# INTERVIEW FINDINGS BY CATEGORY: HARM REDUCTION

## Harm Reduction

### OPIOID CONSUMERS

Consumers addressed questions about their thoughts on three harm reduction strategies: needle exchange programs, fentanyl testing kits, and the increased availability of buprenorphine 'off the street' as a stop gap to treatment access. Needle exchange programs received near unanimous support.

***"In Salem NH, you can't buy needles which is just crazy. You either have to go to Mass or to Manchester,' 'I don't know why they fucking don't have it in NH,'"***

***"There are a lot of people who are not comfortable going into the pharmacy and having some pharmacist staring at him like he is a drug addict and treating him badly… and a lot of pharmacies are non-cooperative anyway. I have had pharmacists look at me and say 'that's illegal. I can't give that.' And I say, 'Don't lie.' You do need a needle exchange program. It needs to be [here]."***

**Needle exchange programs received near unanimous support**

Consumers felt that the implementation of a needle exchange program in the state is a ***"wonderful idea"*** and ***"will help prevent the spread of diseases."*** Most consumers are ***"all for it"*** noting that ***"Vermont has a needle exchange…and In Massachusetts you can just go into any pharmacy and buy them."***

The suggestion of increased availability of fentanyl testing kits as a harm reduction strategy was not nearly as well-received as the idea of needle exchange programs. Responses fall along a heavily negatively weighted continuum, from ***"That's a good idea. I never thought about that before,"*** to ***"I don't know if people would use it"*** to ***"[it's] wasting product,"*** to ***"I don't know if those are going to help anybody really,"*** to ***"If they know its [Fentanyl] in there, those people that are seeking are going to want it more."*** One consumer bluntly stated that fentanyl testing kits are ***"not really practical because honestly, if I was sick and I went to go cop, I'm not going to take time to test for shit first. I'm just going to throw the shit in the spoon and fucking put it in my arm."***

Increasing the availability of Suboxone makes good sense to the majority. The general feeling is that: **"More doctors should prescribe it.' 'What is the big threat of Suboxone off the street? Nobody is out there using Suboxone. Drug addicts do not search out Suboxone to abuse…**

**these are the people who are actually starting to think about treatment and if it is easier for them to get some treatment real quick from the guy next door then you are going to do that because it is so hard to get treatment any other way."**

A few holdouts believed harm reduction strategies simply enable users to continue to harm themselves; however, they are significantly outnumbered. Other suggestions for harm reduction strategies did not surface in these interviews.

### FIRST RESPONDERS AND EMERGENCY DEPARTMENT PERSONNEL

Many R/ED personnel agreed that harm reduction strategies are necessary given the current issues at hand. ***"I'm all in favor... This is the thing... It's a disease. Patients are going to use and abuse these drugs regardless of what we do, so to minimize the side effects. I would use the same argument that I would use for bystander Narcan, which is, let's admit it's here and do the best we can to try to minimize the impact"*** *(ED).*

The necessity of needle exchange programs in particular was cited frequently due to *"reports of needles found on playgrounds and hiking trails" (Police)* as well as in parking lots. Several expressed concerns about infectious diseases: ***"I'm 100% for needle exchange, and the reason I am is because of the Hepatitis C and the HIV side of it"*** *(EMS);* ***"[I'm] for needle exchange programs because again there's published data that it lowers transmission of blood borne diseases"*** *(ED).*

Harm reduction practices may benefit not only consumers, but also responders. Many responders expressed the need to protect themselves because of risks of transdermal overdoses and needle punctures: ***"I've searched cars... just littered with syringes. It's scary because you're taking the extra time to go through and make sure you don't get stuck. We've had officers here stuck with needles. They go through the treatment and it's tough on them and their family." (Police) "As I'm sure you know, fentanyl can be transferred through the skin, so certainly we take huge precautions, and they can be inhaled and all that stuff in its powder form. You can end up overdosing your officers if you're not careful how you handle it. We handle any crime scene full booties and gloves and things like that"*** *(Police).*

One responder explained that most tests are happening in the lab now, rather than in the field, because of the risk of overdose: ***"That's changing because the dangers of fentanyl is very scary. Typically, if we had a powder product we would field test it in the past. Now, we're not really doing that because if I just touch it on my skin I could die in overdose"*** *(Police).*

Responders reported that dealers sometimes warned consumers about the potency of a batch of drugs as a form of street harm reduction: ***"Based on the text messages, the dealer was***

***concerned and saying, 'Be careful. Make sure there's somebody with you. This is a hot batch.' They're pretty much putting that warning out because they know that they just had a heroin overdose from their batch, and so now that they're selling it, they're letting their customers know that this is a hot batch and be careful"*** *(Police).* However, ideas about the frequency with which dealers warned consumers varied among responders. One claimed that ***"they [dealers] don't care about that. They could care less about that"*** *(Police).* Another responder discussed the possibility of alerting the public to a batch of opioids that has caused many overdoses. However, this responder cautioned that this approach is likely to have the opposite of the intended effect because many consumers actively seek drugs that have caused overdoses.

Some responders had conflicted attitudes toward harm reduction, either feeling like they do not know enough to have an opinion or that ***"it's like telling them it's okay"*** *(Fire).* This sort of ambivalence was common among police officers: ***"I don't know. I don't think you can stop the person from using one way or another. I mean, so if they can be safe about it, I guess. I don't necessarily have an issue with that, I guess. It's weird because I also don't want to promote... I'm kind of contradicting myself. I'm torn on that"*** *(Police).*

**SUMMARY**

There was unanimous support amongst opioid consumers and R/ED personnel for needle exchange programs as a harm reduction strategy. R/ED staff reported that this would not only benefit consumers, but the responders who are often in contact with syringes.

Furthermore, consumers offered that wider availability of Suboxone could be an additional harm reduction strategy, whether on the streets or by provider prescription. Interviewees did not believe testing kits in the community would be advantageous and did not offer additional means of harm reduction.

# INTERVIEW FINDINGS BY CATEGORY: EXPERIENCES WITH TREATMENT

## Experiences with Treatment

### OPIOID CONSUMERS


**Figure 11. Representative Quotes Highlighting Theme of a Perceived Lack of Treatment Availability in New Hampshire**

# INTERVIEW FINDINGS BY CATEGORY: EXPERIENCES WITH TREATMENT

Underscoring the importance of treatment for opioid use disorders in New Hampshire, it is important to note that consumers report not being able to cut down or stop using opioids on their own. When consumers did make contact with treatment programs, their experiences suggest significant barriers to accessing treatment, as well as being successful in treatment. Waiting lists are notable for how often they are referenced:

***"Every time I've tried to get into places except for the last time, it was a really long waiting list, at least a month... the hardest part is getting treatment right when you need it"***

***"The wait for a Suboxone clinic was months. Months and months, like literally. Usually when they do call you or when the places that called me called me, it was, 'Can you come right now?' If you can't come right now they're like, 'Oh, well now you're back to the bottom of the waiting list.'"***

***"Although there are a lot of different treatment facilities out there and way more now than ever was or anything like that... the problem is that they're nearly impossible to get into. I had to call and call, and call. I tried to get in treatment centers for six months and either they were full or they didn't take my insurance, or I hadn't used long enough, or I wasn't using the right drug, or I didn't live in the right town. I didn't make enough money or just whatever. It was ridiculous. It took me forever. It seemed like no matter what I tried or where I turned, I could not get help."***

Summarizing how waitlists function as significant barriers to getting help, two consumers quotes make it plain:

***"[Waitlists] are one of the key things for addicts because nobody wants the wait. It discourages you...that's why I think so many people don't end up going, because there's just not enough places that can get you in within a reasonable amount of time,"***

***"I feel like the window for asking for help and seeking treatment is very small because they [addicts] don't always want to do it. When you know somebody who's willing and able and ready and physically standing there in the halls of the [treatment program] in front of you, and you say, 'Come back in 8 weeks,' that's crazy. You could be dead tonight. Eight weeks is a fucking long time in the trenches."***

Lack of available programs emerged as a perceived barrier as well and contributed to the lengthy waiting lists:

# INTERVIEW FINDINGS BY CATEGORY: EXPERIENCES WITH TREATMENT

***"I'd definitely make more sober houses, more halfway houses. There's only a few out here, there needs to be more on the sea coast and there just needs to be more of them. There needs to be more beds available"***

***"[There are] no medical detoxes in New Hampshire. And rehabs, a lot of them want you to be at least 30 days clean…A lot of them when you call, they'll suggest you go to a clinic, like Suboxone or a methadone clinic, which is really hard because there is always a waiting list. When you want to get clean, there is no immediate help"***

Finally, the tenor of frustration at gaining access to treatment when a consumer was ready to get help is exemplified by the following quote: ***"Although there are a lot of different treatment facilities out there and way more now than ever was or anything like that… the problem is that they're nearly impossible to get into. I had to call and call, and call. I tried to get in treatment centers for six months and either they were full or they didn't take my insurance, or I hadn't used long enough, or I wasn't using the right drug, or I didn't live in the right town. I didn't make enough money or just whatever. It was ridiculous. It took me forever. It seemed like no matter what I tried or where I turned, I could not get help."***

Several consumers mentioned treatment facilitators include individual counseling, group counseling, and most salient to consumers, pharmacotherapies. Consumers pointed to the need to talk one-on-one with a counselor as an essential ingredient to treatment. One young woman explained, ***"if I had my way and I was in charge, I would integrate a one on one counseling appointment at least every couple of weeks or once a month to really check in and be able to talk about any issues you have. I would say every two weeks. I think that would really be my money's worth."*** Another felt that, ***"if I didn't have my counselor, I wouldn't be where I am today,"*** **while yet another consumer said,** ***"I think counseling has probably been the most helpful part [holding me accountable for my actions]."***

Underscoring the importance many placed on the power of accountability to another human being, one consumer stressed that ***"It's not just about medications… my counselor will meet with me 10 times a day if I want, and it's no charge. My doctor sits down with me. He knows my name. We have urine tests. They send them out to a lab so you ain't getting away with crap. She [counselor] knows that relapse happens… when I had my relapse, it was like a week after I went, and I know I wasn't gonna have a urine test, but I felt so guilty about it because they really do build a connection and relationship with you, so I called her to tell her…"***

From the perspective of what is not helpful, one consumer suggested that the least helpful part of treatment for him was the lack of individualized treatment options. ***"It's not individualized…it's***

# INTERVIEW FINDINGS BY CATEGORY: EXPERIENCES WITH TREATMENT

***not for each person so if you have 20 people in there, it's pretty vague. It's just a lot of sitting around being bored like, 'this doesn't have anything to do with me.'"***

Group counseling surfaced as another essential ingredient to effective treatment for many consumers. Mapping onto the notion of accountability previously mentioned regarding individual counseling, one person said: ***"It's nice to hear other people and share stories. It's nice people that you trust, this is your people in a group. [We] hold each other accountable."***

Others found opportunities in the social support offered in a group setting: ***"See*[ing] *people much worse off than I am"***; ***"just taking medication isn't enough…Hav[ing] that person there that is there to always talk you out of the bad decisions you want to make when your brain goes back to addict mode,"*** as well as ***"gendered groups."***

Medication references dominated the consumer responses about experiences with treatment and what they found most helpful. Suboxone was the overwhelming topic of choice and this medication's role in assisting with recovery was shared repeatedly.

Many Suboxone references assert the benefit of this medication over methadone in terms of the associated withdrawal,

***"'I know people think [Suboxone is] a crutch, talk shit about it, but in my personal experience, I feel like it's done more good than anything else."***

***"Honestly, being on Suboxone, I have never felt better, ever. Even when I was using, I didn't feel as good as I do now being on Suboxone. I never have bad experiences with it. It always stays consistent with my body. It seems to work just as good today as it did the first day I started using it."***

***"I noticed that since I started doing Suboxone, that I have decreased my use a lot since then. I was using every day… I probably use once or twice a week now."***

***"Suboxone has been great, it's been a miracle. I still go to meetings 3 times a week. I'm not required to go there, I don't have to take Suboxone. It's definitely given me a second chance at life. I've got my kids back. I feel like I got my soul back. I just got a good job."***

perceptions that methadone is more focused on making money than helping people recover, and, in one instance, because of the lack of required group counseling:

***"Suboxone seems to be the best thing that has worked for me so far. Methadone worked as well, but … It was business first there. If you don't have your $15 a day, then goodbye. Suboxone is different because I have Medicaid and my Medicaid pays for it."***

***"Suboxone is a lot easier to get off than MTD"***

***"My experience with methadone wasn't really a good one. It was more of a business than trying to actually help people. They would let people go ridiculously high on their dose, I think you had to go to group therapy once a month which is ridiculous…it was pretty apparent that is was more of a moneymaker than for any humanitarian reasons."***

One lone consumer found methadone superior to Suboxone: ***"Suboxone, I abused it. I can shoot it, so I abused it…. When I tried the methadone, I was very against it. I thought it was the worst thing you could possibly try…[however] It's like a miracle thing, because I've never done this well on anything before. I just started filling out the paperwork today to start going down 2mg at a time. Within the next year, I'm hoping to be off the methadone."*** However, overall Suboxone may be more familiar to interviewees, as the minority had experience with methadone.

***"If you think of when you were using, you would wake up every day and your first thing would be to look for stuff. You would sit in the car sometimes and wait for your dealer for four hours, but you can't go and wait in line for 10 minutes to get your dose. It's cheaper. A lot of people, it's paid for by insurance. I'm over income, so I have to pay $130 a week for it. That's a lot cheaper than buying heroin every day."***

Vivitrol received scant attention from consumers. However, the one consumer who mentioned experience with the medication provided unqualified support compared to Suboxone: ***"If you really want to get clean, then the Vivitrol is really the only way to go. The Suboxone is just delaying the inevitable, because you are going to get sick."***

Lastly, <u>issues related to cost</u> pervaded the discussion of treatment, with many consumers expressing dismay at an array of funding-related issues. These funding-related issues include a lack of providers who accept state insurance (***"It's crazy, they'll tell you [that] you have to go to a program as part of your parole. Well, you can't go to a fucking program unless you have insurance and out of the four programs or whatever there are, only one of them will accept state insurance"***), insurers who pay for medication but not other

components of treatment deemed by most consumers as necessary (***"My insurance doesn't even cover group. It only covers the medication"***), high copays ***("I have to rob Peter to pay Paul to come up with my $65 copay every week…I have a lot of bills"***) and that, in some instances, Suboxone is cheaper outside of the treatment context (***"I actually wanted to get into this Groups but they were full. Until recently they weren't accepting any new clients, but I'm not really interested. I don't have money for it. It's cheaper to buy on the street. I can get the same amount as everyone else does here for a cheaper price"***).

Talk of cost as a barrier is somewhat offset by a few consumer comparisons of the costs of treatment and the costs of continued opioid use: ***"I think a lot of people don't realize … I heard a lot of people complaining about the price of coming to this. It's not cheap but going from doing hundreds of dollars a day of heroin to spending a couple hundred dollars a week on recovery. It's a no-brainer for me. I've said that in group before and it wasn't the most popular. Depends on if your life's worth it."***

### FIRST RESPONDERS AND EMERGENCY DEPARTMENT PERSONNEL

When sharing their experiences with the treatment system, R/ED personnel explained that there are few, if any, treatment referral processes in place after stabilizing a patient after an overdose. Two ED providers discussed offering access to recovery coaches, but one lacked knowledge about patients' receptivity to this option. The other said that the response to recovery coaches is ***"pretty poor"*** and that ***"users are not interested in sticking around and waiting for them to show up. More often than not, the patient will either leave AMA [against medical advice] or leave without continuous treatment before the recovery coaches can talk to them"*** *(ED).*

R/ED personnel explained that they can share pamphlets and contact numbers with patients, but believed that ***"giving them a business card is not really the referral that they really need"*** *(Fire)*. Some feel uninformed about the process: ***"It's not well organized. I don't know much about it. I haven't been very well educated on exactly what we would be referring to"*** *(EMS).* One ED provider noted that ***"a very, very small percentage of the overall narcotic patients"*** *(ED),* are referred to psychiatric care, predominately in instances where the overdose was a suicide attempt.

R/ED personnel described several barriers to instituting treatment referral processes. One responder doubted that Eds have the time, resources, and appropriate providers to make referrals. Regarding availability to assist with treatment referrals, staffing limitations were noted for fire/EMS and police as well. For example, ***"I don't have extra officers to transport people around. I need officers enforcing the law"*** *(Police).*

# INTERVIEW FINDINGS BY CATEGORY: EXPERIENCES WITH TREATMENT

Many R/ED personnel discussed a lack of available services to which to refer patients: ***"I guess one of my concerns would be the availability of those resources even if they technically exist. Are they really 24/7? Are they really open for everybody or is it one of those if they've got beds they'll help you, but otherwise we'll turn people back to the street, so that's a concern"*** *(Fire).* Two responders discussed a lack of knowledge about existing services, and one explained that patients are not alert enough to consider a referral after being treated in the field and that a referral ***"would be best met at the hospital during their recovery time"*** *(Fire).* Another explained that there is not adequate funding to the organizations that are qualified to conduct referrals. Uncertainty about the effectiveness of treatment services was pervasive. ***"People will get out of a 30-day program or a 28-day program or a seven-day detox and they'll be using the next minute"*** *(Fire);* ***"I mean, I'm conflicted. I don't think programs work as far as ... I've seen people come out of rehab and come right back to it. I think there's a small margin of success. I don't know. I don't know what's better if incarceration is better or treatment"*** *(Police).*

There were mixed opinions expressed about medication-assisted treatment (MAT). Many R/ED personnel expressed concerns that the medications can be misused and that ***"substituting one addiction for another, I can't really see how it's going to work in the long run"*** *(EMS).* However, others discussed the benefits: ***"I am completely for it, and I think it can be done to the very highest standards of evidence-based medicine. Especially given that we have 40 years of published data to its effectiveness. That we need to de-stigmatize the use of legal opiates in the management of chronic opiate addiction. It has to be done by professionals, because drugs like methadone, and buprenorphine can also kill if misused, or mis-prescribed. It's high risk stuff, and no one going into this should be under any illusion that it's easy, but it's effective. Recidivism rates are lower, and survival, which is really what we're all about here, is much better"*** *(ED).*

There is a consensus among the R/ED interviewees that consumers are unable to stop using opioids without help. For example, ***"once you're addicted, it's like any other addiction. It changes your brain chemistry and you need to be... You need help. You can't do it yourself to get clean, I would imagine"*** *(Police).*

Most also agree that consumer motivation impacts the effectiveness of treatment: ***"You got to have the person or patient or a subject, whatever you want to call them, has to be willing to get treated in order for it to work. It's like anything else, anything that you try or try to stop doing or something, you got to be, in your mind you got to be wanting to do that to actually make it work"*** *(Fire);* ***"A lot of times I think people who come in on their own, 'I'm done,' do a***

***lot better than people who are forced to come in by their families. If you don't have that passion to get out of it"*** *(Fire).*

### Recommendations for the Treatment System

Perhaps the most widely shared opinion among R/ED personnel was the need for increased availability of all services related to addressing the opioid crisis, especially treatment:

***"There's not enough. It's better than it was a year ago, but with the scope of the problem that we see and the number of people that we have looking for treatment, there's not enough"*** *(EMS)*

***"I just think that having the treatment facilities out there needs to be kind of at the forefront right now. I think they just need to get more of those treatment facilities out there and more options for them"*** *(EMS)*

***"Immediate referral for drug and alcohol detox. The red carpet. Our own homegrown Betty Ford, with a state commitment to say, 'This matters'"*** *(ED)*

R/ED personnel explained that funding-related barriers also must be addressed. One such barrier is often insurance. R/ED personnel expressed that insurance should not prevent someone from getting treatment: ***"I think if somebody wants to do it then they should have that ability to do it whether or not their insurance can afford it or anything. That's usually a huge crutch"*** *(Police).* Another issue is funding for treatment programs, which R/ED personnel currently find insufficient: ***"Put more money into it... I mean, everything comes down to money, really. You need to make it more available"*** *(Police).*

Additionally, R/ED personnel agreed that access to treatment must be simplified: ***"It [treatment access] has to be easy, and it has to be coordinated. It can't be difficult to obtain. The person essentially has got to be put in a position where they have to do very little other than say, 'Yep, I'm ready'"*** *(Fire).*

Some R/ED personnel also emphasized that treatment should be more individualized: ***"I think that they need to understand that treatment has to be out there, but it has to be out there in many different forms because not one treatment that's right for one person is going to be right for the other, so I think there needs to be many different treatments out there, many different options for them"*** *(EMS).*

The need to reduce stigma was also discussed. A responder explained that community members need to be aware of their own biases: ***"Also, you can't have people saying, 'Well, yeah, that's a great place to put it in this little Victorian house, but I don't want it in my neighborhood.' But you'll be the first one to complain that there's not treatment out there, but you don't want it in your neighborhood. I think that whole 'I want to see it, but not in my backyard' thing has to go away"*** *(EMS).*

Similarly, an ED provider discussed challenging the stigma among his colleagues: ***"I am a little more direct in confronting bad thinking among colleagues about this. Which doesn't necessarily win me friends. I try to be polite about it, but people don't like their beliefs challenged necessarily"*** *(ED).*

Several R/ED personnel contended that services must address the full range of co-occurring problems, including mental health problems, other drug use, and housing, especially as underlying mental health issues were mentioned by a few R/ED personnel as critical to understanding some patients' use of drugs. One ED provider explained that identifying drug use as an isolated problem is shortsighted: ***"To me, the biggest problem is that these patients … The narcotics are only part of their problem. Their socioeconomic environment, their resources, their monetary, financial, legal, other problems all conspire to make them in this situation that really is tough to get out of. It's not simply a drug problem for most of them, in my opinion"*** *(ED).* Another subset of R/ED personnel acknowledged housing as critical in addressing the issue: ***"We need supportive housing"*** *(Fire).*

Two ED providers emphasized that the opioid crisis should be addressed through a multi-pronged approach. One stressed that treatment, prevention, and harm reduction must work together. For example, ***"syringe exchange or clean needles, couple that with recovery resources or counseling or referrals"*** *(ED).*

Another provider summarized his thoughts on addressing the crisis through multiple layers: ***"I would have a federally and state funded addiction treatment clinic, with all the moving parts, including methadone, buprenorphine, and other accepted medically assisted treatments. I would have trained, certified professionals at all levels. From the physicians, to the nurses, to the psychologists, to the counselors. I would have residential setups for the pregnant women, and help with them. I would continue the buprenorphine in the internal medicine and family medicine clinics, because there's a category of patient who works, who considers themselves a 'good citizen,' but doesn't want the stigma of walking into the methadone clinic once a day, on public display. Those people could be accommodated under that model. It simply takes more money, and more personnel to fight this, and some real estate, a business plan if you will"*** *(ED).*

# INTERVIEW FINDINGS BY CATEGORY: EXPERIENCES WITH TREATMENT

One responder also noted the importance of providing services for families affected by opioid use, particularly services for children, though this responder did not provide further details.

**SUMMARY**

Responders and consumers overwhelmingly acknowledged that consumers are unable to stop using opioids without help, yet noted a lack of available services in New Hampshire. Lengthy waitlists and trouble navigating the treatment system prevent consumers from obtaining treatment. Few responders offered treatment referrals after overdose events because of staffing shortages, limited knowledge about treatment options, and a dearth of open treatment slots.

Both groups recommended increasing treatment options for opioid use disorders, especially Suboxone, medically-assisted detoxification, and group and individual counseling. In addition, treatment for co-occurring mental health problems must be more available. Funding was another major barrier to treatment access. Consumers encountered difficulties paying for their treatment, while responders noted a lack of funding for programs.

# INTERVIEW FINDINGS BY CATEGORY: PREVENTION

## Prevention

### OPIOID CONSUMERS

Ideas about how best to prevent continued escalation of the opioid crisis in New Hampshire included messaging for prevention experts and those who implement prevention efforts in the state, physicians who prescribe opioids, treatment providers and law makers. The consensus among consumers is that middle school or earlier is ***"a good time to start the conversation."*** One consumer clarified that, ***"I think we need to start educating kids younger, because I definitely – besides at home – I didn't hear about drugs until high school and I was doing them long before that."***

The education that consumers believe is best suited to deter youth from experimenting with opioids involves scaring youth by showing how average people descend into the depths of opioid addiction: ***"Show a successful person in a commercial and then show them starting to use in the bathroom at work. Show them starting to use in their car outside of their work. Show them losing their teeth, losing their everything. Then show them dead on the side of the street somewhere."***

> ***"We have to get past this stigma of it... It's not the homeless person on the street... it's your teacher, it's really close to home."***

Prescribers are admonished by consumers to prescribe opioids prudently to prevent future problematic opioid use among the wider New Hampshire population: ***"Just limit the accessibility to getting anything."*** Further, patients who are prescribed opioid analgesics must be educated about the addictive potential of these drugs, and must also be held accountable in the event that they misuse and/or divert their medications. Physicians and treatment providers are encouraged to increase the availability of Suboxone: ***"Drug addicts do not search out Suboxone to abuse…these are the people who are actually starting to think about treatment …and if it is easier for them to get some treatment real quick from the guy next door then you are going to do that because it is so hard to get treatment any other way."*** Also, increasing treatment options in general: ***"I know a lot of people- I think they should offer more funding into- I know a lot of people who need treatment, who really wanna get there, but they can't go to a place like this or where I go. They can't afford it."***

Consumers also suggested the need to work to dismantle stigma surrounding opioid use disorder by highlighting that it is no longer just marginalized groups who are falling prey to this disease:

# INTERVIEW FINDINGS BY CATEGORY: PREVENTION

***"We have to get past this stigma of it… It's not the homeless person on the street… it's your teacher, it's really close to home."*** Dismantling stigma is expected to also play a role in interrupting intergenerational substance use because, as one consumer reports, ***"I know some people, if there's addiction in their family they're afraid to tell anybody because they don't want to get taken out of the family."***

## FIRST RESPONDERS AND EMERGENCY DEPARTMENT PERSONNEL

R/ED personnel focused on four major targets for preventing future opioid use and overdose: educating youth and families, improving the management of pain, and mobilizing the entire community.

Just like the consumers, R/ED personnel unanimously endorsed early education as a critical medium for preventing opioid use and overdose. This education encompassed teaching young people about drug use (e.g., ***"But we got to get into the schools. We got to start educating everybody"*** *(Fire))* and understanding pain *(e.g.,* ***"I think we need prevention programs that are all about… and getting people to understand that pain is a normal part of life and a normal part of healing"*** *(ED))*, in addition to providing resources for young adults who may already be using drugs *(e.g.,* ***"I think that there needs to be far more education for our youth, along with places, phone numbers for them to call, and just be like, 'Hey, listen. I'm thinking about using. I need help'"*** *(EMS)).*

> ***"I saw the transition from normal, what I perceived as normal, to a pain emphasis, and everybody was getting something pretty intense for pain management, and that expectation of not feeling pain. We see the pendulum kind of swinging back. I think many of us in the ER started to swing it back before it came to the forefront the way it did, because I think we innately were more aware of the fact even before it was front page news and before the state was on 20/20." (ED)***

R/ED personnel viewed interrupting the intergeneration cycle of drug use as another necessary component of improving prevention strategies, ***"It's a cycle. I think educating families would be a huge part of it"*** *(Police).*

To improve the management of pain and reduce nonmedical prescription opioid misuse, R/ED personnel advocated for eliminating the trend toward "pain as a fifth vital sign" to reduce the pressure on providers to prescribe opioid analgesics.

# INTERVIEW FINDINGS BY CATEGORY: PREVENTION

***"One is if you're going to come up with a plan on how to tackle this issue, it needs to be complete community involvement. It's not something that only one organization, or one entity, or one slice of the community pie can fix. Everybody has to be involved, and until you go out and ask in the community what people's capabilities, resources, backgrounds, professions are, you're not going to have the right answer, no matter how hard you try." (EMS)***

R/ED personnel generally supported the newly adopted limits on opioid prescription in New Hampshire, but also advocated for more patient education about pain and opioid analgesics. ***"As we go from healthy young people… to aging bodies… they need a lot of counseling and teaching to say, 'This is part of the human condition, it's going to hurt. Don't expect me to fix it, it will fix itself, sort of. You are aging'"*** *(ED).*

For patients with chronic pain, R/ED personnel wanted more non-opioid options for pain management, ***"You can cut off the amount of drugs that are being prescribed for pain, but you have to have other options for them as well"*** *(EMS).*

Finally, R/ED personnel felt that patients receiving opioid analgesics need additional education about the effects of opioids and the risks of becoming physiologically dependent.

Ultimately, R/ED personnel believed that the entire community must be mobilized and involved. R/ED personnel felt a responsibility to advocate for their patients, but emphasized that prevention must encompass the entire community to be effective.

**SUMMARY**

There was concurrence among opioid consumers and R/ED personnel that education on substance use and its consequences must occur earlier than it currently is, before middle school, and that prevention efforts should include dismantling stigma and intergenerational substance use.

Furthermore, agreement was reported on engaging physicians in addressing the opioid crisis by eliminating pain as the "fifth vital sign", prescribing opioids more prudently (e.g., greater patient education and utilization of non-opioid options), and increasing the availability of Suboxone. R/ED personnel ultimately voiced that the entire community must be mobilized to effectively prevent contributing to the opioid crisis.

# INTERVIEW FINDINGS BY CATEGORY: LAWS AND POLICIES

## Laws and Policies

### OPIOID CONSUMERS

Consumers did not generally seem well informed about laws that affect opioid users in New Hampshire, but they were quick to describe the laws as ***"harsher," "stricter,"*** and ***"not easy going at all."***

Opioid consumers recounted many examples of interactions with New Hampshire law enforcement officers that conveyed their perceptions of being targeted and/or harassed unnecessarily, above and beyond what is prescribed by law. Consumers spoke of being, ***"charged with felony possession of a straw,"*** or ***"arrested for an empty needle."*** One person ranted that ***"there was no drugs in the car, just an empty bag, but NH wanted to pick up charges against me, so yeah, I was arrested and held with an extremely high bail…I thought it was a bit extreme."*** Another recounted an experience being pulled over by the police in New Hampshire and having his Narcan kit taken away. He said the officer told him, ***"'You are not allowed to have this,' and I was like 'That's funny, they give it out in Vermont."'*** One consumer summarized, ***"I think that the law's coming down harder on the opioid user than they ever have."***

Perceived harassment is compounded by mistrust of law enforcement as evidenced by references to the Good Samaritan Law:

***"Correct me if I'm wrong because I'm not too up to date but my perception of that if somebody OD's in front of you and you call, [the police are] gonna do nothing, right? I feel like people are kind of skeptical. I definitely would be."***

***"I'll ask a person I'm getting high with, 'If I go out, will you call 911? I don't care if you throw me out on the sidewalk, but just promise me you'll call the police,' because people are scared."***

***"I think that the law's coming down harder on the opioid user than they ever have."***

When asked what consumers would change about the laws that affect opioid users in New Hampshire, the predominant theme was to make more treatment available through either increases in treatment availability, treatment options, including opening a medical detoxification program or passing something akin to Massachusetts's Section 35 that enables a loved one to have someone detoxed against their will, or increasing the number of insurance companies that cover treatment for opioid use disorders. Pair this theme with the frequent

mention of how jail fails to address the needs of the opioid user [mutual exclusivity of jail and treatment] and the frustration is not hard to understand:

***"You might have to sit in jail for 5 years, then, if you want to be clean, go after [to treatment]"***

***"What is prison going to do? Absolutely nothing…just give you a worse mentality than ever"***

***"They said they offered AA meetings and stuff like that, but people never showed up to [run them]"***

Besides being unable to obtain treatment in jail, Suboxone appears to be the most readily available opioid in jails which, in a number of instances, is underscored as the reason some consumers do not consider it a path to sobriety if/when they seek treatment. Finally, felony convictions signal the pointlessness of getting clean to some. One called this the ***"snowball effect"*** – ***"now I'm a felon, I've ruined my life."***

## FIRST RESPONDERS AND EMERGENCY DEPARTMENT PERSONNEL

R/ED personnel were asked several questions about New Hampshire policies and laws that affect people who use opioids. While this was not pervasive, a few responders were explicit about their lack of knowledge around these policies and laws, stating such things as ***"I don't know exactly what the laws are"*** *(Fire),* and ***"they come up with 900 of them every year, so I don't know"*** *(Police).*

Others expressed concern about the unintended consequences of the crackdown on opioid prescriptions, one of which is the possibility of pushing people toward illicit drugs: ***"I will say that if someone truly has pain or someone truly has an addiction, I honestly don't believe that my not prescribing them opiates is going to stop them from somehow attaining them. I'm fearful that we are pushing more people to illicit drug use by becoming restrictive with these things, but I don't have any data to back that up"*** *(ED).*

Another potential consequence is not treating pain effectively: ***"I think that's good in a way but I also think that's harming people that really need their meds as well… Because there's a lot of people out there that have no other way to go, that they have to have those pain meds. It's preventing them from getting their proper care because there's no other treatment for them for that pain issue"*** *(Fire).*

ED providers described prescription drug monitoring programs (PDMP) as useful tools but as cumbersome in emergency departments: ***"It's designed for someone who's got a full-time office staff to do that. It's just got to be way more streamlined if it's ever going to have an impact. That would be my biggest plea, to make this thing extremely user-friendly"*** *(ED);* ***"I love***

***prescription drug monitoring programs. I just think to mandate it as every single time in a busy ER is incompatible with my other goals for patient care"*** *(ED).* Two providers also noted the need for PDMPs to cross state lines; otherwise, they are substantially less useful for communities that are close to borders.

Similar to ED providers' mixed opinions on PDMPs, police officers felt conflicted about the Good Samaritan Law. Officers seemed to think that the law saves lives and that it is good ***"if there's evidence showing that it has encouraged more people to call to stop people from dying"*** *(Police).*

However, some officers felt like the law was a barrier to their duties and that ***"some people can use it as a shield to hide behind"*** *(Police).* Oftentimes officers would express both pros and cons of the law: ***"The whole aspect where if you call for help because of an overdose, that you can't be arrested for something that's on the scene, I think those laws have helped to a degree, but I also think that they've hindered law enforcement because some of the best information you get on drug dealing actually comes from evidence you find at scenes and things like that. While I think it's helped some people actually pick up the phone and call, I think it's hindered in a way, but I think it's competing harms, like would you rather see the person get help and actually live from the overdose, or would you rather see them get prosecuted?"*** *(EMS, former Police)*

Several officers and a firefighter also discussed a desire to increase prosecution for drug offenses:

***"I think that users and abusers, they should be spending more time behind bars to teach them a lesson"*** *(Fire)*

***"We need to do something with the laws to prosecute multiple offenders much more strictly or at least abide by the guidelines you have in place"*** *(Police)*

***"Law enforcement side, we need more of it. There needs to be more, going after the bigger people. It's not that we're not trying; it's just that, honestly, if you talk to all the different people at different task forces around here, there's so much. You put out a fire with a squirt gun, really"*** *(Police)*

However, one of these officers acknowledged that many people who use opioids are ***"buying drugs and then selling enough to support their habit. A lot of these users aren't big-time drug dealers; they're people who are supporting their habit"*** *(Police).*

# INTERVIEW FINDINGS BY CATEGORY: LAWS AND POLICIES


**SUMMARY**

Consumers were not well informed about New Hampshire laws that may impact people who use opioids. In general, consumers expressed frustration and mistrust toward law enforcement officers and the criminal justice system, particularly the lack of treatment available in jails. This mistrust also contributed to doubts about the Good Samaritan law, which could reduce consumers' likelihood of calling 911 after witnessing an overdose. Police officers also expressed feeling conflicted about the Good Samaritan, and some did support increased prosecution for drug-related offenses.

Some responders also expressed a lack of knowledge about New Hampshire laws that affect opioid consumers, though were most knowledgeable about laws surrounding opioid prescribing, prescription drug monitoring programs (PDMP), and the Good Samaritan law. Responders had mixed opinions regarding these laws. Crackdowns on prescribing may reduce opioid prescribing, but might cause opioid consumers to seek illicit drugs and may prevent pain from being treated effectively. PDMPs are viewed as useful, but burdensome.

# DISCUSSION: UNIQUENESS OF NEW HAMPSHIRE

## NEW HAMPSHIRE'S JUXTAPOSITION WITH NATIONAL DATA

The following national data, along with the interviews from this study, emphasize the critical points where New Hampshire stands out from the rest of the United States.

### Prevalence of substance use in New Hampshire

New Hampshire consistently ranks in the top ten states of drug use, according to the Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a).

### Opioid prescribing in New Hampshire

While overall rates of opioid pain relievers were consistent with national rates in 2012, New Hampshire had significantly higher prescribing rates of long-acting/extended release pain

reliever, high-dose opioid, and benzodiazepines prescribed concurrently (Centers for Disease Control and Prevention (CDC), 2014).

Rates of prescription pain medications per 100 people (CDC, 2014)

| Region | Opioid Pain Reliever Prescriptions | Long-acting/extended release opioid prescriptions | High-dose opioid prescriptions | Benzodiazepine prescriptions |
|---|---|---|---|---|
| New Hampshire | 71.7 | 19.6 | 6.1 | 41.2 |
| U.S. National Average | 82.5 | 10.3 | 4.2 | 37.6 |

### Opioid-related overdoses in New Hampshire

Since 2014, the state of New Hampshire has seen a disproportionately high rate of opioid overdose compared to other states, especially involving the use of fentanyl. From 2013 to 2014 alone, the Centers for Disease Control (CDC) reported a 73.5% increase in opioid overdoses in the state; estimations of that number have only increased in the years since. In the 2013-2014 reporting period, New Hampshire residents died of synthetic opioid-related overdoses at a rate of 12.4 per 100,000. The second-closest state to that rate during that reporting period, Rhode Island, saw synthetic opioid-related overdose deaths at a rate of 7.9 per 100,000. In December 2016, the CDC released updated data for the 2014-2015 reporting period. Alarmingly, New Hampshire saw a doubling of synthetic opioid-related overdose deaths per capita; 24.1 per 100,000 in New Hampshire died from synthetic opioid-related overdoses in 2014-2015. The second-closest state reporting deaths in that period was Massachusetts, which saw 14.4 per 100,000 (Centers for Disease Control and Prevention (CDC), 2016; Rudd, Aleshire, Zibbell, & Gladden, 2016).

### Substance use treatment admissions in New Hampshire

In 2011, New Hampshire had higher rates of treatment admissions for opioids other than heroin per capita than the national average (Substance Abuse and Mental Health Services Administration (SAMHSA), 2015b). Despite this, only 1.4% of New Hampshire treatment admissions for any substance use disorder in 2011 were to medication-assisted treatment programs (Substance Abuse and Mental Health Services Administration (SAMHSA), 2015a). New Hampshire has the fewest buprenorphine-waivered physicians per 100,000 residents in the northeast (Knudsen, 2015). Nationally, states had an average of 8.0 (SD=5.2) waivered physicians per 100,000 residents, while Northeastern states had an average of 15.5 (SD=6.3) waivered

physicians per 100,000 residents. New Hampshire lagged behind the national and Northeast average, with 7.1 waivered physicians per 100,000 residents.

From 2001 to 2011, New Hampshire consistently had lower rates of treatment admissions per 100,000 residents than both the national average and the New England average (Substance Abuse and Mental Health Services Administration (SAMHSA), 2015b).

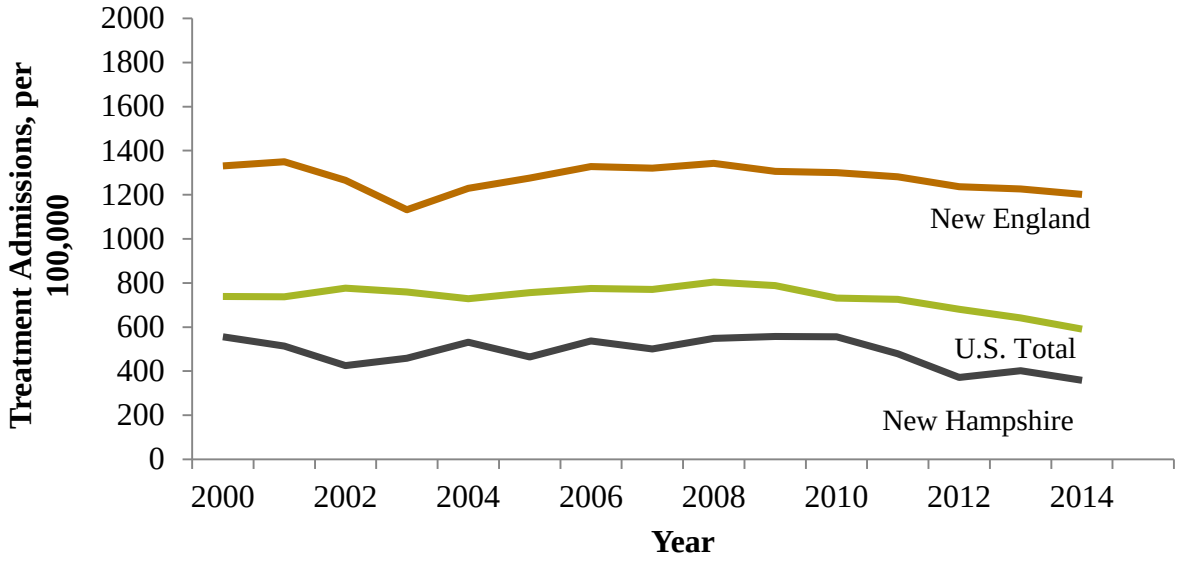


**Figure 12. Treatment Admission Rates per Year (SAMHSA, 2015b)**

### Mental health disorders in New Hampshire

From 2000 to 2014, NSDUH data suggest that rates of mental health disorders in New Hampshire are similar to the national average. The percentages of New Hampshire residents with depression, thoughts of suicide, and severe mental illness have not changed significantly during this time period (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b). Rates of treatment for mental health disorders were also comparable to the national average from 2010 to 2014 (New Hampshire Bureau of Drug and Alcohol Services, 2015; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b).

### New Hampshire funds for health and treatment

Compared to the other New England states, New Hampshire had lower total and per capita spending for treatment in 2014 (NH Governor's Commission, 2015).

# DISCUSSION: UNIQUENESS OF NEW HAMPSHIRE

Public Health Treatment Spending per State (NH Governor's Commission, 2015)

| Region | State/General Fund Expenditures 2014 | Population (2013 Census estimates) | Per Capita General Expenditures 2014 |
|---|---|---|---|
| New Hampshire | $4,846,868 | 1,323,459 | $3.66 |
| Vermont | $14,661,043 | 626,630 | $23.40 |
| Connecticut | $155,784,688 | 5,586,080 | $43.44 |
| Maine | $18,239,306 | 1,328,302 | $13.73 |
| Massachusetts | $90,106,640 | 6,692,824 | $13.46 |
| Rhode Island | $7,511,957 | 1,051,511 | $7.14 |
| New England | $48,525,084 | 2,434,801 | $19.93 |

New Hampshire also has lower public health funding per resident than the national average, according to the Trust for America's Health (Trust for America's Health, 2016).

Public Health Funding per Resident (Trust for America's Health, 2016)

| Region | Funding per Resident |
|---|---|
| New Hampshire | $66 |
| U.S. National Average | $94 |
| Vermont | $114 |
| Massachusetts | $102 |

### New Hampshire has no needle exchange programs

The United States has one of the lowest rates of needle exchange availability in the developed world. New Hampshire is the only Northeast state with no needle exchange programs or laws explicitly legalizing needle exchange (LawAtlas, 2016).

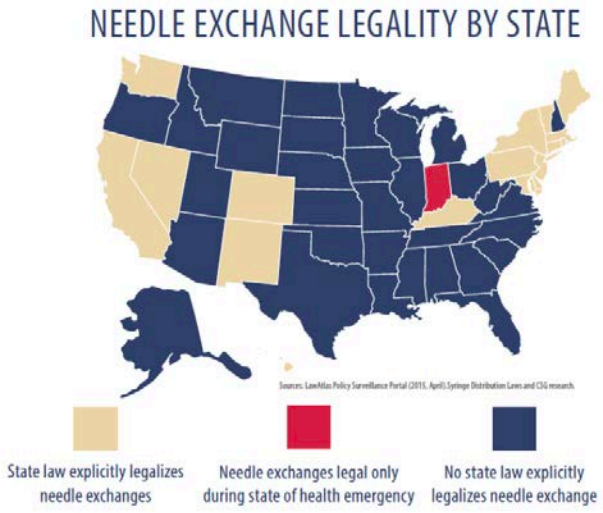


**Figure 13. States with Needle Exchange Programs (LawAtlas, 2016)**

### Law enforcement Fentanyl encounters in New Hampshire

In 2015, New Hampshire was one of the three states that had the highest rates of law enforcement encounters (drug submitted for analysis) testing positive for fentanyl by laboratories (rates over 20.0 per 100,000 residents: NH, MA, and OH) (Gladden, Martinez, & Puja, 2016).

# DISCUSSION: UNIQUENESS OF NEW HAMPSHIRE

## SUMMARY

The urgency of this study was driven by the aim of understanding what is unique about New Hampshire that is fueling the increased opioid-related overdose deaths. State authorities pressed the issue further in Phase 1, voicing concern regarding the historical high trends of alcohol and drug use beyond the current opioid crisis in the state. Based on available national data and interviews conducted in this study, there are unique aspects to New Hampshire compared to other states in the Northeast and across the country.

First, New Hampshire has prescribed significantly higher rates of long-acting/extended release pain reliever prescriptions, high-dose opioid pain relievers, and benzodiazepines concurrently compared to national averages (Centers for Disease Control and Prevention (CDC), 2014). Given what we've learned from interviews on trajectory of opioid use, this is one of the key paths to later heroin and fentanyl use when opioid prescriptions are terminated. Furthermore, this has historically made prescription pain medications more available for diversion on the streets. With recent prudence in prescribing, and consequently less illicit availability of pills, the demand has shifted to heroin and other synthetic opioids like fentanyl.

A startling reality in New Hampshire is the shortage of funds for health and treatment. Compared to other New England states, New Hampshire has had lower total and per capita spending for treatment (NH Governor's Commission, 2015), along with lower public health funding per resident than the national average (Trust for America's Health, 2016). Lack of early prevention and treatment availability were expressed by both opioid consumers and R/ED personnel across the state. When programs did exist in their area, long wait lists and steep costs were further barriers, particularly for medication-assisted treatment. In 2011, only 1.4% of New Hampshire treatment admissions for any substance use disorder were to medication-assisted treatment programs, so this may be an area to focus expansion efforts (Substance Abuse and Mental Health Services Administration (SAMHSA), 2015b).

New Hampshire has a lower rate of Suboxone prescribers per capita than the national average or other Northeastern states. Nationally, states had an average of 8.0 (SD=5.2) waivered physicians per 100,000 residents, while Northeastern states had an average of 15.5 (SD=6.3) waivered physicians per 100,000 residents. New Hampshire lagged behind the national and Northeast average, with 7.1 waivered physicians per 100,000 residents (Knudsen, 2015). Opioid consumers unanimously pronounced greater availability and access to Suboxone as not only an effective and preferred treatment method, but also a strategy for prevention and harm reduction. Because Suboxone may not be the optimal pharmacotherapy for individuals with chronic pain who have used non-prescription fentanyl (Rosenblum et al., 2012), increasing the availability of methadone

would be another critical step to offering more medication-assisted treatment options. The absence of needle exchange programs in New Hampshire has also been acknowledged as a concern across interviewees. Although not unique to the United States, it should be noted that the other region in the country experiencing a spike in fentanyl-related overdoses along with HIV-positive diagnoses, Appalachian counties in Indiana and Kentucky, has responded to the crisis by enabling local governments to implement needle exchange programs as a public health response (Indiana General Assembly, 2011).

An additional noteworthy characteristic about New Hampshire is its interstate access and proximity to the supply chain of opioids, specifically the manufacturing of fentanyl in Lawrence, Massachusetts (Seelye, 2016). Consumers and R/ED personnel corroborated that fentanyl and FLH are predominately entering from the Massachusetts border and that New Hampshire is a vulnerable target given the profit potential for dealers trafficking over the state border. Furthermore, FLH is attractive to consumers in New Hampshire given its lower cost, higher potency, and availability compared to other opioids.

To reduce overdose rates in New Hampshire, breaking down barriers to accessing and using Narcan is an important step. Opioid consumers noted fears of legal prosecution, concerns about side effects, and a lack of knowledge about Narcan access, indications for use and laws as substantial barriers to Narcan use. Additional training, community outreach, and education may be necessary to increase Narcan uptake and use among opioid consumers and other community members (Mueller, Walley, Calcaterra, Glanz, & Binswanger, 2015).

Further consideration should be given to New Hampshire's unique rural setting. This could give way to increased boredom among residents and contribute to seeking mood altering states, along with jobs and lifestyles that increase the risk for accidents and injuries resulting in prescription pain killers (e.g., logging and wood splitting) (Runyon, 2016). Intergenerational substance use may be a particularly problem in rural regions because research suggests that prescription opioids are more commonly diverted from family members than other individuals (Keyes, Cerda, Brady, Havens, & Galea, 2014). Because kinship networks are wider in rural regions, these connections may facilitate the procurement of prescription opioids (Keyes, 2016). Self-sufficiency and individualism are core values of rural New Hampshire that may reduce help-seeking behaviors among those experiencing problematic opioid use (Carpenter-Song, Ferron, & Kobylenski, 2016). New Hampshire's "Live Free or Die" motto, potentially justifying risky behaviors, also warrants deliberation.

# NEXT STEPS

## FURTHER DEVELOPMENT

Following this NDEWS Report of the "Understanding Opioid Overdoses in New Hampshire" rapid epidemiological study, detailed analyses of the full sample will be completed. This will lend to a full sample publication of findings, along with in-depth publications on the various categories and emergent themes. Moreover, pointed recommendations and proposals for state and federal consideration will be provided.

Based on data from this research, preliminary considerations for New Hampshire's approach to tackling the opioid overdose crisis include:

- Increase public health funds targeting substance use;
- Expand prevention programs in elementary and middle schools;
- Strengthen treatment to include broader availability, modest cost, and inclusion of medication-assisted options and holistic approaches;
- Incentivize physicians to become buprenorphine-waivered providers;
- Assist physicians with prudent prescribing of opioids, educating patients, and alternatives to pain management;
- Support first responder and emergency department personnel with vicarious trauma associated with responding to overdoses;
- Initiate needle exchange programs;
- Collaborate with Massachusetts on addressing the manufacturing and trafficking of fentanyl and other opioids; and
- Launch programming to dispel stigma and fear:
    - Educate consumers (e.g., Narcan and Good Samaritan Law)
    - Education physicians and pharmacists (e.g., chronic disease management and value of Narcan)
    - Educate law enforcement (e.g., alternative approaches to punitive measures)
    - Educate the public (e.g., opioid crisis is not isolated to one demographic/area and breaking the intergenerational cycle of addiction)

# REFERENCES CITED

Carpenter-Song, E., Ferron, J., & Kobylenski, S. (2016). Social exclusion and survival for families facing homelessness in rural New England. *Journal of Social Distress and the Homeless, 25*(1), 41-52. doi:10.1080/10530789.2016.1138603

Centers for Disease Control and Prevention (CDC). (2014). Vital signs: Variation among states in prescribing of opioid pain relievers and benzodiazepines- United States, 2012. *Morbidity and Mortality Weekly Report, 63*(26), 563-568.

Centers for Disease Control and Prevention (CDC). (2016). *Wide-ranging data for epidemiological research (WONDER)*. Retrieved from Atlanta, GA: http://wonder.cdc.gov/

Cicero, T. J., Ellis, M. S., Surratt, H. L., & Kurtz, S. P. (2014). The changing face of heroin use in the United States: A retrospective analysis of the past 50 years. *JAMA Psychiatry, 71*(7), 821-826. doi:10.1001/jamapsychiatry.2014.366

Gladden, R. M., Martinez, P., & Puja, S. (2016). Fentanyl law enforcement submissions and increases in synthetic opioid-involved overdose deaths- 27 states, 2013-2014. *Morbidity and Mortality Weekly Report, 65*(33), 837-843.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*, 59.

Senate Enrolled Act No. 461, (2011). Indiana General Assembly.

Jones, C. M., Logan, J., Gladden, R. M., & Bohm, M. K. (2015). Vital Signs: Demographic and substance use trends among heroin users - United States, 2002-2013. *Morbidity and Mortality Weekly Report, 64*(26), 719-725.

Keyes, K. M., Cerda, M., Brady, J. E., Havens, J. R., & Galea, S. (2014). Understanding the rural-urban differences in nonmedical prescription opioid use and abuse in the United States. *American Journal of Public Health, 104*(2), e52-59. doi:10.2105/ajph.2013.301709

Knudsen, H. K. (2015). The supply of physicians waivered to prescribe buprenorphine for opioid use disorders in the United States: A state-level analysis. *Journal of Studies on Alcohol and Drugs, 76*(4), 644-654.

LawAtlas. (2016). The Policy Surveillance Portal. Retrieved from http://legacy.lawatlas.org/query?dataset=syringe-policies-laws-regulating-non-retail-distribution-of-drug-paraphernalia

# REFERENCES CITED


Mueller, S. R., Walley, A. Y., Calcaterra, S. L., Glanz, J. M., & Binswanger, I. A. (2015). A review of opioid overdose prevention and naloxone prescribing: Implications for translating community programming into clinical practice. *Substance Abuse, 36*(2), 240-253. doi:10.1080/08897077.2015.1010032

National Drug Early Warning System (NDEWS). (2016). *NDEWS New Hampshire HotSpot Report: The Increase in Fentanyl Overdoses*. College Park, MD.

New Hampshire Bureau of Drug and Alcohol Services. (2015). *New Hampshire State Epidemiological Profile of Mental, Emotional, and Behavioral Health*. Concord, NH: NH Department of Health and Human Services.

New Hampshire Information and Analysis Center. (2017). *New Hampshire Drug Monitoring Initiative: 2016 Overview Report*. Concord, NH: NH Department of Health and Human Services.

NH Governor's Commission. (2015). *State Fiscal Year 2014 Annual Report*. Concord, NH: NH Department of Health and Human Services.

Rosenblum, A., Cruciani, R. A., Strain, E. C., Cleland, C. M., Joseph, H., Magura, S., . . . Portenoy, R. K. (2012). Sublingual buprenorphine/naloxone for chronic pain in at-risk patients: Development and pilot test of a clinical protocol. *Journal of Opioid Management, 8*(6), 369-382. doi:10.5055/jom.2012.0137

Rudd, R. A., Aleshire, N., Zibbell, J. E., & Gladden, R. M. (2016). Increases in drug and opioid overdose deaths: United States, 2000-2014. *Morbidity and Mortality Weekly Report, 64*(50-51), 1378-1382. doi:10.15585/mmwr.mm6450a3

Runyon, L. (2016). Why is the opioid epidemic hitting rural America particularly hard? *Net Nebraska: Nebraska's PBS and NPR Stations.* Retrieved from http://netnebraska.org/article/news/1055577/why-opioid-epidemic-hitting-rural-america-particularly-hard

Seelye, K. Q. (2016, March 25, 2016). Heroin epidemic is yielding to a deadlier cousin: Fentanyl. *The New York Times*. Retrieved from https://www.nytimes.com/2016/03/26/us/heroin-fentanyl.html?_r=0

StataCorp. (2015). Stata Statistical Software: Release 14. College Station, TX: StataCorp, LP.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014a). *National Survey on Drug Use and Health (NSDU): Model-based prevalence estimates*. Bethesda, MD.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014b). *National Survey on Drug Use and Health (NSDU): State estimates of substance use and mental disorders*. Bethesda, MD.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2015a). *National Admissions to Substance Abuse Treatment Services: TEDS 2004-2014*. Arlington, VA.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2015b). *State Admissions to Substance Abuse Treatment Services: TEDS 2001-2011*. Arlington, VA:.

Suzuki, J., & El-Haddad, S. (2017). A review: Fentanyl and non-pharmaceutical fentanyls. *Drug and Alcohol Dependence, 171*, 107-116. doi:10.1016/j.drugalcdep.2016.11.033

Trust for America's Health. (2016). *Investing in America's health: A state-by-state look at public health funding and key health facts*. Washington, DC.

# APPENDIX

Table of Identified Categories and Themes

Qualitative Interview Guide for Consumers

Qualitative Interview Guide for Responders

Brief Demographic Survey for Consumers

Brief Demographic Survey for Responders

# APPENDIX

| Categories and Themes | Consumer | R/ED |
|---|---|---|
| **Trajectory** | | |
| Early experimentation | X | X |
| Severe injuries | X | X |
| Substance use among nuclear family | X | X |
| Co-occurring mental health problems | X | X |
| Abrupt taper of prescription | X | X |
| **Formulation of Heroin and Fentanyl** | | |
| Differences between heroin and fentanyl (color, taste, potency, subjective experience, onset and duration of effects, cost) | X | X |
| Powder over patch or pills | | X |
| Administration through injection and snorting | | X |
| **Fentanyl-Seeking Behaviors** | | |
| Neutral or negative toward fentanyl | X | |
| Actively seeking fentanyl | X | X |
| **Trafficking and Supply Chain** | | |
| Lack of knowledge about trafficking (EMS/ED/Fire) | | X |
| Fentanyl coming from Massachusetts and New York | X | X |
| Original sources China and Mexico | X | X |
| Distribution by cartel members | X | X |
| Changes in availability 2014-2015 | X | X |
| Reasons for fentanyl increase (potential profit in NH, ease of transportation and manufacturing) | X | X |
| **Experiences with Overdoses** | | |
| Breadth and depth of the opioid problem | | X |
| Seeking drugs that cause overdose | X | X |
| Causes of increased overdoses (fentanyl's potency, product variability, inconsistencies in mixing product, inexperience with fentanyl high, '*chasing the high*') | X | X |
| Protocol for treating overdoses | | X |
| Conflict between goals of police and EMS | | X |
| **Experiences with Narcan** | | |
| Barriers to Narcan use (lack of knowledge, cost, fear of police, fear of physical side effects, stigma) | X | |
| *'Short-term fix'* | | X |
| No unanticipated side effects | X | X |
| Increased availability | | X |

# APPENDIX

| Categories and Themes | Consumer | R/ED |
|---|---|---|
| Unintended negative consequences | | X |
| **Harm Reduction** | | |
| Support for needle exchange programs | X | X |
| Ambivalence toward fentanyl testing kits | X | |
| *'Sad reality'* and conflicted attitudes | X | X |
| Needed to protect responders and consumers | | X |
| Increase availability of buprenorphine | X | |
| **Experiences with Treatment** | | |
| Cannot stop without help | X | X |
| Experiences getting treatment | X | |
| Treatment facilitators (buprenorphine) | X | |
| Treatment barriers (no available services, complex to access, funding issues) | X | X |
| Barriers to instituting referral procedures | | X |
| Need to increase availability of services | X | X |
| **Prevention** | | |
| Early education and intervention | X | X |
| Prudent prescribing | X | X |
| Patient education about opioids | X | X |
| Dismantle stigma and mobilize community | X | X |
| **Laws and Policies** | | |
| Lack of knowledge of laws | X | X |
| Perceived harassment and mistrust of law enforcement | X | |
| Mutual exclusivity of jail and treatment | X | |
| PDMP useful but cumbersome (ED) | | X |
| Conflicted feelings toward Good Samaritan law (Police) | | X |
| Desire for more prosecution (Police & Fire) | | X |

# APPENDIX

Subjective Experiences of Opioid and Fentanyl Use

Qualitative Interview Guide for Consumers

Sample Topic Guide[1]

---

Introduction

I would like to talk with you about your life, your experiences using substances, and your knowledge about overdose in New Hampshire. I will also ask you about your use of opioids, which are prescription painkiller drugs like oxycodone or fentanyl, and illegal drugs like heroin, and your experiences receiving substance use treatment services in New Hampshire. I'm interested in understanding these things from *your point of view*, from *your perspective*. I am here to learn from your experience; you're the expert.

As I've already said, what we talk about for our research is confidential and anonymous. I will not discuss this interview with anyone except other members of the research team. Please try to be as honest and open as you can so we can learn from your experience and potentially help save the lives of others who may be at significant risk of overdose or death.

If there are questions that you do not feel comfortable answering or discussing, you do not have to answer them. Please tell me and we'll move on to the next question. If you need or want to take a break at any time, please let me know. If you get tired and would like to continue the interview at another time, please let me know. This interview will take approximately 60 minutes of your time.

Before we go on, do you have any questions for me?

---

[1] As is standard in qualitative research, interview questions will be revised and refined as the research progresses. In this sample topic guide we present the broad thematic topics and sample questions that may be covered in the interview. The interviewer will probe, as appropriate, to inquire more specifically into these domains of interest.

# APPENDIX

**Substance Use Experience**

1. Maybe we can start by having you tell me a little about your use of drugs in general? [Note: encourage participant to speak open-endedly about his/her experience.]
   - How would you say you're doing right now? Getting better? Worse?

**Knowledge about Overdose in New Hampshire**

*In the next few questions, I'll ask you about your experiences with overdoses. Anything you can share may be really helpful so please do not leave any details out.*

2. Have you ever overdosed on drugs? Tell me about that/those experience/s?
   - What drug did you overdose on?
   - How did you use that drug?
   - Did you overdose accidentally?

3. Recently, there have been many drug overdoses in New Hampshire. What have you heard about these overdoses, if anything?
- Are there discussions on the street about the causes of these overdoses?
- What kinds of drugs are people overdosing on around here?
- What do you think is in those drugs? (A single drug versus a mixture of drugs?)
- How are people using those drugs? (Intravenous use? Oral use? Other?)

4. Where do you think the drugs causing these overdoses come from?
- Are local dealers selling them? Where do you think they're getting them?
- Are people ordering these drugs online?

5. Do you think people are seeking out drugs that might have caused overdoses?

6. Have you had any experiences with Narcan?
- Is Narcan easy to get?
- How do you get Narcan?
    - What side effects or things did you notice after you received Narcan?
    - Have you witnessed or heard about anyone receiving Narcan and having negative effects from it? If yes, what types of effects? [if effects are suggested, probe about brain damage at the end of the exchange]

**Opioid Use Experience**

*Now I'd like to ask you some questions specifically about your experiences with opioids like heroin or fentanyl.*

7. I can see from the information sheet you filled out for me that you started using opioids around ____ years ago. Can you tell me a little about your use of opioids? [Note: Interviewer should use this to prompt for drug use trajectory and specifically about fentanyl.]
- How do/did your use of opioids affect your life? What about fentanyl specifically?
- Have you ever tried cutting down or stopping use? What has been difficult? Any obstacles that really stand out?
- Were you ever prescribed opioids for chronic pain?

*Now I'd like to ask you some questions specifically about using fentanyl in New Hampshire.*

8. Try to remember the first time you used fentanyl…would you say you looked for it specifically or was it more by accident that you used it?
- Please describe that first experience…
- Do you take it in combination with other drugs, like heroin or cocaine?
- If you believe you know you have used fentanyl in the past/currently, *How do you know* you have used fentanyl as opposed to heroin or a heroin/fentanyl mix [word of mouth? dealer advertising? media? subjective experience different in any way from POs or heroin?]
- How did you take/use it?

9. If you would describe yourself as primarily a heroin user, would you say you use/seek fentanyl due to the low availability of heroin? low purity of heroin? and/or high price of heroin? If yes to any of these questions, please elaborate…

*Now I am going to ask you about your sources...Remember I'm not going to give this information to anyone and I'm not going to ask you for any names.*

10. Tell me, if you can, a little bit about how you got fentanyl or where it came from?

11. In states where people buy prescription pills off the street it's possible that fentanyl overdose deaths might increase because many counterfeit pills are sold as diverted pain relievers (meaning they're made with fentanyl and other unknown drugs but sold as legitimate prescription pills) and it's hard to tell if they're fake or real.
- What is your reaction to that statement?
- How available is heroin in this area?
- How available are prescription opioids (not fentanyl) in this area?

— How available is fentanyl in this area?Where do 1,2, 3 come from? (…to the best of your knowledge)… your dealer gets (1,2,3) from X who gets it from X…
    - o If you are close to/familiar with the supply chain in some way, please describe variability in the availability of different opioids…

12. A recent *New York Times* article on fentanyl included a statement from a former nurse who is on methadone after years of shooting up heroin. She said of fentanyl, "it's cheaper, and the high is better, so more addicts will go to a dealer to get that quality and grade…even if it means they could die."
— What is your reaction to that statement? Does it ring true?

13. If you were to characterize/describe a fentanyl high: Is the fentanyl high different than a heroin high? If so, how does it differ? (qualitatively 'better'?, 'fast-acting'?)

14. Imagine you hear that someone you know OD'd on a heavy mix or a hot spot in a bag sold by one of your dealers… describe how you might react?

15. In a recent Valley News article (a NH newspaper) one man said he's seen countless friends, girlfriends and strangers "fall out and come back" in the throes of an overdose, or not come back at all. He, too, "died once," he says, but his friend's mom brought him back. He wasn't happy about it. "Most shooters want to die; they have a death wish," he said. "Death is a gift for people like us…suggest not doing it [fentanyl] if you don't want to die."
— What are your thoughts on this? (Agree/disagree?)

16. I'm going to read you some statistics from a recent Union Leader article.

In 2015, there were 399 overdose deaths in New Hampshire.
151 were caused by fentanyl alone.
74 were from fentanyl combined with other drugs.
36 were from heroin and fentanyl combined.
31 were from heroin alone.
"Two-thirds of the drug overdose deaths in New Hampshire last year involved fentanyl, a powerful opioid that is becoming the drug of choice for addicts here. The drug crisis that has been devastating families across the state is now largely a fentanyl epidemic." (Union Leader, January 2016)

- Does it feel like a crisis to you on the street?
- When you hear statistics like these and when you hear people talk about opioid use and overdose due to opioids in NH in 'crisis' terms, what comes to mind for you? What is your reaction? (Do you think what NH is experiencing right now is a crisis or an epidemic?)

**Substance Use Treatment Services in New Hampshire**

*Now let's talk about your experiences receiving substance use treatment services in New Hampshire.*

17. Please tell me a little bit about your experiences getting treatment for your opioid use, if you have ever sought treatment…?

— Why did you begin treatment in New Hampshire in the first place?
— Please tell me about your experiences with medication-assisted treatment (like methadone, buprenorphine, or naltrexone) in New Hampshire?
— What has been helpful about the treatment you've received in New Hampshire?
— What hasn't worked so well? What would you change if you were in charge?

**New Hampshire State Policy**

*I want to talk to you a little bit about some laws in New Hampshire that affect people who use opioids.*

18. Have you ever been arrested on drug charges in NH, or been arrested and found in possession? How many times?

— Have any of those arrests ever led to substance use treatment?
— Have you heard of the Gloucester (pronounced Gloster) Angels program in MA? When people are found in possession by police they are given the option to either enter treatment or be charged.
    o Do you think a program or system like that would work and get people into treatment and sober in NH?
— Do you have any experience with drug court in NH? What do you know about it? Do you think it is/could be beneficial to getting people into treatment?

19. How well do you think you understand New Hampshire state laws that affect people who use opioids [recent prescribing crackdowns, child services involvement, possession charges, overdose arrests, etc.]?

— In your experience, what has been helpful?
— What hasn't worked so well? What would you change if you were in charge?

20. If anything were possible, how would you prevent people from using opioids in the first place?

— What do you think the state could do to make prevention more effective?

21. What do you think the state could do to make treatment more effective [increase treatment options, collaborative care (like housing), open more OTPs, starting more

state-funded OTPs instead of relying on private companies, increasing treatment options for those on state Medicaid, etc.]?

22. What are your thoughts on harm reduction practices [fentanyl testing kits so people know what they are buying/taking, needle exchange programs, buying buprenorphine or methadone off the street while you wait to get into a program]?
- Is Narcan being used as a harm reduction strategy? (Are people using Narcan with a sober buddy (Lazarus or Narc parties) so they can use more or a higher potency?)
- Are there harm reduction strategies that people are doing on the street in this area?

23. Historically, New Hampshire has always had high rates of drug use. What do you think is the reason people in New Hampshire use drugs [higher rates of mental health issues, community relationships, environment, job opportunities and infrastructure, family situation, things like that]?

**Wrap-up**

*Well, we're just about finished with the interview. We've covered a lot of ground today. I want to thank you for sharing your experiences with me.*

24. Before we stop for today, are there any things that you'd like me to know about your story that you want to make sure gets heard?

25. How do you feel right now about this interview and what we talked about?

# APPENDIX

Subjective Experiences of Opioid and Fentanyl Use

Qualitative Interview Guide for Responders

Sample Topic Guide[2]

---

Introduction

I would like to talk with you about your perspectives on responding to and treating overdoses from opioids, fentanyl, and/or heroin in New Hampshire. I'm interested in understanding these things from *your point of view*.

As I've already said, what we talk about for our research is confidential and anonymous. I will not discuss this interview with anyone except other members of the research team. Please try to be as honest and open as you can so we can learn from your experience.

If there are questions that you do not feel comfortable answering or discussing, you do not have to answer them. Please tell me and we'll move on to the next question. If you need or want to take a break at any time, please let me know. If you get tired and would like to continue the interview at another time, please let me know. This interview will take approximately 60 minutes of your time.

Before we go on, do you have any questions for me?

**Overdose and Fentanyl Experience**

1. I'd like to start by asking you to characterize and describe the overdose problem in NH from your perspective.

[2] As is standard in qualitative research, interview questions will be revised and refined as the research progresses. In this sample topic guide we present the broad thematic topics and sample questions that may be covered in the interview. The interviewer will probe, as appropriate, to inquire more specifically into these domains of interest.

# APPENDIX

*Now I'd like to ask you some questions specifically about opioids like heroin or fentanyl. We're interested in learning about your experiences with opioids in your community, and responding to and treating overdoses from these drugs.*

2. Please tell me a little about the people you see in your work with opioid overdoses.
- User characteristics (age, race)
- [For first responders], What's going on at the scene (drugs at the scene, route of administration, bystanders)
- Do you see overdoses from any one drug more than another in your line of work?
- What is your understanding of fentanyl use in New Hampshire?
- Where do you think the drugs causing these overdoses are coming from?
- Do you hear reports that users are seeking out certain drugs because they are causing overdoses?

3. What are your assessment/investigative protocols for overdoses?
- What is the process?
- Does knowing what the person used affect your course of treatment?
- Is fentanyl routinely tested for by law enforcement upon confiscation of substances such as heroin, cocaine, etc.
- Is acetyl fentanyl or other fentanyl analogs routinely tested as well upon confiscation?
- Are lab results currently shared with other agencies?
- Is there a referral protocol after emergency treatment?
- How is that referral handled?
- How do you feel about this process?

4. Have you ever had to administer Narcan (naloxone) to someone? What was that like?

5. Have you noticed any trends or patterns in administering Narcan in New Hampshire?
- Have you witnessed any unanticipated side effects from a Narcan administration?
- Have you witnessed or heard about any Narcan administrations that resulted in brain damage?
- Have you heard of people participating in Lazarus parties or Narc parties?

6. What is your view on the use of Narcan?

7. Please tell me about an overdose or an experience with opioids that still sticks with you, if there is one?

8. Has treating this problem affected you personally? Has it affected you professionally?

9. What is your opinion of opioid users? Would you say you have any biases one way or the other? What about fentanyl users? Has that opinion changed over time?

**Substance Use Treatment Services in New Hampshire**

*Now let's talk more about your experiences referring people to substance use treatment services in New Hampshire.*

10. Tell me a little bit about your experiences getting people into treatment for their opioid use.
- What has been helpful about your treatment referral system?
- What hasn't worked so well? What would you change if you were in charge?

11. What is your viewpoint on medication assisted treatment (methadone, buprenorphine, or naltrexone)?

12. What is your viewpoint on harm reduction as a treatment strategy (testing kits on the street, needle exchange programs)?

13. What are your ideas for better prevention and treatment in New Hampshire?

14. If you have not had the opportunity to help connect someone to treatment for their opioid use, please share a colleague's experience if you can recall it with any detail.

**New Hampshire State Policy**

*I want to talk to you a little bit about some laws in New Hampshire that affect people who use opioids. I want to get your understanding of whether public policy does enough in NH to address this issue, from your personal point of view and your professional experiences.*

15. What, in your experience, has been helpful about New Hampshire state laws regarding opioids [recent prescribing crackdowns, child services involvement, arrest laws, the new Good Samaritan immunities, the Prescription Drug Monitoring Program (PDMP), etc.]?

16. What hasn't worked so well? What would you change if you were in charge?

— What changes would make your job easier?

17. What do you think the state could do to make prevention and treatment more effective?

**Fentanyl Product and Trafficking**

18. Are you aware of specifics about fentanyl as a product?
— How is it sold? (powder, pill, patch)
— What are the different cocktails you've encountered?
— When do you think fentanyl hit the supply chain in NH?
— Do you know who is producing it? (If cut with heroin, who is performing the cutting of the fentanyl into the heroin product can be identified? If in pill form, who is producing the pill can be identified?)
— In your opinion, are low-level dealers aware that fentanyl is present in the products they are selling?
— Are dealers making buyers beware?
— Do you see fentanyl being used as a marketing tool?
— Do you think buyers are aware that fentanyl is present in the products they are buying?
— In your experience, are buyers seeking out fentanyl?

19. What is your experience with trafficking of fentanyl?
— Are there specific groups in NH or surrounding states that you know of that are bringing them into the area?
— How do you think fentanyl is getting into NH?
— How do you think it's getting into the US? [Probe for Internet orders]

20. Historically, New Hampshire has always had high rates of drug use. What do you think is the reason people in New Hampshire use drugs [higher rates of mental health issues, community relationships, environment, job opportunities and infrastructure, family situation, things like that]?

**Wrap-up**

*Well, we're just about finished with the interview. We've covered a lot of ground today. I want to thank you for sharing your experiences with me.*

21. Before we stop for today, are there any things that you'd like me to know about your experiences that we haven't covered?

*Thank you for your time, and the work that you do responding to this crisis.*

# APPENDIX

**Brief Demographic Survey for Consumers**

Study ID: _____

Gender
☐ Male ☐ Female ☐ Transgender ☐ Prefer not to answer

Race
☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐ White ☐ Other
☐ More Than One Race ☐ Unknown or Not Reported

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Age:

Highest level of education
☐ Less than high school degree ☐ High school diploma/GED ☐ Some college, no degree
☐ Associate's degree ☐ Bachelor's degree ☐ Master's degree
☐ Graduate degree

Employment status
☐ Working full-time (40 hrs/wk) ☐ Working part-time ( less than 40 hrs/wk)
☐ Looking for work, unemployed ☐ Retired ☐ Disabled, permanently or temporarily
☐ Keeping house ☐ Student ☐ Other
☐ Only temporarily laid off, sick leave or maternity leave

Marital status
☐ Married ☐ Re-married ☐ Widowed ☐ Divorced ☐ Separated
☐ Never Married ☐ Living with Partner

Housing status
☐ Own a home ☐ Rent a home/apartment ☐ Live with someone (no rent)
☐ Residential/halfway house ☐ Shelter ☐ Homeless

County you live in:

How old were you when you started using alcohol?

How old were you when you started using drugs (other than opioids)?
☐ Marijuana Age of first use:
☐ Cocaine Age of first use:
☐ Hallucinogens Age of first use:
☐ Stimulants Age of first use:
☐ Benzodiazepines Age of first use:
☐ Sedatives or hypnotics Age of first use:
☐ Inhalants Age of first use:
☐ Other Age of first use:

# APPENDIX

How old were you when you started using opioids?
☐ Prescription pain killers Age of first use:
☐ Heroin Age of first use:
☐ Fentanyl Age of first use:

Have you ever used fentanyl?
☐ Yes, Fentanyl alone
☐ Yes, Fentanyl mixed with another drug
Please list:
☐ No ☐ Unsure/I don't know for certain

How long ago did you last use prescription pain killers?
☐ Past week ☐ Past month ☐ Past 6 months ☐ More than 6 months ago

How long ago did you last use heroin?
☐ Past week ☐ Past month ☐ Past 6 months ☐ More than 6 months ago

How long ago did you last use fentanyl?
☐ Past week ☐ Past month ☐ Past 6 months ☐ More than 6 months ago

How many times have you been in treatment for opioid use?
☐ Outpatient __ ☐ Intensive Outpatient __ ☐ Residential __
☐ Detox __ ☐ Opioid Treatment Program (methadone/suboxone) __
☐ I've never been in treatment

How many times have you been in treatment for mental health problems only?
☐ Outpatient __ ☐ Intensive Outpatient __ ☐ Residential __
☐ Inpatient/hospitalization __
☐ I've never been in treatment for mental health problems

Are you currently on a waiting list at a treatment center?
☐ Yes ☐ No

What medications have you been prescribed for your opioid use problem?
☐ Naltrexone/Vivitrol ☐ Currently ☐ Previously ☐ Never
☐ Buprenorphine ☐ Currently ☐ Previously ☐ Never
☐ Methadone ☐ Currently ☐ Previously ☐ Never
☐ I've never been prescribed medications for opioid use disorder

How many times have you overdosed?
☐ Heroin __ ☐ Fentanyl __ ☐ Both __ ☐ Other __
☐ I've never overdosed

Have you ever been given Narcan (or naloxone) to reverse an overdose?
☐ Number of events: __
☐ Highest number of administrations during one event: __
☐ I've never had Narcan to reverse an overdose

# APPENDIX

**Brief Demographic Survey for Responders**

Study ID: _____

| |
|---|
| Gender<br>☐ Male ☐ Female ☐ Transgender ☐ Prefer not to answer |
| Race<br>☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander<br>☐ Black or African American ☐ White ☐ Other<br>☐ More Than One Race ☐ Unknown or Not Reported |
| Ethnicity<br>☐ Hispanic or Latino ☐ Not Hispanic or Latino |
| Age: |
| Department or Division<br>☐ Police ☐ Fire ☐ EMS ☐ Emergency Department |
| County you work in: |
| Department role: |
| Number of years you've been in this role: |
| Number of opioid overdoses you have responded to: |
| Number or percent of opioid overdoses that have involved fentanyl: |
| Number of people you have personally administered Narcan/naloxone to: |
| Average number of Narcan/naloxone doses you give each person: |