

NDEWS HotSpot Report

Naloxone Substudy: Cleveland, Ohio

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INTRODUCTION

The findings from a qualitative substudy on opioid injectors' experiences, attitudes, and perceptions concerning the use of naloxone (Narcan[®]) are highlighted in this report. This substudy topic emerged from and was connected to a more comprehensive qualitative National Drug Early Warning System (NDEWS) HotSpot research project in which trends in opioid, heroin, and illegal fentanyl use among opioid injectors in Cuyahoga County, Ohio, were assessed. The interview guide developed for the broader study on trends was modified to accommodate the aims of this substudy. The topic of naloxone use (and users' experiences using it to reverse overdose or having it used on them) integrated seamlessly with the topics of the original study.

Cleveland, OH, Site

Dr. Lee Hoffer, Dr. Allison Schlosser, and Kayla Buckelew at Case Western University in Cuyahoga County piloted the naloxone addendum developed by the workgroup with seven initial subjects and provided detailed feedback to NDEWS staff. NDEWS staff used this feedback to revise the naloxone addendum.

The researchers collected basic demographics, drug use history, and fentanyl patterns and trends as a part of their HotSpot study. Additional topics addressed in the revised naloxone addendum are listed as follows, and the revised addendum which includes open and close-ended questions is attached.

Knowledge about naloxone:

1. Knowledge About Naloxone
2. Access to Naloxone
3. Experience With Naloxone
4. Perceptions and Attitudes Toward Naloxone
5. Influence of the Availability of Naloxone on Drug Use Behaviors

The data collected on these *naloxone-related themes* are summarized in this report. Although some of these themes overlapped with the broader topics associated with the HotSpot study of local heroin and fentanyl use trends, the analysis in this report has been limited to naloxone. A separate report will be prepared for the HotSpot study.

METHOD

For this study, open-ended interviews were conducted with 30 active injection drug users in Cuyahoga County. Interviews were conducted between February 1 and March 22, 2019.

Participants were recruited from the Circle Health Services Syringe Exchange Program (SEP) in Cleveland, Ohio. Circle Health Services has operated this SEP since 1994, and it operates in two

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sites: a mobile exchange on Cleveland’s westside and a clinic-based exchange program on the eastside. For this study, participants were only recruited from the eastside SEP.

All participants in this study were 1) clients of the SEP, 2) older than 18 years of age, 3) not currently in residential or inpatient treatment, and 4) had injected at least five times in the last 30 days. Participants were recruited with the assistance of SEP staff, who informed SEP clients of the opportunity to participate in the study after they had completed their SEP visit.

If clients expressed interest in participating, a researcher discussed the project with the potential participant and verified they had not been previously interviewed for the study. Researchers administered a verbal consent process for study participation. All interviews were conducted in private rooms at the SEP and lasted approximately 45–60 minutes.

An open-ended, semistructured interview guide was used for this study that consisted of questions concerning the participants’ drug use history, as well as of their use and attitudes about heroin, fentanyl, and naloxone. At the end of the open-ended interview, participants were asked to respond to a series of closed-ended statements about naloxone using the Likert scale response.

Each participant was interviewed one time only, and no identifying or personal information was collected. After establishing eligibility using the participant’s SEP identification (ID) number, participants were assigned a random study ID number for data collection and management. Participants received \$20 for their participation in this study. All data collection processes and procedures for this study were approved by the Case Western Reserve University Institutional Review Board. There were no protocol deviations.

Data Analysis

Three researchers conducted interviews (Dr. Hoffer, Dr. Schlosser, and Kayla Buckelew) for this study. After each interview, the researcher took notes on the general themes and topics of the interview. Researchers relistened to the interviews to verify themes and generated a “themes document” outlining central findings on the topics of interest (as listed earlier). Only a targeted selection of quotes from interviews are presented in this report. A complete analysis of the data is forthcoming. The research team is confident, however, that the summary findings provided here reflect the majority of participant responses. The result of producing the naloxone semistructured interview guide was rapid saturation of participant responses to the topics under investigation.

DEMOGRAPHICS (N = 30)

Male: 76%

White, non-Hispanic: 83%

African American: 10%

Hispanic: 2%

Age average: 39, Age range: 20–60

Used fentanyl: 90%

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SUMMARY OF FINDINGS

1. Knowledge About Naloxone

- A. Although not all users recognized the term “naloxone” itself, all users were familiar with Narcan.
- B. Most users had a kit that included Narcan, although the majority had not received formal training on how to use it or received brief training through the distribution program DAWN (Deaths Avoided With Naloxone) associated with the SEP.
- C. Most participants kept naloxone in their homes; some also stored it in their cars. Several reported they did not carry it with them because they used opioids exclusively in their homes and/or they did not go to many places they thought they might need to use it.
- D. Participants reported first learning about naloxone from the local news, word-of-mouth among opioid users, and/or staff at the SEP.

2. Access to Naloxone

- A. Most participants reported that naloxone is available and were aware they could access it at the SEP.
- B. Many users thought it should (and could) be made more available, however: for example, by being offered at more locations (i.e., pharmacies and in suburban/rural communities), marketed to nonusers, more widely advertised (e.g., on Facebook[®]), and available anonymously.
- C. The most common factors limiting naloxone access reported by participants were related to limited transportation.
- D. Some participants cited embarrassment and shame (for drug use) as reasons people do not go to public places (e.g., a pharmacy) or a clinic to obtain naloxone. Several users did not know whether naloxone/Narcan was available at pharmacies or whether all pharmacies had the drug.
- E. A few participants reported that some opioid users are too “lazy” to go to clinics where naloxone is available.
- F. Most participants described the process of obtaining naloxone through the distribution program associated with the SEP (project DAWN) as easy and quick, and several commented that the program staff were friendly and helpful.
- G. Participants reported that the local DAWN program does a good job distributing naloxone.

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3. Experience With Naloxone

- A. Most participants had some experience being revived or reviving others, but these experiences varied. Some users had many experiences, whereas a few had none. Most users had at least one experience either seeing naloxone used, using it on someone else, or having it used on themselves.
- B. These experiences sometimes made participants reflect on their own use, but they generally reported that their experiences with naloxone did not affect their drug use behaviors or drug use habits.
- C. In general, the drug use behaviors, habits, and trajectories participants reported did not overlap with the use of naloxone. Naloxone did not seem to be a factor that influenced their use or use patterns.

Experiences being revived:

- D. Some participants reported seeking opioids immediately after being revived to quell withdrawal symptoms.
- E. Although nearly all participants reported being grateful to individuals who revived them and/or called emergency responders, some were upset when initially revived because they were disoriented, did not recall overdosing, and/or believed they were “nodding out” but not fully overdosing (thus not justifying the use of naloxone).
- F. Experiences of recovery after being revived varied: Some participants reported few physical effects after regaining consciousness, some reported intense withdrawal symptoms, and a few were hospitalized for days after being revived.

Experiences reviving others:

- G. When participants revived someone with naloxone, they did not report issues using the Narcan nasal spray and often replaced their kit soon after use. Many anticipated using multiple doses to revive someone and kept numerous kits for this reason (e.g., one participant recently obtained 10 kits from the local distribution program to keep at his or her home).
- H. Participants generally reported that they did not call 911 after reviving someone with naloxone. Additional medical help is perceived as unnecessary after a revival.
- I. Several users reported that calling 911 was risky because although the police may not arrest them for using naloxone, they may have warrants for their arrest on other (non–drug-related) charges.
- J. Some participants reported that the person they revived was angry once he or she regained consciousness, but this was anticipated and did not dissuade them from reviving others in the future.

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- K. Because of fear of anger from the person who was revived, a few participants expressed reluctance to use naloxone on someone unless certain the person would die without it (making statements like “it’s a last resort.”). Most participants, however, did not have reservations about using naloxone to revive someone, regardless of the individual’s response.
- L. In addition to using naloxone, some participants took additional measures to revive people from overdose, including basic CPR, doing a sternum rub, laying the person on his or her side, slapping the person to keep him or her awake, and putting ice on the person’s body.
- M. Participants were generally highly motivated to revive fellow users who overdosed. Users also noted an awareness of the drug use habits of people they typically used with, and if they did not know the person or the amount they typically used, they anticipated that they might need to administer naloxone.
 - “If it was my worst enemy, I would revive them.” (0571)

4. Perceptions and Attitudes Toward Naloxone

- A. Most users viewed naloxone positively, commonly referring to it as “a lifesaver” that all users should carry. Almost all reported that they are grateful to have naloxone available:
 - “It’s a lifesaver, if you need it.” (6909)
 - “It’s great. It saves lives, so I can’t say anything bad about it.” (7005)
 - “We’ve been now trained to carry around naloxone, and we do, and thank God we do.” (6921A)
- B. Many users described naloxone as a “safety-net” to have available in emergencies but not something that enables opioid use. A subgroup of participants reported that some opioid users think naloxone gives users “nine lives” and is a “get out of jail free card” that might make some users more comfortable taking risks (6110); the participants responding in this way typically distinguished themselves from these individuals.
- C. Some participants described their awareness that people who don’t use opioids view naloxone as enabling reckless drug use (e.g., “They can play with fire a little more”), but interviewees were adamant that this is typically not the effect of naloxone. Participants did not report engaging in riskier drug use behaviors because they had naloxone:
 - “No. No one thinks like that. It is there in case something happens. Pretty much a regular using heroin addict knows what they do every day, what they need to get right, get off sick, they know the amount they are use to doing, what they need to do.” (8673)

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- D. Some users maintained a negative attitude toward the precipitated withdrawal brought on by naloxone but recognized naloxone as generally positive and necessary.
- E. Most users reported no stigma associated with being revived by naloxone among users. Many expressed gratitude that naloxone was available to revive these individuals, as well as expressed compassion for them. Some noted that they wonder whether people who have been revived many times are “reckless” in their opioid use. Participants sometimes described a combination of these beliefs:
 - “[I think] thank God somebody was there with Narcan for you. And then after that, if you were brought back with Narcan, do you really want to go through that again?” (7752)
 - “Users have a lot of compassion for one another ... Most people didn’t just wake up and say, ‘Hey, I want to be an addict,’ that’s just not the way it goes.” (4305)

5. Influences of the Availability of Naloxone on Drug Use Behavior

- A. Most users were adamant that naloxone does not affect their day-to-day drug use behaviors. They describe naloxone as a tool that they have but do not think about while using drugs. In general, the drug use patterns described by participants were not unusual in any way:
 - “Somebody’s going to get high regardless, you’re not going to stop them.” (6909)
 - “The way it effects your daily life, the life or death thing doesn’t even come into play, it doesn’t even bother you, you don’t even care about that, to be honest with you. I don’t know... I just want to stay well. I don’t want to be sick anymore.” (2811)
 - “I don’t think it really effects how much you use. You’re going to use however much you can get. That’s just how it is. Say if you were starvin’ and someone put a plate in front of you, you’re gonna eat whatever you can eat, you know? This is the same scenario.” (2811)
 - “I think if you’re an opioid user it’s something you should have in your house, and people that you’re around should have it. It’s an effective tool to keep you from dying. I don’t think you should change your use for it—like I don’t think you should be more reckless or anything. That’s ridiculous.” (0571)

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- B. Some participants reported that drug use behaviors are influenced more by the increased presence of fentanyl in the heroin supply than by the availability of naloxone (e.g., increasing frequency and amount of use because of more potent fentanyl in the heroin supply):
- “I think as to whether people say, ‘well, now I can use more fentanyl because I have Narcan,’ no, I don’t think you could draw a line between that. I think people would use the same amount of fentanyl as they would if they had Narcan or they didn’t have Narcan, and just, now they have the option of having Narcan so they can possibly save themselves if somebody overdoses.” (7336)
- C. Most users expressed increased feelings of comfort or safety as a result of having naloxone, but some noted their awareness that naloxone does not guarantee survival in the event of an overdose, especially when using fentanyl or heroin adulterated with fentanyl.
- D. Even if they had naloxone, a general increased awareness of overdose risk motivated several users to take additional harm reduction measures (e.g., using fentanyl test strips distributed by the SEP, taking multiple small injections, and using only in the presence of others).
- E. Naloxone seems to be part of a general pattern (or strategy) associated with being more cognizant of the high risks associated with overdose. This attitude has clearly been influenced by fentanyl and the high, and variable, potency of the drug used alone or mixed with heroin:
- “[It’s not a] get out of jail free card.” (7005)
 - “Don’t nobody wanna play Russian roulette with their life.” (1091)
 - “Narcan came on the scene and everybody is grateful, people are grateful for it because they get to live another day. Without Narcan lots of people would have died.” (6921A)

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Table I. Data From Survey Questions

N=30	Don't Agree at All			Strongly Agree	
	1	2	3	4	5
People who have naloxone kits are more likely to take opioids	33%	13%	17%	17%	20%
People who have naloxone kits are more likely to take bigger doses of opioids than they would if they didn't have the kit	20%	17%	23%	10%	30%
People who have naloxone kits are less likely to take bigger doses of opioids than they would if they didn't have the kit.	70%	17%	10%	0%	3%
People who have naloxone kits are more likely to use opioids safely without risking overdose.	27%	7%	20%	13%	33%
If I know that there is a naloxone kit nearby, I feel safer when I use opioids.	10%	0%	13%	13%	63%
When I have naloxone available, I am more likely to use opioids.	53%	13%	13%	0%	20%
When I have naloxone available, I am more likely to take bigger doses of opioids.	43%	20%	13%	7%	17%
When I use opioids alone and have naloxone, I feel more confident about my safety.	50%	10%	7%	10%	23%
If I used too much opioids, I would be able to administer naloxone on myself before I lost consciousness.	67%	13%	10%	3%	7%

Findings on Using the Naloxone Likert Questionnaire, Recommendations, & Modifications

1. Most participants were aware of the public/media narrative concerning naloxone use potentially increasing the use of opioids and enabling reckless use. They did not appreciate the stigma associated with this narrative. Many interpreted the survey questions as implying this narrative and seemed insulted and frustrated by the insinuation. This made asking the survey questions difficult and uncomfortable. Afterward, several participants described the experience as “embarrassing.”
2. Generally, the survey questions were confusing to ask and equally confusing for participants to answer. Many of the statements had to be read multiple times, and participants often asked for clarification (particularly when responding to questions 2 and 3).
3. Although the response categories were scaled, most participants answered “yes/no” or with qualitative statements. Participants often needed to be prompted to answer using the 1–5 scale.
4. In multiple interviews, answers given to the survey questions contradicted statements participants made about naloxone during the open-ended portion of the

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interview. These contradictions may be a result of the confusing nature of the survey questions or of feelings of stigmatization elicited by perceived assumptions underlying survey statements.

5. Several participants specifically critiqued survey questions after completing them. One participant, for example, stated that, “A lot of those questions need to be simplified and shortened.”
6. Several participants believed that questions 2 and 3 were intended to trick them, and they found them insulting to their intelligence.

CAVEATS AND LIMITATIONS

Although the authors are confident that the findings reported here capture the majority of participant responses, this study has limitations. First, the DAWN project was located at the SEP, and as a result, participants in this study may be more informed about naloxone than users who do not come to the SEP. Second, there were few African American or Hispanic opioid users in this study. Trends and attitudes might be different in this population. Third, this study did not involve fieldwork observation. It is important to observe how people who use drugs behave in their everyday lives as this adds depth and context to interview data and may cover up its limitations. Fourth, social desirability challenges are likely associated with asking questions about naloxone use because people who use drugs are aware of negative public perceptions of naloxone.

CONCLUSION

Opioid injectors clearly appreciate naloxone/Narcan. They view the drug as an important safety tool and associate it with saving lives (both their own and those of others). Greater access to naloxone is important to people who use opioids. They consistently report using naloxone to revive people with whom they use drugs. They also administer naloxone even when aware of the negative (short-term) consequences to the people they revive.

The opioid injectors in this study did not report riskier drug use because of naloxone availability. Therefore, our findings do not support the assumption that because people who use opioids feel “safer” with naloxone, this has (or is) changing their use patterns. Participants did not report using more opioids, more potent drug, or drugs in larger amounts because they had naloxone.

These outcomes seem related to fentanyl taking over the opioid market in Cleveland. Most participants knew (by observation) or assumed they were injecting fentanyl or heroin adulterated with fentanyl. Participants reported using opioids more frequently to avoid withdrawal because fentanyl does not last as long as heroin (participants reported that fentanyl lasts 3–4 hours, whereas heroin lasts 10–12 hours). This change in use pattern, however, was only reported when a person was comparing his or her fentanyl/heroin use with (prior) heroin use. The findings from the larger HotSpot study indicate that before fentanyl saturated the Cleveland drug market (in around 2016), most users were injecting fairly consistent, medium-potency heroin. Because of the much greater

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potency of fentanyl and the inconsistent potency of batches of the drug, many participants reported increased strategies to reduce risks associated with injecting opioids, including making sure the naloxone is available before injecting.

Finally, participants described managing their drug habits in the same ways they always have (i.e., using to avoid withdrawal, using more when they have more resources, and using less when they have fewer resources but generally using stable amounts). Yet our findings reveal that people who use opioids are taking more measures to protect themselves from overdose. One possible reason for the decoupling of naloxone availability and less-risky drug use is that people who use opioids understand that the risks of injecting fentanyl are at a maximum. They are aware of their heightened risk of overdose, and possibly of death, if they continue to use in ways they did in the past. In this way, the use and attitudes about naloxone presented in this study reflect how users have responded to a new environment in which any injection could result in a fatal overdose.

Cuyahoga County Opioid HotSpot Study

Interview GUIDE (Opioid Users)

Introduction: (READ) In this interview I will be asking you questions about YOUR past use of illegal drugs. These will include your history of drug use, your opioid use, your experiences with opioid overdose, and your treatment experiences. We hope to use this information to improve services for people who use opioids.

There are no right or wrong answers and you can refuse to answer any question by saying “pass.” I will not share any of your personal information with anyone outside our research team. If we discuss what you tell us with anyone we will not use your name.

Background & Demographics

1. How old are you?
2. What race/ethnicity do you identify with?
3. What is your gender identity?
4. What is the highest level of education you completed?
5. Are you from Cuyahoga County?

(If yes) How long have you lived in the area?

Can you tell me about the neighborhood you grew up in?

6. Can you tell me about your current living situation?

How long have you lived there?

Who lives there with you?

7. Did you have a (legal) temporary, part-time or full-time job?

(If yes) What do you do? How long have you done this type of work?

(If no) When was the last time you worked? What did you do?

Do you work “under-the-table”? What do you do?

8. Are you married or do you have a significant other?

9. Do you have children?

How many? How old are they?

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Drug Use History

1. Can you tell me about how you started using opioids (i.e., heroin, black tar, fentanyl, Opana, morphine, codeine, Percocet, OxyContin, methadone, or buprenorphine/Suboxone)?

When did you start using? How old were you?

What types opioids did you start using?

Who did you start using with?

Do you consider yourself “addicted” to opioids? When did you realize you were addicted?

2. Have you ever used methamphetamine?

(If yes) When do you use it? How do you use it?

[Probe for past and current use, social contexts of use, mode of administration, pattern of use (binge, consistent), use in combination with other drugs]

3. How has the types of drugs you use shifted over time?

[Probe for changes in opioids used, changes in other drug use, and contexts of changes]

4. How would you describe your current opioid “habit”?

How often do you use? Did you have a consistent schedule?

How much do you usually use at one time?

How long have you used like this?

Do you get “high” when you use?

5. Did you usually use by yourself or with others?

Who do you usually use with (relationships not names)?

How did you meet the people you use with?

How would you describe your relationship with the people you use with?

6. Where do you usually use? (Public/private locations)

Fentanyl Patterns and Trends

1. How common is fentanyl use in the area?

Is fentanyl a popular drug among users?

[Probe for changes in popularity over time, popularity among certain groups of users]

How do users identify fentanyl?

How available is fentanyl? [Probe for consistent or sporadic access]

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Is fentanyl being marketed (distributed) specifically as fentanyl?

Is fentanyl being disguised and mixed with heroin (or other drugs, e.g. cocaine) without user knowledge?

(If yes) How are heroin users responding?

2. How do people use fentanyl?

[Probe for: 1) mode of administration; 2) by itself or combined with other drugs; 3) intentionally or accidentally]

3. Do you ever seek out fentanyl when you buy drugs?

Have you ever intentionally used fentanyl?

What effect does fentanyl have on you?

Have you ever overdosed when you used fentanyl? [*Probe for circumstances and outcome*]

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Proposed Revised Naloxone Addendum

October 23, 2018

Knowledge about Naloxone

1. Have you heard of Narcan or naloxone opioid overdose antidote? (existing Q Y/N)

(If yes) How did you first learn about it?

How have your beliefs about it changed over time?

2. Do you currently have narcan/naloxone? (existing Q Y/N)

(If yes) Where did you get it? [*Probe for DAWN, pharmacy, another opioid user*] (existing Q Y/N)

Can you walk me through the process of getting a kit? What is in the kit?

Do you carry the kit with you? [*Probe for where they carry the kit, how often they carry it on them?*]

Access to Naloxone

3. Do you think that naloxone is available and easy to get? Why? (existing Q)

4. How has the availability of naloxone has changed how opioid users think about their drug use? (existing Q Y/N)

[*Probe for changes in how users think about “good” (i.e., potent) drugs, the idea of “killer dope”*]

5. What do you think prevents people from obtaining naloxone kits? (new Q)

6. What can you tell me about Good Samaritan laws? (new Q)

[*Probe for knowledge of state Good Samaritan law. What is the law? How does it work?*]

7. How can programs that distribute Naloxone improve their services to meet the needs of users? (new Q)

Experience with Naloxone

8. Have you ever received training about how to administer naloxone? If yes, From whom?

9. Have you ever seen someone else being given naloxone to reverse an overdose? (existing Q Y/N)

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(If yes) How many times?

When was the last time you saw this?

Can you walk me through what happened the last time you saw someone else given naloxone? [Probe for what drug(s) they used, who they were with, how they were treated (formal/informal care), etc.]

10. Have you ever overdosed from using opioids? (existing Q Y/N)

(If yes) How many times?

When was the last time you overdosed?

Can you walk me through what happened the last time you overdosed? [Probe for what drug(s) they used, who they were with, how they were treated (formal/informal care), etc.]

Has someone ever administered naloxone to you to revive you from an overdose? (**existing Q Y/N**)

(If yes) How many times? ___ ___ ___ (**existing Q**)

Who administered it? (focus on last time OD'd)

How did you respond? [Probe for physical and emotional responses.]

How did others around you respond? (e.g., the person who administered it, people you were using with)

Did someone call 911?

(If Yes) Who responded to the call? EMS, Police, Fire?

What happened? [Probe for interactions with emergency responders, how they were treated, and the outcome.]

How did the experience change the way you think about opioid use or addiction?

How did the experience change the way you use opioids or other drugs? [Probe for changes in level of opioid use, schedule of use, precautions taken to prevent future OD, sense of safety provided by naloxone, etc.]

How did the experience change the way you think about entering a treatment program?

11. Have you ever administered naloxone to someone else to reverse their overdose? (existing Q Y/N)

(If yes) Can you walk me through what happened?

Did you call 911?

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(If Yes) Did you stay to wait for a first responder? [Probe for reasons to stay or not stay: knowledge of Good Samaritan laws, fear of repercussions, outstanding warrants, stories from friends about calling 911, etc.]

Who responded to the scene? Police, EMS, or Fire?

What happened? [Probe for interactions with EMS, Police, or Fire, how they were treated, what the outcome was]

(If No 911 call) Why did you choose not to call 911? [Probe for reasons to stay or not stay: knowledge of Good Samaritan laws, fear of repercussions, outstanding warrants, stories from friends about calling 911, etc.]

12. Have you ever administered naran/naloxone to yourself? (existing Q Y/N)

[Probe for if they know others who have done this, if they think it is possible]

13. Have you ever had a friend or family member die from an opioid overdose? (existing Q Y/N)

[Probe for relationship to the person, how the death influenced their life in general and drug use and desire for treatment specifically]

Perceptions and Attitudes of Drug Users about Naloxone

14. How do people who use opioids think about naloxone? (existing Q)

15. Has Naloxone changed how opioid users think about overdose? If yes, how? (new Q)

How has it changed how users think about the chances they will die from an overdose?

How has it changed how users think about the need for treatment?

How do users think about what it means to “die” and be brought back to life with Naloxone?

16. How are people who have been revived with Naloxone thought of by other users? (new Q)

Are people who have been revived with Naloxone thought of any differently by other users?

[Probe for social stigma, loss of relationships, unwillingness of dealers to sell to them, lack of access to services and other resources.]

17. How do dealers think about Naloxone? (new Q)

[Probe for how dealers might draw on Naloxone in their sales such as using it to promote opioid sales (e.g., as a selling point).]

18. What prevents people from using it to revive someone? (new Q)

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TO BE FILLED OUT FOR ALL PARTICIPANTS

SUBJECT ID# _____

Influence of the Availability of Naloxone on Drug Use Behaviors

1. Please indicate how much you agree with the following statements on a scale of 1 to 5 with 1 being “Don’t Agree at All” and 5 being “Strongly Agree”

Don’t
Agree

Stron
gly

	1	2	3	4	5
People who have naloxone kits are more likely to take opioids (for example: oxycodone, codeine, Roxicet, Percocet, methadone, buprenorphine, heroin)					
People who have naloxone kits are more likely to take bigger doses of opioids than they would if they didn't have the kit					
People who have naloxone kits are less likely to take bigger doses of opioids than they would if they didn't have the kit.					
People who have naloxone kits are more likely to use opioids safely without risking overdose.					
If I know that there is a naloxone kit nearby, I feel safer when I use opioids.					
When I have naloxone available, I am more likely to use opioids.					
When I have naloxone available, I am more likely to take bigger doses of opioids.					
When I use opioids alone and have naloxone, I feel more confident about my safety.					
If I used too much opioids, I would be able to administer naloxone on myself before I lost consciousness.					

Closing

1. Is there anything that you’d like to add before we finish? Anything else about your experiences that you’d like to share? Anything that you think is important that we didn’t talk about? (new Q)

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VERBAL CONSENT INFORMATION SHEET

Cuyahoga County Opioid Use Hotspot Study

You are invited to take part in a research study conducted by Dr. Hoffer and colleagues at Case Western Reserve University. Please ask for an explanation of any words you do not understand.

This study is about illegal drug use. You have been selected as a possible participant in this research because you have identified to us that you currently inject heroin or other opioid drugs.

Background Information

Why is this study being done? Dr. Hoffer and his research team are conducting this study to understand opioid use in Cuyahoga County. A total of 30 people will be invited to participate.

What am I being asked to do? You are being asked to participate in one confidential interview lasting up to 60 minutes. This interview is about your personal experiences using opioid drugs.

Procedures

- 1. Before your interview:** If after reviewing this information sheet you would like to participate, you will be assigned a unique random identification number. This number will not be linked to any of your personal information. We will not collect any of your personal information such as your real name, address, or phone number.
- 2. The interview:** You will participate in an interview that will last approximately 60 minutes. You will be asked questions about your past and current drug use and your knowledge of local drug use beliefs and practices.

It is important to understand two things about the interview: 1) we are not interested in, and will not ask for, the names of any specific people, and 2) YOUR NAME WILL NEVER BE ASSOCIATED WITH ANYTHING YOU SAY DURING ANY INTERVIEW.

How long will I be in the study? You will be participating in one interview that will last approximately 60 minutes.

Risks and Benefits to Being in the Study

- 1. Risks:** There are risks associated with participating in this study, but they are rare. You may find some of the topics of the interviews make you uncomfortable because of their personal nature, because they may bring to mind unpleasant memories, or because they ask you about illegal behaviors you have participated in. You may refuse to discuss

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any topic or refuse to answer any individual question that makes you uncomfortable.

The risk that confidentiality could be broken is a serious concern, but very unlikely to occur. To protect confidentiality, you will be given a number to identify your data in this study. Additionally, we will not collect any personal, identifying information from you, and there will be no paper record of your participation in the study. We also request that you refrain from mentioning names of dealers, associates, friends, etc.

2. **Benefits:** There are no direct benefits to you for participating in this study. You will have the opportunity to participate in a research project, which may lead to improvements in delivering intervention and prevention programs to opioid users. You also may feel personal satisfaction from having the opportunity to discuss your experiences with the researcher interviewing you for this study. Our intent is to make your participation in this study comfortable and non-threatening.

Compensation

There are no costs for you to participate in this study. You will be paid \$20 cash if you complete the interview to compensate you for your time and effort.

Confidentiality

The research team will only use and share your information as talked about in this form. The research team will also make sure information cannot be linked to you (de-identified). De-identified information may be used and shared for other purposes not discussed in this consent form.

This study is sponsored by a research grant from the National Institutes of Health. Representatives of the sponsor will have access to your research records for monitoring the study. The research team also will send study results to the sponsor. Information sent to the sponsor will be de-identified. The sponsor will protect the confidentiality of your information and will only use data to complete federal responsibilities for audit or evaluation of this study.

Voluntary Nature of the Study

Taking part in this research is completely voluntary. You may choose not to take part in this research study or you may withdraw your consent at any time. If you choose not to participate, it will not affect your current or future relations with Case Western Reserve University or Circle Health Services. There is no penalty or loss of benefits for not participating or for discontinuing your participation. However, you will only be paid if you complete the interview.

Contacts and Questions

The researchers conducting this study are Dr. Lee Hoffer and his research team. You may ask any questions you have now. If you have any additional questions, concerns or complaints about the study, you may contact Dr. Hoffer directly at (216) 368-2631.

If the researchers cannot be reached, or if you would like to talk to someone other than the researchers about (1) questions, concerns or complaints regarding this study; (2) research

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participant rights; (3) research-related injuries; or (4) other human subjects issues, please contact Case Western Reserve University's Institutional Review Board at (216) 368-6925 or write: Case Western Reserve University, Institutional Review Board, 10900 Euclid Ave., Cleveland, OH 44106-7230.