentioned included fentanyl test kits and wound care.

Figure 14. Services Used At SSP



During the interviews, participants expressed appreciation for the SSPs in Windham and Rutland counties. Overall, they felt that they had the supplies they wanted and that

“I tell them [peers], you get clean rigs, you get the little container to put the old ones in so you can stop dropping them on the ground, and you bring them in and you get new ones. You get the cookers and, you know, it’s free, so why say no [to using the SSP]?”

the staff were courteous. Participants were aware they could access safer injection supplies, naloxone, and safer sex supplies at SSPs. However, not all Rutland participants were aware of the fentanyl test strips that were available at the Rutland SSP. In particular, participants valued SSPs as a way to help them stay safe from infectious disease. Some felt that they would not have any other option if SSPs were not available, while others explained that they already purchase syringes at pharmacies or would do so if SSPs were not an option.

Many of the participants who had used an SSP reported that they pick up supplies for their peers, either intentionally as part of a pre-existing plan or by passing out the supplies they had picked up for themselves to their peers while they are using drugs together. Fewer participants indicated that they were the recipients of secondary

exchange, though this was more prevalent in Franklin county where access to an SSP was more limited among participants.

- “Well, you know if they need them and I know they need them and they’re using old needles, I just I bring them to them, you know? Tell them, ‘Hey, I got some,’ and I give them a bag, so, yeah.”
- “I usually pick up the max, just because sometimes there’s times when I’ll go a few weeks before I come, or I’ll come once or twice a month, so you know and I do have, I do know people that can’t make it down, so I do grab an extra box or two for them.”
- “I get tons of injecting supplies for my friends, condoms for my friends, condoms for my kids. I have teenage daughters and those things, like, you know, like the condoms, for sure, I would not be able to afford that on my own, for myself or anybody else. I find that people don’t want to go out of their way to get either syringes or condoms or whatever and so they’ll just kind of go without, but if they’re presented with it and there’s not a whole lot of work involved, they’re more than happy to use those things.”

Barriers to SSP use

Across the counties, during the interviews, the most commonly cited reasons preventing participants or their peers from using an SSP were lack of awareness of the SSP, days and hours of operation of the SSP, transportation, and stigma. In Franklin county, the greatest barrier was not knowing about the mobile van and lack of transportation for accessing the SSP in Burlington. For harm reduction services, they either used the SSP in Burlington, used secondary exchange with peers who traveled to Burlington, purchased syringes from pharmacies, or did not use new injection supplies when injecting.

“I’m sure a lot of people don’t want to be judged or feel like they’re going to get in trouble or somebody’s watching them and the fact that they have kind of funky hours and you don’t really know how—like there’s not really advertisement for it, I guess.”

The most frequently mentioned barriers for Rutland and Windham county participants were the hours of operation. Participants described the challenges posed by the SSP being open for a limited number of hours per week:

- “The syringe program here, I know the only downfall to it is the once a week thing. I know that that prevents a lot of people from going because especially the hours and stuff. They work or if they don’t—you know people that live like out

towards like Brandon or in Pittsford or in other parts of Rutland County that's not as accessible as someone like me who lives in town."

- "...I said to myself, 'Oh yeah, it's Wednesday, I should go to the clinic today'...then the next time I remembered...it was like four o'clock, and I was like 'Oh shoot, I guess I'll go next week.'"
- "I think a lot of people are like me, embarrassed of coming in here and they're scared and that's why I have a lot of people that come to me asking me for rigs and stuff because they don't want to come here. It's embarrassing to come here or either that or they just don't have the time, because actually the needle exchange isn't open a lot. They're open maybe, what, twice a week for, what, from ten to noon?... And people who work, I have friends who work maybe eight to five. They can't make it down here, so they can't get it. So another thing is if they can expand hours or maybe be open at night for an hour because a lot of people are working and they can't get here and at lunch break, they're not open enough. They're only open like you said one day a week, that's ridiculous. That's why people are dying every day they need to open a little bit more, have more volunteers here so that they could open because one day a week...how many people you think could be here one day a week between two hours?"
- "...they are out there for people, but they're not really out there."
- "I know a lot of people say they wish it was open on the weekends because they work all week, things like that. So, you know maybe even like a Wednesday and a Saturday thing or a Wednesday and a Friday thing...even just one more day can help so many more people get access to that program. I mean, it's like, I really can't stress like how much one day could really change that program a lot."

Across the counties, many of the participants described experiencing the stigma associated with substance use disorder and discussed ways in which stigma created barriers to accessing harm reduction and other services. One way this manifested was by individuals feeling embarrassed to reveal their drug use, or injection drug use specifically, both to people they encounter in the SSP and to others in the community who might see them at an SSP.

- "I didn't want to see people in here that I might know and then make them uncomfortable and make myself uncomfortable but, really, if they're in here, they're in here for the same reason I am, so really it doesn't matter."
- "...conscientious of people seeing me there, getting the things you know. Obviously, people know what that place is and when you come out of there

they're automatically going to assume the worst. That's the only barrier that originally kept me from going there."

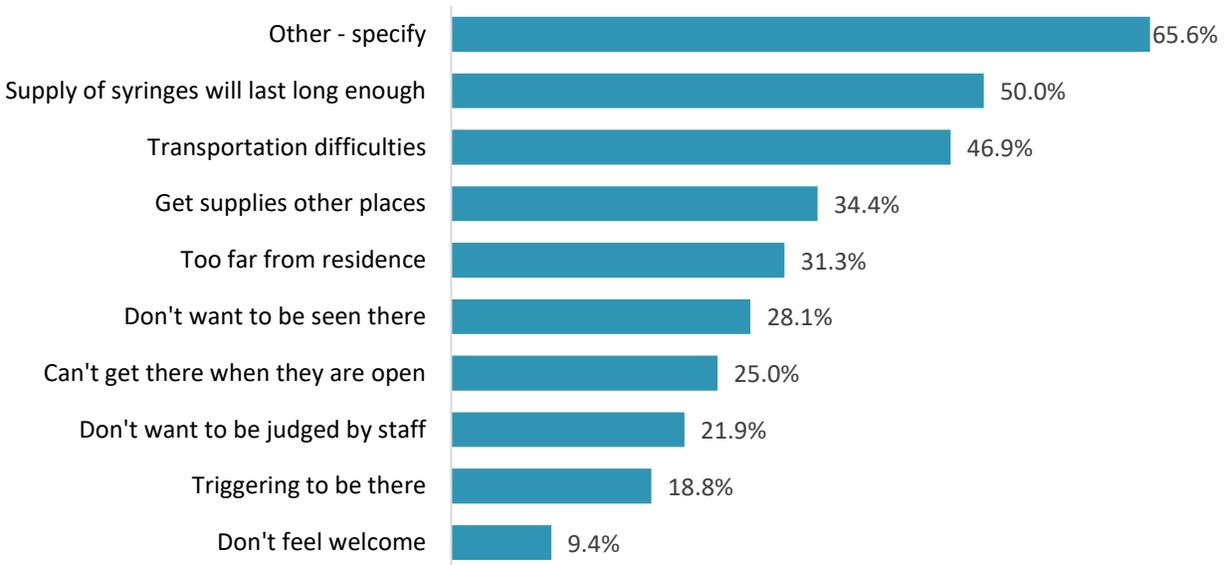
- "I was always embarrassed because you know it's right in town and I know a lot of people. That's where I'm from, and I always hated going in there and seeing people I know. 'Oh, you use needles?', you know? But besides that, it was a good place. I'd always try to go in and out as fast as possible."
- "They think if you go into that [an SSP], you're automatically labeled that. So, say if you go in there and you see the guy that you see at the convenient store every day that doesn't know you from anything. He just knows that you buy a pack of Marlboro's. Now he thinks you're a needle user. And that's where I think a lot of people try to incorporate and they think, like, 'Oh no, you know, so I'd rather use a dirty needle'...I think that they're worried about these labels."
- "Well a lot of people, when you have, I have a counselor and I have people that don't know I do drugs, I mean and when they see you coming out of here, they automatically know you're doing something. What are you coming out of the needle exchange for? I certainly don't work here, they know me, they know my life. Some people don't know anything about my private life, and they see me coming out of here it just doesn't look good and they talk, and they whisper, and I don't like it."
- "Like say his girlfriend don't know and he pulls up and his girlfriend's girlfriend sees him over there, it's like oh my God, who do you think that's going to be calling him 10 minutes from now? His girlfriend, you know what I mean? That's the thing...it takes its toll. The thing is, the whole thing about it is, it's just a dirty, nasty secret."
- Interviewer: And so, what are the reasons that you chose to never go there?

Participant: More or less it's being seen coming out and the embarrassment of people knowing that I use needles and stuff like that, that's what kept me from going there so I would just get them from people that I knew that went there, so I didn't have to be seen going in or out. Not only that, but, like, family. Someone drives by, sees me coming out of a needle exchange, then, you know, it don't look good for your family when they see you coming out of a place like that.

Additional reasons, across the counties, that were described as reasons participants did not utilize SSPs more frequently than at least once within a six month period were: they obtained syringes at pharmacies, they obtained supplies from peers (e.g., secondary exchange), and they had the supplies they needed to last them.

Figure 15 displays participants' responses to the questionnaire's question regarding reasons for never using an SSP or for not using one more frequently. The responses generally are similar to the interview comments. The most common "Other" responses for not using SSP services were due to not injecting drugs and lack of awareness of the SSP and/or its location.

Figure 15. Reasons For Not Using An SSP or Not Using It More Frequently



3g. Comments Regarding Safe Consumption Sites

Although safe consumption sites were not a topic included in the interview guide or mentioned by the interviewer, approximately 10 percent of participants brought them up as an important harm reduction strategy for both the individuals who are using, and also as a way to keep used injection supplies out of the community.

- “I know a lot of people would really benefit from safe injection sites. I have people come to my house all the time just to have some place safe to get high...they’re in really sketchy places, dirty places...and I know that a lot of people are really opposed to these you know injection sites, but it can save a lot of peoples’ lives and it can also like prevent a whole generation of kids from being exposed to this stuff. I’m seeing people taking their kids places that they shouldn’t or leaving their kids places they shouldn’t so that they can have some place safe to inject and that’s scary...It’s going to change the whole game and every single person I’ve talked to about the safe injection sites is all for it. They’re like fuck what everybody else thinks people are dying and we got to start doing something really drastically different here. And if the outside world doesn’t want to look at the ugly epidemic that’s happening that’s their choice but it’s not going to stop

happening just because you're putting your head in your hands... until more people can get clean and stay clean we just need to be as smart about it as we can."

- "It would help overdoses a lot. It would give people a sense of that there are people out there that care, that, okay, they're not letting me die. But, they know we're going to do it anyways, might as well do it clean and safe and don't die. And there's those same people that can help me stop if I choose and get me the things I need, like a job or a place to stay or whatever."
- "Probably a safe place to go to do it because they see them everywhere, and you see needles everywhere. I walk around the river and stuff like that and fish or whatever and there are just needles everywhere. There's no way in hell you can bring your kid down there and not worry about them getting a needle."

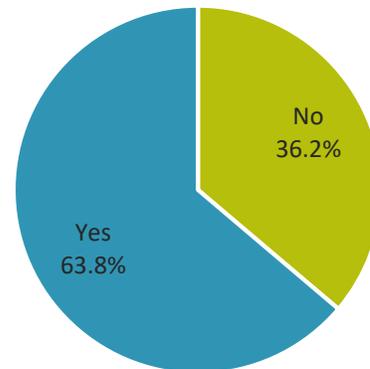
3h. Experiences with Medication Assisted Treatment

In the context of learning about individuals' opioid misuse and insights regarding harm reduction, the interview included asking participants about their experiences, if any, with Medication Assisted Treatment (MAT). MAT is offered throughout Vermont using the "Hub and Spoke" system, which consists of nine treatment Hubs to treat individuals with complex addiction needs, and over 75 Spokes for care integrated into general wellness services (<https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke>). Each of the evaluation's target counties has at least one Hub program in its largest town: BAART Behavioral Health Services in St. Albans (Franklin County), Westridge Center for Addiction Recovery in Rutland (Rutland County), and Habit OpCo and the Brattleboro Retreat in Brattleboro (Windham County). (https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Treatment_Directory.pdf).

MAT as a harm reduction strategy

Nearly two-thirds (63.8%) of the participants were currently receiving MAT through a provider (Figure 16). During the interviews, most participants on MAT described it as having eliminated or significantly reduced their opioid use. One participant summarized their experience on suboxone with the following description, noting how it helped them achieve many positive life changes and avoid a series of hardships and risks, including a potential overdose:

Figure 16. Currently Receiving MAT Through a Provider



- “I know a lot of people that aren’t former drug addicts think suboxone is a horrible thing and that it’s basically another drug to cover up the drugs they were using before...It’s [suboxone] basically turned my life around. I’ve been able to save money since then. We rent a house with land. I have bought my own car. I have a family now and I basically have a stable life and before, when I was using drugs, that never would have happened for me, so suboxone saved me from being on the streets having no money, having no life. I mean I could have overdosed. So many bad things could have happened.”

Participants explained that being on MAT helps them both physically and mentally. This included addressing physical pain for some individuals and avoiding the sickness and worry that would arise from not having access to opioids:

- “I don’t want to use. For others, they go to the clinic just, so they don’t wake up sick. I go because I don’t want to be in pain, physical actual like pain that prevents you from going about your life.”
- “I have scoliosis in my spine. Years back I broke my leg, to where they had a titanium rod in there, but that broke, and when that broke, my leg healed. It was crooked and so I walked on that for three, four years like that and my gait was all wonky and stuff and so that put my spine and my hips and right down through my legs every joint was just aching and burning so I was using a lot and then when I came here and started the methadone, it was almost like a godsend that I could actually feel comfort, like lay down and feel at ease and just kind of sleep through the night.”
- “I know I’m going to get dosed every day. I feel like I don’t have to worry if I don’t have the money to get high or whatever.”

- “But just, knowing I’m not going to be sick tomorrow frees up my mind to think about positive things I can work on or just at work or school or being with the kids and doing stuff with the kids because I’m not sick. I’m not thinking about it.”
- “[Being on MAT]...I don’t have to search for something every day to keep unsick.”
- “...you will be fine for a day or whatever. You don’t have to like take more immediately a few hours later.”

A few participants reported that methadone lessened or blocked their ability to feel a high from opioids. This helped some not use because they felt there was no point, whereas others felt this put them at greater risk for overdose because they increased their use in order to feel high.

- “I want a better life and the other day when I used and that [overdose] happened, it really scared the shit out of me. Yesterday, I used one bag, didn’t even feel it, felt like a waste of money. I just feel like it’s a waste because of my methadone and the fact that it’s not working the right way. I’m not feeling any relief from it. I’m just putting it into my body. That’s it...”
- “If I do methadone there’s no point in doing heroin because I do not get anything out of it. To get anything out of it, I literally almost have to OD myself. Like, I have to do so much it’s pointless. I don’t feel a damn thing. I can sit there, snort three bags, not feel a fucking thing.”
- “Because what’s in methadone blocks the amount of good feeling that the heroin is supposed to implement in to your body....Yeah, more heroin when I do more opiate blocker. Less opiate blocker, less heroin. There’s a positive correlation and a negative correlation.”
- “...there is no rush anymore because the methadone completely kills that, but more than anything it’s just like a pain reliever for myself today.”

Continued opioid use on MAT

Participants frequently reported continued use of opioids while on MAT and noted a few reasons for doing so. Some believed their MAT dose was not adequate to keep them from getting sick. Consequently, some participants ultimately switched MAT programs or stopped altogether because the dosing or some other aspect of the medication did not work for them. Sometimes the challenges with determining appropriate dosing and treatment involved other health conditions that complicated individuals’ dosing.

- “Being on the methadone, not being sick, and not feeling that pain has really helped like a significant amount because the only time I even use now is when

I'm building up on the methadone. So, until I get to that right dosage I still get sick at some point throughout the day and it's kind of more a necessity at this point than it is a want."

- "It [buprenorphine/naloxone program] didn't really work for me. I mean I could take 16 milligrams of [buprenorphine/naloxone] a day, two 8 milligram strips, and still have cravings so I still felt like I needed to pop some pills or to get a ticket."
- "I think that they need to listen to patients more because, yeah, they might not want to dose past 16 but some of us need to start out there because unfortunately then you end up with what's happening now is I have to self-medicate to medicate and I shouldn't have to. I should be able to tell my doctor, 'Hey, this is what's going on'..."
- "...a lot of times they're not getting the right medication doses to take care of themselves so they don't feel sick, so they resort back to using."

As these quotes suggested, some participants expressed frustration in coordinating with their medical provider about their treatment, specifically explaining that they felt "nobody was listening":

- "I would say one of my reasons is I keep trying to tell my provider that my dose isn't, like it's wearing off and he doesn't really listen to me. Like, I haven't even took an extra sip of my stuff today and I'm already, like, I can't sit still because my legs hurt. I keep telling them that my dose isn't high enough and he won't up it, so I'm constantly sipping out of my three day take home until I'm guessing that it's good enough."
- "So, I mean in my eyes I don't think I was trying to become what I've become it was just that nobody was listening. Nobody was helping me get through that step that I needed to get through, so I had to do it on my own."

Other reasons participants mentioned for continuing to use opioids while on MAT included the desire to get high, using it to cope with stress, having a hard time avoiding it in the presence of peers who are using, and finding it hard to stop the routine associated with injecting or "the needle":

- "But now if I go a day without methadone...I'm so sick, it's worse than dope sickness, like ten times worse. So, what makes me do it? Just being in the presence of someone I guess who is doing it, I guess, and wanting the high."
- "I don't crave it as much. I mean I still crave it because, like I said, I really like, you know, the high, but I have, you know, the suboxone now, so I'm not always on edge wanting it."

- “When I get stressed out or upset, I’ll sip it to go to sleep.”
- “...if you walked in and said, ‘I’m injecting my bupe, please help me,’ it’s going to be you’re cut off from your prescription and that’s not going to be helpful because then I’m going go out and buy it off the street or use something else. I just feel like there’s no comfortable place to be able to talk about it and it would be awesome if there was because I feel like that’s—I know a lot of people that do use their bupe like that. Most of them probably don’t even use anything else, but they just cannot stop doing that one thing...I don’t know what it is about that thing, but it’s, like, so hard to stop.”

MAT as an access point for other harm reduction strategies

Many participants who had access to naloxone had received it from the hub in their county. Some participants suggested distribution of other harm reduction supplies at MAT provider offices, such as safer injection supplies.

“To be honest with you I don’t see why this place shouldn’t have free needles for people. I get it they’re not here to advertise getting high, but maybe that’s something that should happen. I mean, I don’t know, see that’s, it’s kind of hard to have a clinic to try to get clean, but they’re giving away needles... why not, say hey guys are you being safe at least right now? You need supplies or something right now? What can we do for you, you know?”

MAT challenges and barriers

Participants mentioned a few main challenges to engaging and staying in MAT. These included differing views among participants regarding what type of MAT policies are most beneficial (i.e., a harm reduction-oriented approach versus an approach with penalties for any illicit use or missed programming), daily attendance requirement for dosing, and transportation.

- “They don’t condone it or anything, but you can still dose every day and smoke weed and I feel like I have to have something. Like, I feel like I can’t just like go cold turkey off everything. I guess that helps.”
- “If they were more stern with me I’d probably be clean. I’d be clean. I’m not saying it’s their fault. It’s my own fault, but it’s like anybody who is trying to get away with something. They’re going to push and they’re going to manipulate and they’re going to lie and they’re going to do whatever they can to still do what they want to do and there’s no repercussions for anything at that place.”
- “I mean, the clinic it’s good, but I thought it was a lot different than what it is. Like I said, it’s like they give you permission to still use or it’s okay now that you’re a crackhead but you’re not doing heroin anymore.”

Meeting individuals' MAT needs sometimes aligned with whether the program was a hub versus a spoke. Some participants who were in a hub felt like they needed that stricter oversight and daily dosing, while others preferred to be in a spoke, particularly due to not having to attend as frequently. Participants mentioned lack of transportation and employment as the main reasons for preferring a spoke to a hub. Participants who received their MAT from a hub and were required to attend daily for dosing reported that accessing the clinic each day was a hardship, especially if they needed to rely on other people to drive them. These transportation challenges often resulted in illicit use, which would further delay their ability to receive take-home doses in the future. Some participants who missed doses due to transportation or other barriers described turning to illicit opioid use to keep from going into withdrawal.

Transportation was frequently mentioned as a challenge for accessing treatment services by individuals who live in rural areas and are not able to access the bus.

- “The only reason I did the dope yesterday and a week or two ago, I did some just because I couldn’t get to the clinic in time. So, I missed it and, you know, you get that feeling. I’m running around trying to find a job, you know, and it’s like I can’t be sick, so I did it and it is what it is.”
- “...what it means is you have to go every day and dose, even Christmas, holidays, nothing, and if you were to go visit a family member or had to travel, they will have to call that county and see where their closest place is, and you can go there while you’re away...every morning I have to wake up and walk the 20 minutes in this weather each direction.”
- “I had a really hard time with transportation. I was utilizing the Medicaid transportation ride. Almost always, nobody would show up on the weekend and there was nobody in the office to call and you miss three days, they cut your dose in half. It’s real important to get there every single day. So that was most of my problem then.”
- “I didn’t have any transportation. That was basically it and I guess how people look at me, judge me, that’s another reason why I didn’t want to go.”

Balancing MAT appointments and childcare was an additional challenge mentioned by some participants:

“Fortunately, I had friends or I, you know, would trust my daughter enough to stay in the car and then have somebody that I know be able to just stand outside the car and watch, but if I didn’t have those options at the time...I would be lying to say that I didn’t say, alright [Name] I’m locking this door behind me, the heat is on, crack your window a tad bit, I will be back as soon as possible. And then you go into it thinking, ‘Man, if there’s a long line or something I’m just going to have

to not do this today'...I think back on that, the maybe two or three times, I had to choose to do that because I didn't have someone with me or somebody I trusted nearby. What if somebody did pull up and now DCF is involved in my life? What the hell? That would suck. All because I wanted to dose and not feel sick or relapse on something. I'm doing it to become a better parent and now someone is telling me I'm not being a good enough parent. Like that's kind of a shitty situation you know?"

One respondent described a program in Brattleboro that offers child care:

Participant: There's a program down there now where you can drop off your kids and then go dose and then pick them back up... a parent comes in with their kids, one, two, three, five, you bring them over, there's like a playground and a daycare center over there.

Interviewer: And is it just for dosing or can you... meet with your counselor?

Participant: Yes, you can if you have to meet with your counselor. It's pretty much anything to do with the hub program, so dosing, counselor, doctor. You can drop off your kids, they'll hang out, play, have lunch if that's the time period or whatever and then you pick them back up. I believe it actually might end at a certain time, like shortly after dosing, that's when that ends, but that is such a huge help.

A few participants reported being worried about getting off MAT once they started and not liking the idea of replacing one drug with another:

"So, I've been thinking about going back now [to MAT] because I've tried to quit on my own and I've weaned myself down tremendously but because it just kind of keeps you in the same mental state, you know, you've got to go get your fix every morning, going to the methadone clinic, and it's an opiate, you're just replacing it legally. I mean at least you know what you're getting. You don't know what you're getting out here on the streets when you buy a bag, but for me personally, you know, and it took a long time to get off of methadone, you know? They increase you way faster than they decrease you. I mean a base dose is 50 milligrams. They suggest a decrease of one milligram a week, it would take you a year to get off of it. That's crazy."

For others, who are facing barriers and are not receiving MAT, there is a belief and hope that being on MAT will result in positive changes:

"I've always thought if I could get on, if I could get on the bupe program... I wouldn't...be doing all this other stuff because right now what makes me keep doing it is because, like, let's say if I don't even have it like, say, for a couple

days, I get so sick...whereas if I were on the bupe program, like I said a couple of my other friends have been on it and they've been doing really good...they don't have that craving or that desire to go get something else because they're not sick anymore because they actually have something every day in their system."

3i. Housing Instability as an Additional Barrier to Harm Reduction Services and Strategies

In addition to the SSP, MAT, and other service barriers discussed in the previous sections, the interview guide included asking participants about housing and how it facilitates or hinders harm reduction practices and recovery. Participants described numerous stressors that homelessness and housing instability pose and, conversely, they expressed how fundamental a safe place to live is.

Barriers to accessing housing generally

Participants discussed hardships and barriers to finding appropriate housing. Problems such as affordability, quality and accessibility for individuals who are currently using drugs or had poor rental history due to previous drug use were mentioned.

- "I really wish they had, like, more rooms, rooming houses, you what I mean, where you can, like, share a kitchen and whatever. They need more of those... You have to have, like, a perfect credit score and be perfect and it's, like, they should at least have like rooming houses for people that aren't going to be able to get into that."
- "Evictions, even if you have like an eviction on your record, they should still have a place where you can still go, you know what I mean and get another chance."
- "I think the next spot to work on would be housing because we don't necessarily have a lack of housing, we have a lack of people who want to take people who have fucked up...so you can't sit there with an empty apartment because somebody is at the clinic and you're too scared so now we have all these empty apartments... so something again like a family advocate...now I need somebody to trumpet ahead of me and be like listen, her record looks shitty, you might think she's going to punch you, she's not, she's awesome I work with her all the time, like I personally can say I will come to her house. You know what I mean I need somebody to basically do that because they don't take my word and they're looking at my record you know what I mean and usually I can like have a one-on-one like I do now, I can be very professional and sell myself well. If you look at my record I'm fucked, and I don't get a call back."

One participant who had problems with their rental history described receiving a second chance, and support with harm reduction, from their landlord:

“He gave me a second try. He didn’t think about my track record. He was thinking about my reason for being up here. He’s thinking about my reason for why I was homeless. I don’t know if I would give myself a chance... Well, he gave me a second chance. He knew that I came up for alcohol and drugs and went to rehab and all that stuff, plus he has Narcan on there, plus it’s a very—there are no appliances that are in danger of sparking or anything like that, so I feel like he does care about the residents.”

Participants conveyed how homelessness and unstable housing contribute to riskier behaviors and loss of hope for recovery. They described not being able to focus on themselves, what they enjoy, their family, or their recovery when they don’t have safe spaces to be. When asked what it is about housing instability that leads to drug use, one participant explained:

“Lots of things. The first thing that comes to mind is obviously the stressors. You know it’s stressful being impoverished and walking the streets all day every day and it’s the boredom, that’s where a lot of addicts are I think. We’re bored, we get high to alleviate the boredom, plus there’s so many addicts out here on the streets it’s a group of us you know, you get like a flock or something you know?”

Other participants provided similar insights:

- “Oh, it’s a terrible feeling like walking around the street at night knowing that no one gives a shit whether you live or die. It’s a hard thing to accept and you know like that’s honestly during my entire time of drug use that’s been probably the biggest trigger for me is not having a place to go or having that feeling like nobody gives a shit you know?”
- “If when people are more stable, I think, you know, they do a lot better with not using, you know what I mean? If they had a safe place to sleep and stay warm and be able to get back and forth to a treatment center they could stay sober and go to groups.”
- “It [housing] gives you a center to like, to want to do better, you know?”
- “I just feel like I could get back on track and get my kids back and they would, I mean, like, they keep me motivated and busy. I wouldn’t be probably talking to half the people I talk to that still do drugs and, but when you have nowhere to go, if you have money or stuff, they’re willing to let you stay there.”

A particular stressor some participants described as being related to their housing situation was risk related to solicitation for sex.

Participant: Being a woman on these streets it’s just horrible.

Interviewer: Where do you usually stay now?

Participant: I'm just staying on the couch, a friend's couch and like he's already solicited me...I'm trying to get out of here, get the hell out of here. It's hell, living on the streets. And I see why people use drugs.... housing would just flip-flop my whole life.

Interviewer: How would having stable housing affect your life and your drug use?

Participant: I don't believe I'd use. Or I'd use less because I'd be stable, have a home to go to. Like this guy's home I feel like he's staring at me and wants sex from me all the time... My whole life is just like a turmoil, just turmoil.

- "I left with like the clothes on my back and was homeless. I slept on park benches. I slept at peoples' houses that I knew, like, wanted to sleep with me and I had to like continually like bat them off because I—you know what I mean, the one thing that I haven't done for drugs is sexual favors and I don't judge anyone who does. I just, that's just not—I refuse to go that far. I will be sick if I have to, but I refuse to go that far. I've never needed it that bad."

Some participants mentioned the need for a Housing First model, where housing is accessible regardless of their current substance use. They described needing the stability of a home and the hope for a better future before they are able to focus on stopping or reducing their drug use.

Interviewer: How do you feel like your situation would be different if you had stable housing right now?

Participant: It would be huge.

Interviewer: In what ways?

Participant: Just being able to sleep. I'd be able to think about my sobriety, think of, you know, put more effort toward trying to—like right now it feels pointless, and maybe that's a bad way to look at it, but it just feels like I'm just getting by, I'm putting so much effort into doing anything that, it's, like, hard to want to change...I think that, it's, stable housing would give me a place to have something to look forward to, something to want to invest in. You know I think my time would be taken up more with, like, wanting to decorate it and wanting to, like, you know plan a house and eventually be able to maybe have my son come visit me, maybe have a place that I could entertain or have, like, a dinner, I don't know, it would be huge.

Some housing support services are accessible to anyone, regardless of their current drug use. This sometimes means that there is drug use occurring at drop-in centers or shelters where people do not have other options for a place to use.

“That [access to housing] would work a lot better because they wouldn’t have to come to like places like here and I’m not saying—this place is a godsend...but, like, if you’re around 120 people that are using, it’s still going to lead you right back to it. A lot of people don’t have anywhere to go. This is a great place to sit, you know what I mean? But, you know, with that, obviously they can’t, they obviously don’t want people using, but they know it’s going to happen, so I just think if they had more residential stuff, it would save people from having to, you know, be out on the streets where, like, they have to be around these people or go to a place where they have to be around these people. That would help, I think.”

Once housed, people are able to see the difference in their behavior and their feelings about obligations and priorities.

“It’s been a lot easier to not do drugs since I have had stable housing. It’s lifted a great deal of stress off of me. Also, I’m in a really nice neighborhood, which means I can go for walks and not run into people that I used to do drugs with or see drug deals going on, things like that. That’s a first for me because every other neighborhood that I’ve ever lived in, everyone that I did drugs with lived nearby me or in the same, or even if they didn’t live nearby me I would see drug deals going on or just see houses, just certain things that would trigger it. It’s definitely made it, I mean, tremendously easier. Also, the fact that I have an obligation to pay rent every month. It’s hard. Like I said, I do catch myself relapsing and being like, ‘Well, this is stupid. You’re going to be short on rent.’ But it does at least put that thought in my head, you know, to at least recognize that that’s bad and try to work on that, or other situations where I would get a craving or something and be like ‘No, you’ve got rent to pay and that’s that,’ and won’t even think about it anymore. So, yeah, if you have stable housing I think it can make not using, I mean, like I said, tremendously easier, you know?”

3j. Participants’ Experiences with Overdose and Accessing and Using Naloxone

Experiences with overdose

Half of the participants (50.8%) reported that they had overdosed one or more times in their lifetime (Figure 17). Among those who had ever overdosed, more than 40% had overdosed within the past 12 months. The vast majority of participants (84.1%) had ever witnessed an overdose (Figure 18). Notably, 42% of the sample had witnessed 2 to 5 overdoses and almost one-third of the sample (30.4%) had witnessed 6 or more overdoses. In addition to asking participants about their experiences with overdose, the questionnaire included an item regarding their perceived risk of dying from an overdose. Over half (53.6%) of the sample responded either “likely” or “very likely.”

Figure 17. Number of Times Overdosed

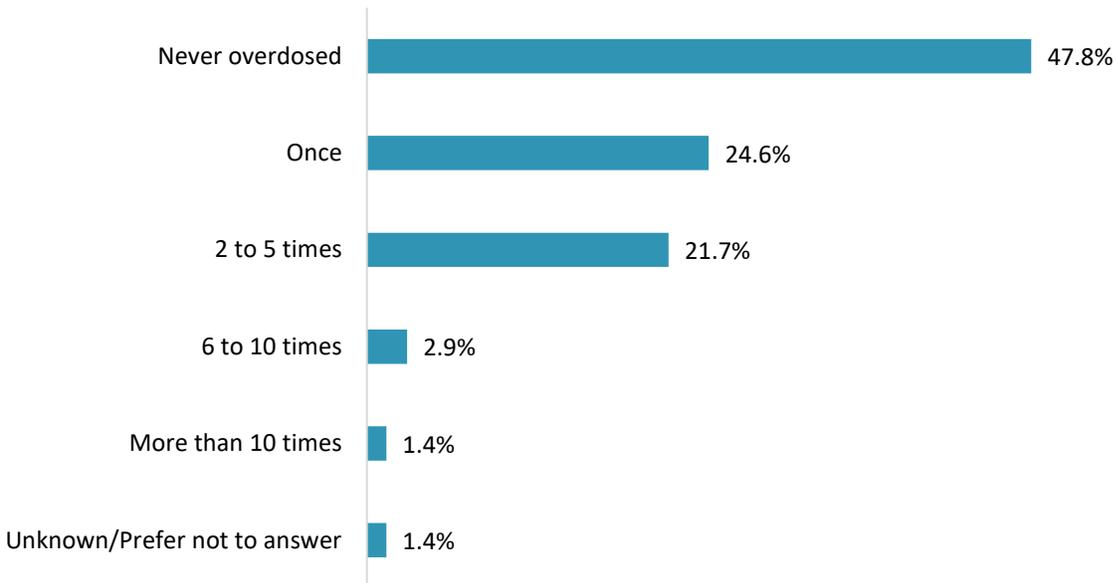
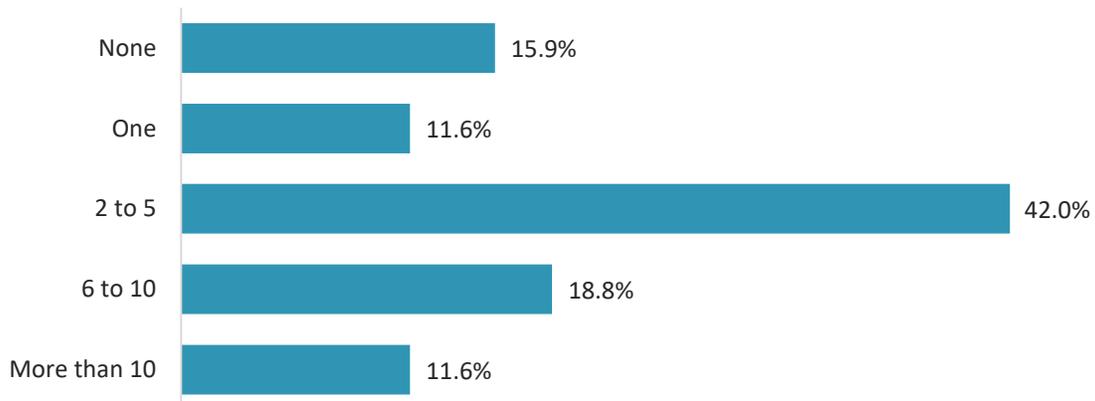


Figure 18. Number of Overdoses Witnessed



In discussing times when they had overdosed, some participants described how they have tried to be safer since then:

- “...that’s when I said I would never do it alone again. And I’ve done it, I’ve done it since, but someone’s always been around.”
- “...I try to be diligent, whereas, times in the past I would go through someone else to get it and I didn’t know what I was putting in my body. I don’t even think I knew what fentanyl was the first time I overdosed. And so, yeah, I just tried to be safer about it, or as safe as I can be, I guess.”

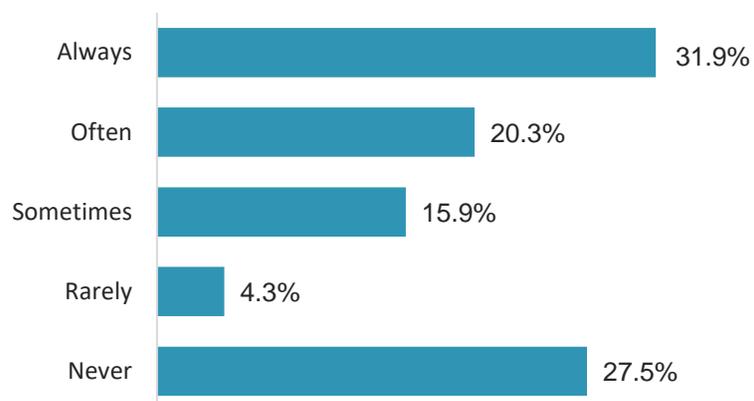
Accessibility and use of naloxone

As presented earlier in the report, two-thirds (66.7%) of the participants who had ever used services at an SSP reported that they had picked up naloxone at the program, as one of the services they reported receiving at the SSP. Receiving naloxone was the second most commonly reported service participants reported receiving at an SSP. During the interviews, participants described naloxone as being readily available and accessible. In addition to SSPs, other locations for obtaining naloxone included MAT hubs, recovery centers, and the Groundworks drop-in center in Brattleboro. A couple participants noted challenges to obtaining naloxone at hubs (e.g., they needed to know to ask for it), while others felt that obtaining it at these locations was easy and straightforward.

Keeping naloxone on hand

While 72% of participants reported keeping naloxone on hand at least some of the time, less than one-third (31.9%) of participants reported doing so always (Figure 19). Further, approximately 28% of participants responded that they never keep naloxone on hand. The questionnaire responses appear to show more variation than the interview comments on this issue. During the interview

Figure 19. Participants' Reported Frequency of Keeping Naloxone on Hand



discussions, participants clearly cited the importance of having naloxone on hand. However, they also shared various circumstances where it is not kept on hand. For example, some individuals described that their only opioid misuse was illicit use of buprenorphine. Consequently, they perceived their overdose risk to be low and did not prioritize keeping naloxone available. In addition, despite the acknowledgment of the importance of having naloxone available and often actually doing so, or being with others who have naloxone, participants also described situations where they encountered barriers that resulted in them not carrying naloxone.

- “I try to have Narcan in my purse or whatever and most people know that. If I start to feel myself going down, I will tell somebody. It hasn't happened yet, but I don't usually do a lot at once and you can't protect yourself every time, but it hasn't happened.”

- “My surroundings at home is with an elderly lady and my 18-year-old son. They obviously don’t know when I’m getting high, but they know that I’m a recovering addict that does use sometimes and they know that there’s Narcan in the house. So, they know if I’m like in the bathroom or the bedroom for too long and all of a sudden, they heard a thump on the floor my son would know to come in, he’d know what it is, and he knows where it is. So, I’ve set myself up that way. And it was hard because I had the Narcan in my house for four or five months and I didn’t tell him it was there, and I kept saying to a couple friends of mine it’s hard because they all think I’m still clean. They think I’m doing good and I don’t want the dynamics to change just because I want them to know there’s you know Narcan in the house. So, I told him, I said listen what is that stuff? I said it’s Narcan, and I told him what it was for and how to use it. Well why? And I said well I’m not an angel, I’m not an angel, I’m a recovering addict and there’s times that I slip up and there’s no sense in having this in the house if you guys don’t know about it.”
- “If I don’t feel like carrying around extra stuff in my backpack I usually don’t carry it, but sometimes I do, you know.”
- “...somebody that I know was arrested and manhandled by some cops because she was looking for a phone on the side of the road and she went—she comes to the clinic and they know she does...She had some [Naloxone] in the car, and they’re like well we need to search your car, just because she had [Naloxone] in her car...that’s another reason why we only carry one around at a time usually too is because it’s easy to get rid of.”

Resistance regarding administering naloxone

Many participants described reluctance around using naloxone, with it often being used as a last resort because it causes instant withdrawal and destroys a person’s high.

“...most addicts are scared to death of [Naloxone]. It puts you into instant withdrawals.”

- “...people are like if I fall out, try to do a sternum rub first. Like, try to do this other stuff first before you administer Narcan, for a lot of reasons. One, because it fucks up your buzz. Two, it makes you really, really sick and you go into instant withdrawal. Three, yeah, there’s a likelihood of going to the hospital. So, there will be a whole conversation about other types of interventions you can use to try to wake somebody up before giving it to them, which is a little bit crazy....”
- “Some people don’t like it [911] called. Some people don’t even want to get [Naloxone] unless it’s necessary, really...Just because they get sick, and they

don't want...I always try the cold water first unless it's already been a few minutes I guess. I'll usually make the call, I don't even usually administer the [Naloxone]. I only have once and that was just a couple weeks ago, or I might have drugs on me, so I might make sure everything is gone...But I always stick around long enough to make sure that what needs to be done is being done, whether there's [Naloxone] or 911 I will make the call if I have to but I'm not, I don't usually stick around."

- "I didn't come out of the bathroom. He came to check on me. You know, he said I was on the floor. My lips were blue. They threw—I was soaking wet when I got up—they threw ice cold water on me. Like, they didn't want to Narcan me, but they did."
- "Oh, they were pissed because they were high. It's like dude you weren't breathing! No, I was fine! No, I assure you, you weren't! Oh, they're always pissed, they're always pissed, yeah."
- "I don't know if it's the stuff they put in it that makes people really ugly, looking like they're not, you know, they're 'Why did you do that? I was fine! I didn't need that, you just ruined my life!' And it's like you try to explain it to them..."
- "...I guess you could say she was my girlfriend at the time, that literally, she fought with me because I let somebody give her Narcan. You let them Narcan me? Yeah! You were almost dead. Of course I did. It's crazy because now they're in their mind, they're, like, 'Oh my God I'm sick and I can't even use again right now.'"

3k. Attitudes Related to Calling 911 for an Overdose

Participants described a range of responses that can occur in the event of an overdose, sometimes with multiple actions being taken before resorting to calling 911 and involving authorities, if at all (e.g., attempting to wake the person who has overdosed by putting cold water on them, slapping or otherwise trying to rouse them, and/or by administering naloxone). Although, as discussed in the previous section, participants are aware there is a desire among some to avoid a naloxone reversal if possible, some participants also described that a peer administering naloxone is preferable to calling 911. The following quotes illustrate this view:

"...it [fear of questioning from police] still keeps people from calling or you know they're trying to do like everything they can before they have to call. Or they're taking the chance to just throw them in the car and drive them up to the hospital..."

- “I think it’s more accepted to be able to save your friend’s life with Narcan or whatever else it takes, you know, pick them up, walk them around, put cold water on them, but obviously Narcan. If you save your friend’s life without calling 911, I’m thinking is the most acceptable way of doing it, you know, so you don’t have to have questions and such, you know what I’m saying? And on occasion I’ve been in houses where I haven’t been the person to Narcan and it’s been used, and I see what happens. You know everyone gets the F out real quick you know because no one wants to be there with a pocket full of drugs or whatever when questions are asked, you know?”
- “If you’re calling somebody else be prepared for the consequences for both and carry your own Narcan. That’s why all of us carry our own Narcan now. Rather help a friend out than call anybody.”

This participant’s recollection of the reactions that occurred during an overdose they witnessed was remarkable in that calling 911 appeared to be characterized as a misstep that could endanger someone’s life, rather than as a recommended life-saving action:

“We didn’t have Narcan, but he just OD’ed. We threw him in the shower with cold, cold water and he was slapping him, and he got him to wake up and he just kept him in the shower, and he was walking him around the room and kept walking. Like, he’s good under pressure, he’s really good. Me, you’d probably die, because, one, I’d call 911, I’m hysterical. I don’t know CPR or any of that and I’d probably be taking your breath instead of giving it, you know?”

Participants repeatedly conveyed their or others’ fear of getting in trouble by calling 911:

- “...that split second there, it was a good second, I was hesitant on calling or not because I was like oh my God I might get locked up for this and then I was like I don’t care she’s dead and I just called.”
- “I would [call 911] if I had to, you know? I’d get nervous that I’m going to get in trouble, but, you know, saving a life is more important.”
- “...a lot of people who are using have warrants and legal trouble and they have bad rapport with the cops so they think they will find a way to get them like to...arrest them, get them in trouble. They think that that’s the enemy, cops are the enemy and if they call 911, a cop is going to show up.”
- “I was told to call 911, so I did. In the meantime, while I’m on the phone, she wakes up and, of course, everybody is freaking out, screaming. It was just me and this couple, and they’re like, tell them never mind! Tell them never mind! Or whatever. So I got off the phone. Well, sure enough, surprise, surprise. They show up and that was really scary.”

As noted in an earlier section, some participants described how they or others might offer assistance in the case of an overdose, including by administering naloxone or calling 911 or both, but then not stick around and wait for emergency medical responders and law enforcement to arrive. By leaving, they seek to avoid questioning and potential consequences. The following quotes provide insights about these actions:

- “I’ve seen somebody call 911 and then leave the person because they still have drugs on them or they were high too and you know they didn’t want any of the police contact, so...I had somebody get really upset with me once because they were on probation and I called 911 when they were overdosing. It’s like, that’s great, you’re here to be mad at me, that’s your life, so freaking what, I called 911? I Narcan’ed you three times and you didn’t come out of it.”
- “I would call 911, I don’t care, I would call 911, whether I did and left, you know. If I wanted to leave, I would leave, because a lot of people don’t want to get involved. Because then the cops, the cops are always asking the question, what kind of bag was it, what’s the name of the bag, you know? Cops shouldn’t ask that question when there’s an OD involved. They shouldn’t ask nothing. What kind of bag did you do? People don’t want to talk to the cops because as soon as they see you talking to a cop you’re going to be labeled a rat and everyone is going to give you shit.”

The participant in the following interview exchange explained the detrimental repercussions of being questioned after calling 911:

- Participant: I mean sometimes, most of the time, EMTs are just worried about getting the person in need of treatment, treated, then they’re worried about saving their lives, and that’s what the focus should be on.
- Interviewer: And you feel like that’s what the focus is on?
- Participant: Yeah and the cops are always the opposite. They’re always invasive, worried about where the hell the dope came from and this and that. They’re not trying to help the situation they’re trying to solve the problem, the bigger problem which isn’t the current problem, and that’s a problem.
- Interviewer: How does that affect the current problem? How does that affect the situation kind of in the moment when the police are asking those questions?
- Participant: Because it makes the people who did call 911 express anger and regret and it makes them anxious really and that can make the

EMTs not do their job properly, hearing all of it going on at the same time.

One participant explained the difference between calling 911 for someone who has overdosed and driving them to the hospital. The explanation indicated concerns about being questioned by emergency medical personnel and law enforcement, along with concerns about stigma and judgment during the encounter:

“It’s like this is a much more serious deal and they’re much more likely to ask questions....It’s just not a great feeling to have a whole group of people come flying into your house who have no concept of what it’s like in your shoes and sort of you know pass judgment on what they’re seeing.”

Others described calling 911, but not specifying that the emergency was an overdose or they have deliberated whether this would be a better approach:

- “If you call 911 and say it’s an overdose the cops will come and then they start drilling and wanting to get in your house and you know that’s not—and so that makes it so people aren’t going to call because they don’t want to deal with it, so I don’t really think that that’s effective. If an overdose is called in, it should just be like anything else because I’ve called for an overdose and said the person fainted and no cops came, just the EMT and they dealt with it and left, and it was much easier...”
- “I was also so upset with my girlfriend there dying, if I would have just said, ‘She stopped breathing. Will you please come?’ But I was like, ‘She’s overdosed’ ...everybody’s like ‘You’re an idiot. You shouldn’t have said that’ ...you can call the ambulance and say, ‘Oh, they’re not breathing,’ but don’t say anything about drugs until they get there, then say she might have taken something...”

Other participants expressed less hesitation about calling 911 and indicating that an overdose had occurred, but one recalled being questioned by peers for doing so:

“...I told them on the phone that it was a drug overdose. A couple of my friends afterwards when I told them that I said that, they’re like, ‘Why would you say that on the phone?’ and I said, ‘Because I want them to be prepared to come and to revive him if it’s possible.’ But they did say, ‘Why would you say that?’”

The following interview exchange sought to gain insight about this issue, with this participant being clear about the ideal response:

Interviewer: What about revealing that it’s an overdose versus not when you’re calling 911? Like do you, when you call 911, do you usually say it’s an overdose?

Participant: You should.

Interviewer: You feel like you should say that?

Participant: Yeah, because it's just how you're dealing with the situation. You don't beat around the bush when somebody's dying.

This participant explained, "they're just anxious and their mind is crazy." Participants' descriptions' suggested that even for those who are willing to call 911, the panic and chaos of overdose situations can lead to erratic responses or a response where no one takes appropriate and timely actions.

Interviewer: "...what are your attitudes about calling 911?"

Participant: "Oh, it's important to do, but if there's time or whatever, you know what I mean? People don't know what to do in emergency situations. They get lost. I mean I had a house full of people. They did not know what to do, so all they did was watch me.

Interviewer: "So, nobody else called 911?...Do you think people thought about it and were scared to do it?"

Participant: "I think they were scared to do it probably. You shouldn't be scared, it's somebody's life. Call them, you know?"

Interviewer: "What do you think makes people scared about calling 911?"

Participant: "They're afraid they're going to get in trouble....Panic, people panic. They don't know what to do in emergency situations. They never had that education for whatever reason, so everybody acts different."

3I. Awareness of and Views on Vermont's Good Samaritan Law

In 2013, Vermont passed H.65, also known as the Good Samaritan Law, which provides protection for the victim of an overdose and any witnesses from drug related offenses if they call 911. Prominent among the sample was a lack of awareness of Vermont's Good Samaritan Law and often a vague awareness of the law among those who had heard about it. At least 35 individuals who were interviewed had never heard of the Good Samaritan Law or were not familiar with the meaning or details of the law. Further, participants commonly expressed the belief that there is a general lack of awareness of the law's existence among their peers, as this quote described:

"I don't think that most people realize anymore that you cannot get in trouble if you're with somebody that overdoses, and you call 911. There need to be

posters up, things like that. People just don't realize, and people get left and that's, yeah, that's definitely a problem."

One participant discussed trying to convince peers that the law exists:

"Yes, this law is true. You know you might have heard about it on the street and it is true because there's still some people that don't believe it's true and I've had people argue with me about it."

"I would probably say more people don't know about it than do know about it, I mean, that's just my opinion."

"I think a lot of people that don't...are the ones that are afraid they're going to get in trouble. That's basically the bottom line, that they're going to get in trouble if they call 911...That's the biggest downfall I think....I didn't know about this Samaritan Law..."

Participants also conveyed a high degree of skepticism about the protections the Good Samaritan Law provides. Repeatedly, participants explained that people are afraid they will get in trouble if they call 911. Participants offered multiple reasons for this fear of calling 911 and the mistrust of the Good Samaritan Law. A fundamental reason is the lack of awareness of the law, including being unsure that it truly exists and unclear about what it entails. Another reason is concern about consequences due to involvement in illegal activity and, possibly, probation violations. These concerns about potential consequences can persist even for those who are aware of the Good Samaritan Law.

"...the people that I've talked to they know about it and most of them say I don't buy it for one second."

Two additional reasons for wariness about the Law pertained to concerns about interacting with law enforcement, or authority in general. This included general concerns or perceptions about coming into contact with law enforcement (e.g., not wanting to get in trouble), as well as concerns due to having heard about others' interactions with law enforcement officers that led them to be wary of the Good Samaritan Law. In addition, some participants' mistrust stemmed from prior negative experiences they had had with law enforcement.

Interviewer: "...Do you think people are aware of that law?"

Participant: I don't think so. I don't think people trust it either.

Interviewer: Okay, tell me more about that.

Participant: I don't think, for a lot of people, they're just, it's like poo-poo, yeah right, that's set up, you know what I mean? People get jaded around this stuff. They don't trust authority.

- "I guess I have kind of trouble trusting cops or believing them that they wouldn't get you in trouble or whatever for possession or whatever..."
- "Nobody will [call] even though they passed that Good Samaritan Law where you cannot be held responsible, searched, anything, but I've heard too many stories even just of late..."
- "I think people know, but I think a lot of people don't know still, but like I said, it's that, with the cops coming and then, it's, like, they turn it on you and they want to get in your house."
- "...they just kept questioning about how, who, when, what...and I just said I don't know. I am here for them, not for that...I didn't get any repercussions. I know some people do, but they're asking questions they shouldn't be...that service is there so you're a good Samaritan, not, you know, you're not going to interrogate me because I'm being a good Samaritan."
- "...I think that's [the Law] probably saved thousands of lives but this particular day when I called 911, the cops were so nasty to me and my mother...everything they asked me I was polite about it...they were searching her car and they had no rights to do that, you know. So that was just a bad situation. But...I would do it again, that wouldn't stop me from saving somebody's life."
- "I've seen people have tried to drag someone out and leave them somewhere, just really screwed up things. I mean the legal thing it's a huge issue. They don't, I mean, the truth is that even though there's that law that says if you call 911 you can't be penalized, first of all, there's not a lot of trust in law enforcement. Some law enforcement officials have earned trust in the drug community, but a lot of times they tell us things that aren't true, or they tell us stuff just to get what they want and then they like turn and go well, no I can lie to you if I need to get information and then, you know, slap cuffs on them. So, there's not a lot of trust."

The following comment summarized multiple barriers individuals faced when responding to an overdose, including fear of getting in trouble, fear of stigma and poor treatment by service providers and others, and concerns about the Good Samaritan Law:

“I think there’s a lot of fear around going to the hospital – what that’s going to look like, am I going to get reported, are they going to treat me poorly because I’m an addict, you know? So, a lot of people will avoid going to the hospital for fear of how they’ll be treated and how they’ll be perceived. And am I going to go to jail? You know, whatever, and I think a lot of times when somebody is overdosing that’s sort of the response that the bystanders have is that ‘Oh my God am I going to get in trouble?’ and they’ll leave because they’re scared to death that somebody is going to find out they’re using or whatever and that has serious ramifications in their life. I think it needs to be much more clear that there won’t be consequences, you know, like the Good Samaritan thing? And I think some people have seen even despite the Good Samaritan Law that they are getting in trouble for bringing people in and then that deters them in the future from saving someone’s life because they don’t want to deal with the ramifications in their own life.”

A few participants commented on positive experiences and encounters they had had with emergency personnel and law enforcement during overdose situations:

“Yeah, cause the cops could have come one night when I had to Narcan my friend and I could have gotten in some serious fucking trouble, but they’re like you guys aren’t in trouble. We’re not going to search anything or you guys whatsoever.”

3m. Harm Reduction Messaging: Participants’ Suggestions for Content of Messages and Methods of Communication

As one of the main objectives of the evaluation, the interview included obtaining participants’ insights and recommendations regarding health messages for individuals at risk for opioid overdose and what they thought would be effective approaches for communicating those messages.

Content of Messaging

Participants had many ideas on the type of information they would like to see shared with individuals at risk for overdose.

Syringe Services Programs

Participants indicated the importance of not only promoting the availability of SSPs, including the location and the hours, but also sharing information about the types of services that exist (e.g., HIV/HCV testing, safer sex supplies, syringe disposal supplies,

naloxone distribution) and that they are free and confidential. Participants also felt it was important to share the rationale behind these programs (disease and overdose prevention and treatment connection) in order to build community support and reduce stigma. In addition, participants noted that it is important to inform SSP members and others who might become members that SSP membership protects against paraphernalia charges.

Overdose risk and prevention

With the rise in fentanyl, participants felt that overdose prevention messaging should include information on the dangers of fentanyl, how to access fentanyl test kits, and also increase awareness that fentanyl has been found in other, non-opioid drugs such as cocaine and marijuana. They also believed it was important to increase awareness of the availability of free and anonymous naloxone.

Good Samaritan Law

Overwhelmingly, participants felt that increasing awareness of the Good Samaritan Law would save lives.

- “If they could put, just even if they could say on the radio about that law, that if you see, if you’re with someone and you do the right thing and call 911 that nobody there will get charged. That message should get broadcast because that might save lives and that would be like one of the biggest things actually because I don’t think a lot of people know that. I’ve seen people run, still, and why, you know? People that usually are sharing together are some kind of friends.”

- Participant: Yeah, I didn’t know, I didn’t hear that. I didn’t—that was right around one of the times that I was using, and I don’t even remember when it came into law like anybody even talking about it. I’ve heard of the Good Samaritan, but I did not know that.

Interviewer: Yeah do you feel like that would change peoples’ behavior if they knew?

Participant: Hell yeah, oh yeah. Yeah, because even if you’re high, hey if I can’t get in trouble, you’re going to save your friend. I definitely think that would make a buttload of difference, absolutely. Yeah. No, and I’ve never heard that.

- “That’s the biggest downfall I think. If people knew, you know, like you said, I didn’t know about this Samaritan Law. That’s good to know. I mean, I’ll start spreading the word now. I mean, I will tell everybody about it, don’t matter.”

Behavior change

Participants believed it is important to educate individuals at risk for overdose and infectious disease transmission about protective drug use behavior changes, such as ensuring they are using the minimum needed to get the desired effect, going slow, using with someone, always having naloxone present, and using new injection supplies each time you inject. This included recommending specific messaging on how to inject safely.

Consequences

Some participants felt that people are not always aware of the dangers or potential complications when injecting or using opioids. Participants suggested that messaging campaigns include details of the unintentional consequences of drug use, such as the trauma for family or friends who witness an overdose or lose a loved one to overdose, and the general changes that opioid use causes in people.

Access to services/resources

Participants were not always aware of the resources available to them in their community. Some felt it would be helpful if there was a phone number or one centralized place (like a social media page) that had all of the local information on financial resources (e.g., fuel assistance, rent support, 3SquaresVT), MAT providers, recovery center calendar and other group schedules, housing and other community resources, and the overall message that places like SSPs and substance use disorder treatment centers are welcoming and non-judgmental.

Methods of Communication

Many participants recommended that word of mouth would be an effective communication method for reaching individuals at risk for opioid overdose. Word of mouth could be either peer to peer, or from a provider directly to an individual (such as from a counselor, health provider, or someone providing services at a human service agency). One participant expressed the opinion that "...Dopers are going to trust other dopers before they trust someone with a college diploma".

Participants also suggested there would be value in face-to-face outreach by harm reduction service providers at specific locations where those at high risk for opioid overdose might frequent. Participants believed it would be particularly helpful to have information on SSPs at substance use disorder treatment locations, for those who are not abstinent from using drugs. The range of suggested places included the following:

- Syringe Services Programs
- Substance use disorder treatment providers (hubs and spokes)
- Residential substance use disorder treatment centers
- Drop-in centers

- State office buildings (locations of Economic Services and Family Services)
- Recovery centers
- Medical providers
- Food shelves and other programs offering supports such as fuel assistance
- Probation and Parole offices
- Libraries
- Locations of group meetings, such as AA and NA
- Safe consumption sites (if they existed)

In addition to recommending promoting messages via outreach, participants felt that it is important to post and disseminate printed materials, especially considering that some individuals are not connected to services or might not feel comfortable sharing information about their drug use with others in a face-to-face encounter. Participants recommended that printed materials (containing health messages and information about services and events) be posted in the above-mentioned places, as well as the following places:

- Bus stations
- Grocery stores and convenient stores
- Courthouse
- Health centers
- Laundromats
- Places where people are known to use drugs in the community, such as certain parks or public restrooms

However, one participant felt that even looking at printed materials in their small town would result in too much unwanted attention:

Participant: Like a poster, that would be cool. Like at the clinics or here at Turning Point. Maybe in the state building, you know places that—obviously not in a grocery store, you know, but at a doctor’s office maybe.

Interviewer: Tell me your ideas about not being at a grocery store.

Participant: Because I feel like if we stand there looking at them, you know, that poster, that people are going to say, ‘Oh, you know, she’s using,’ or, you know. That’s what I’m worried about. Here, not so much in St. Albans.

Electronic methods also were recommended by participants, which included a mix of social media, online advertisements, e-mail, text messaging, phone calls, and advertisements on television and radio. Social media stood out as one of the most commonly recommended methods and included specific recommendations for:

- Facebook pages for specific counties or regions
- A Facebook page created by the Department of Health or local agency that had information on safe drug use, recent overdoses, and recovery supports. One participant felt that having all of the information on the same page would allow people who are currently using to see what is available for those in recovery as a way to increase hope and thoughts towards a healthier future.
- Twitter
- Snapchat

One participant offered this suggestion:

“There’s so much bad stuff going around and if there was maybe a Facebook page that somebody, like, that could go to and it would warn them that there’s a bad batch of dope going around to be careful or something like that, it might help them to not do something stupid.”

In addition, other ideas about communication methods included:

- Town meetings
- School educational programs
- Information booths at community events that are open to the public
- Seminars in the community
- Newspaper advertisements and articles
- VT-211 (ensure that they have accurate information first)
- County-specific resource guide that is distributed at the state office building, recovery centers, SSPs, drug treatment centers, and health provider offices
- An airplane with a banner to raise awareness
- A phone line to call in to anonymously, at any hour, with a pre-programmed message about recent overdoses, bad batches of drugs, and resources such as where to get fentanyl test trips and safer injection supplies

Last, a few participants had ideas about messaging methods that were specific to the content of the message. In particular, one participant thought that in order to increase trust in the Good Samaritan Law, it would be helpful to have the police share information on the Law via a public media campaign. That way, individuals at risk for overdose hear directly from law enforcement that they will not be charged with a drug-related crime if they call 911 in the event of an overdose.

4. Recommendations

Based on participants’ direct suggestions and other findings from the evaluation, this section of the report identifies a number of ways for enhancing access to, and participation in, SSP services, as well as the quality and effectiveness of these services. Some recommendations will clearly be more challenging and/or costly to implement

than others, and their impact on the quality of the services and outcomes achieved will also vary. Furthermore, some recommendations are to give certain difficult issues further consideration, rather than provide specific plans for how these issues should be addressed. We have intentionally not attempted to prioritize these recommendations with respect to their potential importance or perceived effects, nor have we rated them in terms of feasibility. Such considerations will need to be part of a broader discussion among policy makers, program staff, and stakeholders – one for which we expect these findings can make a useful contribution.

The recommendations are organized into the following categories:

- Increase awareness and utilization of SSPs
- Increase MAT engagement and retention
- Improve access to residential programming, including detox programs
- Promote use of naloxone among individuals who are at risk and among the broader community
- Tend to the basic human needs of individuals, including housing, education, employment, and social connection
- Consider the evaluation's implications for messaging and services

4a. Increase awareness and utilization of SSPs and expand availability of safer injection supplies

Increase awareness of programs – Some Franklin county residents mentioned that they travel to the Burlington SSP in Chittenden County to get supplies. The most common reason noted for doing this was the lack of awareness that an SSP mobile van existed in Franklin County. Participants felt that if people knew about the van, it would be used since it helps to overcome the transportation and stigma barriers that participants reported.

Participants recommended that the SSP advertise more in Franklin County to let individuals know of this option by posting flyers at the hub and spokes providing MAT to Franklin County residents and by posting information around town in places like the state office building, libraries, and convenience stores.

Participants also recommended that the outreach and advertisements about all of the SSPs include information about the services being anonymous and that other services are offered (e.g., HIV/HCV testing, naloxone distribution, safer sex supplies).

Expand hours of SSP operation – As mentioned above, participants indicated the limited hours of operation as a barrier to SSP use in Rutland and Windham counties. When life is chaotic, the ability to be at a certain place at a certain time is a challenge. Most participants felt that the SSPs would be used more if they expanded hours of operation, especially if there were some evening and/or weekend hours.

Address stigma in order to increase SSP – Many participants mentioned that people do not always feel comfortable entering the SSP due to fear of being seen and judged. In addition to a larger anti-stigma campaign, it is important for SSP providers to let the community know about other services they offer such as naloxone, HIV/HCV testing, case management, and educational and support programs, so that people may feel more comfortable entering a space that is not exclusively for exchanging safer injection supplies.

Integrate harm reduction services into existing programs – Some participants felt that including certain harm reduction services (i.e., safer injection supplies) in other existing programs (e.g., recovery centers, substance use disorder treatment providers, homeless shelters, community centers, doctor offices) would help increase access and general awareness of the programs.

Expand services at pharmacies – Some participants mentioned frustration that their local pharmacy did not sell syringes, which required them to travel out of town in order to access safe injection supplies. In addition, some participants thought it would be helpful for pharmacies to offer naloxone without a prescription. This would be particularly important in rural areas that are far from other community naloxone distribution sites.

4b. Increase MAT engagement and retention

Expand hours of operation for dosing at hub programs – Many participants felt that expanding the dosing hours at the three hubs (BAART Behavioral Health Services in Franklin, Westridge Center for Addiction Recovery in Rutland, and Habit OpCo and the Brattleboro Retreat in Windham) would improve MAT engagement and retention. Expanding dosing hours provide more options for people who work, have transportation barriers, or who have childcare scheduling needs (e.g., they need to get their child to school before they are able to dose, but do not have enough time to do that or cannot make that work with the bus schedules) to regularly receive MAT.

Increase spoke providers, or increase awareness of providers, especially in rural areas – People are traveling great distances to receive daily doses at hubs, when a closer spoke would be an easier and more sustainable option. If spoke providers do exist, individuals may be unaware of the services in their town.

Increase awareness of shortened wait times for MAT – due to MAT being unavailable or having a long wait previously, the perception in the community is often that MAT is not available. For those sites that have immediate, or close to immediate, access to MAT, it is important to share that information with potential referring providers and potential patients.

Provide child care during dosing hours and meetings with clinicians – Some participants felt that lack of child care was a barrier for accessing MAT, especially during the summer when school-age children were not in school.

Integrate other harm reduction services into the existing MAT structure – Many participants who had access to naloxone had received it from the hub in their county. This model works well in that many of the patients are still using opioids, at least initially, or are around other people who might be at risk for an opioid overdose. Some participants suggested distribution of other harm reduction supplies, such as safer injection supplies, at MAT provider sites.

Review policies surrounding marijuana use - Many participants reported great emotional and physical benefits of marijuana use, including supportive benefits towards their recovery from opioid use. Some participants reported frustration that their marijuana use interfered with their ability to get take-homes at the hub or access treatment at a spoke.

Discuss the use of MAT as a best practice and address concerns about “replacing one drug with another” – Participants reported being worried about getting off methadone or Suboxone once they started and not liking the idea of replacing one drug for another. It would be important to address these concerns when discussing treatment options with individuals with opioid use disorder.

4c. Improve access to residential programming, including detox programs

Strive for on-demand treatment – Participants felt that it is important to have access to residential and detox programs at the time the individual is ready. Waiting for treatment increases the risk of overdose and individuals choosing to not engage in treatment once the opening exists.

“When somebody is ready and they’re like I need help, they need help immediately...they were clean for two days and they couldn’t get into treatment, so they went right back to it and so now their tolerance was a little bit lower and they overdosed. It happens so many times, you know let me use one more time before I go, overdose. When you get that courage, or something goes that wrong in your life to give you that—like you’re on the freeway and they’re seeing the exit sign and you’re ready to turn off you need to get off at that exit, you can’t go past that exit. You know it might be 16 miles before the next exit and that 16 miles could be a long bumpy road and I think that would change things dramatically.”

Increase the allowable duration of residential stays – Participants felt that 21-28 days was not always enough time to fully address the issues behind their drug use. Many felt that they need longer treatment stays where MAT is initiated and maintained.

4d. Promote use of naloxone among individuals who are at risk and among the broader community

Ensure that the community is aware of naloxone distribution sites – some participants indicated that they were not aware that they could receive naloxone from their local SSP, their MAT provider or the local recovery center. In these settings, it is important to promote the availability of naloxone for those who may not know to ask or seek it out. Promotion could be in the form of informational flyers and word of mouth advertisement by staff and peers. For those individuals who are not accessing these programs, it is recommended that naloxone distribution be expanded to other places such as hospitals, doctor's offices, community centers, Fire Departments, landlords, the office of Economic Services, and community events.

4e. Tend to the basic human needs of individuals, including housing, education, employment, and social connection

Make diverse housing opportunities available – As described above, housing is an important harm reduction tool in that the stability of having a roof over one's head often results in less drug use and/or less risky drug use behavior. Diverse opportunities (sober housing, transitional housing, supportive housing, etc.) allow for individuals to access the type of housing that works for whatever situation they are in to ensure they have the stability of a place to live.

Provide educational or employment opportunities to individuals with current or past opioid use – Participants mentioned the importance of being able to work to earn an income not only to contribute financially to their daily needs and expenses, but also to a sense of purpose and self-worth. Providing education and employment supports for individuals also serves as a prevention tool that could deter drug use in the first place or support recovery.

Expand community building and sober activities, particularly in rural communities – Many participants indicated that drug use initiation was a result of feeling bored or hopeless. We also heard that individuals who were trying to abstain from substances found it difficult to fill the hole that drugs left in their lives. Participants felt that more sober activities that bring people together, but don't necessary focus on the fact that they are sober or for people in recovery, would be helpful.

4f. Consider the evaluation's implications and recommendations for messaging and services

In addition to participants' direct suggestions for content of health messages, the interview data raise several areas for consideration for their implications for health messages and provision of services for individuals at risk for opioid overdose.

Address conflicting feelings about harm reduction strategies

During the interviews, some participants expressed critical or conflicted views regarding particular harm reduction strategies. Attention to the existence of such attitudes and associated concerns could help address potential barriers to use of harm reduction practices and services.

- "...it's enabling really...it was more or less a plus thing...[but] you're giving access to needles...so if you got dope, now you can definitely shoot it because you don't have to pay for the needles. So instead of there's no needle, so I'm sniffing it, I have access to a needle, so I can shoot it."
- "I feel like if I have the syringe handy that's giving me the opportunity to—if they're not around me I won't do the drug."
- "They give you an opiate to cover up an opiate...I have seen my son get sick from [buprenorphine/naloxone] withdrawal if he ran out of his strip and it's like watching somebody come down off of heroin or meth. So, I mean I don't see how that's even helping somebody."

Attend to stigma when raising awareness of harm reduction services

In discussing SSP programs, many participants acknowledged and recommended the importance of advertising the availability of SSPs and their services and suggested ways for doing so. However, often, participants would simultaneously question their recommendation and whether widely advertising SSP services would be acceptable, particularly to the general public. Addressing the stigma suggested by participants' hesitation and second guessing in recommending advertising of SSPs could help improve community norms and individuals' access and comfort regarding using these services.

- "I would say advertise but who wants to advertise that?"
- "...I feel like they could broadcast it a little better, but I also understand that that's a double-edged sword too...without making it sound to the rest of the world that they're just out there making the drug users think it's okay...Well no, that's not, it's just they're trying to not have people get diseases, they're trying not to have

people dropping dead and believe it or not, I mean, drug use will continue forever in this world. But I'm a realist, I get the realities of the world but a lot of people don't..."

Leverage and build on individuals' commitment to act in an overdose situation

Despite the hesitation, fear, and reluctance that many participants described in characterizing bystander reactions to overdose situations, several participants also remarked on their willingness to take appropriate actions despite the fears and other obstacles to using recommended measures, including administering naloxone and calling 911. Promoting and reinforcing the importance of the range of recommended responses in the event of an overdose, such as performing rescue breathing and staying with the person until emergency responders arrive, would be beneficial.

- "They're usually angry. I mean the people. Let's say there's a room full of people and I'm starting to administer Narcan and call 911, everybody is gone. Everybody is running now. No one wants to be there when the cops get there, F this. I've stayed with strangers more than I've stayed with people I know with reversing this kind of stuff and most of the time people are pissed when they come to. They all think, 'I would have been okay. I would have pulled through, this just happens.' 'No, you were turning blue and your freaking lips were—I know enough you were not okay. I had to put the needle in and it's—people get mad. I don't think I've really ever been thanked, and it wouldn't stop me."
- "I couldn't let somebody die. If I didn't call that's murder, if I didn't call and they died, I murdered them basically because I could have did something and didn't, so yeah. I don't know if I would sit there and wait for the cops, but I would definitely call 911 and probably take off, but I would make sure the cops had access to get to the person and where they were."

Address resistance to naloxone administration

To support the timely reversal of overdoses, a critical issue for attention is addressing concerns and reluctance to using naloxone due to individuals' fear of going into withdrawal and feeling sick. This would include increasing the norms and willingness both to administer naloxone and be reversed using naloxone. Related, helping professionals responsible for responding to overdose events, other service providers, and the broader community understand why individuals may immediately use again following an overdose is an opportunity for stigma reduction efforts. Understanding individuals' motivation to alleviate withdrawal symptoms may improve understanding and compassion, and reduce stigma, around the circumstances. In communicating the critical nature of responding with effective measures, including naloxone, attention should be given to addressing many individuals' inclination to at least first try slapping the person or using cold water as revival methods.

Interviewer: Did you call 911?

Participant: Yeah.

Interviewer: What happened when they eventually came?

Participant: They took her. She got out and went and used again. Yeah, that's what most people do because they took the Narcan out of you and I mean it takes the dope out of you and you're sick, so they go use.

Support being prepared and managing panic during overdoses

In describing the panic and chaos that can surround an overdose, an issue that some participants noted is the importance of ensuring that individuals are adequately educated and prepared to respond in these situations. This includes fundamental training in proper use of naloxone and, more generally, preparation for how to respond in the moment when an overdose crisis occurs.

- “And proper Narcan administration, because just sitting there and going over a paper is not enough. People don't do it right and you know you have to like really train people because if you just go over paper when it comes right down to when things are hectically crazy, they're spraying it everywhere. I've seen it, like, a million times. Like, they're not even getting it in the nose, you know. They're just so freaked out. So, I think better training around that would be really good.”
- “...Narcan is self-explanatory. It's really not what you need to do with the Narcan, it's what you need to do with the situation.”

Increase awareness of and trust in the Good Samaritan Law

Although Vermont's Good Samaritan Law has been in effect for over five years, many participants were not familiar with the law or its protections.

“I didn't even know that about the Samaritan, that's horrible. That's something every addict should know because a lot of—I bet there wouldn't be as many overdoses. That's huge, I mean, that's fucking monumental [sic]. I bet that would have saved more lives if people knew it...I had no idea because that's a huge fear, that you're going to jail or if they know that you sold this person this, and they're dying in your place, fuck, no one is going to call. I've heard people driving to the ER and just dropping them off and driving away, but no there's got to be information.”

It is recommended that a public awareness campaign be launched with information on the protections of the Good Samaritan law, including personal stories from individuals who received protection when calling 911 in the event of an overdose. It is also

recommended, based on an idea from a project participant, that consideration be given to including law enforcement in the campaign in order for the community to see that they are on board with providing these protections in an effort to save lives. Attention should be given to building the trust to receive these messages and overcome some individuals' mistrust of authorities.

- “Maybe if more, I don’t know, if police, I don’t know, if they could come across with a message or something that you’re not going to be in trouble...”
- “Some people don’t even believe that that law even exists....I think they should do a better job of getting it out there that, ‘Listen, you’re not going to get in trouble. We don’t even have to take your name.’ Maybe they should anonymously text 911, because I know you can text 911 now. Something that people can feel like—don’t just leave. Don’t just walk out of the apartment. Like do something. Call from that person’s cell phone. Text from that person’s cell phone. Do something....I think the police need to, with their own voice, people need to hear it from their mouth, that ‘We will not mess with you.’”
- “...if they could still somehow advertise more, stressing, you know, the confidentiality and, like, where they’re not going to get in trouble. If it was known, let’s say, you’re doing drugs, you’re not going to get the cops called on you or you’re not going to get in trouble anyway. I think that’s one of the biggest barriers too is where everybody thinks the cops are going to get called or they’re going to get in trouble somehow.”

Address trauma of witnessing overdoses

Given the chaos, stress, and trauma associated with overdose and the repeated overdose experiences many individuals have witnessed, an additional area for attention is attending to this trauma.

“...if I went through that I would never want to do it again, you know what I mean? If they could only see what they went through or what you were going through, because it’s hard. They can’t tell because they’re in it and they don’t watch themselves, so they don’t know, or they’d never do it again, they’d never pick up again because it’s scary, you know what I mean. So, when they don’t realize what’s going on or what happened so it’s like they didn’t go through anything.”

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