Acceptability of Heroin-Assisted Treatment and Supervised Drug Consumption Sites to Address the Opioid Crisis in the United States

Key Informant Perspectives

Allison J. Ober, Jirka Taylor, Martin Y. Iguchi and Jonathan P. Caulkins

RAND Health Care and RAND Social and Economic Well-Being
Preface

Current levels of opioid-related morbidity and mortality in the United States are staggering. Data for 2017 indicate that there were more than 47,000 opioid-involved overdose deaths (roughly similar to deaths from AIDS at its peak in 1995), and 1 in 8 adults now report having had a family member or close friend die from opioids. There has been a near universal call from blue-ribbon commissions and expert panels for increasing access to Food and Drug Administration-approved medications for those with an opioid use disorder; however, jurisdictions addressing opioid use disorder and overdose may wish to consider additional interventions beyond increasing access to these medications. Two interventions that are implemented in some other countries but not in the United States are heroin-assisted treatment (HAT) and supervised consumption sites (SCSs). Given the severity of the opioid crisis, there is urgency to evaluate tools that might reduce its impact and save lives.

This working paper is part of a series of reports assessing the evidence on and arguments made about HAT and SCSs and examining some of the issues associated with implementing them in the United States. The target audiences include decision makers in rural and urban areas grappling with opioids as well as researchers and journalists. This document is a report on key informant views on the acceptability and feasibility of implementing HAT and SCSs in selected U.S. jurisdictions heavily affected by the opioid crisis. The other parts of this series of reports include: (1) a summary report of all the components of the research study; (2) a review of the HAT literature; (3) a review of the SCS literature, and (4) a report on international experience with the implementation of HAT and SCSs.

RAND Ventures

The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

RAND Ventures is a vehicle for investing in policy solutions. Philanthropic contributions support our ability to take the long view, tackle tough and often-controversial topics, and share our findings in innovative and compelling ways. RAND’s research findings and recommendations are based on data and evidence, and therefore do not necessarily reflect the policy preferences or interests of its clients, donors, or supporters.

Funding for this venture was provided by gifts from RAND supporters and income from operations. The research was conducted under RAND Health Care and RAND Social and Economic Well-Being research units.
## Contents

Preface ............................................................................................................................................. ii
Tables .............................................................................................................................................. v
Executive Summary ....................................................................................................................... vi
Acknowledgments ........................................................................................................................ xiii
Abbreviations ............................................................................................................................... xiv
1. Introduction ................................................................................................................................. 1
2. Methods....................................................................................................................................... 1
   Site selection ............................................................................................................................................. 1
   Recruitment and data collection procedures ..................................................................................... 2
   Interviews ............................................................................................................................................. 2
   Provider and PWUO Focus Groups ..................................................................................................... 3
   Study Participants ..................................................................................................................................... 3
   Qualitative Data Analysis ......................................................................................................................... 4
   Limitations ................................................................................................................................................ 5
3. The Counties ............................................................................................................................... 6
   Ashtabula County, Ohio ........................................................................................................................... 7
   Carroll County, New Hampshire .............................................................................................................. 8
   Cuyahoga County, Ohio ........................................................................................................................... 9
   Hillsborough County, New Hampshire .................................................................................................. 10
4. Key Informant Perspectives about HAT ................................................................................... 11
   Overview ................................................................................................................................................ 11
   Do key informants believe HAT could help improve outcomes for PWUO? ........................................ 11
      Reasons HAT could help improve outcomes ..................................................................................... 12
      Reasons HAT might not help improve outcomes ............................................................................. 17
      Not sure if HAT would help improve outcomes ................................................................................ 24
   Do key informants believe HAT would be acceptable to community members? ................................ 25
   What might facilitate community acceptance and implementation of HAT? ....................................... 37
   HAT Summary ....................................................................................................................................... 45
5. Key Informant Perspectives about SCSs .................................................................................. 46
   Overview ................................................................................................................................................ 46
   Do key informants believe SCSs could help improve outcomes for PWUO? ........................................ 46
      Reasons SCSs could help improve outcomes ..................................................................................... 47
      Reasons SCSs might not help improve outcomes ............................................................................. 53
      Not sure if SCSs would help improve outcomes ................................................................................ 61
   Do key informants believe SCSs would be acceptable to community members? ............................... 61
   What might facilitate community acceptance and implementation of SCSs? ..................................... 73
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of SCS findings</td>
<td>77</td>
</tr>
<tr>
<td>6. Summary and Key Findings</td>
<td>79</td>
</tr>
<tr>
<td>References</td>
<td>83</td>
</tr>
<tr>
<td>Appendix A. Key informant interview questions</td>
<td>87</td>
</tr>
<tr>
<td>Appendix B. PWUO focus group questions</td>
<td>91</td>
</tr>
<tr>
<td>Appendix C. Provider focus group questions</td>
<td>94</td>
</tr>
</tbody>
</table>
Tables

Table 1. All HAT Themes Cited by Key Informants (Professionals and PWUO).............................. vii
Table 2. All SCS Themes Cited by Key Informants (Professionals and PWUO)............................ ix
Table 3. Characteristics of selected counties.................................................................................. 2
Table 4. Interviews by type and county.......................................................................................... 3
Table 5. Focus groups by type and county (and number of participants)........................................ 4
Table 6. Client focus group participant characteristics.................................................................... 4
Table 7. Could HAT Help Improve Outcomes for PWUO? All Themes Cited by Key Informants (Professionals and PWUO)................................................................. 11
Table 8. Do Key Informants Believe HAT Would be Acceptable to the Community? All Themes Cited by Professionals and PWUO............................................................................................. 25
Table 9. Could SCSs Help Improve Outcomes for PWUO? All Themes Cited by Key Informants (Professionals and PWUO)....................................................................................................................................... 46
Table 10. Do Key Informants Believe SCSs Would be Acceptable to the Community? All
Themes Cited by Professionals and PWUO....................................................................................... 62
Summary

This study sought key informant perspectives on two programs designed to help address the opioid crisis that have been legally sanctioned in other countries but not yet in the U.S.: heroin-assisted treatment (HAT) and supervised drug consumption sites (SCS). Heroin (more formally referred to as diamorphine or diacetylmorphine) has been prescribed in other countries for people whose opioid use disorder (OUD) has proved refractory to other treatments. The premise is similar to the use of well-studied and long-accepted medications such as methadone: Offer a legal, quality controlled, free or low-cost pharmaceutical opioid as a replacement for expensive illicit market opioids whose potency and adulterants are potentially dangerous and whose sale enriches criminal organizations. Supervised consumption sites (also known as drug consumption rooms, safe consumption sites, or safe injection facilities) are places where users can consume already-purchased street drugs using free clean injection supplies in the presence of trained staff who monitor for overdose or risky injection practices and intervene when necessary. Some SCSs also provide additional services, including referrals to treatment and access to drug testing kits (which can identify dangerous adulterants, such as fentanyl, in bags sold as heroin).

HAT and SCSs have been implemented in several European countries and in Canada; Australia opened an SCS in 2001 and considered HAT but did not deploy it. However, there are barriers to implementing each in the United States. Heroin is listed as a Schedule I drug under the U.S. Controlled Substances Act (CSA), meaning it has no currently accepted medical use and so cannot be prescribed; however, it is possible to conduct human research with heroin and other Schedule I drugs. The legal status of SCSs is also problematic since the CSA forbids anyone from making any place available, “with or without compensation, … for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance” (21 U.S.C. §856), but states may nonetheless have authority to operate SCSs under their police powers since protecting public health is a power reserved to the states (Beletsky et al., 2008). Despite these legal ambiguities, more than a dozen U.S. cities are having discussions about allowing SCSs and some are projected to open soon (Lopez, 2018).¹

This study aimed to assess whether HAT and SCSs are acceptable ways to help address the opioid crisis and feasible to implement in communities in the United States that have experienced high rates of opioid overdose deaths. As such, this report represents findings from a novel examination of the feasibility of HAT in the United States and expands an existing literature on the feasibility of SCSs to include additional communities in United States currently in crisis. We conducted a series of interviews and focus groups with key informants in Ohio and

¹ There is at least one unsanctioned supervised consumption site operating in the U.S. (Kral and Davidson, 2017).
New Hampshire, two states ranked among the top three in the country by age-adjusted opioid overdose death rates. Consulted key informants included people who use opioids (PWUO) as well as other stakeholders identified because of their professional occupation (henceforth referred to as “professionals”), such as public health officials, criminal justice representatives, etc. Within each state, we focused on one rural and one urban county. Interviews and focus groups were designed to capture key informants’ perspectives about the nature and extent of the opioid crisis in each county, current efforts to address the crisis, gaps in services for people who use opioids, and perspectives about the potential effectiveness of SCSs and HAT for helping address the crisis and acceptability of both programs to community members. This report is part of a five-component report on HAT and SCSs that consists of the following (1) a summary report of all components; (2) a review of the HAT literature; (3) a review of the SCS literature, and (4) a report on international experience with the implementation of HAT and SCSs. All components can be found here: http://www.rand.org/hat-scs. In this report we present findings from U.S.-based key informant interviews and focus groups.

**Key HAT Findings**

Key informants in both individual interviews and focus groups were invited to comment on whether they thought HAT could help improve outcomes for people who use opioids (PWUO) and whether they believed HAT would be acceptable to the community. Table 1 lists all themes that emerged and their frequency (i.e., low, medium, high, or very high frequency is indicated if the theme emerged in 1-25%, 26-50%, 51-75%, or 76-100% of transcripts, respectively) that answer the two questions above. The denominator is the number of transcripts, not participants. If multiple focus group participants mentioned a theme, it was only counted once. We include an indicator of frequency to show how the emergence of themes differed between professionals and PWUO.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Professionals* N=80</th>
<th>PWUO* N=79</th>
</tr>
</thead>
<tbody>
<tr>
<td>Could HAT Help Improve Outcomes for PWUO?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reasons HAT could help improve outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HAT programs would provide clients with a drug with known composition</td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td>HAT may be suitable for those who tried previous treatment</td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td>HAT represents another option for opioid substitution therapy</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>PWUO would benefit from medical supervision</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Reasons HAT might not help improve outcome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HAT programs would enable/perpetuate drug use</td>
<td>Low</td>
<td>High</td>
</tr>
</tbody>
</table>

2 The definition of HAT used by interviewers and focus group facilitators to describe the intervention to key informants who were not familiar with HAT is listed in the interview and study protocols in Appendices A-C.
| Prescription heroin would be used alongside street drugs | Low | High |
| Gaps in HAT provision (e.g., due to insurance lapses) would be problematic | Low | Medium |
| PWUO may not be trusting of a HAT program | Low | N/A |
| HAT may give rise to staff safety issues | Low | Low |
| **Not sure if HAT would help improve outcomes** | | |
| Need to see evidence to comment on effectiveness | Medium | N/A |

### Would HAT Be Acceptable to the Community?

| Would HAT Be Acceptable to the Community? | High | Low |
| HAT implementation would be impeded by community values, and local culture | | |
| Community would think that HAT enables/perpetuates use | Low | Low |
| Community members would be concerned about neighborhood effects | Low | Low |
| Community members would be open to HAT as an extension of existing MT options | Low | Low |
| Community members would be concerned about diversion of prescription heroin | Low | N/A |
| Community would be in favor of providing PWUO with a drug with known composition | Low | N/A |
| PWUO face stigmatization in their communities | Low | Low |
| Community members would be reluctant to provide funding | Low | Low |

**NOTES:** N/A: Not applicable; theme did not arise in any transcripts; Low frequency: Theme arose in 1–25% of transcripts; Medium frequency: Theme arose in 26–50% of transcripts; High frequency: Theme arose in 51–75% of transcripts; Very high frequency: Theme arose in 76–100% of transcripts.

*Professionals include all non-PWUO key informants who participated in an interview (N=44) or focus group (N= 5 groups and 36 providers) who were invited to participate based on their current profession; it is acknowledged that some PWUO might also be "professionals"*

**PWUO who participated in 10 focus groups**

1. **Interviewed professionals and provider focus group participants suggested that HAT programs could potentially improve outcomes for PWUO, but expressed concerns about the program enabling opioid use.** Among the most frequently mentioned benefits of HAT were providing PWUO with a drug of known composition and offering a potentially suitable option for PWUO who have tried but have not succeeded with other treatments. With respect to perceived drawbacks, professionals primarily expressed concern that HAT programs would enable drug use and do little to address the individual’s underlying addiction problem.

2. **PWUO currently engaged with treatment services for their opioid use were more skeptical of the effectiveness of HAT than other key informants.** PWUO in focus groups expressed concerns that HAT would enable drug use and street drugs would continue to be used alongside HAT. PWUO who were actively using opioids and not currently in treatment were the most open to HAT, particularly with respect to the fact that HAT clients would be prescribed a safe drug, although these PWUO also identified a series of potential drawbacks. PWUO in particular, along with some other key informants, also expressed concern that any gaps in continuity caused by capacity or insurance issues could result in being dropped from treatment and left with an active addiction, similar to the experience many had with prescription opioids.

3. **Despite potential benefits for some PWUO, both professional and PWUO key informants suggested that HAT implementation may not be feasible due to practical and legal concerns and potentially to community resistance.** The most frequently cited reason that HAT likely would be difficult to implement was the belief that potential implementation would be impeded by local community values and culture, as well as stigma toward PWUO, impediments that have been common in attempting to establish
needle exchange programs (NEP) and other programs for PWUO. Other, albeit less frequently mentioned obstacles to HAT acceptability included local opposition around siting of the program (referred to by key informants as “NIMBYism,” reflecting the acronym for the colloquialism “not-in-my-backyard,”) as well as concerns surrounding the diversion of prescribed heroin.

4. **Making evidence on HAT effectiveness available to community stakeholders is considered critical to any debate surrounding HAT.** Approximately a third of interviewed professionals expressed desire to learn about the evidence underlying HAT programs. Other key informants (both professionals and PWUO) suggested that community education about HAT and the evidence of its effectiveness (to the extent that it exists) would be required to even begin the argument for the implementation of HAT and to influence the corresponding policy debate. A related observation made by some interviewed professionals was that emphasizing the medical nature of HAT may be effective in addressing some concerns community stakeholders may have. Several interviewed professionals pointed out that a small-scale pilot program may be useful to demonstrate how a HAT service operates and examine whether it can be effective in improving outcomes for PWUO, and whether it is acceptable to the community.

**Key SCS Findings**

Key informants in both individual interviews and focus groups were invited to comment on whether they thought SCSs could help improve outcomes for PWUO and whether they believed SCSs would be acceptable to the community. Table 2 lists all themes that emerged and their frequency (i.e., low, medium, high, or very high frequency is indicated if the theme emerged in 1-25%, 26-50%, 51-75%, or 76-100% of transcripts, respectively) that answer the two questions above. The denominator is the number of transcripts, not participants. If multiple focus group participants mentioned a theme, it was only counted once. We include an indicator of frequency to show how the emergence of themes differed between professionals and PWUO.

**Table 2. All SCS Themes Cited by Key Informants (Professionals and PWUO)**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
<th>Professionals N=80</th>
<th>PWUO** N=79</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Could SCSs Help Improve Outcomes for PWUO?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCSs could help prevent overdose deaths</td>
<td>Medium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCSs could help link PWUO to treatment and other resources</td>
<td>Medium</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>SCSs could provide PWUO with a safe, nonjudgmental place to use</td>
<td>Low</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>SCSs could provide clean needles and information to prevent HIV, HCV and abscesses</td>
<td>Low</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>SCSs could provide drug composition testing</td>
<td>Low</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td><strong>Reasons SCSs might not help improve outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PWUO would view it as a law enforcement trap</td>
<td>Medium</td>
<td>High</td>
<td></td>
</tr>
</tbody>
</table>

3 The definition of SCSs used by interviewers and focus group facilitators to describe the intervention to key informants who were not familiar with HAT is listed in the interview and study protocols in Appendices A-C.
| SCSs would be stigmatizing for PWUO | Medium | Medium |
| PWUO would be reluctant to travel to an SCS after purchasing drugs; they want to use immediately | Low | High |
| SCSs would enable/perpetuate opioid use | Medium |
| SCSs would create a forum for drug dealers | Low | Medium |
| PWUO do not want to be monitored while using | Low | Low |
| SCSs increase risks for PWUO | Low | Low |

**Not sure if SCSs would help improve outcomes**

Need to see more evidence | Medium | Low |

### Would SCSs Be Acceptable to the Community?

| SCS implementation would be impeded by community values and local culture | Medium | Medium |
| Community members would believe SCSs enable/perpetuate use | Medium | Low |
| Community would say “Not in my Backyard” (NIMBY) | Medium | Low |
| Stigma against PWUO would impede implementation | Medium | Medium |
| SCSs are not a priority in the community right now | Medium | Low |
| There might be more buy-in for SCSs in “less rural” areas | Low | N/A |
| Rural communities do not have the resources to implement SCSs | Low | N/A |
| Community members would believe SCSs normalize opioid use | Low | Low |
| SCSs would affect neighborhoods and community resources | Low | Low |
| SCSs would “clean up” the streets and reduce strain on police and EMS | Low | Low |

**NOTES:** N/A: Not applicable; theme did not arise in any transcripts; Low frequency: Theme arose in 1–25% of transcripts; Medium frequency: Theme arose in 26–50% of transcripts; High frequency: Theme arose in 51–75% of transcripts; Very high frequency: Theme arose in 76–100% of transcripts.

*Professionals include all non-PWUO key informants who participated in an interview (N=44) or focus group (N= 5 groups and 36 providers) who were invited to participate based on their current profession; it is acknowledged that some PWUO might also be “professionals” **PWUO who participated in 10 focus groups.

1. **Both professional and PWUO key informants noted harm reduction benefits to SCSs, but also perceived drawbacks such as that it may enable opioid use, and practical barriers, including PWUO lack of desire to travel to an SCS after purchasing opioids.** Among the main benefits noted were preventing overdose and disease, and providing treatment linkage, a safe, judgement-free place for PWUO to use, and drug composition testing. Some professionals and PWUO also thought SCSs would enable or perpetuate opioid use. PWUO in all focus groups, rural and urban, saw SCSs as impractical due to the time needed to travel to an SCS after purchasing drugs, with rural PWUO emphasizing its impracticality due to overall transportation challenges. PWUO also worried SCSs would be a law enforcement trap for PWUO; this concern was also anticipated by professionals. Some PWUO currently receiving MT noted that SCSs could provide a safe place to use while waiting to get into treatment.

2. **Despite supporting some benefits of SCSs, interviewees and focus group participants generally believed that their communities as a whole likely would not currently accept SCSs as a viable strategy for helping address the opioid crisis due to cultural, resource, and practical barriers.** Although this view was particularly salient among informants from the rural counties, neither of which currently has a NEP, or adequate naloxone distribution, detoxification services, treatment provision, or sober living facilities, even urban informants who supported the concept felt that an SCS in their community was not the current priority for addressing the opioid crisis. Key informants generally believed that putting funding into evidence-based programs that already have gained traction with community members would be a more prudent investment of limited available resources. Moreover, key informants cited multiple reasons that SCSs likely might not be acceptable to community members, including conservative cultural
landscapes, lack of endorsement of a harm reduction approach to opioid use disorder, long-standing stigma and fear around addiction, and general “NIMBYism” around placing such facilities in areas that would be accessible to PWUO.

3. **Despite cultural and policy-related barriers, implementation may be more feasible in more urban communities with existing (and perhaps more long-standing) harm reduction programs, greater treatment resources, and adequate transportation, particularly if there is evidence to support it.** Although some interviewees and focus group participants had reservations about SCSs and believed that their communities have other more pressing priorities, professionals in the two urban communities were more inclined to believe that with education and evidence, SCSs could eventually be accepted by community members, as NEP and MT have been accepted, at least by key stakeholders and policy makers. This was particularly the case in Cuyahoga County, where there has been a NEP since 1995, first legal through local emergency orders, and then legalized statewide in 2013. These interviewees tended to believe that with time and persistence, like MT and NEP, SCSs likely would be adopted.

4. **As with HAT, publication of evidence on SCSs and community education were seen as essential in fostering community acceptance of SCSs.** A number of key informants (both professionals and PWUO) expressed belief that more education around SCS and more published evidence would facilitate acceptance and generate potential community buy-in, on the assumption there is adequate evidence of SCS effectiveness. This call for more evidence was also made by key informants who were skeptical of SCSs or expressed reservations about the SCS model. Among other steps that could help address community concerns towards SCSs were integrating the service with an existing medical facility and introducing a mobile supervision service, with the perceived dual benefit of reaching PWUO who may not come to a fixed SCS and of minimizing neighborhood concerns associated with a fixed SCS location. However, neither of these steps was fully endorsed as adequate for addressing community concerns.

Conclusions

Interviews and focus groups with key informants across four counties in two states with among the highest opioid overdoses deaths in the U.S. suggest that both programs—HAT and SCSs—hold several potential benefits for PWUO, including reducing overdose deaths and keeping PWUO safe from infectious diseases; at the same time, each program gives rise to a range of concerns, chief among them enabling drug use and likely community resistance, both of which could limit implementation at the present time. Nevertheless, some key informants suggested this situation may change over time, particularly in more urban areas with relatively strong service provision. For SCSs, key informants in the urban counties noted similarities with the establishment of NEP and acceptance of MT, and thought that while the program might meet resistance among community members, in time, like the NEP and MT, the program could be increasingly accepted. Key informants in rural counties suggested that their communities are unlikely to embrace these programs before the counties have established NEP and adequate treatment services for PWUO and noted practical barriers such as lack of anonymity for PWUO and poor transportation. Indeed, with regard to SCSs in particular, PWUO from all counties
expressed practical concerns, such as not wanting to travel after purchasing opioids and viewing the SCSs as a law enforcement trap, which could limit use of SCSs, especially in smaller communities. Professionals thought one aspect of HAT that might make it acceptable to community members is that it is a medical intervention, conceivably supported by the medical community. Interviewed professionals and provider focus group participants alike almost unanimously indicated that more evidence and removal of legal hurdles is needed for either program to be accepted in any of the four communities and that successful implementation requires more education about substance use disorders and the need to address pervasive stigma against PWUO.
Acknowledgments

We are deeply indebted to more than 150 people who shared their experiences and opinions with us during interviews and focus groups. We are thankful to those in New Hampshire and Ohio who helped us set up the focus groups and to Leo Beletsky for making introductions. We are also very grateful for the detailed feedback we received from Ricky N. Bluthenthal, Susan S. Everingham, Keith Humphreys, Paul Koegel, and Melinda Moore. We also thank Howard Shatz for the tremendous support and advice provided throughout the project. The views presented here are only those of the authors.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>CSA</td>
<td>Controlled Substances Act</td>
</tr>
<tr>
<td>EMS</td>
<td>emergency medical service</td>
</tr>
<tr>
<td>HAT</td>
<td>heroin-assisted treatment</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>OUD</td>
<td>opioid use disorder</td>
</tr>
<tr>
<td>MT</td>
<td>medication treatment</td>
</tr>
<tr>
<td>NEP</td>
<td>needle exchange program</td>
</tr>
<tr>
<td>NIMBY</td>
<td>not in my backyard</td>
</tr>
<tr>
<td>PWID</td>
<td>people who inject drugs</td>
</tr>
<tr>
<td>PWUO</td>
<td>people who use opioids</td>
</tr>
<tr>
<td>QRT</td>
<td>Quick Response Team</td>
</tr>
<tr>
<td>SCS</td>
<td>supervised consumption site</td>
</tr>
</tbody>
</table>
1. Introduction

Current levels of opioid-related morbidity and mortality in the United States are staggering. Data for 2017 indicate there were more than 47,000 opioid-involved overdose deaths (roughly similar to deaths from AIDS at its peak in 1995; Centers for Disease Control and Prevention [CDC], 2011, 2018), and the actual figure is likely 20 percent to 35 percent higher since death certificates do not always list specific drugs (Ruhm, 2018). Further, these fatalities exclude those who die from complications from infectious diseases like human immunodeficiency virus (HIV) or Hepatitis C contracted by sharing injection drug equipment. A number of blue-ribbon commissions and expert panels have made recommendations about how to mitigate the harms from opioids. There has been a near universal call for increasing access to FDA-approved medications for those suffering from opioid use disorder (OUD). Increasing the availability and reducing the costs of these forms of treatment (referred to as medication treatment, or MT, in this report) must remain a top priority.

There are, though, additional options for helping to stem the crisis. Heroin-assisted treatment (HAT) and supervised consumption sites (SCSs) are two interventions that provide services to people who use opioids (PWUO) that have been legally implemented in some international jurisdictions but not in the United States. HAT programs provide legal, quality controlled, free or low-cost pharmaceutical heroin to protect PWUO from seeking illicit market opioids whose potency and purity are not known to the user. HAT programs are offered in Canada and a number of European cities. HAT programs are intended for people who have tried more conventional forms of treatment (e.g., methadone) multiple times and aim to help people stabilize their lives. Other terms are sometimes used to describe HAT, including heroin prescription and heroin-supported treatment.

SCSs refer to facilities where PWUO and other substances can consume already-purchased street drugs in the presence of trained staff (sometimes volunteers, sometimes health professionals), who monitor them for overdose, and receive sterile injection drug use materials. Clients can sometimes test their drugs for adulterants and engage with social services. SCSs have been legally sanctioned in Australia, Canada and a range of European countries. Other terms used to describe SCSs include safe consumption sites, safe injection facilities, overdose prevention sites, and drug consumption rooms.

In addition to literature on the effectiveness of HAT and SCSs which we discuss elsewhere (Smart 2018, Pardo et al. 2018), there is a body of literature that assesses the prospect of introducing SCS services from the perspective of various stakeholder groups, primarily in international but also in some U.S. jurisdictions.

In the Canadian context, the Toronto and Ottawa Supervised Consumption Assessment (TOSCA) study analyzed existing survey data and conducted qualitative research to analyze
attitudes towards a potential SCS (i.e., preceding the establishment of currently existing SCSs in the two cities) from a variety of types of stakeholders. The results were published in the main TOSCA report (Bayoumi et al. 2012) and a series of derivative papers. In one of these papers, Bayoumi et al. (2012) analyzed data from two previous surveys (the Toronto 2006 Enhanced Surveillance of Risk Behaviours among Injecting Drug Users (I-Track), targeting people who use drugs (n=477), and a survey of drug users conducted by Leonard et al. (2008) as part of a needs assessment in Ottawa (n=250) to assess the potential uptake of SCSs in Toronto and Ottawa. The authors found that up to 75% of respondents indicated they would use a supervised injection facility and around 65% of respondents indicated they would be interested in using a supervised smoking facility. SCS use projections were similar in both cities and across both sexes.\(^4\) In follow-up papers, Strike et al. (2014) examined general population survey data to assess trends in community support for a potential SCS. The authors drew on the 2003 (n=1,212) and 2009 (n=968) iterations of the Centre for Addiction and Mental Health (CAMH) Monitor surveys. These annual representative surveys ask approximately 2,000 Ontarians, selected via a two-stage probability design, about substance misuse, mental health and their opinion on various policies. The authors found that support for the implementation of SCSs in the province increased between 2003 and 2009, although the majority of respondents continued to hold mixed views (defined as not agreeing or disagreeing uniformly with four statements regarding potential benefits of SCSs). In another paper from the same study, Watson et al. (2013) reported results of consultations with people who use drugs and other stakeholders on whether SCSs should be established in Toronto and Ottawa and, if so, how it should be implemented. The authors held 28 focus groups and 26 one-on-one interviews with 236 individuals. These included 95 people who used drugs (63 in Toronto and 32 in Ottawa) and 141 other stakeholders (61 in Toronto and 80 in Ottawa), consisting of police and EMS professionals, city employees and officials, business owners, residents, and healthcare providers. People who use drugs generally regarded SCSs positively as a potential source of health and safety benefits. By contrast, other stakeholders expressed skepticism, questioning the need for an SCS in either city. Furthermore, they pointed out several implementation challenges, including political resistance, smoking bylaws, and staff exposure to second-hand smoke (the latter two in relation to the possibility of accommodating smoking in the SCS). Strike et al. (2015) provided further analysis of the data from interviews and focus groups with community stakeholders (n=141) and identified the following reasons for stakeholders’ ambivalence with respect to SCSs: 1) insufficient knowledge about SCSs, 2) lack of clarity whether the community needs an SCS, 3) concerns over the siting of an SCS and

\(^4\) Users’ willingness to use an SCS has been explored in other jurisdictions as well, see, e.g., Fry (2002), Kerr et al. (2003), O’Shea (2007), Hunt et al. (2007), and VanderLaenen et al. (2018). DeBeck et al. (2012) explored whether users’ self-reported willingness to use an SCS is predictive of actual future use. Based on data from a prospective cohort of drug users in Vancouver, BC, they found that previously declared willingness to use an SCS was a significant predictor of actual use (OR = 1.67).
potential damage to communities and businesses, 4) concern SCSs will hamper neighborhood development, 5) opportunity costs of SCSs, which could divert resources from treatment and prevention, 6) need for evaluation and readiness to shut down SCSs in the event of negative results, and 7) concern SCSs does not represent a sufficiently broad response to drug use. In a separate paper, Watson et al. (2012) drew on the same data collection efforts but focused exclusively on how police officers perceived SCSs, based on 18 interviews with law enforcement personnel from Ottawa and Toronto. They noted that police officers were unanimously opposed to the introduction of SCSs in their cities, suggesting that SCSs are not effective in addressing addiction, can undermine policing efforts, and send an ambiguous signal with respect to the acceptability of illicit drug consumption. Watson et al. (2015) also drew on data from the interviews and focus groups with people who use drugs and other stakeholders to examine their perspectives on SCSs and age restrictions. They reported that while the key informants generally agreed on the need to prioritize the safety of young people, there were notable differences in their experiences and the way they viewed the agency of young people. Kolla et al. (2017) also drew on a subset of the data above and explored in greater detail stakeholder sentiments with respect to potential neighborhood effects of an SCS. The authors analyzed data from seven focus groups with 52 participants (residents, community group, and neighborhood representatives) and three one-on-one interviews. The authors observed that while participants recognized potential benefits of an SCS, they were also mindful of potential negative effects at the neighborhood level, particularly the risk of public nuisance.

A few studies in Canada also explored the perspective of stakeholders outside of large cities. Bardwell et al. (2017) examined stakeholders’ views vis-à-vis a potential SCS in London, Ontario. The study was based on interviews with 20 key informants, representing the following sectors: health care, social services, government, police and first responders, and business and community organizations. There was unanimous support for the introduction of an SCS in the city, although some key informants expressed implementation preferences or conditions. These points included a question about whether the SCS should be in a central location (with some key informants in favor and some against), concerns about possible community effects, and strong support for the provision of complementary services as well as long opening hours. Mitra et al. (2017) also focused on a potential SCS in London, Ontario, and conducted a survey of drug users in the city recruited via flyers and peer outreach (n=197). The majority (86%) of users indicated they would be willing to use an SCS. Of these, 63% said they would use it always/usually, with the remaining 37% indicating they would use it sometimes/occasionally. Respondents with unstable housing situation, public injectors, and those injecting opioids and crystal methamphetamine were more likely to report a higher frequency of potential use. Elsewhere, Fischer and Allard (2007) conducted a stakeholder survey as part of their feasibility study on the introduction of an SCS in Victoria, British Columbia. The survey took the form of semi-structured interviews and involved 23 drug users and 45 other stakeholders (health and social care providers, law enforcement, business and community organizations, political and
government representatives). Stakeholders came out strongly in support of the introduction of an SCS, with most recommending a decentralized model with multiple locations and embedded in existing services. At the same time, stakeholders acknowledged potential negative impacts on the community and agreed their minimization was essential. Also in Canada, Katz et al. (2017) conducted a national survey of emergency physicians to gauge their attitudes towards SCSs. The survey received 280 responses of which 250 met inclusion criteria for analysis. The majority (74.5%) of respondents indicated they would support the introduction of SCSs in their communities, 10.8% would not, and 14.7% did not know. An even higher share of respondents would refer their patients to an SCS (84.6%), while 4.3% indicated they would not. In qualitative responses from physicians who were not supportive of SCSs, a frequently mentioned theme was that the current level of evidence did not support their introduction.

In the United States, Kral et al. (2010) conducted a survey of people who inject drugs (PWID) in San Francisco (n=602) to examine their views on the potential introduction of an SCS. A large majority (85%) indicated they would use the facility if it was convenient for them to do so. Among these, 50% reported they would use it every day and 26% indicated they would use it 3-6 days per week. Public injecting in the past 6 months and injection of speedballs were the only variables that were significantly associated with the likelihood of using an SCS. When presented with a series of potential rules for using the SCS, such as time limits for injections and a ban on sharing drugs, most respondents found these acceptable. Exceptions to this finding were a requirement to show ID upon entry, a requirement to live in the neighborhood to be able to use the facility, and the presence of video cameras in the facility.

Also in San Francisco, Wenger et al. (2011) explored community response to a potential introduction of an SCS in the city’s Tenderloin district. To that end, the authors conducted interviews with 20 stakeholders, including community and business organization representatives, law enforcement, service providers, religious leaders, school officials, and politicians. While stakeholders expressed openness to further dialogue regarding any SCS plans, they voiced concerns that the introduction of an SCS could result in a degradation of the neighborhood. To that end, interviewed stakeholders expressed interest in existing evidence of SCSs’ effect on community-level outcomes.

Similar considerations of community acceptability and political factors have also been explored in literature focusing on needle exchange programs (NEPs) in the United States. NEPs are a harm reduction intervention targeting PWUO, the introduction of which has been controversial in some contexts. For instance, Tempalski et al. (2003) examined which factors predict the presence of a NEP in U.S. metropolitan areas. They found political factors and population size to be associated with greater likelihood of having a NEP; by contrast, need for an NEP among the local population of people who use drugs was not found to be a predictor of a community having an NEP. In more recent studies, Tempalski (2007) and Tempalski et al. (2007) found that the distribution of NEPs in the United States had been shaped by local social and political factors, including structural constraints (e.g., political, legal or economic...
barriers), degree of stigmatization of drug users, and action by local stakeholders and activists. In another study, Tempalski et al. (2007) examined patterns of local opposition to NEPs in the form of “inequitable exclusion alliances,” or institutionalized expressions of socio-economic and political processes that contribute to an ongoing exclusion of vulnerable populations.

This paper follows similar lines of inquiry as those outlined above and explores the views of key informants in the U.S. towards HAT and SCSs. The motivation for doing so stems from the severity of the opioid crisis in the U.S., the different cultural and economic landscape relative to the international jurisdictions where HAT and SCSs have been implemented, the interest in several cities in the U.S. in implementing SCSs in particular (e.g., Philadelphia, Seattle), and the relative dearth of literature on acceptability and feasibility of SCSs in the U.S., particularly in urban and rural areas outside large coastal cities, areas where opioid overdose deaths are highest. To our knowledge, to date no one has assessed the acceptability of HAT in the U.S.

To assess whether HAT and SCSs are viewed as effective ways to help address the opioid crisis and perceived as feasible to implement in communities in the United States that have been hit hard by the opioid crisis, we conducted a series of interviews and focus groups with key informants in Ohio and New Hampshire. Key informants included people who use opioids (PWUO) as well as other stakeholders identified because of their professional occupation (henceforth referred to as “professionals”), such as public health officials, criminal justice representatives, etc. The selection of these states was driven by a desire to gather insights of stakeholders from areas that are hit hard by the crisis (they are two states ranked among the top three in the country by age-adjusted opioid overdose death rates based on 2016 data, the latest year available at the time of the study) and that have thus far not been covered in existing literature, which predominantly focuses on large urban centers. Within each state, we focused on one rural and one urban county. Interviews and focus groups were designed to capture key informants’ perspectives about the nature and extent of the opioid crisis in each county, current efforts to address the crisis, gaps in services for people who use opioids, and perspectives about the effectiveness of SCSs and HAT for helping address the crisis acceptability to community members. All interviewees and focus group participants were asked about both HAT and SCSs; sometimes informants were asked about SCSs first and sometimes they were asked about HAT first. We sought to answer the following questions.

1. Do key informants believe HAT and SCSs could improve outcomes for PWUO?
2. Do key informants think HAT and SCSs would be acceptable in their community?
3. What might facilitate community acceptance and implementation of HAT and SCSs?

---

5 We are mindful that at least some of consulted PWUO may also be “professionals”. The use of “professional” in this report is not a comment on any individual’s job status; rather, it is meant to capture the fact that one group of key informants were invited to inform the research project on the grounds of their occupation.
This report contains 6 chapters. In Chapter 2 we describe our methods, including site selection, recruitment, data collection, and participant characteristics. Chapter 3 provides a brief overview of the opioid crisis in each county, as well as key informant perceptions of the crisis and gaps in services for people who use opioids (PWUO). Chapters 4 and 5 describe key informant perspectives on the effectiveness and acceptability of HAT and SCSs, respectively. Chapter 6 provides a summary of the study’s findings.

This report is part of a five-component report on HAT and SCSs that consists of the following: (1) a summary report of all components; (2) a review of the HAT literature; (3) a review of the SCS literature, and (4) a report on international experience with the implementation of HAT and SCSs. All components can be found here: http://www.rand.org/hat-scs.
2. Methods

Site selection

We focused on one rural and one urban county within each of two states with the highest opioid overdose deaths. Our main goal was to target both urban and non-urban jurisdictions that have been hit hard by illicitly-supplied opioids, and to select counties that would allow for regional and racial diversity. At the time of selection, the most recent mortality data available for state-level comparisons were the 2016 age-adjusted opioid overdose death rates from the CDC. New Hampshire and Ohio ranked #2 and #3, respectively (#1 was Ohio’s neighbor West Virginia). In Ohio, using 2016 CDC data, Cuyahoga County (which includes Cleveland) had the largest number of opioid deaths as well as the largest per capita rate among Large Metropolitan Counties. Further, given our interest in having racial diversity in our sample, Cuyahoga was a logical choice because the county is 31% Black, making it more diverse than other counties in either state. Among nonmetropolitan counties (i.e., those defined by the NCHS urban-rural county classification scheme as micropolitan and noncore), Ashtabula County was tied for the largest absolute number of opioid deaths and the top 5 for rates. In New Hampshire, analyses of CDC data found that Hillsborough County (which includes the city of Manchester and Nashua, the state’s two largest cities) had the largest absolute and per capita figures for opioid deaths in the state. Among nonmetropolitan counties, Carroll County had the highest rate and the absolute number (14) was similar to other nonmetropolitan counties in New Hampshire except for Merrimack County, which had 34 overdose deaths. Since Merrimack includes the capital and has a population of approximately 150,000, a larger population than desired for the rural county, we chose Carroll. The characteristics of all four selected counties are summarized in Table 3.

---

6 Due to budgetary constraints, we had to limit our inquiry to four counties but still aimed to ensure diversity in our site selection.

7 We felt it important to ensure some degree of racial diversity in the selected sample to capture key informant perspectives that may be reflective of various racial disparities pertaining to the opioid crisis and aspects such as drug arrests or possible differences in users’ attitudes towards services for opioid users (see e.g., Howard et al. (2010) for a brief overview of literature on possible attitudinal factors in race disparities in methadone treatment).

8 The reason for selecting NH and not OH was a desire to have some geographical variation in the selected jurisdictions. The reason for selecting OH and not WV was twofold. First, the absolute number of total opioid deaths in OH is many times higher than in WV. Second, the selection of OH offers the possibility to select a county that is more racially diverse than is the national average.
Table 3. Characteristics of selected counties

<table>
<thead>
<tr>
<th>County</th>
<th>Population (2016)</th>
<th>Opioid-related deaths per 100,000 people (2016)</th>
<th>Ranking in counties in opioid overdose death rate in the state</th>
<th>Percent white (2017 estimate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carroll County, NH</td>
<td>47,289</td>
<td>29.605</td>
<td>#4 out of 10 (#1 among nonmetro)</td>
<td>97.1%</td>
</tr>
<tr>
<td>Hillsborough County, NH</td>
<td>407,761</td>
<td>42.917</td>
<td>#1 out of 10</td>
<td>90.7%</td>
</tr>
<tr>
<td>Ashtabula County, OH</td>
<td>98,231</td>
<td>38.684</td>
<td>#13 out of 88 (#4 among nonmetro)</td>
<td>93.2%</td>
</tr>
<tr>
<td>Cuyahoga County, OH</td>
<td>1,249,352</td>
<td>40.021</td>
<td>#10 out of 88 (#1 among large central metro)</td>
<td>63.8%</td>
</tr>
</tbody>
</table>

Source: CDC, U.S. Census Bureau

Recruitment and data collection procedures

Interviews

We conducted telephone interviews with state- and county-level key informants working in professions relevant to the opioid crisis. We identified initial key informants by word of mouth and internet searches on Google for individuals involved in efforts to address the opioid crisis. We then asked everyone we interviewed to recommend additional professionals at the state- or county- levels who were familiar with the opioid crisis and, asked them to provide contact information. Key informants included representatives from state and local government, and criminal justice, harm reduction (including first-responders), medical, social service, and substance use disorder professions. We first sent an introductory email to all potential interview participants describing the study and inviting them to participate in a 45-60-minute telephone interview. If participants did not respond immediately, we sent 1-2 additional follow-up emails, and followed up with a telephone call. If participants were willing, we set up a time to conduct the interview.

We developed interview and focus group protocols (see Appendices A-C) that were designed to capture the following information: (1) Perspectives on the nature and extent of the opioid problem within the county; (2) current services for PWUOs and gaps in services; (3) prior knowledge of and opinions about the effectiveness of HAT and SCSs; (4) opinions about whether HAT and SCSs would be acceptable to community members; (5) facilitators, if any, that could increase the acceptability of HAT and SCSs; and (6) any additional recommendations for addressing the opioid crisis. We first asked broad, open-ended questions within each domain to capture a range of perspectives, and then probed for more detailed responses. All interviews and focus groups were recorded and then transcribed.

Two members of the research team conducted each interview, with one leading the interview and the other primarily taking notes. The interviewer read a consent form aloud and requested
verbal consent from the participant to participate in the interview and to be recorded. All interviews were recorded and transcribed. The study was approved by the RAND Human Subjects Protection Committee (HSPC).

**Provider and PWUO Focus Groups**

We established contacts with social service, harm reduction, recovery, and substance use disorder treatment professionals in each county (some of whom were recommended by prior interviewees) who facilitated planning of four types of focus groups: (1) frontline service providers (i.e., people who regularly have face-to-face contact with PWUO; (2) PWUO who are actively using and not currently in treatment; (3) PWUO currently in treatment at a facility that offered medication treatment (MT); (4) PWUO currently in treatment at a facility that did not offer MT. Our community contacts helped establish dates and times for the groups and facilitated recruitment. The contacts sent pre-written, IRB-approved email invitations to all potential provider focus group participants and distributed IRB-approved flyers to potential PWUO focus group participants. All participation was voluntary and anonymous, in that we did not collect participant names during the focus groups and did not link comments with any respondent identifiers. Providers and PWUO each were asked to complete a brief, anonymous survey to capture background characteristics. All focus group participants were provided with a meal during the focus groups. PWUO also were given a $25 gift card for participating. The groups were conducted by two members of the research team; one served as the facilitator and the other primarily took notes. The facilitator read the consent form aloud prior to the groups and asked for verbal consent to participate and to be recorded. All focus groups were recorded and transcribed.

**Study Participants**

<table>
<thead>
<tr>
<th></th>
<th>New Hampshire</th>
<th></th>
<th>Ohio</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State</td>
<td>Rural</td>
<td>Urban</td>
<td>State</td>
<td>Rural</td>
</tr>
<tr>
<td>Criminal Justice Professional (including Law Enforcement)</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Harm Reduction Professional (including First Responders)</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medical Professional</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Policy Professional</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Treatment Professional</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2</td>
<td>7</td>
<td>9</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>
Table 5. Focus groups by type and county (and number of participants)

<table>
<thead>
<tr>
<th></th>
<th>New Hampshire</th>
<th>Ohio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State Rural</td>
<td>Urban</td>
</tr>
<tr>
<td>Service Provider</td>
<td>0</td>
<td>1 (7)</td>
</tr>
<tr>
<td>PWUO Active</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PWUO MAT</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PWUO Non-MT</td>
<td>0</td>
<td>2 (14)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0</td>
<td>3 (21)</td>
</tr>
</tbody>
</table>

Table 6. Client focus group participant characteristics

<table>
<thead>
<tr>
<th></th>
<th>Carroll (rural NH, n=14)</th>
<th>Hillsborough (urban NH, n=19)</th>
<th>Ashtabula (rural OH, n=28)</th>
<th>Cuyahoga (urban OH, n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age</td>
<td>36</td>
<td>31</td>
<td>36</td>
<td>35</td>
</tr>
<tr>
<td>Percent male</td>
<td>50%</td>
<td>53%</td>
<td>54%</td>
<td>44%</td>
</tr>
<tr>
<td>Percent white</td>
<td>100%</td>
<td>79%</td>
<td>89%</td>
<td>78%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>7%</td>
<td>26%</td>
<td>10%</td>
<td>17%</td>
</tr>
<tr>
<td>High school</td>
<td>50%</td>
<td>32%</td>
<td>48%</td>
<td>33%</td>
</tr>
<tr>
<td>Some college</td>
<td>36%</td>
<td>32%</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>College degree</td>
<td>7%</td>
<td>11%</td>
<td>10%</td>
<td>17%</td>
</tr>
<tr>
<td>Currently or previously used opioids (other than medically prescribed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td>79%</td>
<td>74%</td>
<td>78%</td>
<td>83%</td>
</tr>
<tr>
<td>Percocet, Oxycontin, Oxycodeone</td>
<td>50%</td>
<td>42%</td>
<td>39%</td>
<td>61%</td>
</tr>
<tr>
<td>Vicodin, Norco, Hydrocodone</td>
<td>43%</td>
<td>37%</td>
<td>32%</td>
<td>61%</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>71%</td>
<td>79%</td>
<td>39%</td>
<td>56%</td>
</tr>
<tr>
<td>Suboxone</td>
<td>43%</td>
<td>42%</td>
<td>25%</td>
<td>44%</td>
</tr>
<tr>
<td>Injection as main way of administration</td>
<td>71%</td>
<td>58%</td>
<td>75%</td>
<td>72%</td>
</tr>
<tr>
<td>At least 3 prior treatment episodes</td>
<td>21%</td>
<td>53%</td>
<td>46%</td>
<td>56%</td>
</tr>
</tbody>
</table>

Qualitative Data Analysis

We used standard qualitative methods (Jehn and Doucet 1996, 1997; Miles and Huberman 1994; Ryan and Bernard 2000, 2003; Willms et al. 1990) to identify themes around our primary research questions (effectiveness of HAT and SCSs, acceptability to community members, and potential implementation facilitators). Two research team members read all transcripts to identify themes (overarching categories describing phenomenon under study), looking for repetitions across all key informant interviews and focus groups. Next, they independently developed an initial listing of themes within each broad category, and then developed a codebook listing each
theme accompanied by a detailed description, inclusion/exclusion criteria, and typical examples. Using Dedoose (a qualitative data management program), the two researchers marked areas of text pertaining to each theme. They practiced with a random sample of 20% of transcript sections, coding independently and reviewing together. If coder disagreement revealed ambiguity in the codebook, additional codes were added. Next, both coders worked on new passages independently, after which we measured coder consistency; “good” consistency was obtained, evidenced by a Kappas of .77 (Cohen 1960). Finally, the researchers examined the themes and assessed how the discussion varied qualitatively by key informant type and by county.

Limitations

Our approach has some limitations. Our sample was small and was not selected randomly, thus findings cannot be generalized. “Active use” was defined as self-reported use of illicit opioids and not currently in treatment; we could not independently verify that active users were actively using opioids or not in treatment. While we made an effort to capture a wide range of perspectives, some stakeholder groups, such as politicians, business persons, and representatives of affected families, were not among our key informants. Interviewees and focus group participants were asked to reflect on possible support or resistance from other stakeholders in the community, views that could be biased by personal beliefs and that seemed to be based on recent experiences with needle exchange program (NEP) and MT implementation. In addition, key informants’ reflections about acceptability of HAT and SCSs by stakeholder groups in the community may be generalizations, and may not reflect variation in acceptability within these groups or the true extent to which various stakeholder groups may be familiar with the concept of HAT or SCSs and associated literature. Last, three key informants who had already participated in telephone interviews were also present in frontline focus groups. Nevertheless, we spoke with multiple types of key informants in each county and themes that arose within counties often were repeated across key informants, suggesting themes that could also arise in other counties exploring feasibility of HAT and SCSs. Still, most areas currently contemplating or about to implement SCSs are large metropolitan areas in coastal states with political and public health contexts different from those of New Hampshire and Ohio. It is plausible that if we had focused our qualitative research on these cities, we would have heard different opinions about feasibility of implementing those programs from PWUO and other key informants.
3. The Counties

This chapter provides more detailed information about each of the four counties selected as focus areas for this report.
Ashtabula County, Ohio

Brief overview (2016 data)

| Population | 98,231 |
| Population density (per square mile) | 71.81 |
| Largest city | Ashtabula |
| Number of all overdose deaths (2016) | 39 (38 opioids) |
| Number of all overdose deaths (per cent change since 2013) | 160% |
| Opioid overdose death rate per 100,000 population | 38.68 |
| Ranking in the state by opioid overdose death rate | #13 out of 88 (#4 among nonmetro) |

Key Informant Perceptions of County Culture and of the Opioid Crisis

**The Culture.** Ashtabula county is located in northeast Ohio. It is the largest county by area in the state but one of the smallest in population, with most of the population density concentrated in the northern part of the county. Key informants described Ashtabula as a county that is struggling economically, given a recent record of job losses, and a population falling either into low or middle-income groups. One interviewee commented that the “margin of social success is so thin in Ashtabula County.” Informants pointed out that there is a history of substance abuse in the area, with the county ranking among the highest in the state in the absolute number of methamphetamine laboratories.

**The Crisis.** Key informants described the opioid crisis as a “widespread problem,” “apocalyptic,” “massive,” and “crippling.” The crisis has impacted people of all ages and backgrounds, although interviewees and focus group participants reported that the age of the affected population is probably decreasing. Key informants identified two broad groups of people using opioids. One group has had intergenerational history of substance misuse, with “very limited resources, family, or friends’ support.” The second group developed their heroin addiction after using prescription opioids. First responders were also highlighted as an affected population, showing signs of strain and fatigue. The influx of fentanyl was described as a “gamechanger,” leading to a spike of overdose deaths. However, some interviewees expressed optimism that overdose deaths may have slowed down since early 2018.

Key Informant Perceptions of Gaps in Current Services for People who use Opioids

**Current Services.** Ashtabula offers a range of services for PWUO, but key informants noted limited capacity and accessibility. There are two residential treatment facilities in the county and three outpatient services, one abstinence-based and two offering MT. The county recently opened an ambulatory detox for Medicaid clients and a walk-in clinic to engage people seeking treatment. The county also created a Quick Response Team (QRT) composed of police and service providers. The QRT follows up with people who overdose, and offers resources and linkage to services. Other factors mitigating the impact of the crisis are Medicaid expansion, intensified community collaboration, improved data collection, and specialized court dockets, as well as cultural shifts among stakeholders, including law enforcement. There is no NEP in the county. All law enforcement personnel carry naloxone.

**Gaps in Services.** Key informants described multiple service needs resulting primarily from capacity and funding constraints. One of the two residential facilities does not accept Medicaid, leaving users without private insurance dependent on the other facility, which has a limited number of beds. This results in long waiting times for PWUO. Among the two MT services, one accepts only Medicaid/Medicare, leaving only one option for people with private insurance. MT is not offered by any hospitals, community health clinics, or private practice prescribers, and there is no Medicaid-accessible residential detoxification center. Key informants also noted that geographical distances and transportation represent a barrier. Another barrier stressed by interviewees is stigma faced by PWUO, exemplified by low uptake of naloxone distribution programs, and lack of early prevention efforts.
Carroll County, New Hampshire

Brief overview (2016 data)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>47,289</td>
</tr>
<tr>
<td>Population density (per square mile)</td>
<td>47.65</td>
</tr>
<tr>
<td>Largest city</td>
<td>Conway</td>
</tr>
<tr>
<td>Number of all overdose deaths (2016)</td>
<td>16 (14 opioids)</td>
</tr>
<tr>
<td>Number of all overdose deaths (per cent change since 2013)</td>
<td>300%</td>
</tr>
<tr>
<td>Opioid overdose death rate per 100,000 population</td>
<td>29.61</td>
</tr>
<tr>
<td>Ranking in the state by opioid overdose death rate</td>
<td>#4 out of 10 (#1 among nonmetro)</td>
</tr>
</tbody>
</table>

Key Informant Perceptions of County Culture and of the Opioid Crisis

**The Culture.** Carroll county is a rural county in northern New Hampshire comprised of seasonal residents of “economic privilege” who live near resorts—ski resorts in the north and Lake Winnipesaukee to the south—as well as permanent residents, many of lower socioeconomic status. Key informants described Carroll as a county of “haves” and “have nots.” Younger permanent residents tend to work multiple jobs in retail, hospitality, and landscaping to afford the high cost of living. According to key informants, 56% of the population earns $15 per hour or less, with rent often exceeding income by 30% or more. The county has no regular public transportation and no cities or city hubs. Key informants described the culture as embracing the state’s “live free or die” motto, and as having an attitude of “take care of your own and pull yourself up by your boot straps...”

**The Crisis.** Opioid deaths per capita put the crisis as the third worst in the state, behind Nashua and Manchester, New Hampshire’s largest cities. Key informants describe the opioid crisis as “pervasive” and “crippling,” and impacting the community in several ways, including increasing crime and straining the workforce. Many described the crisis as getting “exponentially worse” due to the influx of fentanyl and carfentanil. According to key informants, heroin is no longer available for PWUO to purchase, and users now prefer and seek fentanyl because of its greater intensity.

Key Informant Perceptions of Gaps in Current Services for People who use Opioids

**Current Services.** Key informants described current services for PWUO in Carroll county as severely limited, with one 60-bed residential treatment center that until recently only accepted private insurance, two grass-roots recovery centers with outpatient treatment, and a 7-bed sober living house for women. A smattering of primary care practices and a community health center in the northern part of the county and pain clinic in the south part of the county offer MT and there is one MT program for pregnant and post-partum women. Two hospitals reportedly have, or plan to have, recovery coaches available for PWUO. Naloxone is carried by all law enforcement officers and is available at recovery centers.

**Gaps in Services.** Key informants described Carroll County as having a dire lack of services for PWUO. There are no needle exchange programs, no detoxification centers, no residential treatment beds, and only one sober living house. There are 7 licensed alcohol and drug counselors in the entire county, and only a few MT providers. Key informants noted that drawing experts to the county and keeping them is difficult. Hospitals reportedly are reluctant to offer detoxification to PWUO because of stigma against users and the belief that PWUO “ought to be able to help themselves.” Insurance coverage, long waiting lists, and lack of transportation impede access to available services in other parts of the state, and limit continuity of care with MT and other services after treatment. PWUO noted that the lack of immediate access to treatment beds often results in more opioid use. While the recovery centers were considered by all interviewees and focus group participants to be very helpful to PWUO, they run on temporary grant funds, have few resources, and are always at risk of losing their funding.
Cuyahoga County, Ohio

Brief overview (2016 data)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>1,249,352</td>
</tr>
<tr>
<td>Population density (per square mile)</td>
<td>1,003.02</td>
</tr>
<tr>
<td>Largest city</td>
<td>Cleveland</td>
</tr>
<tr>
<td>Number of all overdose deaths (2016)</td>
<td>547 (500 opioids)</td>
</tr>
<tr>
<td>Number of all overdose deaths (per cent change since 2013)</td>
<td>115%</td>
</tr>
<tr>
<td>Opioid overdose death rate per 100,000 population</td>
<td>40.02</td>
</tr>
<tr>
<td>Ranking in the state by opioid overdose death rate</td>
<td>#10 out of 88 (#1 among large central metro)</td>
</tr>
</tbody>
</table>

Key Informant Perceptions of County Culture and of the Opioid Crisis

The Culture. Cuyahoga County is located in northeastern Ohio, and is the second most populous county in the state. Cleveland is the county seat. Key informants described the county as one of the poorest in the state with high rates of poverty. However, as highlighted by key informants, unlike rural counties that also struggle with poverty, Cuyahoga County also includes very high-wealth areas and high-income individuals, who contribute to the local tax base. Historically, Cuyahoga County has been supportive of local levies to fund health services, which has resulted in comparatively strong provision of publicly funded services. Multiple interviewees also pointed out that the 12-step program originated very near Cuyahoga County, giving rise to a strong abstinence-based treatment community.

The Crisis. Key informants described the crisis as “horrible”, “out of control”, and “like a tsunami”. The majority of key informants felt the situation was getting worse, although a small number suggested it was not clear whether the problem may have plateaued or at least substantially slowed. Key informants also felt the situation would have been much worse without existing naloxone distribution in the county. Key informants identified the influx of fentanyl as a major driver of the recent increase in overdose deaths. This was seen as immediately following a previous rise in heroin overdose deaths, which in turn followed a prescription opioid crisis. Key informants noted the crisis cut across all population groups, with a recent trend towards a younger and more diverse affected population. Several interviewees also stressed a recent increase in people presenting for cocaine and methamphetamine.

Key Informant Perceptions of Gaps in Current Services for People who use Opioids

Current Services. Key informants generally noted Cuyahoga has relatively strong service provision across the entire continuum of care in comparison with the rest of the state. The availability and capacity of services has grown recently, supported by increases in funding, but key informants felt it still fails to meet the needs of the population. Cuyahoga ranks high in the state in the number of methadone and buprenorphine providers. The county has a number of publicly funded treatment facilities, including three detoxification units. Key informants noted that Medicaid expansion has helped residents access services. The county was among the first in the state to establish a drug court and was the first to open a needle exchange service. There is a robust naloxone distribution program, and naloxone is also carried by local first responders. Like Ashtabula, Cuyahoga County also operates QRTs. Several jurisdictions in the county also operate the Safe Passage program, in which police stations operate as a no-questions-asked open door facility for people seeking treatment.

Gaps in Services. The biggest gap highlighted by key informants was difficulty providing immediate access to treatment services. This observation was particularly applicable to inpatient services and detoxification facilities but was also mentioned in relation to MT provision. Other challenges mentioned by key informants included insurance-related difficulties (e.g., co-pays or services not covered by insurance), gaps in dual diagnosis treatment, and an onerous regulatory regime for MT providers. Despite ongoing efforts, key informants also noted the need for greater coordination across existing services and stigmatization of users from some in the medical community as well as law enforcement.
Hillsborough County, New Hampshire

Brief overview (2016 data)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>407,761</td>
</tr>
<tr>
<td>Population density</td>
<td>457.02</td>
</tr>
<tr>
<td>Largest city</td>
<td>Manchester</td>
</tr>
<tr>
<td>Number of all overdose deaths (2016)</td>
<td>199 (175 opioids)</td>
</tr>
<tr>
<td>Number of all overdose deaths (per cent change since 2013)</td>
<td>193%</td>
</tr>
<tr>
<td>Overdose death rate per 100,000 population</td>
<td>42.92</td>
</tr>
<tr>
<td>Ranking in the state by overdose death rate</td>
<td>#1 out of 10</td>
</tr>
</tbody>
</table>

Key Informant Perceptions of County Culture and of the Opioid Crisis

**The Culture.** Hillsborough county mainly consists of two cities, Nashua and Manchester, which are about 20 miles apart, and the more rural communities around and between them. Nashua has a population of 80,000, and is considered a white-collar town. Manchester has a population of about 110,000, is the largest city in the state, and has a lower median income, more poverty, and three times as many overdoses as Nashua. Overall, key informants described the county (like the rest of the state) as fairly conservative politically, and about “20 years behind Massachusetts” with regard to services for PWUO, as evidence by a protracted, 10-year battle to legalize a needle exchange program (NEP). NEPs were finally legalized in 2017, with the first in the county (and second in the state) launching in early 2018 in Nashua. They described attitudes towards PWUO as generally stigmatizing, with a common belief that PWUO ought to be able to “just stop using.”

**The Crisis.** Key informants described the opioid crisis in Hillsborough county as “an epidemic,” “pervasive,” and “highly visible,” and as having a “catastrophic” impact on first responders. “Victims” of the crisis are described generally as white male “laborers” between 18 and 40, with a subset of young women, either pregnant or with children. Key informants cited immediate availability of opioids on the street, due to proximity to the highway and the influx of fentanyl as making the problem exponentially worse. Some cited the stabilizing death rate in early 2018 as an indication that the crisis may be improving while others suggested that, while death rates might be going down due to increased naloxone use and a community-driven program called Safe Station, opioid use may not be reducing or adequately treated.

Key Informant Perceptions of Gaps in Current Services for People who use Opioids

**Current Services.** Most key informants, including PWUO, described the county as having robust services for PWUO who want it. There are multiple state- and privately-funded treatment centers, as well as recovery centers, sober living houses, and, in Nashua, the new NEP. Naloxone is widely available throughout both cities. Key informants noted that Medicaid expansion has greatly improved access to services. The centerpiece of crisis intervention services for PWUO in both cities is Safe Station, a program developed through a collaboration of public health officials, first responders, law enforcement, and local political leadership. The program operates in all fire stations in both cities, and offers immediate linkage to detox and treatment. PWUO can walk into any fire station at any time and receive assistance within 10-20 minutes. The Safe Station in Nashua is connected to a Federally Qualified Health Center, which allows for integration of medical and dental care with other services for PWUO. Informal data suggest a possible association between Safe Station and lower overdoses and linkage to treatment and other social services.

**Gaps in Services.** Although services in the county are strong, key informants cited a kind of “cherry picking” by some treatment programs to admit only those with private insurance, an inadequate number of state-funded beds available to those on Medicaid to meet the growing demand for treatment, and the tenuousness of grant-funded programs.
4. Key Informant Perspectives about HAT

Overview

In this chapter, we discuss themes that emerged in interviews and focus groups in response to questions about the effectiveness and community acceptance of HAT, and factors that could potentially facilitate acceptance and implementation. We provide a summary of views about HAT at the end of this chapter.

The material is divided into three subsections that correspond to our three questions: could HAT help PWUO, would key informants and other members of the community accept HAT, and what special features of HAT, if any, might make the community more likely to accept HAT. Some ideas were voiced in response to more than one question, so some themes appear in response to more than one question.

Do key informants believe HAT could help improve outcomes for PWUO?

Key informants in both individual interviews and focus groups were invited to comment on whether they thought HAT could help improve outcomes for PWUO.9 Below we discuss each theme, how themes vary across key informants and counties, and we provide exemplary quotes from key informants. Table 7 lists all themes that emerged and their frequency (i.e., low, medium, high or very high frequency is indicated if the theme emerged in 1-25%, 26-50%, 51-75% or 76-100% of transcripts, respectively) that answer the question above. The denominator is the number of transcripts, not participants. If multiple focus group participants mentioned a theme, it was only counted once. We include an indicator of the frequency to show how the emergence of themes differed between professionals and PWUO.

Table 7. Could HAT Help Improve Outcomes for PWUO? All Themes Cited by Key Informants (Professionals and PWUO)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Professionals*</th>
<th>PWUO**</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAT programs would provide clients with a drug with known composition</td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td>HAT may be suitable for those who tried previous treatment</td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td>HAT represents another option for opioid substitution therapy</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>PWUO would benefit from medical supervision</td>
<td>Low</td>
<td>Low</td>
</tr>
</tbody>
</table>

9 The definition of HAT used by interviewers and focus group facilitators used to describe the intervention to key informants who were not familiar with HAT is listed in the interview and study protocols in Appendices A-C.
### Reasons HAT might not help improve outcomes

<table>
<thead>
<tr>
<th>Reason</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAT programs would enable/perpetuate drug use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription heroin would be used alongside street drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gaps in HAT provision (e.g., due to insurance lapses) would be problematic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PWUO may not be trusting of a HAT program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HAT may give rise to staff safety issues</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Not sure if HAT would help improve outcomes

### Need to see evidence to comment on effectiveness

NOTES: N/A: Not applicable; theme did not arise in any transcripts; Low frequency: Theme arose in 1–25% of transcripts; Medium frequency: Theme arose in 26–50% of transcripts; High frequency: Theme arose in 51–75% of transcripts; Very high frequency: Theme arose in 76–100% of transcripts.

*Professionals include all non-PWUO key informants who participated in an interview (N=44) or focus group (N= 5 groups and 36 providers) who were invited to participate based on their current profession; it is acknowledged that some PWUO might also be “professionals”

**PWUO who participated in 10 focus groups

### Reasons HAT could help improve outcomes

**HAT programs would provide clients with a drug with known composition**

One of the most frequently mentioned perceived benefits of HAT was that patients would be provided with a pharmaceutical drug of known quality. Key informants noted that this would remove risks associated with the use of street-purchased drugs of unknown provenience and composition.

“I think the upside to that is that at least you know what the product is.”

(POLICY PROFESSIONAL, CUYAHOGA COUNTY)

“I can see where it’s still safer than somebody buying it off the street. I am all for getting the criminal side out of drug use.”

(MEDICAL PROFESSIONAL, CUYAHOGA COUNTY)

With the exception of PWUO in MT facilities, this potential benefit was acknowledged by every type of key informant. It was most frequently raised by active PWUO as a feature that would be helpful and was one of the main reasons for their openness to HAT:

Facilitator: “Would people go and use that, do you think?”

Participant: “Either way, people are going to look at it, like, ‘This is going to kill me, this is not going to kill me.’ So whatever they need to do to get there, they're going to do it, even though they’re, ‘Oh, you need to get in treatment to get this clean heroin, that way you don’t die,’ they're going to do that. That would help.”

(PWUO-ACTIVE, CUYAHOGA COUNTY)

Some PWUO who were generally skeptical about the idea of HAT, such as those in abstinence-focused recovery programs, also suggested that the known composition of the drug could bring benefits:

“Yes. I could see that. That, right there, is better than going to go and buy your own stuff and potentially overdosing, and stuff like that. But, I know people would still do it both ways. You know, it just depends on who really wants the help or is really trying to use it the right way.”

(PWUO-NON-MT, HILLSBOROUGH COUNTY)
Interviewees also raised the possibility that heroin and fentanyl users might be attracted to HAT because the prescribed drug would be pharmaceutical-grade, and thus safer.

“If Europeans have that evidence that things are working and there is harm reduction and better taking it away, I believe a lot of people would use a site for heroin or prefer to have it prescribed as opposed to playing Russian roulette.” (TREATMENT PROVIDER, ASHTABULA COUNTY)

HAT may be suitable for those who tried previous treatment

Another reason why some key informants felt HAT may help improve outcomes for PWUO was that it may be effective for some who previously tried other forms of treatment but did not succeed. This sentiment was primarily expressed by service providers and PWUO in MT facilities, although a similar observation was made in discussions with every type of professional.

To illustrate, one policy professional felt that HAT could be useful as a last resort option for PWUO with multiple unsuccessful previous treatment episodes:

“I think if all other methods have been tried and failed, and it’s under a doctor’s supervision, it’s approved and stuff like that, depending on what the research is and what the outcomes are overseas, yes, that could be viable. … The person that’s tried recovery, failed, tried it again, failed, and stuff like that: if they’re truly looking for help and they’re truly looking for recovery, that might be able to provide a structure and the support that, maybe, they need to be successful at it. They might be at a point where, ‘I’ve tried everything else, so why not?’” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

In this regard, other professionals and PWUO specified that the share of the user population that is likely to benefit from (or be suitable candidates for) HAT likely is relatively small:

“Yes, they target the unreachables and the ones that have failed everything else. It’s like experimental chemo for everybody that’s failed regular chemo, that had cancer. Again, it’s flashy and it’s sexy but it doesn’t apply to most people.” (MEDICAL PROFESSIONAL, CUYAHOGA COUNTY)

“It seems we’re looking at a specific segment of the population of heroin users that would use these types of facilities. It wouldn’t be that every single heroin user is going to go to this kind of facility.” (SERVICE PROVIDER, CUYAHOGA COUNTY)

As part of this discussion, several interviewees felt that while the priority should be offering MT, HAT may be a suitable option for those who tried traditional MT programs. One policy professional explicitly suggested that HAT programs should require patients to try other options first:

“For somebody to have at least tried and failed an existing one [treatment program] would maybe be a good requirement.” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

Reflecting whether PWUO would be interested in HAT, a few interviewees noted that there would be some PWUO who would not want to enter HAT even if they met any hypothetical
eligibility criteria related to their previous treatment experience. Some PWUO agreed that HAT may benefit some PWUO, even if they themselves would not be interested.

“There are a lot of individuals who have a substance use disorder who have been using for a number of years who want to be accepted. They want to be able to be a productive member of society. They feel like a failure every time they have a relapse, or every time whatever program doesn’t work. This may be the perfect thing for them. But I am saying there is a population who have tried all of these different things, and have made their own judgement on what they need to do, because they don’t feel like they work.” (TREATMENT PROFESSIONAL, CARROLL COUNTY)

“I’ll try it. I don’t really get high. I just don’t be sick. I’ve got to work. We lost everything in a fire, and it’s been a rough grind ever since. I can’t believe I’m still doing heroin. Four months now. 1st January we lost, and it’s been rough. Four cats, four people bouncing around from a hotel to finding a house, and we’ve still got to find a house. It’s crazy. All I do is work, and try not to be sick.” (PWUO-ACTIVE, CUYAHOGA COUNTY)

“I understand what everybody is saying, but, like you said, with so many times that people are failing out of this and that program or whatever... I know a lot of people that have been out there for years. They’ve tried it and – You know what I’m saying? – they think they’ll die if they get clean. They’re going to die doing their drugs. Maybe that’s an option for them.” (PWUO-MT, CUYAHOGA COUNTY)

“I could see it both being useful and negative at the same time. If for somebody methadone and Suboxone [buprenorphine/naloxone] isn’t working and you really want something else, and you really want it but nothing’s working for you, you know what I mean, then I can see it working. Personally, for myself, since I’ve been in recovery, I went to a detox and stuff like that, and that seemed like the only way to work for me. I, personally, wouldn’t agree with it, but I could be open minded and think that it would help others.” (PWUO-NON-MT, HILLSBOROUGH COUNTY)

By contrast, a small number of interviewees did not think that ex-MT users would seek HAT if the only difference between MT and HAT was the drug provided.

“I think that just replacing methadone with a different drug, I think, is missing the problem. I think that they’re attributing the failures of those programs to something different.” (CRIMINAL JUSTICE PROFESSIONAL, ASHTABULA COUNTY)

HAT represents an additional option for substitution therapy

Some interviewees, predominantly treatment providers and harm reduction workers as well as practitioner focus group participants, made the argument that HAT can be understood, and accepted, as another form of MT. As such, similar to other substitution or maintenance

---

10 MAT can be considered an umbrella term for the use of a range of compounds with different chemical properties (SAMSHA, n.d.).
therapies, these key informants suggested that it can be expected to result in positive outcomes for some PWUO.

“I think it’s just another option instead of the Suboxone [buprenorphine/naloxone]. Really, what you’re trying to do, you’re trying to monitor the medications. It would be under a doctor’s care, so I think it would be a lot safer than what they’re taking right now because what they’re getting on the streets can kill them.” (TREATMENT PROFESSIONAL, ASHTABULA COUNTY)

“As long as there is accountability, and it’s monitored the right way, it’s no different, to me, than methadone or Suboxone [buprenorphine/naloxone], or any of these replacements that we are currently using right now.” (TREATMENT PROFESSIONAL, CARROLL COUNTY)

“I don’t see any real big difference between heroin or methadone, you know, as far as if it’s being prescribed by a physician and is closely monitored, I don’t think it makes a big difference.” (SERVICE PROVIDER, CARROLL COUNTY)

At the same time, a small number of Ohio-based interviewees felt there was no need to introduce HAT on top of existing MT provision as, in their opinion, MT should be sufficient to meet the demand for substitution services.

“I don’t know why if methadone and buprenorphine are equally available necessarily that there would be that great of a need.” (CRIMINAL JUSTICE PROFESSIONAL, CUYAHOGA COUNTY)

“I just don’t see how that would be a benefit, other than simply saying, ‘We’re providing medication-assisted treatment.’ … ‘even giving it in a prescribed dose, the only thing you would be doing is, essentially, a maintenance dose, which you can do with methadone.’” (POLICY PROFESSIONAL, OHIO)

In this context, some interviewees and provider focus group participants suggested some PWUO may find HAT attractive because it would expand service options available to them. As discussed in the preceding section, key informants expected that HAT users would be primarily recruited from those who unsuccessfully tried MT:

“I think they would find it a good option. Not all of them are successful with Suboxone [buprenorphine/naloxone], so to have different options. The people who are really wanting to get off of it, they’re willing to try anything. They really don’t care if it’s heroin or what the name is. The ones who really want to get off, they’ll try anything.” (TREATMENT PROFESSIONAL, ASHTABULA COUNTY)

“A lot of the people who are bouncing around Suboxone [buprenorphine/naloxone] or Vivitrol [naltrexone] and methadone would probably morph over to this if it was clean in a safe dosage and then they could live their lives.” (TREATMENT PROFESSIONAL, HILLSBOROUGH COUNTY)

When people are seeking treatment they have their own options that they want, some come in and they’re like, ‘I don’t want any MT medication,’ and some
people do. You’d have a mixed result, just like you would in the community.”
(SERVICE PROVIDER, ASHTABULA COUNTY)

PWUO would benefit from medical supervision

Several interviewees and provider group participants also highlighted the fact that injections would be administered under medical supervision as a positive feature that could help improve outcomes for heroin and fentanyl users. This was a sentiment expressed by multiple types of key informants, particularly service providers. Even providers who were otherwise skeptical about HAT acknowledged the potential benefits of having injections supervised by medical professionals.

“My first thought is, ‘That sounds insane,’ but if I think through it, I’m a fan of whatever keeps people alive long enough to give them a chance to get sober. If it’s Suboxone [buprenorphine/naloxone], methadone, needle exchange, or heroin-assisted treatment... It still sounds weird coming out of my mouth, but if that’s going to keep people alive long enough so they don’t overdose from fentanyl...”
(SERVICE PROVIDER, CUYAHOGA COUNTY)

The benefits of HAT’s medical supervision feature were noted by other types of key informants as well. For instance, one criminal justice professional explained he understood that if there was a medical decision to prescribe heroin, it would be inappropriate to second-guess the perspective of medical professionals as to whether the program works:

“Personally, and as a law enforcement professional, I would have no negative position on that, because if a medical professional feels that that is a productive and effective means of treatment, who am I to say otherwise? I don’t weigh in on what doctors do. They’re doctors, so if they are in favor of it and they are comfortable with it, and provided it is done by doctors and nurse practitioners, whoever has the level of expertise to administer drugs or whoever’s authorized to do it, I’m all for it.” (CRIMINAL JUSTICE PROFESSIONAL, CARROLL COUNTY)

The same interviewee also felt that other stakeholders, including policymakers, law enforcement representatives, and members of the community, would follow the same reasoning, i.e., they would be open to HAT because of its medical nature:

“Making the solution to the heroin crisis a medical, behavioral solution, everybody would be: ‘Great,’ because what do we care? We don’t get involved in prescriptive treatment. There’s no reason to even weigh in. We’d be like, “Okay, if the doctor’s okay with it, I’m okay with it.” (CRIMINAL JUSTICE PROFESSIONAL, CARROLL COUNTY)

Active PWUO and PWUO in non-MT facilities were also among key informants who mentioned as a positive feature the fact that heroin consumption would take place in a medically controlled environment. Among service providers as well as PWUO, this benefit was noted even by individuals who otherwise held very strong reservations about HAT.
“I guess I can see where at least it’s medically monitored, but it doesn’t seem- it seems like a very slippery slope.” (SERVICE PROVIDER, CARROLL COUNTY)

Reasons HAT might not help improve outcomes

HAT programs would enable/perpetuate drug use

Concern over enabling use was the most frequently mentioned reason why key informants did not feel HAT would be effective in improving outcomes for heroin and fentanyl users. Among interviewees, this view was expressed by some policymakers, criminal justice interviewees, treatment providers as well as provider focus group participants. By contrast, it was not raised as an issue by harm reduction and medical professionals.

“I think that if you said that people could go get shot up with pharmaceutical heroin, nobody would get clean. What’s the purpose if they can still feel that way?” (TREATMENT PROFESSIONAL, HILLSBOROUGH COUNTY)

Several interviewees felt that providing PWUO with pharmaceutical-grade heroin would do nothing to address the underlying issue of addiction and would offer PWUO an alternative to not try to stop drug use. In this context, some service providers likened the provision of pharmaceutical heroin to other prescription opioids, which were seen as the root cause of the current crisis.

“Hey, you’re just giving people opioids to correct an opioid problem.” (CRIMINAL JUSTICE PROFESSIONAL, ASHTABULA COUNTY)

“If you talk to most heroin users that’s how they ended up doing heroin in the first place was from the pharmaceutical. The fact that they got prescribed Percocet [oxycodeine/paracetamol], Oxycodone, all these things, and then they couldn’t afford them. Either their prescription got cut off or they just couldn’t afford it.” (SERVICE PROVIDER, HILLSBOROUGH COUNTY)

For a few interviewees, the concern over HAT enabling opioid use mirrored their perception of MT, i.e., in their opinion HAT would have similar negative results as MT. For instance, one criminal justice professional opined:

“At face value, it sounds like we’re just kicking the can down the road. You mentioned medications like Suboxone [buprenorphine/naloxone] and a plethora of other medicines. Drug-addicted people are selling those on the street, so at face value how would that be any different? It just seems like we’re kicking the can down the road.” (CRIMINAL JUSTICE PROFESSIONAL, HILLSBOROUGH COUNTY)

By contrast, some interviewees highlighted a contrast between MT and HAT and were skeptical that PWUO on heroin prescriptions would be able to stabilize in the way at least some MT clients do. As such, HAT would likely perpetuate, or at least fail to stop, street drug use.

“There’s a part of me that feels like I don’t want to just leave the addict suffering for their addiction. Heroin: it doesn’t seem to me like it’s a drug that people go
back and resume a good functional status with.” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

However, one professional explicitly added that they are open to revisit their skeptical view of HAT if presented with evidence of its effectiveness:

“Unlike what some people have seen with people who are stabilized on buprenorphine, where you have this stabilized brain neurochemistry, it’s a very different state for people to be in when they’re in that kind of medication-assisted treatment versus when they’re injecting heroin or particularly fentanyl. … I think there would be a lot of pushback. I think I probably would feel that way too, unless there was some beautiful data showing how it really was incredibly helpful. I just haven’t seen the data.” (POLICY PROFESSIONAL, NEW HAMPSHIRE)

PWUO also shared concerns over HAT enabling drug use. These concerns were shared most forcefully by PWUO at groups held at non-MT facilities:

“Yes. I’ve only been in this area a little while and I’ve yet to meet a heroin addict here where just give him- a little bit is enough to hold him over. I think all you’re doing is giving someone more free heroin unfortunately.” (PWUO-NON-MT, CARROLL COUNTY)

For these PWUO, who were participating in a primarily abstinence-focused recovery program, concerns over HAT to a large extent mirrored their reservations about MT and their preference for abstinence. From their perspective, substitution therapies mean that PWUO replace their addiction to the street drug with addiction to the replacement medication, which can be abused as well, although some participants stressed that MT programs can work for some PWUO.

“I think that Suboxone [buprenorphine/naloxone], methadone, anything, like I never wanted to substitute because it’s a crutch because you’re just switching one habit to another. And I know myself, I’m a drug addict, so I’ll abuse it. And that’ll lead to getting high and abusing your prescription and this and that, so it’s a crutch. It’s just substituting one addiction for another. You’re just switching it out and calling it how you’re getting clean. So that’d be the same thing.” (PWUO-NON-MT, CARROLL COUNTY)

“I mean methadone and Suboxone [buprenorphine/naloxone] have just made the epidemic worse, that’s going to make it even worse if you add that in because now you’re going to have people going to these facilities and them handing it out to you.” (PWUO-NON-MT, HILLSBOROUGH COUNTY)

Similar to some interviewees and provider group participants, non-MT PWUO also recalled the role played by prescription opioids in the generation of the current crisis and felt that the provision of pharmaceutical heroin would lead to a similar outcome in terms or perpetuating the issue:

“I think a huge part of our heroin users started with the pharmaceuticals and started way back. So all we’re doing is perpetuating that problem and we’re
repeatedly starting over, like we can now just shoot you up.” (PWUO-Non-MT, CARROLL COUNTY)

“I’m hearing here and what comes to my mind is that the heroin epidemic began from drug companies flooding the market with opioids. Forcing it or telling doctors it was harmless and it wasn’t addictive and paying them to prescribe this shit. Then heroin dealers saw an opportunity and flooded the market with cheap heroin. That’s what started this epidemic. Ever since then, drug companies have been trying to capitalize on the addiction at the cost of lives by coming up with one addictive substitute after another and that’s just one other item.” (PWUO-Non-MT, CARROLL COUNTY)

Strong reservations about HAT and perpetuated heroin use were also shared by PWUO at focus groups held at MT facilities. According to the views offered, HAT would enable drug users to continue with their habits, and would fail to provide an opportunity for recovery:

Participant 1: “A heroin prescription program would not give you freedom. It would keep you.”
Participant 2: “It would be like, ‘Now you just don’t have to buy it. You get it now legally.’” (PWUO-MT, ASHTABULA COUNTY)

“As a heroin addict my focus is that drug and staying obliviated. So, if we’re giving something like that, people are not going to know how to live life. ... It’s just going to make this town even more sick, that drug makes you sicker and sicker and sicker.” (PWUO-MT, ASHTABULA COUNTY)

Participant 1: “That’s worse than hell.”
Participant 2: “The junkie in me says that’s the best thing I’ve ever heard. But, my sane mind says, ’No.’”
Participant 3: “I want to tell you that that’s a great idea, but that’s because I’m going to go and try to get put on heroin.”
Participant 4: “Legally, and tell my PO, ‘Hey, my doctor said I can do the heroin, so just leave me alone.’” (PWUO-MT, ASHTABULA COUNTY)

Some participants in these groups felt that prescribing heroin could potentially make it less likely that PWUO would make the decision to stop using heroin.

“Until you get to your bottom, you aren’t going to stop, so if you’re just giving this to people, they’re never going to reach their bottom. You know?” (PWUO-MT, CUYAHOGA COUNTY)

“There was a story about one of these conquistadors. He came to an island and there were thousands and thousands of Indians in this island. He’s only got 300 soldiers. When the soldiers got out onto the beach, the captain ordered the soldiers to burn the boat and they have no option. Once they burned the boat, they had no option but to conquer the island because there is no option. You give these types of people that option there’s not going to be that much effort to be clean and work the problems that are available because you’ve got all the options now, so it’s easier.” (PWUO-MT, ASHTABULA COUNTY)

“That doesn’t really give people hope though that they could recover.” (PWUO-MT, ASHTABULA COUNTY)
Along similar lines, some PWUO in MT facilities felt that since HAT would essentially represent a perpetuation of heroin use, many PWUO would avoid the program due to the harms they have experienced while using heroin:

“I’m not saying that you came up with that idea but whoever came up with that idea has no type of experience what it is to be a heroin addict or what is tied up to being a heroin addict. I can bet if you put 1,000 heroin addicts – they’re working in a program in this room – and you asked the question, their answer’s going to be so similar. It’s going to be laughable. Like, how can somebody come up with a solution like that?” (PWUO-MT, ASHTABULA COUNTY)

“Do you know what also? With somebody that never has been a heroin addict, they see a problem with heroin. They think that heroin, we chase it so hard, that that’s our problem. If we could get it somehow, we will stop our own behaviors. For most of us, at least for myself, when you mention heroin that’s all related to so much pain, suffering and misery in my life that when you mention heroin it’s like you’re mentioning the devil. If you can meet with the devil three times a week in a doctor’s office, would you do it then? It’s related to a lot of pain and suffering. It’s just not getting that. It’s just that freedom from that.” (PWUO-MT, ASHTABULA COUNTY)

By contrast, active PWUO were the most open to the idea of HAT, although concerns over enabling were raised at one focus group as well:

“It’s just a legal way to do heroin. That sounds stupid.” (PWUO-ACTIVE, CUYAHOGA COUNTY)

An argument related to concerns over drug enabling voiced by key informants was that provision of HAT may convey the message that it was ok to use drugs and thus normalize drug use. This argument was mostly made by PWUO in MT and non-MT facilities but also some policy and criminal justice interviewees.

“Parents could point out a heroin addict who’s doing it really bad who’s in the paper for something. They’d be like, ‘Look. This is what happens to you when you’re on heroin.’” If heroin is being administered in a doctor’s offices, it’s legal and it’s paid for by insurance, that’s almost teaching the kids, ‘Okay. I can be a heroin addict. Cool.’ Is that going to happen?” (PWUO-MT, ASHTABULA COUNTY)

“I feel like if they offer those types of programs, they’re just going to show the kids that are out here now that it’s okay to go and do drugs.” (PWUO-MT, CUYAHOGA COUNTY)

“I feel like if they offer those types of programs, they’re just going to show the kids that are out here now that it’s okay to go and do drugs.” (PWUO-MT, CUYAHOGA COUNTY)

“With a lot of people that are in recovery, I feel like if they find themselves in a spot, they want to go back out. Instead of recovering, they’re going to go backwards. I don’t know. For me, it wouldn’t help. I would just be like, ‘Well, they’re dispensing heroin, so it’s legal.’ You know what I mean? That’s how I would take it.” (PWUO-MT, CUYAHOGA COUNTY)

Participant 1: “Now you’re making me think that it’s okay for me to do my heroin that’s prescribed, and I can go and get more from my dealer, you know what I mean?”
Participant 2: “I have a feeling that if that happened, and that happens for me…”
So, keep me the junkie that I am, basically, don’t give me any help, and now let me teach my kids how to do heroin.”

Participant 3: “Oh God, right, let me shoot up taking this legal medication.”

(PWUO-MT, ASHTABULA COUNTY)

Prescription heroin would be used alongside street drugs

A notable concern voiced at all focus groups, in particular non-MT PWUO groups, was that any heroin prescribed by HAT programs will be used alongside other street drugs and would thus simply serve to top up PWUO’s consumption. For instance, participants at one PWUO group suggested that PWUO would, over time, develop tolerance to the prescribed drug and would ask for increased dosage. In the event the HAT provider would refuse this request, HAT patients would resort to illicit use.

“After one or two days of doing it I’m going to need six or seven shots and they’re not going to give it to me, so I’m going to go right back into doing it. There’s no purpose trying to stop me from quitting because you’re just actively creating the demon to keep going on a day-to-day basis or wanting more.”

(PWUO-MT, ASHTABULA COUNTY)

Similarly, participants at a different PWUO group suggested that PWUO would supplement prescription heroin because the HAT program would not be able to meet all their needs (e.g., due to its closing hours). One participant also suggested that PWUO would use money saved by not having to buy street heroin to purchase other drugs.

Participant 1: “I feel like people would go and use that as a crutch, then go and cop drugs…”
Participant 2: “Yes, because if they close at 8:00 at night and you need something at 9:00 tonight, what are you going to do, wait until the morning when they open again? That’s not easy.”
Participant 3: “Or they’d save their money. I mean, I know, personally, if that were the case, in my head, I would go and do that, save the rest of my money that I would’ve been spending on heroin and get crack or get meth.” (PWUO-NON-MT, HILLSBOROUGH COUNTY)

Similar concerns were also raised at two provider groups held at non-MT facilities, based on participants’ experience with clients on MT. For instance, during one group service providers discussed how MT clients supplement their substitution medicine:

Participant 1: “The maintenance dose from the doctor is not going to be enough.”
Participant 2: “It’s not just to maintain. Even with Suboxone [buprenorphine/naltrexone] and all of that. I have so many people that will do Suboxone [buprenorphine/naloxone]. Especially the Suboxone [buprenorphine/naloxone] white tablets. They’ll do them but then they’ll stop doing them because they want to get high. They’ll get high, then go back and use that to maintain so they’re not sick.” (SERVICE PROVIDER, HILLSBOROUGH COUNTY)
Similarly, at another service provider group, one participant viewed growing tolerance to prescription heroin as an issue and drew a parallel with their previous experience at an MT facility:

“Tolerance means you’ve got to have more and more to solve the things, so the heroin, if you give them heroin, the client is going to say, ‘Well, I’m uncomfortable, raise my dose.’ … I was in a methadone clinic for a year and a half, and that’s what they would say, ‘I’m uncomfortable, raise my dose.’ They raise it right up until the point where they’re getting a nice buzz out of it, and so tolerance keeps going up, they need more and more and more and more. When I was there, he was high if somebody had 125mg, so now no people there have 250mg of methadone. It’s ridiculous.” (SERVICE PROVIDER, CARROLL COUNTY)

Gaps in HAT provision (e.g., due to insurance lapses) would be problematic

Service providers and PWUO also voiced concerns over possible gaps in HAT service provision and their impact on the client population. Several PWUO raised questions over what would happen to HAT clients in the event they lose insurance coverage, are unable to continue with the program for one reason or another, or the program itself is discontinued. A recurring theme during these discussions was the possibility that PWUO would get kicked off of the service and would be left with no support. From the PWUO’s perspective, this scenario would be akin to what happened with prescription opioids.

“It’s just like the pills. That will eventually run out, and we will be on the streets. … You know doctors will be over-prescribing it. There will be bad doctors, like the pill mills.” (PWUO-ACTIVE, CUYAHOGA COUNTY)

“I mean it’s the same idea with the whole- a lot of people started on the prescription on the pills, it’s the same idea. Something is going to happen, that heroin is going to get taken from you, the safe heroin per se, you’re going to go on the streets, you’re going to die, period.” (PWUO-NON-MT, CARROLL COUNTY)

Participant 1: “If they’re on it and then the doctor cuts them off, then what? What are they going to do next?”
Participant 2: “If they cut them off it’s going to happen all over again.”
Participant 3: “You might as well just bring the pills back.” (PWUO-MT, ASHTABULA COUNTY)

Further elaborating on their concerns, participants at two PWUO groups pointed out that HAT programs implemented in other countries are covered by universal health insurance, while medical coverage in the U.S. remained precarious.

“I mean especially in other countries they have universal healthcare. Here we don’t. I mentioned this before. When we are already addicted to the point where our lives are in shambles, we don’t have regular insurance. The government insurance is not as good. We are not going to facilities that are as good. I have a feeling I don’t think this will ever happen in the States, because we are too close-minded. I mean, I just don’t think it will. But let’s say it did, I don’t think our
government insurance would ever cover that.” (PWUO-ACTIVE, CUYAHOGA COUNTY)

A few focus group participants also felt that making HAT covered by insurance was very unlikely.

“I can’t imagine an insurance company in the state of New Hampshire ever paying for somebody to be legally injected with heroin.” (SERVICE PROVIDER, CARROLL COUNTY)

One criminal justice professional offered a different example of potential risks associated with interruptions in HAT service. The interviewee suggested that incarceration, for instance due to a probation violation, may prevent patients from continuing to use a HAT program. The interviewee pointed out that many jails currently do not allow individuals to take their buprenorphine/naloxone with them, prompting questions about how, if at all, correctional facilities would honor heroin prescriptions.

“It would be like the jail doctor saying, ‘Yes, they need it. We’ve confirmed it, so let’s get them a prescription of Suboxone [buprenorphine/naloxone],’ and have them take it there and then under a supervised med call. A lot of county jails won’t even do that. They’re, in essence, forcing a detox. You know as well as I do that if they’re on that Suboxone [buprenorphine/naloxone] plan and they’re forced to detox, the second they’re out, they are very susceptible to use. If they use, they’re probably going to die.” (CRIMINAL JUSTICE PROFESSIONAL, CARROLL COUNTY)

PWUO may not be trusting of a HAT program

A small number of professionals and active PWUO also suggested that some PWUO may not be trusting of HAT. Key informants also felt that PWUO may fear negative criminal justice and administrative repercussions if they were to attend a HAT clinic.

“I think they [users] would want to know more about it, absolutely. I think if it’s going to hurt them, get them in trouble, take away their kids or be opening up other issues, there could be some hesitation there.” (TREATMENT PROFESSIONAL, ASHTABULA COUNTY)

One harm reduction professional also suggested that PWUO may be suspicious of the provenance of government-provided heroin:

“I think that they will be a little suspect as to where the actual heroin was coming from. For whatever reason, a lot of these folks have their network of individuals that they buy from.” (HARM REDUCTION PROFESSIONAL, HILLSBOROUGH COUNTY)

HAT may give rise to staff safety issues

One interviewee and participants at one user focus group raised the potential issue of staff safety because they would be responsible for managing a stockpile of heroin; another expressed concern that staff working at a HAT facility may be more likely to develop an addiction.
“I’d be afraid to work in a place like that, I’d be afraid of getting mugged going to the parking lot, somebody thinking they could get a key off me.” (MEDICAL PROFESSIONAL, CUYAHOGA COUNTY)

“We have a lot of anesthesiologists who have a problem. The heroin-assisted therapy, I am worried about the safety of the workforce around that, interestingly enough. … We are going to have more people in the workforce with this problem because they touch it and deal with it all the time.“ (POLICY PROFESSIONAL, OHIO)

Not sure if HAT would help improve outcomes

Key informants need to see evidence to comment on effectiveness

Numerous interviewees and provider group participants felt that they were not familiar enough with HAT programs to be able to comment on their effectiveness but expressed interest in the evidence surrounding the intervention. The need to see evidence was mentioned by every type of professional, in particular by criminal justice professionals and service providers.

Some interviewees indicated that they would be open to HAT programs if existing evidence demonstrated their effectiveness.

“I would rely on the data for that. If it’s showing, in other places internationally, that’s it’s helping, I would imagine that it would also benefit people who are injecting drugs here – using drugs here.” (HARM REDUCTION PROFESSIONAL, CUYAHOGA, COUNTY)

Along similar lines, some interviewees felt that evidence would be needed to overcome their own as well as the community’s skepticism towards HAT.

“I think there would be a lot of pushback. I think I probably would feel that way too, unless there was some beautiful data showing how it really was incredibly helpful. I just haven’t seen the data.” (POLICY PROFESSIONAL, NEW HAMPSHIRE)

For some interviewees, the primary question with respect to evidence on HAT was how effective the intervention is compared to other existing treatment options. This line of questioning is related to a perception among some key informants (discussed in greater detail above) that there may not be a need to introduce HAT on top of other existing options.

“I would have to do some more research about it. How much of a benefit does it give against current medication assisted treatments? I don’t know if you know the answer to that. What is its claim that it can offer versus the existing options?” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

11 A review of evidence on HAT effectiveness is discussed in Smart (2018).
Do key informants believe HAT would be acceptable to community members?

Key informants in both individual interviews and focus groups were invited to comment on what the reaction from the community and individual stakeholder groups would be if a HAT program were proposed in their communities. These discussions uncovered a range of themes that apply to the acceptability of HAT, including which stakeholder groups in the community might be supportive of or opposed to the proposal, as well as underlying reasons for possible opposition. Table 8 lists all themes that emerged and their frequency (i.e., low, medium, high or very high frequency is indicated if the theme emerged in 1-25%, 26-50%, 51-75% or 76-100% of transcripts, respectively) that answer the question above. The denominator is the number of transcripts, not participants. If multiple focus group participants mentioned a theme, it was only counted once. We include an indicator of frequency to show how the emergence of themes differed between professionals and PWUO.

Table 8. Do Key Informants Believe HAT Would be Acceptable to the Community? All Themes Cited by Professionals and PWUO

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
<th>Professionals* N=80</th>
<th>PWUO** N=79</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAT implementation would be impeded by community values, and local culture</td>
<td>High</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Community would think that HAT enables/perpetuates use</td>
<td>Low</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Community members would be concerned about neighborhood effects</td>
<td>Low</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Community members would be open to HAT as an extension of existing MT options</td>
<td>Low</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Community members would be concerned about diversion of prescription heroin</td>
<td>Low</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Community would be in favor of providing PWUO with a drug with known composition</td>
<td>Low</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>PWUO face stigmatization in their communities</td>
<td>Low</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Community members would be reluctant to provide funding</td>
<td>Low</td>
<td>Low</td>
<td></td>
</tr>
</tbody>
</table>

NOTES: N/A: Not applicable; theme did not arise in any transcripts; Low frequency: Theme arose in 1–25% of transcripts; Medium frequency: Theme arose in 26–50% of transcripts; High frequency: Theme arose in 51–75% of transcripts; Very high frequency: Theme arose in 76–100% of transcripts.

*Professionals include all non-PWUO key informants who participated in an interview (N=44) or focus group (N= 5 groups and 36 providers) who were invited to participate based on their current profession; it is acknowledged that some PWUO might also be “professionals.”

**PWUO who participated in 10 focus groups

HAT implementation would be impeded by community values and local culture

By far the most frequently mentioned reason for why HAT programs would not be acceptable was a combination of cultural and political reasons. This was true in all four jurisdictions and across all types of interviewees and provider group providers. PWUO also noted the lack of likely cultural and political acceptability, though to a lesser degree.

Numerous interviewees and providers, particularly from rural areas, described their jurisdictions as relatively conservative communities that would not be open to discussions about HAT:
“I think just conservative people in general would have a hard time with that option.” (SERVICE PROVIDER, ASHTABULA COUNTY)

“I think the conservative nature of this community would be up in arms if there was a place where people could just go to be legally injected with heroin.” (SERVICE PROVIDER, CARROLL COUNTY)

“There are very conservative parts of the state where I don’t think this would necessarily fly.” (POLICY PROFESSIONAL, OHIO)

Other key informants echoed this view, and felt HAT represents an intervention so far from the mainstream that it is not likely to be acceptable outside of very liberal areas. Some professionals from urban counties recognized that their jurisdictions were less conservative than the rest of the state, meaning that a HAT program may face somewhat less opposition there than in other localities. However, they felt that HAT would also still need to gain support at the state level, which they did not consider likely.

“I think that with something like this, this is very, very, very drastic. This is a progressive movement. This is totally left field. It’s not even heard of. It’s not familiar in the state. I think that it would just take a lot of education and a lot of community buy-in, and I mean a lot.” (HARM REDUCTION PROFESSIONAL, HILLSBOROUGH COUNTY)

“If the US ever does heroin prescriptions, it’s probably going to be in fairly small locations, because there are a lot of states in the country that will just ban it. Because, they just ban anything that seems like it makes sense from a public health stand point. So, a lot of places, it will get banned. The places it will be available, to be perfectly blunt, are in blue states and probably, primarily in urban areas, and those are places where there’s a fair amount of buprenorphine and methadone available.” (MEDICAL PROFESSIONAL, CUYAHOGA COUNTY)

In concrete terms, some interviewees noted that any potential opposition to HAT would come from the same sources as general opposition to harm reduction services as well as medication-assisted treatment. For instance, reflecting on the operations of a NEP in an urban county, one harm reduction professional pointed out that the service continues to meet resistance from some members in the community.

“With the introduction of the syringe service, I’ve met a number of community members where, one, they’re not educated. They have no idea of the concept of harm reduction and what that means, or how their family member, sibling or whatever it is could benefit from it. I actually had one guy call the number to get services and it was a father of a daughter that was in recovery. Excuse me for a language, but he told me that we were ‘fucking crazy’. He said, ‘Do you know what these kids are doing with this stuff?’” (HARM REDUCTION PROFESSIONAL, HILLSBOROUGH COUNTY)

Other interviewees pointed out that MT is still not universally accepted in their jurisdictions. In this context, introducing a heroin substitution service would only exacerbate people’s reservations about MT:
“You also have people who are just generally opposed to replacing one addiction with another. I think some people would be so kind of very discouraged by using heroin to treat people, because it’s ruined so many lives, I think that could also have some negative feelings.” (POLICY PROFESSIONAL, OHIO)

To illustrate further, several interviewees and provider group participants from Ohio pointed out that Alcoholics Anonymous originated in Akron, OH and continues to be a dominant component of services for people with substance use disorder. As such, abstinence-based treatment providers as well as associated service providers, such as faith groups, would be expected to strongly oppose HAT.

“Religious professionals would definitely push back from that because religion is a big base. People forget about that in Cuyahoga County, but there are a lot of different religious-based programs out there that support abstinence of any angle – sexual, drug abuse... They’ve got powers in numbers in religious groups, so they would definitely push back from that.” (SERVICE PROVIDER, CUYAHOGA COUNTY)

Related to existing reservations about MT, several interviewees noted that local communities were concerned about opioid prescriptions, which were considered to be at the root of the current crisis. In this context, HAT may be perceived as yet another prescription opioid and would thus be lumped in the same category as the perceived source of the problem.

“People are really concerned about a prescription of these medications that got people in these situations to begin with, so I understand that it’s a little bit different giving somebody 30 Percocet [oxycodone/paracetamol] for, like, an ER visit, versus having them administered to you in a controlled setting. I think that people would be hesitant about it.” (CRIMINAL JUSTICE PROFESSIONAL, HILLSBOROUGH COUNTY)

“I think people wouldn’t be comfortable with it, because there’s such a low level of tolerance and comfort for prescribing something less potent, like Percocet [oxycodone/paracetamol], and it’s appropriate. People had been getting prescriptions for controlled narcotics for toothaches, broken fingers, other things. You might get 30 days’ worth, and you really need two days’ worth and an anti-inflammatory is appropriate.” (MEDICAL PROFESSIONAL, CUYAHOGA COUNTY)

“I think in the climate we have going right now, no-one would want to hear anything about it. I think it would be met with a great deal of resistance because of the numbers, the huge numbers of people that are dying. And they are going, ‘You want to provide it? Legally or not legally?’ Because what we are doing right now is, people around here are upset with the pharmaceutical companies for over-prescribing and now we want to legalize the drug that all the people turn to when they can’t get the opiates.” (TREATMENT PROFESSIONAL, HILLSBOROUGH COUNTY)

To demonstrate the prevailing cultural context and the resulting likely unacceptability of HAT, some interviewees pointed out that their jurisdictions still lacked or had been split on other services for PWUO that may be considered less controversial than a potential HAT program. Examples given by key informants included local discussions surrounding the introduction of
harm reduction measures such as needle exchange programs and naloxone distribution, as well as ongoing challenges with MT coverage.

“We had a hard time getting providers to sign on to MT, put it that way.” (POLICY PROFESSIONAL, HILLSBOROUGH COUNTY)

“I actually do not think there would be any support for a heroin-assisted therapy. It took us a few years to just get to medication-assisted treatment.” (POLICY PROFESSIONAL, OHIO)

“I don’t want to say ‘no’, but I think it would be not necessarily as well received. I mean, particularly because we’re still. Suboxone [buprenorphine/naloxone] has not got a very great connotation in the States. So, that is an FDA-approved medication.” (POLICY PROFESSIONAL, OHIO)

Given the ongoing lack of other, less controversial, services, several interviewees and provider group participants from both rural counties and from Hillsborough County felt that other areas were a much more urgent priority. According to these key informants, efforts to improve the provision of already existing services and to close gaps in services for PWUO should take precedence over any considerations of new services such as HAT. Examples of areas that require greater attention included an expansion of MT as well as harm reduction programs such as a NEP. This sentiment was particularly compounded by the fact that interviewees and provider group participants considered HAT to be unacceptable to policymakers and community members. As such, given limited resources and political capital, the pursuit of HAT did not seem to be a good choice to these key informants.

“I think there are a lot of fires that need to be put out currently, and there’s a lot of damage control that needs to take place. With that, I think that there needs to be more consistency with what is already taking place in the state before we implement anything else new.” (HARM REDUCTION PROFESSIONAL, HILLSBOROUGH COUNTY)

“We can go and educate people but we don’t have a needle exchange program. We don’t even have a place for Ashtabula community to safely deposit dirty needles.” (TREATMENT PROFESSIONAL, ASHTABULA COUNTY)

“I would be elated if people had access to buprenorphine. I would be so happy if people who used opioids in Carroll County had easy access to buprenorphine or methadone. That’s how far behind we are. … Do I think it [HAT] would help? Absolutely. Do I think it’s feasible tomorrow? No. I guess that I would be happy if people had access to buprenorphine.” (HARM REDUCTION PROFESSIONAL, CARROLL COUNTY)

If the community ever decided that offering HAT was a desirable step, these discussions would likely take place later in the future. For instance, at one group, service providers felt establishing a NEP and potentially an SCS were more immediate priorities.

Participant 1: “We had a hard time getting people to let people breathe [establish naloxone distribution].”
Participant 2: “I know, medication-assisted therapy has taken how long? How many years have we been working with that one?”
Participant 1: “Which is the reason the next step is giving them safe needles and then the next step is letting them use around us and down there is giving them the drug.” (SERVICE PROVIDER, ASHTABULA COUNTY)

Community members would believe HAT enables/perpetuates use

Closely related to the observations about local community culture, some key informants also felt communities would not find HAT acceptable on the grounds that it enables drug use. This was a point made particularly by focus group participants (both practitioners and PWUO), policy representatives, and medical interviewees.

For instance, one policy interviewee from a rural county felt that there would be community pushback against the idea of making it possible for PWUO to continue using heroin.

“I think there’d be a lot of community resistance … We’d start getting a lot of pushback about the messaging and, ‘Why would we be giving them a drug we’re trying to get them off of?’ It would take a long time for the community to move in that direction.” (POLICY PROFESSIONAL, ASHTABULA COUNTY)

Similarly, interviewees and provider focus group participants from an urban county also suggested there would be community pushback against HAT, similar to but likely stronger than what has been the case with other previously implemented services.

“Oh my gosh. It would be even worse than it is now with ‘You’re encouraging people.’ That whole condoning and you’re giving people permission to use drugs and all that stuff.” (TREATMENT PROFESSIONAL, HILLSBOROUGH COUNTY)

“‘There is just going to be a bunch of people on heroin running around my city.’ That’s probably what would be going through the majority of people’s minds.” (PWUO-NON-MT, HILLSBOROUGH COUNTY)

A few key informants offered their thoughts on concrete sources of opposition based on concerns over drug enabling; these discussions revealed a broad range of stakeholders that may share the concern over enabling. For instance, one urban policy professional felt that family members who have lost their close ones would be opposed to the idea of providing people with heroin and thus perpetuating their ability to use. The interviewee drew a parallel with family members’ opposition to the local NEP, which they see as supporting people’s use.

“We’re just giving them empty syringes and cookers and cotton and containers to put things in. To say, ‘We’re going to give you now heroin,’ people would have- family members would have a problem with that, especially those that have lost folks.” (POLICY PROFESSIONAL, HILLSBOROUGH COUNTY)

The same expectation about the attitude of affected family members was brought up at a PWUO group in a rural county:
“If I was over at, or my mom for instance, looking on TV and it said, ‘Hey, we’ve decided to start giving heroin addicts heroin to cure their disease,’ she would probably look at me and be like, ‘Are you effing kidding me? What are they thinking? How do they possibly think that would work?’” (PWUO-MT, ASHTABULA COUNTY)

Elsewhere, a medical professional from an urban county felt that service providers would not be comfortable with helping clients continue their heroin use, despite the potential benefits stemming from medical supervision.

“I think there’s a conflict there of: ‘Am I doing anything to truly help this person?’ Yes, you might be taking away the harm of injection and the harm of having to buy [street-sourced drugs], but you’re not necessarily getting to the underlying issue of addiction. So, I think most providers still want to get that addiction treated more than they think about the complications related to the illegality of it.” (MEDICAL PROFESSIONAL, CUYAHOGA COUNTY)

A similar observation was made at a PWUO group in an MT facility where participants felt its counselors would not be supportive of HAT and the perpetuated heroin consumption.

“I don’t think a lot of the counselors here would like it either. The IOP counselors or somebody else here. It’s all in your brain. For instance, this is what they teach us in IOP. … You’re still feeding your addiction. Your brain is still going to want it. You’re really not bettering yourself in any way, shape or form.” (PWUO-MT, ASHTABULA COUNTY)

Echoing PWUO’s concerns over the perpetuation of heroin use under a HAT program, one interviewee also felt that at least some PWUO would be very skeptical of HAT on the grounds it does not address their underlying addiction.

“I think some people feel so desperately stuck in this that they might also feel like, ‘Instead of trying to help me with my problem, they’re just going to embrace the problem and give me a way to just live in my problem forever.’” (POLICY PROFESSIONAL, NEW HAMPSHIRE)

First responders were also identified by service providers as a group that may be opposed to HAT if they felt that it does not help people stop using drugs.

Facilitator: “Do you think there are some groups that are more opposed than others as a whole?”
Participant 1: “First responders. EMTs.”
Participant 2: “Absolutely, because they’re watching people die these horrific deaths. Hospitals.”
Facilitator: “Are you saying that they would be more likely to be against?”
Participant 1: “I think they would be against.”
Participant 2: “Against.”
Participant 1: “Because they see the end result and so I think they just want people to stop.” (SERVICE PROVIDER, ASHTABULA COUNTY)
Community members would be concerned about neighborhood effects

A few key informants felt that the siting and design of a HAT clinic is an important consideration and may be a source of opposition from the community. Several interviewees opined that HAT clinics would not be acceptable to the communities in which they were to be located and drew a parallel with the optics of lines at methadone clinics.

“The community would say, for sure, ‘We cannot have a line out back of people waiting to get their heroin, so that it looks like we’re handing out heroin here to people who show up off the street.’” (POLICY PROFESSIONAL, CARROLL COUNTY)

“I don’t think they [the community] want to see lines at five o’clock in the morning like methadone, and I think that would be the concern everywhere else.” (TREATMENT PROFESSIONAL, OHIO)

One criminal justice interviewee also pointed out that co-locating HAT provision with other health services for general population may further exacerbate community concerns:

“It probably should be treated like methadone, in that you could have a separate site or you can have a certain day, because everybody wants somebody to be helped; they just don’t want to stand in line behind them, because there’s still this lack of embrace with people that have this problem. They’re still considered junkies, and criminals, and lowlifes. That’s not going to go away. It’s just like when methadone clinics came up: everybody wanted methadone treatment, but nobody wanted one in their neighborhood. That probably would change because now you’re putting heroin addicts in the waiting room with mommies, and daddies, and babies waiting for their flu shot. I think the infrastructure of a program is as important as the program.” (CRIMINAL JUSTICE PROFESSIONAL, CARROLL COUNTY)

Community members would be open to HAT as an extension of existing MT options

According to a few key informants, the perceived similarity between MT and HAT (as discussed under the first research question) is also related to questions about its acceptability. For instance, a PWUO at a non-MT facility suggested that those who are ready to accept MT should by extension also be inclined to support HAT.

“How can you be for methadone maintenance but not heroin maintenance?” (PWUO-NON-MT, HILLSBOROUGH COUNTY)

Similarly, one treatment professional suggested that arguments leveled against HAT, if any, would mirror those raised in opposition to MT more broadly. At the same time, one criminal justice interviewee disagreed and noted that despite the similarity between various agonist agents, HAT still did not seem as acceptable:

“Listen, methadone is not that much different than heroin. I’m very well aware of that. I do think that the branding of it does matter. Even in my own mind, as I’m thinking about this problem, I don’t know why it matters. Knowing that it’s just molecularly similar, I don’t know why I feel so strongly one way as I don’t the
other way. That’s difficult for me to square, and I think I’m a pretty rational person.” (CRIMINAL JUSTICE PROFESSIONAL, ASHTABULA COUNTY)

One harm reduction professional suggested another form of HAT’s similarity to MT in that, according to the interviewee, the introduction of HAT would attract hospitals and medical providers and would become a growing profitable endeavor. A similar sentiment was also voiced at an active PWUO group where a participant opined that prescribers would be keen to provide HAT.

Facilitator: “Do you think doctors would be on board with it?”
Participant: “Yes.”
Facilitator: “Doctors around here?”
Participant: “Obviously yes, they’re shoving the pharmaceutical part down your throat, so let them shove the other stuff down your throat.” (PWUO-ACTIVE, ASHTABULA COUNTY)

Community members would be concerned about diversion of prescription heroin

A few key informants noted that diversion of prescribed heroin represented a potential issue that may affect the acceptability of a potential HAT program. When discussing this risk, interviewees and provider group participants frequently likened HAT to the current situation surrounding buprenorphine/naloxone, which they reported to be commonly sold on the street. Law enforcement representatives were identified as a stakeholder group that may be particularly concerned about the possibility of heroin diversion.

“I could probably see law enforcement saying, ‘Wait a minute. We already just went down the road of not being able to control prescribing practices for physicians. But we’re going to put narcotics in the hands of individuals who are dealing with the disease of addiction, and have them be responsible for not selling it, not using it, not abusing it.’” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

This opinion was seconded by a criminal justice interviewee who agreed HAT may be perceived as encouraging or leading to the diversion of heroin.

“We already have people that resell their medication-assisted treatment medications. I think that there would be a branding issue of, ‘Hey, you can just come in and get – in essence – free heroin and maybe divert it out.’” (CRIMINAL JUSTICE PROFESSIONAL, ASHTABULA COUNTY)

One treatment professional suggested that members of the community may be alerted to the risk of diversion if there is a documented instance of prescribed heroin being sold on the street. In other words, to the extent that the public would be supportive or at least tolerant of a HAT program, this public support would be likely to dissipate if HAT was seen as enabling the diversion of pharmaceutical heroin.

“The issue would be the minute some of that got diverted. The minute that got diverted in that story, you get into the public dialogue of, ‘What are we doing here? We’re writing prescriptions to somebody who is a heroin addict for heroin.
Then, they’re selling it so they can get fentanyl, or they are selling it so they can do whatever. Or it’s ending up in our jails, or ending up in our courts.’ That’s when people would say, ‘What the heck are you doing?’” (TREATMENT PROFESSIONAL, OHIO)

In discussions over potential risks of inappropriate use of HAT by clients, one non-MT PWUO group as well as one policy professional also raised the issue of doctor shopping. To address this risk to both effectiveness and acceptability, a potential HAT program would have to be able to demonstrate how PWUO would be prevented from accessing multiple prescriptions.

Community would be in favor of providing PWUO with a drug with known composition

A small number of key informants felt that the known composition of drugs prescribed in HAT programs might help generate public support. According to this line of reasoning, the impact of problematic drug supply in the form of fentanyl and its analogs (and the fact that the community is increasingly aware of this problem) could make HAT a more acceptable proposition.

In this regard, one policy interviewee made an explicit comparison between SCSs and HAT and felt that the medically controlled context and composition of prescribed heroin could be more acceptable to the community than SCSs where PWUO would continue to bring drugs of unknown composition.

“The heroin would be prescribed by a licensed practitioner, which may give individuals who would be opposed more peace of mind than a safe injection site where somebody is bringing in drugs of uncertain purity.” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

PWUO face stigmatization in their communities

Numerous interviewees and provider group participants felt that an important factor underlying opposition to HAT would be stigma against PWUO and the prevailing view of addiction as a moral failing. This sentiment was expressed by key informants in all jurisdictions, although provider focus group participants from an urban county suggested that the stigma may be smaller in bigger cities.

“Say we looked at this disease in parity with other chronic diseases, I think people would be accepting of that. But I don’t think people are ready for this in the United States.” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

A number of key informants from Ohio added that even MT clients continue to face stigma in their communities where a substantial portion of services and support network is dominated by a 12-step-based approach that does not accept clients on MT. As a result, several treatment providers reported their clients have to hide the fact they are on MT when attending local support groups.

“There are many 12-step meetings, and many people in 12-step programs – unfortunately – that also don’t understand the medical science. So, my patients
have also been told, ‘If you take that medicine, i.e. methadone or Suboxone [buprenorphine/naloxone], number one, you are not sober, number two, you will have to find a new sobriety date, number three, I will not serve as your sponsor.’ So they basically get shunned from 12-step meetings. The very groups of people that are supposed to be supportive of heroin addicts sometimes, once they find out that they’re on a medication for their illness, turn then away and shame them. … It’s common enough that I have to tell my patients to lie about the fact that they’re not taking that medicine so that they can get the help they need in a 12-step meeting.” (MEDICAL PROFESSIONAL, CUYAHOGA COUNTY)

Community members would be reluctant to provide public funding

Related to the challenge of stigma, several professionals felt that their communities would be unlikely to provide financial support to a potential HAT program. For instance, one policy interviewee from New Hampshire stressed the local political climate was not amenable to funding programs such as HAT.

“If there was any requirement of finance from the state, and that includes oversight, no. It would never fly. This is just an unbelievably fiscally conservative state” (POLICY PROFESSIONAL, NEW HAMPHIRE)

In Ohio, service providers agreed that the public is reluctant to spend public money on vulnerable populations:

“I had somebody report to me that they were confronted for having a candy bar on the conveyor belt and using an Ohio swipe card. The fact that people are still judging what they use food stamps for…” (SERVICE PROVIDER, ASHTABULA COUNTY)

Several interviewees suggested that community concerns over public spending may be lessened if the program had demonstrable community benefits, i.e. gains accruing beyond the client population.

“It would have to be somehow translated to a way that the community could see the benefit for the community, not just every individual person. ‘Oh yes, now we just made it easier for them to the drug. Who is paying for this? Are my taxes paying for this?’ People just go around and around, it’s the same thing that you see with the Narcan [naloxone]. ‘How come Narcan is given free but people can’t get an EpiPen free?’ I believe the same kind of issues would come up.” (TREATMENT PROVIDER, ASHTABULA COUNTY)

In this regard, two interviewees raised the potential of HAT to reduce demand for illicit opioids, thereby easing the strain placed on law enforcement and drug supply interdiction efforts. Another interviewee suggested that various stakeholders may be receptive to HAT on the grounds that it may result in reductions in problem behavior such as overdoses and thus decrease first responders’ or criminal justice costs.

“There is probably going to be a lot of buy-in from communities and it’s also coming down to money but the expenses of EMS flying ambulances up and down the street all day because there is another overdose, if it is going to cut down on the expense of ER visits, I guess if people see money benefits, they
might be more open to it.” (TREATMENT PROVIDER, ASHTABULA COUNTY)

General reflections on community acceptability

In addition to the themes above, key informants offered general observations in terms of who may be more likely to be open to HAT and who may be expected to be a source of opposition without specifying the underlying reason. Stakeholder groups that were identified as potentially more open to HAT, frequently on the condition that existing evidence supports HAT, included harm reduction professionals, public health networks, mental health organizations, medical providers such as hospitals, as well as families affected by the crisis. With respect to affected families, however, this was disputed by some key informants, who felt affected families would not be in favor of HAT.

By contrast, four stakeholder groups tended to be mentioned by interviewees and focus group participants as likely not supportive of HAT. Politicians were regarded as unlikely to be in favor, due to a perceived lack of popular support for HAT. Abstinence-focused treatment specialists were also highlighted as a source of opposition, signaled by their ongoing opposition to MT. Residents in communities where HAT clinics would be located were also expected to be opposed to the program. Lastly, law enforcement agencies were also considered unlikely to view HAT favorably. However, some interviewees perceived recent shifts in attitude among law enforcement professionals vis-à-vis services such as naloxone provision, suggesting that the extent of law enforcement opposition to HAT may be smaller than commonly assumed. Similarly, several key informants noted that the extent of the crisis in their jurisdictions may lead to greater openness to previously untried interventions, such as HAT:

“If you’d ask me five years ago would New Hampshire ever cover substance use in a Medicaid expanded program I would have said no. Would they allow for syringe exchange, I would have said no. I’m still quite shocked at what the severity of the crisis has brought in terms of policy changes that I never thought would ever occur.” (TREATMENT PROFESSIONAL, HILLSBOROUGH COUNTY)

Reflections on technical feasibility of HAT programs

In addition to insights about the political and societal acceptability of HAT programs in their communities, key informants were invited to comment on any technical obstacles to a potential HAT program in their jurisdictions. In general, relatively few key informants discussed technical obstacles, focusing instead on the question of acceptability. In fact, two interviewees felt that there were no existing technical barriers to the implementation of HAT.

“We’ve got MT providers springing up left and right. The ability to do it technically is a piece of cake, in my view. We already have MT providers.” (TREATMENT PROFESSIONAL, HILLSBOROUGH COUNTY)

Still, a number of professionals raised several issues, which could be broadly categorized as either pertaining to legal considerations or to issues surrounding capacity.
With respect to legal barriers, multiple key informants pointed out that the introduction of HAT would necessitate a change in existing legal arrangements. Furthermore, according to the interviewees, the involvement of government, either at the state level or at the federal level, would likely be necessary to oversee the program and its operations, including aspects such as the procurement of prescription heroin.

“Unless you’re saying that the Federal Government or the State Government would procure it and would measure its potency, I don’t know how you could do that any other way.” (POLICY PROFESSIONAL, OHIO)

In this context, two interviewees raised the question of the relationship between the state and federal government and suggested that some form of federal consent was likely necessary.

“I liken it to medical marijuana, where we have to have independent testing labs, and create licenses for producers of this stuff. I mean, it wouldn’t be something you could ship across state lines. … Then, you’d have to worry about the DEA and the Justice Department. I mean, there’s cover for medical marijuana, there’s not cover for this, unless it was like an FDA clinical trial, you know?” (POLICY PROFESSIONAL, OHIO)

“It’s just like with medical marijuana, we think the FDA has to approve. If we’re going to call them prescription drugs, then they should be approved by the FDA.” (POLICY PROFESSIONAL, OHIO)

Rural key informants also pointed out that their jurisdictions may not have the capacity to provide a HAT service, given its relatively high demands in terms of staffing to supervise injections multiple times a day. Interviewees felt that their existing medical facilities, such as hospitals or family doctor practices, would not be in a position to take up the provision of HAT:

“If the hospitals were to do that, I don’t know if they’d be able to sustain it. If it’s a couple of times a day, I don’t know if they could give that type of person, with their staffing, that type of attention. … We have your community doctors’ offices, but, again, I don’t think that even if you were to do it at a family doctor practice, they’re not going to be able to sustain that.” (CRIMINAL JUSTICE PROFESSIONAL, CARROLL COUNTY)

In addition, rural key informants highlighted the need to find physicians who would be willing to prescribe heroin. One NH treatment professional pointed out that their community already suffers from a lack of medical professionals so adding HAT to the portfolio of services may be problematic.

“It’s really going to be capacity to deliver this too … There is definitely a need to increase capacity for professionals in the field, because a lot of these programs, we can’t offer because we can’t recruit the staff that’s required to be able to do it.” (TREATMENT PROFESSIONAL, CARROLL COUNTY)

A similar challenge was stressed by a treatment professional in OH, although the interviewee felt the challenge may be surmountable.

“You’d have to have a physician. Getting a doctor on-board would be interesting. If we could get an injection site, I don’t see why we couldn’t give prescriptions.
It’s just a matter of having a physician, and, you know, Akron’s doing some great things with needle exchange, and that’s so close to us.” (TREATMENT PROFESSIONAL, ASHTABULA COUNTY)

By contrast, another treatment professional familiar with provision in both rural and urban counties did not think capacity or the ability to find physicians would be an issue, as long as the intervention was supported by evidence.

“I think that it’s not really a matter of capacity. The physicians, if there was reasonable clinical evidence behind it, would write prescriptions for that. I don’t think that would be the issue.” (TREATMENT PROFESSIONAL, OHIO)

In addition, in situations where the HAT service would be co-located with other medical services, one rural criminal justice professional suggested that existing facilities may struggle to incorporate HAT in a way that would not interfere with their other services. For instance, their facilities may not allow the degree of separation between HAT clients and other patients that the medical center feels may be necessary. The interviewee suggested that community health centers or organizations such as Planned Parenthood may be in a position to take on board HAT; the issue for the interviewee’s jurisdiction was that there was no such facility operating in the county.

“In our county anyway, I don’t believe that we have a Planned Parenthood or something like that that is a community health center. It would be medical, but not necessarily just hospital-related-type stuff. … We don’t have one of those, so it would have to be a hospital or a doctor’s office, but I don’t think they have the staff or the space to provide that.” (CRIMINAL JUSTICE PROFESSIONAL, CARROLL COUNTY)

What might facilitate community acceptance and implementation of HAT?

Key informants in both individual interviews and focus groups were also invited to comment on what could make the implementation of HAT in their jurisdictions more acceptable. Points raised by interviewees and focus group participants in response to this question ranged from ways to inform and approach the policy debate about the implementation of HAT to various implementation features.

Educate stakeholders about evidence on HAT and emphasize its medical nature

In discussing potential facilitators, the aspect most frequently mentioned by key informants was the need to make available evidence on the effectiveness of HAT programs on outcomes of interest. This point reflected informants’ conviction that a strong evidence base would be necessary to make the argument for the implementation of HAT and to be able to influence the corresponding policy debate.

“I think the only way to do it and again, I’m not really familiar with these programs, so, myself, I don’t know how successful they are or aren’t, I don’t know. You know, it’s putting forth what the evidence shows. Like, I know, for
example, the courts are very much into looking at what the actual evidence is, versus what people think should happen or should work or whatever.”
(CRIMINAL JUSTICE PROFESSIONAL, HILLSBOROUGH COUNTY)

“That’s how we move policy, with data.” (POLICY PROFESSIONAL, ASHTABULA COUNTY)

Along with the publication of evidence, on the assumption it demonstrates the effectiveness of HAT, some professionals suggested that active education efforts will be necessary to reach out to stakeholders and community members who may not be familiar with HAT and services for heroin and fentanyl users in particular. For instance, one rural harm reduction interviewee recalled that education efforts were instrumental in engendering support for other existing services in the area:

“I think the reason that harm reduction works is because of education. It’s not until we educate people and present the research and the data that we’re going to win people over. I still, consistently, have to provide information to people about needle exchange. ‘What do you mean, you go out and give people needles?’ It’s educating people. For me, it’s one by one or through social media. I think having an evidence-based approach to this would really be helpful for the people who sit at the tables that make decisions, whether that’s the legislature, the public health networks or the trainability networks. I think it’s having a campaign to educate people about improving services in their community.” (HARM REDUCTION PROFESSIONAL, CARROLL COUNTY)

Similarly, one rural policy professional drew a parallel with past efforts to introduce MT services in the area, a process in which community education was key:

“Again, a lot of stuff goes back to data. We would have to start showing enough data that we had individuals that… The medication piece of the treatment and the treatment piece of the treatment… I’ve sold medication-assisted treatment in my community as, ‘The medication is the thing that reduces the cravings, that helps clear the person’s mind so that they can engage in treatment. The treatment piece of that, it’s outpatient treatment, it’s motivational interviewing, or the behavioral therapy, substance abuse, cognitive behavioral therapy. Whatever evidence-based practice we’re using, it’s the treatment that’s really going to get the person over the goal line. The medication helps them get there.’ That’s how I sold it.” (POLICY PROFESSIONAL, ASHTABULA COUNTY)

Key informants who commented on the topic generally expressed optimism regarding stakeholders’ interest in evidence.

“I think they’d respond well if there was lots of education on it. Like I said, if there were outcomes, how it’s presented, evidence-based models they can view and have a discussion with all of the experts in the area. I think it could be received very well. I think the local hospital would like to know more. Anybody who’s a first responder would want to know more about it, especially with outcomes. I hate to say it, but nobody wants the flavor of the month type program. Do you know what I mean? They want to see a program that’s going to have some end result. Even if they have no idea what it’s all about, they want to
say, ‘I know this person has a certain percentage chance of recovery and sobriety after this assist.’” (TREATMENT PROFESSIONAL, ASHTABULA COUNTY)

However, one criminal justice interviewee felt that there would remain a segment of community members who would not be receptive to any data.

“So I think there are some stakeholders that are very invested in that, but then I think there are other people that, they don’t care, they don’t pay attention to what the evidence says. They just think what they think in their minds and that’s, kind of, it, you know?” (CRIMINAL JUSTICE PROFESSIONAL, HILLSBOROUGH COUNTY)

The possibility to inform public opinion through education efforts was also raised by active PWUO, who felt that community opposition to HAT could be attributable to a lack of familiarity with HAT.

Participant 1: Some of the community would probably want to go against it at first.”
Participant 2: “Because they don't understand.”
Participant 1: “Because they don't understand. But once I think they got a better understanding of how helpful it would be and knowing that it would help getting the people off and they would be getting a clean substance instead of something that has been cut up. (PWUO-ACTIVE, ASHTABULA COUNTY)

In discussing the need for education, several professionals suggested that the focus should be on emphasizing the medical nature of HAT and the fact that heroin consumption would take place in a regulated, medically supervised, environment, similar to MMT.

“I think it depends on how it’s framed. If it’s framed like a methadone program, I think people would be more comfortable with it than, ‘Here I write you a script for a pound of morphine and you go out and you do it on your own.’” (MEDICAL PROFESSIONAL, CUYAHOGA COUNTY)

Two professionals from the two rural counties also suggested that it would be important to demonstrate the cost-effectiveness of HAT. According to these interviewees, HAT was likely to be met with resistance from their respective communities that may be reluctant to spend public money on services for people with substance use disorders. Having the ability to prove that HAT would result in benefits to the entire community would be very important to help overcome this obstacle. One urban interviewee also suggested that an important aspect to emphasize when discussing HAT is the extent to which it undercuts illegal drug markets.

Use the label “diamorphine” to avoid the term “heroin”

We asked key informants whether there was any merit in using the term diamorphine in lieu of heroin as a way to make HAT more acceptable in their communities. The vast majority of interviewees and focus group participants who shared their thoughts on the topic agreed that avoiding the term heroin would make a difference and could lead to greater acceptability of HAT. In support of this observation, key informants from all jurisdictions noted that there was stigma associated with heroin in their communities and felt that community acceptance of HAT
would be impacted by the fact it would involve a prescription of heroin rather than another opioid.

“Even having the word heroin associated with some type of theory, because of stigma, there is going to be a lot of backlash with that in this part of the country.” (TREATMENT PROFESSIONAL, CARROLL COUNTY)

“I do believe it would make a difference just in the perception. It’s just a word and you are replacing it with something else, but something that doesn’t already come with the baggage of what heroin means to people. Maybe people lost loved ones from heroin overdoses and then it becomes a sensitive topic if you prescribe heroin, but if you call it something else it might not hit home as hard for some people. Even if it’s the same thing but you call it something different, it doesn’t have that negative baggage that heroin comes with.” (TREATMENT PROVIDER, ASHTABULA COUNTY)

One criminal justice professional felt that by using the term diamorphine, the discussion surrounding HAT would resemble that on MT programs, without the added stigma of heroin.

“I do think it would definitely be more palatable to people that are looking at it on the outside. I do think that would definitely be more palatable. Then you just end up with the same arguments that you have now, against that treatment, which are, ‘Hey, you’re just giving people opioids to correct an opioid problem.’” (CRIMINAL JUSTICE PROFESSIONAL, ASHTABULA COUNTY)

One policy professional from Ohio was also supportive of the use of the term diamorphine and likened the branding considerations to the fact that, by law, needle exchange programs in the state are referred to as blood-borne pathogen prevention programs.

“I mean, it really is all about how you market it. … when you use ‘heroin’, it removes any kind of level of clinical nature and treatment. You go back to thinking of like, sticky, black tar… Yes, renaming it might be better.” (POLICY PROFESSIONAL, OHIO)

Service providers and PWUO were also generally in favor of using the term diamorphine. However, this sentiment was not uniform: in one rural service provider group and a non-MT PWUO group some participants disagreed with the idea that changing the name would make a difference.

Implement HAT without relying on public money

Three interviewees from three different counties suggested that communities would find HAT more acceptable if its implementation did not rely on public funding. This suggestion reflects a theme discussed in earlier sections of this paper – a perceived reluctance of communities to spend money on services for people with substance use disorder.

“I think there’ll be some concern about whether you’re spending taxpayer dollars on something like this. I would say if we could get a private philanthropic resource to invest in this and then approach the legislature about a small pilot.” (TREATMENT PROFESSIONAL, HILLSBOROUGH COUNTY)
According to interviewees, private financing may also be advantageous because it may enable HAT implementers to avoid regulatory burden that could be associated with public funds. One NH-based interviewee offered an example of the adoption of the state’s needle exchange legislation, where a contributing factor was the fact that it did not involve substantial obligations for the state.

“I think the reason that we were able to pass the Needle Exchange Bill in July is because there was very little red tape. There was no burden to the state. … I think that New Hampshire has a very libertarian outlook, especially in our legislature. I see them leaning more towards something to empower people to be supervisors that wouldn’t really cost much and wouldn’t raise taxes, as they say here, and that’s a very big thing. … They see a building with somebody in a white lab coat and they see dollar signs. ‘Why are we spending money on these people?’ That’s what they would say.” (HARM REDUCTION PROFESSIONAL, CARROLL COUNTY)

However, one medical professional pointed out that even with the avoidance of public funding, some sources of opposition were likely to persist. One example of a persistent concern would be worries about community-level impacts and NIMBY-like sentiments.

“I guess if it was privately funded. Like, ‘Don’t use my tax dollars for that.’ If some billionaire came in and said, ‘I’m building this,’ what could people say? They would say, ‘Not in my neighborhood.’” (MEDICAL PROFESSIONAL, CUYAHOGA COUNTY)

Start with a pilot program

Three interviewees from urban counties and participants at an urban user focus group suggested a suitable way forward could be to establish a pilot scheme or a trial before proceeding with a full service. From the perspective of community acceptability, the benefits of a pilot would be to demonstrate how a HAT service operates and examine whether it can be effective in improving outcomes for its clients as well as the community. If the pilot is indeed successful, this could be expected to help make the community more open to the provision of HAT.

“Yes, you would have to probably start small and show some really strong successes for it to sort of grow. I mean, you’d have to really win over people little by little.” (POLICY PROFESSIONAL, OHIO)

Demonstrate arrangements are in place to avoid diversion

Several professionals stressed that putting arrangements in place to avoid diversion was critical to maintaining community acceptance of the program. In practical terms, this likely meant requiring the prescribed drugs to be administered onsite and not allowing any take-home doses.

“…it can’t go out onto on the streets. I think there’s that rumor that people are selling their prescriptions and doing all that stuff. Someone who doesn’t understand, they want to see that contained type program, it’s monitored well and it’s not being taken advantage of. That there’s an actual end result. That’s my
professional opinion.” (TREATMENT PROFESSIONAL, ASHTABULA COUNTY)

“I think, taking that tack and certain forms or certain restrictions in terms of places of use and those kinds of things. The more you can dress this thing up to look medical or be medical, not that people get loaded syringes to take home and do it what they want, but they have to use on site, etc. All those kinds of things, I think, would bring down resistance to a pilot substantially.” (MEDICAL PROFESSIONAL, CUYAHOGA COUNTY)

“Whether it’s heroin-replacement or Suboxone [buprenorphine/naloxone], or methadone, or what have you, is if we can get this so that some of the concerns we talked about in terms of security and in my backyard and so on and so forth, then I think we’ll have something that is a winner.” (TREATMENT PROFESSIONAL, OHIO)

In this context, several key informants discussed the implications of allowing various forms of heroin administration for the effectiveness and acceptability of HAT. Importantly, a few professionals stressed that injections are a practical way to verify that PWUO have taken their dose and, by extension, to prevent diversion, even though one treatment provider noted the demanding structure a HAT program would impose on PWUO.

“I like the injectables for lessening the diversion but then it would depend, is this going to be extended release or is it going to be once a day come in and get- then you are going to blow the veins, or you can get a port for injecting. It’s just too much when it comes to injecting. Do they come in and administer it themselves? Do they come in and have maybe a nurse administer it? The sites have to be clean. Probably inhaling or swallowing but I’d be concerned with diversion.” (TREATMENT PROVIDER, ASHTABULA COUNTY)

Similarly, another treatment professional felt that, while some PWUO may prefer pills, these may be more prone to diversion (i.e., sale of the medication on the street), which would lead to substantially reduced community support for the program.

“As long as it’s administered under a doctor, whatever works for the client. Some of them don’t want to take the shots, they’d rather have the pills. My concern is, if the pills are out on the street there’s going to be misuse and there’s going to be theft. It’s going to be the same as the opioids are right now with somebody going into your bathroom and taking them.” (TREATMENT PROFESSIONAL, ASHTABULA COUNTY)

At the same time, some key informants, although not everyone who commented on this point, opined that the use of injectable heroin could contribute to a negative perception on the part of some community members. By extension, if a potential HAT program offered other forms of administration in lieu of injections, this could help overcome some community concerns.

However, participants in two active PWUO groups argued strongly against the exclusion of injections. They warned it would strongly discourage clients from using the program as injecting was an important part of the using experience sought out by the using population.
“I can share a junkie’s point of view, it doesn’t matter what you put in a syringe. I was like a garbage can. You can liquify it I would shoot it.” (PWUO-ACTIVE, ASHTABULA COUNTY)

Keep HAT as a low-profile program

Participants at two PWUO groups suggested it would be beneficial for any potential HAT program to keep a low profile for two unrelated reasons. PWUO at a group held at an MT facility felt it would be desirable to avoid advertising the program broadly so as not to attract too many new PWUO.

“I definitely don’t think it should be advertised or a big thing. It should be kept secluded and reclusive, so that not everybody knows about it and thinks it’s cool. The kids want to go there.” (PWUO-MT, ASHTABULA COUNTY)

Participants at an urban active PWUO group stressed that a HAT facility should be as discreet as possible to help clients avoid being stigmatized or afraid to use the program.

“[Clients] must feel they're not exposed out there on the street. A building like here and there, make a big ass line outside. It’ll be something, like, you go inside the facility, you pick a number or whatever. Anything indoors. … People are going to feel more safe going there. A lot of people, they’ve got jobs, because a lot of people, people know, and they don’t want to be seen out there.” (PWUO-ACTIVE, CUYAHOGA COUNTY)

Complement HAT with wraparound services

Service providers and PWUO felt that the effectiveness of a potential HAT program may depend on whether supervised consumption is accompanied by a suite of complementary services. According to these focus group participants, heroin prescriptions should not be seen as a standalone intervention that could be effective on its own, but rather should be conceived as working in conjunction with other wraparound services. Similarly, one treatment professional from a rural county argued other needs such as housing need to be attended to for people in the program.

“How are the basic ADLs being met, the housing, the transportation, the food and the hygiene? That needs to go along with that if this is a last resort. People get kicked out of hotels, they get kicked out of shelters or they get kicked out of family members’ homes. The question is, is there a way of providing more secure housing while in a program like this with the basic needs along with it? Realistically.” (TREATMENT PROFESSIONAL, ASHTABULA COUNTY)

Service providers noted that the need to focus on complementary services is equally applicable to MT programs, although existing MT practice does not always meet this standard.

Participant 1: “I think, regardless of whether it’s Suboxone [buprenorphine/naloxone], prescribed methadone, prescribed heroin, the difference is, what other kind of treatment is being used in conjunction with that to help these people find a better way of living, a healthier way of living? I mean, if it’s going to be like the Suboxone [buprenorphine/naloxone] programs we have
where they suggest you go to counseling then that’s pointless. … Methadone, where they bring you in for 15 minutes and meet you once a week, it’s pointless. You know, the problem is, with medication-assisted treatment, is not the medication that’s used, it’s the assistance that’s not happening.”

Participant 2: “The medication is supposed to be assisting the treatment. It shouldn’t be the only treatment unto itself.” (SERVICE PROVIDER, CARROLL COUNTY)

Similarly, participants at an MT PWUO group and at an active user group felt that HAT could be successful if it came with complementary services that could address multiple facets of clients’ disorder.

“All maybe if there was some sort of therapy, figuring out what’s going on with them... I mean, I personally don’t think that anybody that uses heroin has had a wonderful life in childhood. There’s probably something that went on. If they had to use that and dig into the person’s life... I don’t know. I imagine it would work.” (PWUO-MT, CUYAHOGA COUNTY)

Integrate HAT with an existing medical facility

Several key informants, predominantly but not exclusively from rural counties, suggested that a HAT program may be more acceptable if it were integrated with a medical facility. Among concrete suggestions for co-location arrangements, hospitals were most frequently suggested as a potential host institution. For instance, one professional involved with a hospital service in a rural county felt that their organization may be a suitable venue for a HAT program.

“We’d prescribe it appropriately, control it appropriately and follow it up appropriately, in the context of a clinical program and messaged appropriately so that, somehow or other, we keep the newspaper from headlining that [hospital] was handing out heroin. If it’s the right thing to do, we’ll do it.” (POLICY PROFESSIONAL, CARROLL COUNTY)

Similarly, service providers at a group held in an urban county offered an example of a local hospital, which could host a HAT service. Having a HAT program integrated in the hospital’s wider portfolio could help address at least some of the community’s potential concerns.

“If it was managed through a reputable hospital like the [hospital] or something like that, then it would be more accepted, rather than just some place opening up their doors and being there.” (SERVICE PROVIDER, CUYAHOGA COUNTY)

Elsewhere, however, one treatment professional from a rural county argued that treatment providers would be a better fit for a HAT program than medical providers. This was because, according to the interviewee, there was currently strong resentment towards prescribers in the community owing to their perceived contribution to the opioid crisis. By contrast, treatment providers may be in a better position to gain community’s buy in, particularly for a controversial project such as HAT.

“I would say probably in a treatment facility would gain more acceptance from the community. I feel like the community blames the medical community a lot for a lot of the problems in this area. There is a lot of blame there. … I think from
a community standpoint you have more buy in coming from the treatment providers. They are accepted, currently, but that is because we are not offering a wide array of controversial programming either.” (TREATMENT PROFESSIONAL, CARROLL COUNTY)

HAT Summary

Interviewees as well as provider focus group participants felt that HAT programs could offer some benefits but also notable drawbacks in attempting to improve outcomes for heroin and fentanyl users. Among the most frequently mentioned benefits, key informants noted the benefits of providing PWUO with a drug of known composition and felt that HAT may be suitable for PWUO who have unsuccessfully tried other treatment options. With respect to perceived downsides of HAT, professionals primarily expressed concern that HAT programs would enable drug use and do little to address the underlying addiction problem. Notably, approximately a third of interviewees expressed desire to learn what the evidence underlying HAT programs was to better inform their judgment regarding its effectiveness.

Participants in focus groups with PWUO engaging with treatment services were much more skeptical of the effectiveness of HAT. In fact, some participants at rural focus groups held at an abstinence-based facility laughed when they were asked about their views on HAT. The predominant concern voiced by these groups was that HAT would perpetuate drug use and would be used by patients to top up their illicit drug use. By contrast, active PWUO were the most open to the idea of HAT, in particular the fact that HAT clients would be prescribed a safe drug, although they also identified a series of potential shortcomings.

With respect to the acceptability of HAT in their respective communities, key informants across the board tended to view the prospect of HAT implementation as extremely infeasible. This was a sentiment expressed particularly in rural areas, although even informants from urban counties and state-level interviewees generally felt HAT would not be acceptable, at least currently. The most frequently cited reason behind this observation was a belief that any potential implementation of HAT would be impeded by local community values and culture. Other, albeit less frequently mentioned obstacles to HAT acceptability included local, NIMBY-style opposition and concerns surrounding the diversion of prescribed heroin.
5. Key Informant Perspectives about SCSs

Overview

In this chapter, we discuss all themes that emerged in interviews and focus groups in response to questions about the effectiveness and community acceptance of SCSs, and factors that could potentially facilitate acceptance and implementation. Below we discuss each theme and how themes varied across stakeholders and counties, and we provide exemplar quotes from interviewees and focus group participants. We provide a summary of views about SCSs at the end of this chapter.

The material is divided into three subsections that correspond to our three questions: could SCSs help PWUO, would key informants and other members of the community accept SCSs, and what special features of SCSs, if any, might facilitate community acceptance of SCSs. Because some ideas were voiced in response to more than one question, they appear in more than one section.

Do key informants believe SCSs could help improve outcomes for PWUO?

We asked open-ended questions about whether key informants in both individual interviews and focus groups thought SCSs could help improve outcomes for PWUO. Below we discuss each theme, how themes vary across key informants and counties, and we provide exemplary quotes from key informants. Table 9 lists all themes that emerged and their frequency (i.e., low, medium, high or very high frequency is indicated if the theme emerged in 1-25%, 26-50%, 51-75% or 76-100% of transcripts, respectively) that answer the question above. The denominator is the number of transcripts, not participants. If multiple focus group participants mentioned a theme, it was only counted once. We include an indicator of frequency to show how the emergence of themes differed between professionals and PWUO.

Table 9. Could SCSs Help Improve Outcomes for PWUO? All Themes Cited by Key Informants (Professionals and PWUO)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Professionals* N=80</th>
<th>PWUO** N=79</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reasons SCSs could help improve outcomes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCSs could help prevent overdose deaths</td>
<td>Medium</td>
<td>Very High</td>
</tr>
<tr>
<td>SCSs could help link PWUO to treatment and other resources</td>
<td>Medium</td>
<td>High</td>
</tr>
<tr>
<td>SCSs could provide PWUO with a safe, nonjudgmental place to use</td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td>SCSs could provide clean needles and information to prevent HIV, HCV and abscesses</td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td>SCSs could provide drug composition testing</td>
<td>Low</td>
<td>Medium</td>
</tr>
</tbody>
</table>
Reasons SCSs might not help improve outcomes

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>PWUO would view it as a law enforcement trap</td>
<td>Medium</td>
</tr>
<tr>
<td>SCSs would be stigmatizing for PWUO</td>
<td>Medium</td>
</tr>
<tr>
<td>PWUO would be reluctant to travel to an SCS after purchasing drugs; they want to use immediately</td>
<td>Low</td>
</tr>
<tr>
<td>SCSs would enable/perpetuate opioid use</td>
<td>Medium</td>
</tr>
<tr>
<td>SCSs would create a forum for drug dealers</td>
<td>Low</td>
</tr>
<tr>
<td>PWUO do not want to be monitored while using</td>
<td>Low</td>
</tr>
<tr>
<td>SCSs increase risks for PWUO</td>
<td>Low</td>
</tr>
<tr>
<td>PWUO who participated in 10 focus groups.</td>
<td>Low</td>
</tr>
</tbody>
</table>

**Not sure if SCSs would help improve outcomes**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need to see more evidence</td>
<td>Medium</td>
</tr>
</tbody>
</table>

NOTES: N/A: Not applicable; theme did not arise in any transcripts; Low frequency: Theme arose in 1–25% of transcripts; Medium frequency: Theme arose in 26–50% of transcripts; High frequency: Theme arose in 51–75% of transcripts; Very high frequency: Theme arose in 76–100% of transcripts.

Professionals include all non-PWUO key informants who participated in an interview (N=44) or focus group (N=5 groups and 36 providers) who were invited to participate based on their current profession; it is acknowledged that some PWUO might also be “professionals”

**PWUO who participated in 10 focus groups.

Reasons SCSs could help improve outcomes

SCSs could help prevent overdose deaths

Interviewees and focus group participants – PWUO in particular – thought SCSs could be effective at preventing overdose deaths. Most who commented thought that at the very least, even amidst community opposition and personal ambivalence, SCSs could help keep people alive. As noted by PWUO and professionals:

“Again, that goes back to point blank, it’s to save lives. It’s to make sure we’re not dying. You can’t get people into treatment who are dead. It’s literally the number one, that’s the end of the sentence about a safe, whatever it’s called…” (PWUO-NON-MT, HILLSBOROUGH COUNTY)

“My feeling is that if I keep that person alive long enough, they will develop some form of recovery.” (MEDICAL PROFESSIONAL, CUYAHOGA COUNTY)

“We have tried everything we could think of in Cuyahoga County, and we have actually been successful in implementing the vast majority of it. The numbers keep going up, not down, in terms of fatalities. My personal view is, I’m running out of options so why the heck not try it? I understand and respect the argument that you’re permitting this, does that send the wrong message? I work with police all the time. Are we asking police to look the other way? I understand all of that, but I’m at the point where I’m willing to try anything.” (CRIMINAL JUSTICE PROFESSIONAL, CUYAHOGA COUNTY)

PWUO who were actively using opioids at the time tended to support SCSs with few or no reservations because it can prevent overdoses:

“[SCS] saves lives, is what it does.” (PWUO-ACTIVE, CUYAHOGA COUNTY)

“Well, there will be fewer people that are going to die, because the fentanyl is what’s killing people here.” (PWUO-ACTIVE, CUYAHOGA COUNTY)
In contrast, some PWUO who were receiving treatment (MAT or non-MT) tended to favor treatment over harm reduction (including SCSs), but did note that SCSs could help prevent overdoses among PWUO waiting to get into treatment. PWUO discussed several reasons they might have to wait for treatment, including long waiting lists and the requirement of some programs that focus on MT that require PWUO to be in active use to begin the program, even if they are clean of opioids when they first apply. According to these PWUO, some programs that offer MT require a “dirty” urine to be admitted to prevent those coming into the program with the sole aim of selling the medication on the street. These PWUO, all currently in treatment, had this to say:

“It’s literally because all the people who are dead, we can’t help them if they’re dead. You can’t help an addict if they have overdosed and died. So, I know it doesn’t sound like a good thing, it doesn’t promote an environment or recovery, and this and that, but it’s just to save lives.” (PWUO-NON-MT, HILLSBOROUGH COUNTY)

“I feel like it would bring the crime rate down and the overdose rate. But then, on the other hand, what is that really going…? That’s just going to be maintenance It’s like it’s okay, you know, to keep using. Maybe if that service also offered information or other services that provide you help to get clean, maybe then I would think it would be something that would be positive.” (PWUO-MT, ASHTABULA COUNTY)

One PWUO offered this comment about an SCS potentially being useful for preventing overdose before being admitted to an MT program:

“Even me coming here. I was clean for a month and a half. Even for me to get that proper treatment, I had to be dirty when I came here. I went back out and I used one time. Just to have a dirty urine screen, I overdosed. For those of us that are out there still using but waiting to get help and everything, I think those facilities would be great.” (PWUO-MT, ASHTABULA COUNTY)

SCSs could help link PWUO to treatment and other resources

This theme emerged in professional interviews and focus groups and PWUO groups, with greater frequency among in-treatment PWUO and professionals in both Ohio counties (Ashtabula and Cuyahoga). One actively using PWUO from Cuyahoga County opined that “no one wants to actually receive counseling when they are on a mission to get high,” but other stakeholders, including PWUO, pointed out that just having staff present at an SCS on a long-term basis could ensure that PWUO could be connected to services when they are ready, through a “warm handoff” to services from trusted staff. As stated by these stakeholders,

“Maybe when we’re there, surrounded by a couple of people who care, and this and that, they’re able to provide services if we ask for them. It’s not like you go there and they’re shoving stuff down your throat. Point blank it’s to save lives and the next point of it is to help us get treatment for people who have no idea how, no idea where or just don’t have the desire to reach out. But, if you keep going to this place and keep seeing people that care while you’re sticking needles
in your arm, eventually those are the people that are going to be able to take your hand and help you get into a safe place.” (PWUO-NON-MT, HILLSBOROUGH COUNTY)

“The reason why people when you save them with Narcan [naloxone] don’t all go to treatment and stay sober for the rest of their life – you know, quote unquote, scared straight, is because on a stage of readiness for behavior change, they were pre-contemplative when they woke up this morning and they might be contemplative after their overdose, but they’re rarely ready for action. But, they sooner or later will be ready for action, and so if you can provide a safe place for shooting, that has naloxone there and has something to clean the works, etc. When they are ready for action, the person you saved has a much better chance of being healthy and still being alive, when they are ready to make some changes in their lives.” (MEDICAL PROFESSIONAL, CUYAHOGA COUNTY)

Notably, while stakeholders believed SCSs could facilitate linkage to treatment, nearly all expressed the need for more treatment resources, particularly in the two rural counties.

“Certainly, I mean, the overdoses, if you can prevent an overdose, that in and of itself has value. I think, again, that would be great in getting people connected to services, but there need to be more services available.” (CRIMINAL JUSTICE PROFESSIONAL, CARROLL COUNTY)

Throughout all the discussions, key informants drew parallels between needle exchange programs (NEP) and SCSs, primarily when discussing the benefits of potential linkage to treatment and other social services and the probability of community acceptance. However, while some cited treatment linkage as another positive attribute of SCSs, others cited it as possibly the only way to “sell” SCSs to community members who do not fully subscribe to a harm reduction philosophy. As summed up by this interviewee,

“Politically, I think there’s still a lot of fear and ambivalence about what the correct step is to take. In my mind it’s an issue of engagement. If people come and they use safe injection sites and it establishes the pathway for a relationship and access to treatment, I think that’s a good thing in the long run.” (TREATMENT PROFESSIONAL, HILLSBOROUGH COUNTY)

Similar to comments supporting SCSs because of its potential to prevent overdoses despite reservations about the concept as a whole, some comments about treatment linkage benefits also reflected some key informants’ willingness to accept SCSs out of desperation, even against their own beliefs.

“Give me time to digest it. I see the benefit of a barrier-free shelter. I’m in that avenue, if you know where I’m going on this. Accepting someone who’s in use and who’s willing to accept information for sobriety. My thoughts are, could that be the next step for the person?” (TREATMENT PROFESSIONAL, ASHTABULA COUNTY)

“Over the course of time, initially, I thought, ‘Well, I think that’s a bad idea because…’ It sounded to me like the only thing people were really trying to do was just not change the lifestyle but keep the people from inconveniently dying. I’ve come to change my thinking on that, though, because I think that if you
adopt a model where the person can go and use their illegal drugs, it’s a ‘bigger picture’ kind of thing, where, yes, you can put these folks in access to treatment and you can put them in connection with that warm handoff.” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

SCSs could provide PWUO with a safe, nonjudgmental place to use

Although this theme overlaps somewhat with other harm reduction benefits of SCSs, comments here pertained distinctly to beliefs that an SCS could provide a safe haven for PWUO where they are accepted, not judged, and safe from law enforcement, over and above other harm reduction benefits. These key informants suggested that having a space where PWUO are shown both compassion and safe injection could act as a mediator of sorts, ultimately leading to the broader benefits of overdose prevention and treatment linkage:

“I think if there’s a safe space that shows compassion to people who use, where you’re not kicked out if you are using in front of them, I think that actually is something. I think generally people don’t want more people to die. They really don’t like seeing everyone die. I don’t know that that’s universal.” (POLICY PROFESSIONAL, OHIO)

“Motivated people, if they could get to safety and be in that constant contact with people who cared about them and drove home that thought, probably would turn to a safer way of using. Maybe go on to a more medicated-assisted treatment and then maybe change it and say ‘I want to back away from everything with support.’ I can absolutely see that there would be a segment of the population that would take advantage. Advantage in a positive way.” (TREATMENT PROFESSIONAL, HILLSBOROUGH COUNTY)

“... say they put that [SCS] in. Okay. Everyone is going to know what it's for. So, if you have a problem people will come out and be open and honest with it, maybe the lying will stop, maybe overdoses will reduce. You never know. Especially if it's supervised, meaning you don’t… You guys aren’t going to let someone sit there and die, right?” (PWUO-ACTIVE USER, ASHTABULA COUNTY)

Key informants also noted that “safety” could include keeping people from injecting and leaving needles in public places, which would not only increase the safety of PWUO, but also could alleviate burden on other community members. As noted by these key informants,

“As long as the word got out there that they weren’t being harassed, they weren’t being judged, they weren’t being arrested. I think you would probably get people who would go there, and again, it’s got to be a heck of a lot better situation than where they go in the restroom of the Dunkin’ Donuts, a back alley off one of the inner-city streets and use, and nobody’s there to monitor them.” (HARM REDUCTION PROFESSIONAL, HILLSBOROUGH COUNTY)

“I think it would be a major burden off not just the police, who have to look out for this stuff, but it would be a major burden off the community as well because… I mean, I work downtown and you hear all the time from other, like, stores and stuff, ‘Oh, we had an OD in our bathroom today.’ Workers at these stores will find people all the time. Now it would give them a place. Instead of the gas station bathroom, the supermarket bathroom, wherever, it would give
them a place to go and use. If they OD, the facility will call because a lot of times when we find them, we can’t – someone who’s OD’d – a lot of times it’s at the point where it’s beyond help.” (PWUO-NON-MT, CUYAHOGA COUNTY)

Last, some PWUO discussed safety in the context of feeling safe from law enforcement:

“But if we can get away with it, I mean, ‘Oh, I’m not going to jail, I can go here and be in possession of something? Oh, great, I’m going to go there. Like, let me go there.’ That’s what I would think about it. [Safe from] the law, yes, that’s how I think about it.” (PWUO-NON-MT, HILLSBOROUGH COUNTY)

SCSs could provide clean needles and information to prevent HIV, HCV, and abscesses

SCSs as a strategy for preventing diseases emerged among professional interviewees and service provider groups and among PWUO groups, although PWUO discussed abscess prevention and treatment more than HIV or HCV prevention. Notably, neither rural county (Ashtabula or Carroll) currently has a legal NEP and, while some pharmacies sell needles and some have what are referred to as “secondary needle exchanges” in which people buy needles or obtain them from a legal NEP in another county and distribute them to PWUO, key informants in both rural counties expressed frustration with the lack of community support for NEPs.

Like other comments about SCSs being effective and accepted primarily for overdose death prevention but little else, some comments here also reflected on HIV and HCV prevention and the protection of public health as the very least that could be done to address the crisis, and a benefit that might appeal to community stakeholders reluctant to embrace a full harm reduction approach.

“We’re saying, ‘If you’re going to have this addiction, and you’re not ready to change, we should at least give you the safest way possible to do it so that you’re not spreading HIV and hepatitis C to other people in the community and leaving your dirty needles all over the streets.’” (MEDICAL PROVIDER, CUYAHOGA COUNTY)

“We’re basically going to set up a government funded area for people to use illegal drugs. I can understand and appreciate why anyone would have to do a double-take when they hear that. I do think it could reduce harm, which I think should be our main goal. If you had people coming in, they’re coming into this facility so they’re going to be safe and they’re going to not spread additional bloodborne illness.” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

“Obviously, I do [think SCSs could improve outcomes], but the reason why I was a little bit glib there on defining the outcome is that I think we, in the medical field, have done a terrible job of defining the outcome. If the outcome is, let’s keep people out of the morgue, and let’s keeping people from having other expensive co-morbid things going on, like Hepatitis C or HIV etc., I 100% do [think this could improve outcomes].” (MEDICAL PROVIDER, OHIO)

PWUO comments around disease prevention and health promotion also noted SCSs’ usefulness for providing information about “safe shooting” and preventing and treating abscesses, more than on HIV or HCV prevention:
“I think it’s important because a lot of people get abscesses. I’ve seen it on the necks. The whole thing about bad needles is, with somebody who uses one, if it gets dull, they don’t care. If it falls off, they don’t care. I understand, like he said, that it encourages it, but not a lot of people actually use that. I’ve known people who would rather go to Walmart and try every pharmacy before... I mean, I personally have never even gone to the needle exchange.” (PWUO-MT, CUYAHOGA COUNTY)

“You know you’re not fully in, but you are getting the blood return, and you are like, ‘I’m getting blood return so it’s got to be in.’ Then the next day you have some crazy abscess or something. I went online. We had stuff, and I went, ‘How to shoot up, tips to shoot up.’ I think [information about how to shoot up at the SCS] would be helpful.” (PWUO-ACTIVE, CUYAHOGA COUNTY)

SCSs could provide drug composition testing

A handful of interviewees and focus group participants noted that offering drug composition testing could be a benefit of an SCS for PWUO, could help prevent overdoses, and could potentially help make SCSs acceptable to policy makers. These key informants were referring specifically to fentanyl testing strips, which can be used to test heroin for the presence of fentanyl. The theme was mentioned by frontline service providers and actively using PWUOs, primarily in the two Ohio counties.

Even ambivalent key informants seemed to think testing the composition of drugs to prevent overdoses could be a tangible benefit of SCSs:

“I think what a site like this could do is you could use the strips to make sure that your heroin is not laced with something, and that might be a point of access for that. I think there might be more support for perhaps pieces of this as opposed to the entirety of it. To grow institutions to promote healthier use of drugs, I think, would be quite controversial, although I clearly understand the public health implications, not unlike the needle exchange programs.” (POLICY PROFESSIONAL, OHIO)

“That’s a hard question for me to answer. I can tell you that looking at it at face value, if there’s a safe environment where someone can have drugs tested before they inject them, would that positively affect overdose numbers? I think it will but I don’t know enough about a program like that where I would say allowing people to inject drugs is encouraging them not to inject drugs. I don’t see how that would benefit the crisis in general. It may benefit that particular individual at that particular time, but if we’re going to fight the crisis as a whole, I don’t know enough about a program such as that to say that that’s going to be beneficial.” (CRIMINAL JUSTICE PROFESSIONAL, HILLSBOROUGH COUNTY)

PWUO also noted the benefit of drug composition testing:

“You are already out in that area to get dope, so why not stop there and do it? At least do your first shot there, so you know what it is.” (PWUO-ACTIVE, CUYAHOGA COUNTY)

“I think it would be good, at least the testing of it, to make sure that it’s not going to kill you. I don’t think the dope is going to kill me. It’s what they are putting in with it.” (PWUO-ACTIVE, CUYAHOGA COUNTY)
“You’ve got to bring in safe dope, not any fentanyl. Bring us the correct dope, I want to do heroin, when I do heroin I don’t die, and I don’t see people die. You would have to bring us controlled dope.” (PWUO-MT, CUYAHOGA COUNTY)

**Reasons SCSs might not help improve outcomes**

Professional interviewees and service providers, as well as PWUO, raised several reasons SCSs might not help improve outcomes for PWUO.

**PWUO would view it as a law enforcement trap**

PWUO and professionals thought SCSs might be viewed by PWUO as a law enforcement trap—a place for the police to target PWUO for arrest, either for drug possession or some other reason. For some, this was viewed as a reason that SCSs might not be effective at all, while for others it was noted as a barrier that could be overcome and compared to the trust typically earned by a harm reduction program over time.

PWUO suggested that their fear of law enforcement might prevent them from using an SCS, despite it having some potential benefits.

Participant 1: “I feel like the cops would just stop it.”
Participant 2: “Right, they’d be around the block, like, every five minutes.”
Participant 1: “They know who we are anyway.”
Participant 2: “Yes, they all know us.” (Laughter)
Participant 1: “Yes, they’d be waiting for you to pull over.”
Participant 2: “They’d be waiting for us to walk out.” (Laughter)
(PWUO-MT, ASHTABULA COUNTY)

Participant 1: “And it’s the fact that you can scream, ‘It’s safe,’ all you want, I know I would never ever feel like that’s going to be a safe place to go.”
Participant 2: “Oh, I’d be petrified. I would be petrified.”
(PWUO-NON-MT, CARROLL COUNTY)

“I wouldn’t go there [to an SCS] if I was using, purely because if it’s known that there’s a place where a bunch of people are using drugs, cops are going to be all around there.” (PWUO-MT, CUYAHOGA COUNTY)

The prevailing sentiment among professional interviewees and focus group participants was that PWUO would not use an SCS until they were sure that they wouldn’t be arrested for possessing narcotics or identified for other reasons, such as by child protective services or immigration officials, and that there might always be some PWUO that are so mistrustful that they would never use an SCS.

“Individuals are still scared to meet us out in public, so we don’t have a bricks-and-mortar [needle exchange] site. Everything is done on foot with a backpack or a toolbox. We have to meet them in the alleyway. We have to meet them behind a building or something. We have to meet them after hours because they’re afraid of the cops, which has also coincided with the fact that, since 1st February, our call volume really hasn’t increased a whole lot. I think that the same is probably going to be with if we were to implement a safe injection site. The culture needs to be created, and that’s what we’re trying to do here in Hillsborough County, if
you will, with the syringe service that we have. It’s creating the culture versus letting the culture catch up to the process.” (HARM REDUCTION PROFESSIONAL, HILLSBOROUGH COUNTY)

“You can’t really have an open house for someone who’s in drug use because a lot of times they have probation officers, they have warrants out for their arrest or there are people looking for them. It’s a safety issue and also a compliance issue, so I’m thinking they’re going to go by what’s going on in their situation and saying, ‘How would this benefit me? Am I going to get in trouble? Am I going to get arrested?’” (TREATMENT PROFESSIONAL, ASHTABULA COUNTY)

To allay PWUO concerns about law enforcement, some professionals suggested that trust could be increased if the SCS were run by an existing, trusted entity, like a NEP, as discussed by this stakeholder:

“If it were run by [an NEP], or another trusted organization, then I can see it being a really good fit and I can see clients wanting to engage. I think it might not have the same appeal if it’s run by the Health Department … Especially depending on what happens with immigration reform, just depending on the person’s status as far as being legally a citizen or not. I feel like that’s where, sometimes, the trust of the local more politically connected organizations – It’s just less effective, because it’s hard for the community to trust them.” (HARM REDUCTION PROFESSIONAL, CUYAHOGA COUNTY)

Others noted that while trust could be established, it would take a very long time:

“I believe in this community it would take a long time for people to begin to trust. They’ve done it underground for so long and they don’t even trust social workers because they’re afraid of what we could do or call the police. I think it would take quite some time for people to accept it.” (TREATMENT PROVIDER, ASHTABULA COUNTY)

“It’s hard to get a foot in and get somebody to feel like this is for real, this is safe, this is trustworthy and I’m not going to get arrested. Those are the kinds of things it looks like are already a barrier for people engaging with the syringe program. Hopefully as time goes on they’ll get more comfortable with it. I imagine it would be something along those same lines.” (HARM REDUCTION PROVIDER, HILLSBOROUGH COUNTY)

“Because we’re a small community it could take time and working it out. It may work, I just don’t think it would happen overnight. I think it would take quite some time for people to begin to trust, to know that they’re not going to get into any kind of trouble and they’re not going to be turned in. You’re not going to be recording what they’re doing and turning it into the courts. Like I said, it would take more time.” (TREATMENT PROVIDER, ASHTABULA COUNTY)

Some stakeholders, including PWUO, suggested that SCSs might be viewed as less of a law enforcement trap in urban areas compared with rural or suburban areas:

“I think that maybe that’s a model that works in more urban areas. A safe injection facility in this community would stick out like a sore thumb. You would have people fighting each other over drugs, you would have parents going in there, enraged, looking for their children. You would have the police probably circling it.” (TREATMENT PROVIDER, CARROLL COUNTY)
“Cleveland is pretty good about the needles and everything. They’ve got so much other shit to do. If they had a place where people could just go, and they got high and they were safe, I don’t think Cleveland would have a problem. Suburbs, oh, they would sit outside and wait. They would target, they would wait, they’d see people walking up, they’d pull them up before they got in there. They’d sit on whatever the border was, like, if it was if you’re a mile, like for the needle exchange, if you’re a mile from any of the exchanges then they won’t mess with you. If you’re in the suburbs.” (PWUO-ACTIVE, CUYAHOGA COUNTY)

SCSs would be stigmatizing for PWUO

Some professional and PWUO key informants suggested that the stigma and shame experienced by PWUO might prevent them from using an SCS altogether:

“I don’t know if they would do that [use an SCS]. Some of them don’t want to be labelled as users, so I don’t know if they would be willing to come out of the shadows, with the chance of being seen, walking in and walking out of one of those places by someone that they might know that maybe doesn’t know that they do have a habit. There may be some stigma with that that some of them aren’t willing to come to terms with.” (CRIMINAL JUSTICE PROFESSIONAL, CARROLL COUNTY)

“I’m not sure [if PWUO would use an SCS]. There’s a lot of stigma that we're trying to reduce just to get folks to actually come and pick up syringes that have not been used. There is stigma to the point where folks won't access help, I don't know, but there's a place where people know that other folks aside from the people who inject would know. I don't know if people would go, because we have folks that are just from all different walks of life, I really don't know.” (POLICY PROFESSIONAL, HILLSBOROUGH COUNTY)

“Completely my opinion, this is just from the interaction that I’ve had with people that use – with addicts. I don’t think that they would find it helpful. I feel like most people with an addiction problem are ashamed of their addiction problem. I don’t think that they feel like parading it out and showing up at the injection site and saying, ‘I’ve got to go to the injection site to use.'” (CRIMINAL JUSTICE PROFESSIONAL, HILLSBOROUGH COUNTY)

In contrast, others thought that an SCS that supports dignity of PWUO could mitigate the experience of stigma:

“Some of them would [use an SCS]. I mean, it depends on how much dignity they have about going into that place, what dignity they’d lose or their integrity as a person on that substance.” (SERVICE PROVIDER, CUYAHOGA COUNTY)

Professionals and PWUO also discussed stigma potentially being greater for PWUO in rural and less well-traveled areas where there is greater potential to identify individual PWUO, and that busy, urban areas may offer greater anonymity and less stigma for PWUO. As noted by these professionals:

“Visible street level folks who are active users [would use an SCS], active injectors, along with folks who may or may not be, who are homeless. The street population, if you will, is visible. It’s easier to move about in those kinds of
settings. If somebody is in a 20, 30,000-population town, everybody knows everything that’s going on. It’s the same reason that pharmacy access is okay, but really pretty ineffective, right? People just don’t want to walk into a pharmacy and be on camera and be identifiable.” (POLICY PROFESSIONAL, NEW HAMPSHIRE)

“Not enough anonymity [for an SCS], it’s too small a community. No, it’s too small a community.” (SERVICE PROVIDER, ASHTABULA COUNTY)

However, PWUO suggested that an SCS likely would be stigmatizing even in urban areas:

“Even with the community, imagine opening something like this in Nashua. People driving by and seeing that line going into the place. Like, people judge. It’s a fact.” (PWHO, HILLSBOROUGH COUNTY)

“I am filled with such guilt and shame when I shoot up that I’m not going to go to somebody and, ‘Could I shoot up here real quick, just in case I die?’” (PWUO-NON-MT, HILLSBOROUGH COUNTY)

PWUO would be reluctant to travel to an SCS after purchasing drugs

This was salient among PWUO focus groups and also arose in a handful of professional interviews and focus groups. PWUO in all counties, rural and urban, in both states, active and in-treatment, seemed to agree that traveling to an SCS after purchasing opioids is not desirable or realistic because they generally want (and need) to use immediately, and that they do not wish to spend all day at the SCS or return multiple times a day. As noted by PWUO:

“I don’t think people would use it much for this reason. At least for me, when I go get my fix, I want to do it ASAP: as soon as possible. If I don’t have water, I’ll use 7-Up. I’ll get water from the gutter. I’ll spit on top or whatever but I’ve got to get fixed because of desperation and stuff like that. I’m sick already. I’m not going to go over there, wait in line and fill some paperwork so a nurse can give it to me.” (PWUO-MT, ASHTABULA OHIO)

Participant 1: “Honestly, how many of you are going to go to your dealer and then wait to get your fix to get to a safe [injection site]?”
Participant 2: “I’m going right in the bathroom and I’m getting it going.”
Participant 3: “That’s why you find people dead in cars, you’re not waiting. Nobody’s waiting.” (PWUO-NON-MT, CARROLL COUNTY)

Participant 1: “Right, and to me, when you get your dope, you’re not going to grab your dope, go all the way to the place and wait. You know what I mean?”
Participant 2: “Your life is short. (Laughter) I’m not going to wait.”
Participant 3: “Right, you’re not going to travel to go to these [SCS].” (PWUO-MT, CUYAHOGA COUNTY)

“But someone like me, when I use I’m shooting up every hour, at least, you know what I’m saying? So, it would be, kind of, when I get drugs I do it until it’s gone. I would be there all day. Honestly, I wouldn’t want to go there and chill there all day. I’d want to be in my apartment, you know what I’m saying?” (PWUO-NON-MT, HILLSBOROUGH COUNTY)
“I know for myself, I’m in active addiction, I’m not like, ‘Oh, I’m going to pick up and then go here to use.’ I literally go pick up and do it right there.” (PWUO-NON-MT, HILLSBOROUGH COUNTY)

“I would say no. I wouldn’t have the time to go there and do that.” (PWUO-ACTIVE, CUYAHOGA COUNTY)

PWUO also noted that traveling after using at an SCS, particularly for PWUO who have traveled far by car, would be problematic:

“That’s another issue about having a safe place like that around here is because there are no buses and it is limited as to how you can travel around here if you don’t have a car or anything like that. A safe place like that might not help very much, at least not in this particular area. The other problem is if you do have a car and you have a license, you’re going in, you’re shooting up, you’re getting high and then you run the risk of going down behind the wheel of your car as you’re leaving, and that creates a whole other set of problems in itself.” (PWUO-NON-MT, CARROLL COUNTY)

Professional interviewees and focus group participants generally shared the same concerns as PWUO, with some noting that transportation in rural areas would be even more of a hindrance for PWUO using an SCS, but even some in more urban areas cited the post-purchase travel time as a barrier:

“I think there might be more buy-in in less rural areas, maybe the larger cities where its access would be much easier. Over here, if you live far away from the- unless you have somebody giving you a ride but who’s going to give you a ride there? Then there is less- I might live in a small town, but it seems like in a bigger city, things like that could blend in a lot easier.” (TREATMENT PROVIDER, ASHTABULA COUNTY)

“I can’t speak for anyone, but based on my experience with some of the folks at the user level is a lot of them don’t have the ability to go buy drugs and just have those drugs sit in their pocket for hours, or however long it’s going to take to get to whatever safe place, wherever the safe place happens to be. They’re going to buy the drugs and they’re going to use them, because they’re buying them because they’re desperate to begin with.” (CRIMINAL JUSTICE PROFESSIONAL, HILLSBOROUGH COUNTY)

SCSs would enable/perpetuate opioid use

Among PWUO, rural PWUO currently in treatment—both MT and non-MT—held strong views about SCSs enabling or perpetuating use (i.e., facilitating the individual’s opioid use and doing little to address the underlying addiction), while sentiments were more nuanced among urban PWUO in treatment and active PWUO. PWUO from the two rural counties had this to say:

“No, it’s a negative way [to address the opioid crisis]. That’s like- yes, that’s a negative one. There’s no other way to call it. I don’t think they should ever put anything like that because people will use that as an advantage and then an excuse. ‘Oh, I can just go somewhere and safely get high.’ I don’t know.” (PWUO-NON-MT, CARROLL COUNTY)
“Also, you know why I would be against something like that even though it has good perspective for family members and stuff like that. If we try to make all this process easy for people, like to give them sandals to walk through hell. If they don’t burn their feet, they’re not going to know how horrible hell is. To me, my struggle and my suffering, that made me hit rock bottom and decide that was not the type of life that I wanted to live anymore.” (PWUO-MT, ASHTABULA COUNTY)

“This whole subject, of bringing programs in to keep it going, using, it makes me sick to my stomach, right? It makes me sick to my stomach.” (PWUO-MT, ASHTABULA COUNTY)

“I don’t know. I just don’t really like, like everyone said, the idea. People should be more urged to recover not just keep using heroin. In some cases, whatever, but I personally wouldn’t do it. I personally don’t feel like I’m classified to decide for each and every person what’s appropriate for them, but for myself, no.” (PWUO-MT, ASHTABULA COUNTY)

“I just feel like it would be a concentration camp for dope, I mean, just kill us all off with that.” (PWUO-MT, ASHTABULA COUNTY)

PWUO in treatment in the urban counties also noted that an SCS perpetuates use, but were less definitive about their stance, and some noted how others incorrectly think that an SCS perpetuates use:

“I mean, I don’t know if I’m having a hard time feeling like it might encourage people to want to do it, you know, because they’ll feel like, ‘Someone’s here. They can watch me. They can make sure I’m safe.’ I don’t know. It’s hard to explain, really.” (PWUO-ACTIVE, CUYAHOGA COUNTY)

“People don’t get that. They think it’s an enabling thing, they think it’s allowing it but it’s not.” (PWUO-NON-MT, HILLSBOROUGH COUNTY)

“There are kids out there that there are afraid of it and trying the drugs and whatnot, but then you get a safe haven where you can go and do it and be safe. I think it could be dangerous there, but, again, I’m 50:50 with it too. It’s the damage you do there if you don’t address the situation.” (PWUO-MT, CUYAHOGA COUNTY)

“I don’t know. I’m 50:50 with it. I don’t agree with it because I think it would open the door to other people with other drug addictions to say, ‘Well, why can’t we have crack stations or whatever they’re called?’” (PWUO-MT, CUYAHOGA COUNTY)

Some actively using PWUO who discussed this issue were not at all ambivalent; they felt strongly that an SCS would perpetuate and condone use, as stated by this PWUO:

“It’s their choice, so you go to that place, it’s almost like you're allowing drug use. You're allowing, you're saying, ‘Come here and bring your drugs, and come and shoot here.’” Then you just use and you can get high. I just don’t see people wanting to quit when you're saying, “‘You know, come on in here and we’ll let you get high here.’” You can see them and you can get high, but if you want to quit, you're going to be like, ‘Why would I want to quit?’” When you're high, and you're still here, and it’s safe and it’s great.” (PWUO, CUYAHOGA COUNTY)
Professionals who commented about SCSs perpetuating use generally discussed it in terms of how other community members would view an SCS, with the exception of a few who were themselves opposed because they believed an SCS would enable opioid use:

“Yes, so a safe injection site without a place to send someone who is crying for help is just a shooting gallery that’s got a defibrillator in it. That’s all it is.”
(CRIMINAL JUSTICE PROFESSIONAL, CUYAHOGA COUNTY)

“I oppose. I mean, maybe it’s because it’s from a nursing standpoint. I just think it’s causing more harm. Yes. It just depends, but I definitely would not think that promoting safe practices of drugs is good. No. It goes against what I believe.”
(SERVICE PROVIDER, CUYAHOGA COUNTY)

SCSs would create a forum for drug dealers

Some key informants—primarily PWUO—expressed concern that SCSs would create a forum for drug dealers. As expressed by PWUO:

Participant 1: “If I see my dealer standing right outside of here, what the fuck do you think’s going to happen?”
Participant 2: “My dealer came into [treatment center] when I was in there.”
Participant 3: “That brings up a good point, because a lot of the dealers that I knew were drug addicts themselves. I didn’t know any dealer that was just in it to make the money, I got it all from addicts. And I’ve sold dope to two-and-a-half people in this room.”
Participant 4: “Two-and-a-half? (Laughter)”
Participant 3: “One was a middleman.” (Laughter) (PWUO-MT, ASHTABULA COUNTY)

“If you’re saying, ‘You can come with drugs and shoot up here,’ what’s going to stop somebody from coming with drugs for themselves? And selling a buck’s worth for the guy who didn’t realize he had to bring his own. He makes 10 bucks.” (PWUO-NON-MT, CARROLL COUNTY)

“You put any two addicts together and it’s like, ‘Hey, who do you know and who do I know? Let’s go.’” (PWUO-NON-MT, HILLSBOROUGH COUNTY)

Some professionals shared this opinion:

“[An SCS] just brings so many questions to the forefront of my mind. We do things like we’ve monitored jail calls before. We have legitimate drug dealers who are not users, and we hear conversations. This isn’t every time, but we’ve heard them where they say, ‘Hey, I’m just going to tell the lawyers that I’m a user and I’m going to try to get in a drug court,’” which undermines the whole program. It just reminds me a lot of some issues that we’re already having to some extent, because there are obviously a lot of folks that will try to do that. These are the real criminals.” (CRIMINAL JUSTICE PROFESSIONAL, HILLSBOROUGH COUNTY)

“Okay, here, we have to monitor people. You have this group of people who are used to buying and selling drugs on the street. Sometimes, that happens here and we have to police that. People are bringing their drugs. So, logistically, I’m just wondering how you would monitor that. It brings gang involvement. It brings violence. It brings a lot of other things to a site where you’re trying to provide
PWUO do not want to be monitored while using

A few PWUO and professionals thought that PWUO would not want to be monitored or watched while they were using opioids, as they would be in an SCS, even though they acknowledged that being monitored might be safer for them. PWUO spoke from their own experience:

Participant 1: “But if I’m getting high I am too paranoid to go where anybody is.”
Participant 2: “That’s the problem.”
Participant 3: “I’m not going to go and shoot dope and be monitored, and if somebody is telling me ways to get clean I’m going to tell them to shove it up their arses. You know, when I’m in active addiction… I’d be like, ‘Don’t tell me how to do this.’”
Participant 4: “I hated all those people, anybody who was in AA I was like… Stop trying to tell me how to… I can do it myself. Obviously, I was wrong ….”

“You don’t want to be in front of a nurse doing that when you know you’re doing something illegal.”

“I know when I was using, because I’m in recovery, I probably wouldn’t have gone somewhere that you were watching me get high.”

SCS increases risks for PWUO

PWUO participants in rural focus groups in both states in MT and non-MT treatment and participants in one professional service provider group expressed concern, some from anecdotal stories, that an SCS would increase risks—risk of overdose and getting robbed in particular—for PWUO.

“…I know is that I’ve talked to someone in Seattle, where he was, they have a house, it’s housing for people to use, I don’t know if they monitor them or not. He said they just carry bodies out, all day long. You know what I mean?”

“Yes. I foresee people selling and buying drugs in them.”
Participant 2: “It can help with something like that in a recovery center.”
Participant 1: “Because you know they’ve got drugs.”
Participant 3: “People get robbed as they walk through the door.”
Participant 1: “Yes, exactly.”
Participant 3: “I mean, that’s what you’ll see.”
Participant 1: “In the parking lots.
Participant 3: “You’ll see that. I mean, you know that whoever’s walking in that place has stuff. That person is going to get robbed.”

“My first-hand experience is with [someone] whose son ended up in the [city] using site, it’s probably in [suburb]. It’s a city block, an old mill building or something that is heated somehow, and people go in there and they use and
inject. They line up the hearses and the EMT trucks outside the door. They take about six or seven overdoses a day out of there to the morgue, and a few others go to the hospital. While it was said, ‘We will have trained facility people there and volunteers,’ it turns out not to be. The people who want to work there are not trained facilitators and recovery coaches, and stuff like that. They’re not referred very well to places. The disheveled condition that he found his son in, he picked him up, threw him over his shoulder and lugged him out of the building. I could spend an hour talking to you about it, which is horrible. So that kind of facility, which I’ve heard proposed for Baltimore and lots of other big cities, would be horrible up here. It’s just enabling people with their addiction and it’s not helping to solve the addiction problem.” (SERVICE PROVIDER, CARROLL COUNTY)

**Not sure if SCSs would help improve outcomes**

Need to see evidence

Several professionals and PWUO discussed the need to see more evidence about SCSs before forming a final opinion and advocating for it in their community. Key informants also expressed that community stakeholders also will need more evidence. Key informants expressed the need for outcome data, specifically on the impact of SCSs on overdose deaths, and on implementation feasibility in similar communities. Some suggested pilot and demonstration projects.

**Do key informants believe SCSs would be acceptable to community members?**

To assess whether key informants believe SCSs would be acceptable to community members, we asked in both individual interviews and focus groups open-ended questions about whether they thought an SCS would be feasible to implement in their communities and about what (and who) the obstacles would be. Several themes emerged that describe cultural and attitudinal barriers to establishing an SCS. Some themes overlap with themes that arose with respect to whether key informants themselves believed an SCS would be acceptable to PWUO, discussed in the prior section.

Table 10 lists all themes that emerged and their frequency (i.e., low, medium, high or very high frequency is indicated if the theme emerged in 1-25%, 26-50%, 51-75% or 76-100% of all transcripts, respectively) that answer the question above. The denominator is the number of transcripts, not participants. If multiple focus group participants mentioned a theme, it was only counted once. We include an indicator of frequency to show how the emergence of themes differed between professionals and PWUO.

---

Table 10. Do Key Informants Believe SCSs Would be Acceptable to the Community? All Themes Cited by Professionals and PWUO

<table>
<thead>
<tr>
<th>Theme</th>
<th>Professionals* N=80</th>
<th>PWUO** N=79</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCS implementation would be impeded by community values and local culture</td>
<td>Very High</td>
<td>Medium</td>
</tr>
<tr>
<td>Community members would believe SCSs enable/perpetuate use</td>
<td>Medium</td>
<td>Low</td>
</tr>
<tr>
<td>Community would say &quot;Not in my Backyard&quot; (NIMBY)</td>
<td>Medium</td>
<td>Low</td>
</tr>
<tr>
<td>Stigma against PWUO would impede implementation</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>SCSs are not a priority in the community right now</td>
<td>Medium</td>
<td>Low</td>
</tr>
<tr>
<td>There might be more buy-in for SCSs in &quot;less rural&quot; areas</td>
<td>Low</td>
<td>N/A</td>
</tr>
<tr>
<td>Rural communities do not have the resources to implement SCSs</td>
<td>Low</td>
<td>N/A</td>
</tr>
<tr>
<td>Community members would believe SCSs normalize opioid use</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>SCSs would affect neighborhoods and community resources</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>SCSs would “clean up” the streets and reduce strain on police and EMS</td>
<td>Low</td>
<td>Low</td>
</tr>
</tbody>
</table>

NOTES: N/A: Not applicable; theme did not arise in any transcripts; Low frequency: Theme arose in 1–25% of transcripts; Medium frequency: Theme arose in 26–50% of transcripts; High frequency: Theme arose in 51–75% of transcripts; Very high frequency: Theme arose in 76–100% of transcripts.

*Professionals include all non-PWUO key informants who participated in an interview (N=44) or focus group (N= 5 groups and 36 providers) who were invited to participate based on their current profession; it is acknowledged that some PWUO might also be “professionals”

**PWUO who participated in 10 focus groups.

The lack of acceptance of SCSs by community members due to community values, local culture, and resistance by politicians was the most frequently cited barrier across professionals and PWUO. There was general agreement across key informants in all four counties that SCSs would face resistance by politicians and by community members for a variety of reasons, including conservative cultural beliefs, fear and stigma; conservative politicians; isolated communities that are not fully aware of the extent of the opioid epidemic; historical precedent for resisting new programs for PWUO, including NEPs and MT, and overall community resistance to the harm reduction philosophy.

Key informants in New Hampshire described their legislature as “the second largest legislative body in the world,” “aging,” and “conservative,” and unlikely to support initiatives that conservative and aging voters would not themselves support. New Hampshire key informants described a long, protracted battle to have a NEP approved, a battle which only was won within the past couple of years, and had no state funding attached and no brick and mortar building to support it; there now are only two NEP in the entire state. Key informants speculated that an initiative to establish an SCS would be met with similar, if not more opposition by legislators and by voters.

Stakeholders in Ohio also described a conservative legislature, but also noted that with the “home rule” system, counties have more control over their own programs. Even so, stakeholders described a “Midwest” conservatism among voters, even in Cuyahoga county, which is typically thought to be more progressive politically than other counties. Like New Hampshire, Cuyahoga won a decades-long effort to establish a NEP. NEP are now supported by a state law that allows
municipalities to set up a NEP without an emergency resolution. Until this law was passed in 2013, Ohio had two NEP—one in Cleveland and one in the town of Portsmouth—that operated through emergency resolutions passed by city councils. Now NEP can be established without an emergency resolution, however, even with the passage of the law, most counties and cities in the state do not have a NEP.

Although less so in Cuyahoga county itself, stakeholders from all counties noted that communities (and the voters within) generally lean conservative fiscally and socially, which can translate into lack of support for harm reduction. Although stakeholders in both states noted that discussion about SCS has taken place among public health and social service officials (e.g., the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) boards in Ohio, and the Regional Public Health Networks in New Hampshire), stakeholders still felt that the majority of the voting public—but more so in the rural counties—likely would not currently support SCSs. As described by these stakeholders:

“We think, in this conservative state, it’ll never happen. Maybe in Massachusetts or Vermont. In New Hampshire, we can barely get - even in the healthcare industry – two or three that believe syringes are necessary or that Narcan [naloxone] is a necessary thing in your medicine chest. There are a lot of ethical issues to consider with clean sites.” (TREATMENT PROFESSIONAL, CARROLL COUNTY, NH)

“We are one of the oldest, aging, or at least one of the oldest, aging counties in the nation. It’s an older generation, and stigma has a lot to do with it. It really does. I mean, I think that’s going to be the biggest barrier.” (TREATMENT PROFESSIONAL, CARROLL COUNTY, NH)

“We’d love needle exchange. We’d love safe injection sites. We would love any of that stuff. That’s been very difficult, culturally, to convince people of. I would say the farthest we’ve gone in that direction is naloxone kits, and that’s even been a struggle in terms of the community at times.” (TREATMENT PROFESSIONAL, ASHTABULA COUNTY)

“The people who tend to vote, tend to be older. They tend to go to Church more. I doubt many drug addicts make up a core voting group. I could imagine that would be a tough political sell for a politician.” (CRIMINAL JUSTICE PROFESSIONAL, CUYAHOGA COUNTY)

Some key informants thought community resistance stemmed from a lack of knowledge about and lack of support for harm reduction and from a leaning toward abstinence-based approach rather than from general conservatism. This view was particularly salient in Ohio, which many stakeholders explained is “the birthplace of Alcoholics Anonymous (AA).” As described by this stakeholder:

“When I say, ‘they,’ of course, we have stakeholders and I want to tell you a little bit about that as well. I looked at the first [NEP] meeting that we had and I looked at the sign-in sheet. Police, law enforcement, treatment facilities, you know, politicians, people from various organizations, HIV providers. We have the same conversation over and over and over. Basically, the treatment facility
people, because they have an abstinence-based mindset, and a lot of people feel like we’re promoting drug-use.” (HARM REDUCTION PROFESSIONAL, CUYAHOGA COUNTY)

Many key informants were left discouraged after their NEP initiatives, and are further disheartened by the pace of MT adoption and resistance even to naloxone distribution:

“Given what we saw happen with the needle exchange story here, it makes me feel like… We couldn’t even get that. I don’t even know how many years, I’m sure it’s all documented, but there was a very, very, long process of trying to consider and getting the needle exchange idea shot down. Only after that long battle did it finally get approved. And then nobody wanted to pay for it, so nothing happened. Just because it was approved, nothing happened. If that had such a tough sell, just to give people access to clean drug work[s], I can’t imagine why they would readily embrace a safe injection site. I don’t know why they would, I don’t know why they would.” (POLICY PROFESSIONAL, NEW HAMPSHIRE)

“Even if that were legitimately brought up as a possibility in the communities, I can well imagine that in this county there would be a lot of pushback. There would be a lot of stigma aligned with those kinds of services. We’ve already seen that with naloxone distribution. There is a lot of stigma that people have to overcome in order to even get themselves to the naloxone distribution events.” (POLICY PROFESSIONAL, ASHTABULA COUNTY)

“… Narcan [naloxone] stuff, we’ve been hammering on for four years and now maybe half the county thinks it’s okay, and that’s a huge win. It’s taken forever and ever and ever and now its availability is more widespread.” (SERVICE PROVIDER, ASHTABULA COUNTY)

Community members would believe SCSs enable/perpetuate opioid use

Many key informants stated that in addition to potential general political and cultural resistance, a specific argument against SCSs would be that they would be seen as enabling or perpetuating opioid use and not treating the underlying addiction.

“I think the trains of thought on this are, “Okay, it definitely would help us reduce the number of runs from an EMS or a police standpoint. It definitely would help us reduce the collateral damage associated with intravenous drug use. On the backside, though, the concern was, ‘Is having a safe injection site really working to eliminate the addiction?’” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

“I think the climate in this city would frown on the fact that we’re allowing a place for somebody to use. It would almost be like you’re contributing to that bad habit of the individual.” (HARM REDUCTION PROFESSIONAL, HILLSBOROUGH COUNTY)

“We’re already seeing pushback on the concept of syringe services because people just don’t understand that you’re not enabling people by doing this. I think it’s that public misinformation probably more than anything. The concept that people can’t just get past that you’re encouraging drug use when you provide these types of services. Condoning, encouraging, whatever the right word is. To
me, that’s seems like the most obvious. Unfortunately, even when you provide them with information it doesn’t really go anywhere, their mind is made up.”
(TREATMENT PROFESSIONAL, HILLSBOROUGH COUNTY)

Several key informants described that an AA-driven, abstinence based philosophy in Ohio, and “libertarian” and “live free or die” attitudes in New Hampshire underlie an ongoing view of opioid addiction as a moral failing. According to key informants, these views have affected acceptance of NEP, MT, and naloxone in the past, and support the view that SCSs enable use. As described by these professionals,

“Our treatment philosophies are based in AA. AA was born in Akron, so there’s a very strong 12-Step feel. The AA is, ‘You’ve got to hit rock bottom out there.’ The whole harm reduction piece of it is pretty counter to most people in AA. I think because it’s such a strong AA area, there would be a lot of pushback, like what you were saying in the outpatient...” (SERVICE PROVIDER, CUYAHOGA COUNTY)

“I would think that the prevailing sentiment in New Hampshire would be that addiction is a moral dilemma and that if people wanted to stop, they would stop. And that looking at all these other things would be promoting use and making it acceptable.” (TREATMENT PROFESSIONAL, HILLSBOROUGH COUNTY)

Community would say “Not in My Backyard” (NIMBY)

Key informants also noted that there likely would be resistance to having an SCS within “their” neighborhood or community, even if the overall concept were generally accepted and supported, at least superficially. Stakeholders described this is as the “NIMBY” phenomenon. As explained by this stakeholder,

“You might just have the whole ‘not in my backyard’ gang who are, theoretically, on board with it, but maybe not as interested. “Where do we put the site?” I could see that happening. It’s not easy, as I recall, setting up a methadone clinic, and those are far more established medication-assisted therapy places. I think the political climate isn’t really supportive of this yet, and it will probably be one of those things that maybe some cities will try it, have success with it and then it starts the cycle in motion. They’ve been trying to push for Cleveland to think about it and our county to think about it, but it’s really not been at all warmly received.” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

Others described having had “NIMBY” experiences when trying to find sites for recovery and treatment centers, and anticipated the same for SCSs due to fear of increased crime and violence or risks to drug PWUO themselves, and lower property values. This concern was noted across all four counties, as noted by these stakeholders:

“Well, we’ve already seen some prospect from neighbors about even where the recovery centers are located, at least in sister communities. They, kind of, don’t want it in their backyard, that type of mentality. So, I think that if there was going to be an injection site, that would probably be more of a concern for people.” (HARM REDUCTION PROFESSIONAL, HILLSBOROUGH COUNTY)
“There is lots of vacant land in Cleveland, there is lots of abandoned housing. I’d imagine it could be set up in a place that would have minimal impact. That being said, I understand the fear. We see drug dealers setting up outside methadone clinics, there is no reason to think they wouldn’t be set up outside of safe injection sites. Does that lead to an increase in property crimes for people looking to get just enough money to support their habit? The majority of the property crimes we see are related to people doing petty burglaries, and things like that, to feed their addiction.” (CRIMINAL JUSTICE PROFESSIONAL, CUYAHOGA COUNTY)

“I think that, with anything, it depends on the area. For instance, with recovery housing, I know that – just from our communications with other boards across the state and at the state level – there has been some pushback with recovery housing and inpatient treatment facilities springing up in certain neighborhoods. In our area, there has been a little bit of pushback from the community about recovery housing in certain neighborhoods but not in others. There is such a difference in all of our communities, when you talk about stakeholders, and where we might get pushback.” (POLICY PROFESSIONAL, ASHTABULA COUNTY)

“It’s the NIMBY, the not in my backyard, in our community particularly. We’re in a National Forest, it’s a service industry driven economy, people can barely make a wage – at least the middle class and the service class – so when we start to scream addiction and we need help for these people. ‘Well, that’s not happening here.’” (TREATMENT PROFESSIONAL, CARROLL COUNTY)

There was some suggestion that there would be more “NIMBY” in suburban versus urban areas:

“It depends on the area. (Laughter) Suburbanites are probably not going to let you do it in their area. Even though the majority [of PWUO], 96%, are coming from the suburbs, they don’t want to admit that people are coming because they don’t want their property value to drop. They don’t want people to complain, so they don’t admit to the issues. They don’t admit to drugs being in the school.” (SERVICE PROVIDER, CUYAHOGA COUNTY)

“In the suburbs they’re just not looking at helping people out. It’s about how they look, that’s the way. How they look, or- This is not going to look right here, because looking for a bunch of addicts around my neighborhood, oh, they don’t like that.” (PWUO-ACTIVE, CUYAHOGA COUNTY)

Stigma against PWUO would impede implementation

Although stigma against PWUO clearly underlies NIMBY and goes hand in hand with cultural beliefs, some key informants discussed stigma as a separate issue, and emphasized it as a likely cause of community resistance to SCSs. Often the description of stigmatizing beliefs was related to the belief that “addicts” make the choice to use, and a reason to justify not providing harm reduction assistance through an SCS. These stakeholders described these beliefs in their communities this way:

“You’ve got a whole lot of old people that already have their preconceived notions of addiction anyway, like, ‘Well, they made the choice to stick the needle
in their arm and they can stop anytime they want.’’ (CRIMINAL JUSTICE PROFESSIONAL, ASHTABULA COUNTY)

“I think it’s the philosophy. ‘You’re just going to let these dirty addicts… You’re going to give them a clean place to use? You’re basically saying, It’s okay to have your addiction.’’ There’s the opposition.” (MEDICAL PROFESSIONAL, CUYAHOGA COUNTY)

“The other one would be denial, for lack of a better word. It’s somebody else. It’s some nefarious individuals who are using these drugs. They chose it, it’s a personal lifestyle and it’s a moral failing. It’s not my community. You’ve probably heard the saying, not my community, not my kid. They don’t think it’s real. If it’s happening in their community, they think by sponsoring it is maybe a word they would use, sponsoring illegal drug use. That you’re going to increase it and encourage it as opposed to stopping it.” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

“... sometimes what I hear is, ‘I just want to help the good people.’ I’m not sure who the good people are, but the suggestion is that it’s not people who have opioid use disorder. There’s still this, ‘You must be a morally weak person if you have this, or a crook, if you have this problem.’ We still have misunderstanding in that particular space.” (POLICY PROFESSIONAL, NEW HAMPSHIRE)

“I think that you are going to run into even more stigma about that than we have for even a methadone clinic. I think it’s a heavy lift.” (TREATMENT PROFESSIONAL, OHIO)

SCSs are not a priority in the community right now

Some key informants who otherwise supported SCSs commented that there are more pressing priorities right now in addressing the opioid crisis than establishing an SCS. Several commented that they, themselves, not just other community members, feel that an SCS should not take precedence over expanding existing evidence-based services, such as NEP, detox facilities, and MT, as well as other services that improve and support access to care, such as transportation and social services. Although perhaps slightly more emphasized by those in the rural communities, the sentiment was shared by several key informants. Urban interviewees spoke about prioritizing the expansion of existing services:

“I, just, am looking at it from the standpoint I’ve been in public health long enough. You put a lot of money, you put a lot of time, you put a lot of emphasis on a good law, it gets killed for the wrong reason. Instead of, maybe, spending money on something we don’t know. Maybe we spend money for those treatment agencies and get money to increase beds and increase awareness, maybe expand the needle exchange. Those are some of my thoughts.” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

“In terms of all of the other things that we could do right now to improve mortality or lessen mortality and improve health, it would not be the highest on my list ... My priority would be to get rid of the waiver requirement, open more detox facilities, hire more medical professionals to work in this area and pay them appropriately for it.” (CRIMINAL JUSTICE PROFESSIONAL, CUYAHOGA COUNTY)
Rural professionals felt similarly, but with an emphasis not on expanding existing services but putting these services in place for the first time:

“What would be immediate help for us, because some of these things might be so far out, there might be so much legislation but some kind of transportation vouchers maybe for people to get into treatment so they don’t have to owe everybody and their brother a ride to get here. Things that are immediate help. ...We don’t have a needle exchange program. We don’t even have a place for Ashtabula community to safely deposit dirty needles. Not even for insulin, so forget about heroin but people who are on insulin don’t have a takeback program or anything like that. Those tangible things, if you do those before the bigger stuff, it would have a huge impact.” (TREATMENT PROFESSIONAL, ASHTABULA COUNTY)

“I think [an SCS] is way down the line. We need primary treatments, assessments, intervention, detox. That’s so far ahead. We need the most basic, basic levels of care first. And the transportation to get people where they- This is a very rural area. We do not have a city ... We’re fighting for licensed alcohol and drug counselors to provide weekly counseling. We’re fighting for transportation to get them to their counseling visits. We’re so far back before all this stuff that you’re talking about and it’s an uphill battle, if you can get those things going.” (POLICY PROFESSIONAL, CARROLL COUNTY)

“I think there are so few resources right now that if we’re going to get any money into this community, it’s for treatment. People are asking for treatment, and we don’t have sober housing. They’re on the streets. We don’t have what they need and what they’re asking for. To give them something like that, to me, it doesn’t sit well with me at all. That’s a misuse of money.” (SERVICE PROVIDER, CARROLL COUNTY)

“We have to crawl before we can walk and we’ve got to walk before we can run.” (POLICY PROFESSIONAL, CARROLL COUNTY)

State professionals also weighed in on the current priorities in each state:

“... again, this is Midwestern Ohio, and I think safe injection sites, well frankly, let me get a methadone center before we go there, I guess, is how I feel about it. Or, how about a needle exchange program at the very least? I think that shows the Midwestern conservatism, and that people are looking interested in advocating, but it’s going to be smaller steps than what we are discussing here.” (TREATMENT PROFESSIONAL, OHIO)

“... users of these substances don’t even try to get into treatment anymore because it’s just not something that feels in any way accessible. I think that’s the problem, we have so many barriers to access to resources. There are so many levels of resources that we can think about. Even Narcan [naloxone], they feel is not accessible in the way it needs to be in our communities. Nor is Suboxone [buprenorphine/naloxone] treatment, and on and on. So I hesitate to focus on an injection facility as a solution at this point. It just feels like that is so far from the first step of what’s needed in this state.” (POLICY PROFESSIONAL, NEW HAMPSHIRE)

Several PWUO also commented on SCSs not being the current priority:
Participant 1: “The needles thing, I totally agree with the needle exchange because, ‘Oh, my needle’s worth another needle.’ I wouldn’t be going and paying this out, right.”
Participant 2: “People were paying $20 for used needles.”
Participant 1: “That’s what I’m saying. That would change a lot around here with the disease control, which you were asking about.”
Participant 3: “I feel like there are better services out there that we could try before bringing some sort of…[an SCS].” (PWUO-MT, ASHTABULA COUNTY)

“We need a longer detox that’s longer than seven days, because you can go to New Path and New Day, they will get you in just like that, but you’re there for seven days and in seven days you’re ready to go out and get high right away. I’m making calls on my way home before I get out, ‘Who can pick me up?’” (PWUO-MT, ASHTABULA COUNTY)

“Instead of a [SCS] they should do a medically assisted treatment and sober living. Why are we going to some place to shoot up, we’re going to go wherever we damn well please. I think it’s a waste of money and resources.” (PWUO-NON-MT, CARROLL COUNTY)

One interviewee pointed out that prioritizing resources on an SCS reflects a lack of equity. As stated by this interviewee, the focus on the opioid epidemic, which is predominately affecting Whites, shifts resources away from non-Whites who suffer from disparities in health care:

“What we are saying with NAS [neonatal addiction syndrome] is the white babies matter more than the black babies who are dying or preterm birth. Like is that not what we’re saying? It’s a very interesting thing to me to see what gets funded and what doesn’t. Clearly that’s a very broad acknowledgement of the difference in the racial and ethnic groups that actually have the problem. But, I could see someone saying, ‘Sure. You are going after stuff that affects the middle-class people, and you’re still going to leave us stuck in the quicksand.’ I think since you’re writing this very broad piece for policymakers, I think having a broad perspective at the beginning as it relates to health equity might be helpful.” (POLICY PROFESSIONAL, OHIO)

One criminal justice professional emphasized that, while SCSs might ultimately help active PWUO, more needs to be done to address the supply of opioids:

“That’s great that we’re helping people who are afflicted with it now, but, if heroin wasn’t available, we wouldn’t be worried about where they can inject it, because they wouldn’t be injecting it. The frustration from the law enforcement side is that we obviously support rehab, we support all these programs, but let’s not lose sight of the fact that some of these programs wouldn’t be needed if heroin/fentanyl never made its way into the country to begin with.” (CRIMINAL JUSTICE PROFESSIONAL, HILLSBOROUGH COUNTY)

There might be more buy-in for SCSs in “less rural” areas

Although this was implied in some of the discussion about the effectiveness of SCSs for PWUO, some informants also believed that community buy-in as a whole might be greater in less rural, or more urban areas.
“I think there might be more buy-in in less rural areas, maybe the larger cities where its access would be much easier. Over here, if you live far away from the-unless you have somebody giving you a ride but who’s going to give you a ride there? Then there is less- I might live in a small town, but it seems like in a bigger city, things like that could blend in a lot easier.” (SERVICE PROVIDER, ASHTABULA COUNTY)

**Rural communities do not have the resources to implement SCSs**

Lack of resources emerged as an issue in both rural communities. A few professionals noted that there are so few resources to implement existing evidence-based practices, including NEP, that it would be hard to imagine have the resources—staff in particular—to work at an SCS. As noted by this rural professional, in response to being asked about barriers to a NEP:

> “People to do the work. I think we have that problem everywhere. It takes a really solid cohort of people, with leadership and some sort of prior experience. Not really a whole lot. It just really takes a group of people to say, ‘We want to do the work. We know where these people are. We want to go out, giving them the materials.’ There are people with experience who can get the starter kit and a grant from NASEN, the North American Syringe Exchange Network. I just don’t know many people in Carroll County, like I said, who would make the calls and say, ‘Hey, do you want to go out and do needle exchange work on Saturday night?’ It’s going to take some harm reductionist to be in that community with their finger on the pulse of the injection drug community. I don’t know where to begin with that.” (POLICY PROFESSIONAL, CARROLL COUNTY)

**Community members would believe SCS normalizes opioid use**

A small number of professionals and PWUO noted concerns that despite logical public health benefits of SCSs, some community members—politicians in particular—would view SCSs as normalizing opioid use, views that are based on fear, stigma, and/or a lack of education and understanding of harm reduction. As noted by these informants:

> “I think the conservative right, which is, fortunately, not as common in Cleveland as it is in other parts of Ohio… I think the silly arguments you hear about things, like the HPV vaccine, human papillomavirus. That was going to promote people having sex: “It’ll promote people to use drugs more readily, or more often, or more intensely,” or all sorts of nonsense arguments that haven’t been based in fact but rather in fear. I think that [to be on the side of, ‘Is legalizing drugs bad?’] most people would put that idea on the fringe.” (MEDICAL PROFESSIONAL, CUYAHOGA COUNTY)

> “You also have people who don’t understand, really, what harm reduction is. They may not understand, by providing such a service, other things that you’re actually combating, whether it’s the spread of HIV, MRSA, or hepatitis C. Definitely, within the state, we have seen an expansion of that, but I don’t think that people understand necessarily. Usually, you’re giving them permission to do it. You’re substituting a drug for a drug. That even goes along with medication-assisted treatment. It’s just not really understanding the scope of the problem as well as different interventions to address the problem.” (POLICY PROFESSIONAL, OHIO)
“I think what I’ve heard is that we want people not to use drugs, not to change that into, ‘It’s okay to use drugs as long as you use them safely and don’t get infectious diseases that can kill you and be spread to other people.’ Even though there is plenty of evidence from a population health perspective that needle exchange programs work, I think our public health partners have done that quietly as opposed to putting a banner out over it, just because of the sensitivity around that. There’s still a lot of stigma. I think what we’ve seen is this problem is so pervasive that some of our public figures are very vocal until they have a family member or someone in their district that has the issue, and then we start to see a little bit more compassion. But I still think we have work to do in this space. (POLICY PROFESSIONAL, OHIO)

“Yes, I mean, if I were to put myself in someone who has no education, whatsoever, on addiction I would be like, ‘That’s just going to be a place that’s going to make people think it’s okay to shoot heroin. It’s just going to lead more people to doing heroin,’ when obviously that’s not the case. But, that’s what a lot of people would think, you know?” (PWUO-NON-MT, HILLSBOROUGH COUNTY)

SCSs would affect neighborhoods and community resources

Some informants—professionals and PWUO—expressed that SCSs might not be acceptable to communities because of their perceived negative effects on neighborhoods and community resources.

“You have this group of people who are used to buying and selling drugs on the street. Sometimes, that happens here and we have to police that. People are bringing their drugs. So, logistically, I’m just wondering how you would monitor that. It brings gang involvement. It brings violence. It brings a lot of other things to a site where you’re trying to provide safe services, so how do you keep it safe?” (SERVICE PROVIDER, CUYAHOGA COUNTY)

Participant 1: “[An SCSs is] not bad for me, but bad for the community.”
Participant 2: “There will be people hating it.”
Participant 1: “People being disrespectful to it, and throwing their needles out the window and things. If people acted right and were respectful and did their thing and left, but you know they wouldn’t. People would be out being disrespectful.” (PWUO-ACTIVE, CUYAHOGA COUNTY)

One treatment professional noted concerns over property values when trying to site a new treatment center, and quoted what he heard community members say about this: “You are going to impact my property value. You are going to impact my safety. There’s really no control you have over these people. Quite frankly, there is no control these people have over their own addiction.”

Similarly, one policy professional predicted community resistance over siting of a proposed SCS:

“If you make a proposal that you’re going to create half a dozen safe use facilities in Cuyahoga County, the very next question I would imagine is going to
be, ‘Where are they going to be?’ Then the next thing that would come as far as opposition goes is business owners and community members in the suggested locations would not want that in their vicinity. They’re thinking that it’s going to come with negative baggage to have drug use being sponsored by their government in their backyard. It’s that naivety thing again like it’s not already happening there. The same drug use is happening, it’s just happening behind closed doors in an unsafe way. Somehow bringing it into the public eye and shining a light on it, then people get up in arms and say, ‘No, I don’t want this here in my neighborhood.’ I’m just imagining if you have a business owner in a strip plaza and right down the plaza from them you’re going to install a safe use facility, I can imagine quite a bit of pushback to that. To maximize your chance of success it would almost have to be a free-standing building.” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

SCS would “clean up” the streets and reduce strain on police and EMS

Professionals and PWUO noted that one way to increase community buy-in is to highlight that an SCS could serve to take users off of the streets, and that it could reduce resource burden on the police and EMS.

“Okay, it definitely would help us reduce the number of runs from an EMS or a police standpoint. It definitely would help us reduce the collateral damage associated with intravenous drug use.” (POLICY PROFESSIONAL, HILLSBOROUGH COUNTY)

Participant 1: “I believe that [an SCS] would help.”
Facilitator: “And how could it help?”
Participant 1: “Well, for one thing, people would stop just throwing their needles on the ground. You walk around buildings and see them everywhere, dude.”
Participant 2: “You see a lot on the ground. As you pass by it on the street you see them, there are needles on the ground. A kid could come by, go by and pick them up.” (PWUO-ACTIVE, ASHTABULA COUNTY)

“This is, maybe, not the best way to say it. Unless it’s like a crowd-control kind of thing, where they say, ‘Okay. We don’t want these people in our parks in Manchester anymore, so let’s find a place that everybody can go.’ So I guess you could imagine that could be one perspective that some people might have as they think through this.” (POLICY PROFESSIONAL, NEW HAMPSHIRE)

“In the community, it’s actually a good thing because it gets a lot less people off the streets. You don’t have all the people walking around the streets, using. It also decreases the fact of people having to be called ambulances, so that saves money in all the cities too. I’m all for it because then you’ve got someone there to monitor it.” (SERVICE PROVIDER, CUYAHOGA COUNTY)

One professional noted the reduction in burden for EMS and police as a potential benefit perceived by community members, but also noted other barriers, such as siting and consequences of neighborhood effects, that would counteract these benefits.

“On the backside, though, the concern was, ‘Is having a safe injection site really working to eliminate the addiction?’ The other thing that came up is, like I said, if we’re looking at siting criteria, if we’re looking at a state like Ohio – where our syringe exchange law couldn’t be called syringe exchange, it had to be blood
borne pathogens prevention... I think the time and effort to get this thing running and get it open, it might be a great thing but as soon as somebody either has a dealer outside - that gets busted looking to hook somebody up outside the clinic... The first time somebody, unfortunately, ODs, whether it be in the facility or in the parking lot, the first time there is a robbery... There is just a lot of stigma to this.” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

What might facilitate community acceptance and implementation of SCSs?

Key informants in both individual interviews and focus groups were asked what could facilitate community acceptance of SCSs. Some suggestions arose spontaneously, without prompts, while other suggestions were discussed in response to prompts. Education and evidence, which arose spontaneously, were the most endorsed facilitators of SCSs. When the interviewers asked directly about other facilitators, such as housing an SCS in a medical facility or mobile van, or not allowing use by injection at the facility, there was support by some, but not all.

Educate the community and publish evidence about SCSs

Key informants suggested, without being prompted, that more education around SCSs and more published evidence would facilitate acceptance and potential implementation of an SCS. Education and evidence were the most endorsed potential facilitators of SCSs. Key informants suggested beginning the process with basic education, as this interviewee put it:

“I think certain stakeholder groups would be very supportive, but I think they would want more information and they’d want to understand the model more. I think a small dose of it would probably be easier than a large dose, if you know what I mean. Something that’s going to be worked in versus, ‘Here we are.’ You want to make sure that all avenues are covered and that education is out there to help explain what it is.” (TREATMENT PROFESSIONAL, ASHTABULA COUNTY)

Other key informants also emphasized the importance of education, but added that without state government support, an initiative to establish an SCS would not be successful, and government support, in turn, requires evidence of positive outcomes. And still others noted that more hard evidence, not just anecdotes, is required.

“I think, until they have evidence that they can take to legislators – and legislators that are willing to fund it – then you don’t get a lot of movement if you’re talking about Government funding. If foundations want to start funding it, the same thing we’re going to say – because we’re Government – is, ‘What is the evidence that tells me that this really does improve ultimate outcome for that person, ultimately leads them into treatment, ultimately leads them... What am I trying to achieve with that? Am I just trying to keep them alive, like I am with naloxone? Or am I really using this as a relationship-building activity in order to eventually get that person into treatment?’” (POLICY PROFESSIONAL, ASHTABULA COUNTY)

73
“I keep hearing, ‘Vancouver does this.’ ‘This country does this.’ I’d love to see some good peer-reviewed journals that show that it works. Some peer-reviewed journals that show that, “Okay, you might have an individual that’s coming to this safe injection site. One of the things that we would do, is we have a social worker on site - after the individual leaves, or prior to the individual leaving – that talks about the benefits of recovery and which services are available. Not only to them, but maybe also to their family – to understand the disease of addiction.” (POLICY PROFESSIONAL, CUYAHOGA COUNTY)

“Present the information or the research from other countries that have it and show that their death rates are going down. People are willing to take that because we have a major problem in this city.” (PWUO-NON-MT, HILLSBOROUGH COUNTY)

Professionals suggested that the process to gain community buy-in needs to begin by presenting evidence to the community as a whole, about SCSs and by presenting basic information about addiction and harm reduction:

“I think it’s just like the drug prevention coalition. I think education would have to be… I think there would have to be some meetings, information given out, hit the schools and get to the parents. I think education is going to have to be key and where people are going to be able to voice what their opinions are. Maybe in other communities or other studies they can show that whatever their fears are aren’t going to come true.” (TREATMENT PROFESSIONAL, ASHTABULA COUNTY)

“... it just comes down to culture and education. What’s the message that we’re putting out into the community and what kind of buy-in do we have?” (HARM REDUCTION PROFESSIONAL, HILLSBOROUGH COUNTY)

“... you always want to do the education. So if you provide and you empower people with enough information and enough knowledge they get to make really good decisions based on the information that you provide. So that's how we show to address most of the stuff that we do, we provide the education. We meet with the folks, we have very candid conversations about things, you know.” (POLICY PROFESSIONAL, HILLSBOROUGH COUNTY)

“I think maybe possibly opening the community’s eyes to the fact that there are alternative theories of addiction, the benefits and needs for social supports and things like that to prevent substance use but then also to facilitate treatment would be huge. I’m not sure I see it happening.” (SERVICE PROVIDER, HILLSBOROUGH COUNTY)

Others offered that education also would have to include legal and liability issues, as well as education of law enforcement providers in particular:

“... there would have to be a lot of education around that. I have my hesitancies around it, I'm used to the harm reduction model, I do have my hesitancies around that piece because of licensure and liability.” (POLICY PROFESSIONAL, HILLSBOROUGH COUNTY)

“Although again, it seems like when they [law enforcement] understand the syringe services program they tend to embrace it a little bit more. I think it’s all about education and helping to change people’s preconceived notions about these
types of program.” (TREATMENT PROFESSIONAL, HILLSBOROUGH COUNTY)

Integrate the SCS with a Medical Facility

In response to a question about whether integrating an SCS with a medical facility would facilitate community acceptance, some supported the idea, albeit not with great enthusiasm. Several stakeholders offered that attaching an SCS to a community health center or hospital might “normalize” it and make it more politically feasible, provided that legal issues were resolved, but they also noted that hospitals might not be quick to embrace the idea:

“Maybe if they were in a facility connected to or within a hospital. It might make it more attractive towards the general community. I am not sure hospitals would be lining up to say, ‘Pick me.’” (CRIMINAL JUSTICE PROFESSIONAL, CUYAHOGA COUNTY)

“For families who aren’t involved in this, there is a real lack of general awareness about what all this looks like. I feel like if we normalize safe injection sites as part of the milieu of services that are provided, normalized them in that way, that would be the best way to go – at least for a place like Cleveland. Although I don’t know. You see the headlines of Baltimore trying this, and Seattle working on it – different sites who are really trying to push for something like that. It’s hard. If it’s making the headlines, it’s not necessarily normalized into the day-to-day services in a city. It’s hard to know if it’s possible to do it that way.” (HARM REDUCTION PROFESSIONAL, CUYAHOGA COUNTY.)

One professional noted the benefits of integrating medical and dental care with the SCS:

“I would suspect that more than you might imagine would probably embrace it. Particularly, if there was some way to get some type of healthcare rolled into it... Many of these people have had no dental care, or a lack of dental care, for a long time. Just by virtue of the fact that they went in and got a tooth that’s been killing them for three years taken out, or had some dental work done, it made a tremendous difference in their lives, which may, at some point, have a downstream impact on the fact that they might not need to get high all the time to feel better about themselves, you know?” (HARM REDUCTION PROFESSIONAL, HILLSBOROUGH COUNTY)

Some PWUO also supported, at least partially, the idea of a clinic- or hospital-based SCS, as noted by this PWUO:

“I would feel comfortable getting high in a clinic, yes. I just need to think. I can’t imagine it, although I used to get high at my mum’s in her driveway so that someone was always nearby because you push the envelope, but you don’t want to die. You just want to be high.” (PWUO-NON-MT, ASHTABULA COUNTY)

Integrate the SCS into a Mobile Van

Key informants were asked if integrating an SCS into a mobile van might make the SCS more effective for PWUO, reflecting comments about PWUO not wanting to travel after purchasing opioids, and whether it would facilitate community acceptance of an SCS; the idea was met with mixed reviews. A few participants supported the idea, suggesting that bringing the
SCS to PWUO would eliminate logistical challenges that currently deter PWUO from using the brick and mortar NEP. As noted by these professionals:

“I think a mobile SCS would be interesting; the syringe exchange [in Cuyahoga County] is a van, although static. We did a survey at 2016, people inject in their cars; we found that people are travelling a fair amount to get to the exchange so mobile provision may be interesting.” (HARM REDUCTION PROFESSIONAL, CUYAHOGA COUNTY)

“I think the availability has just increased because now you’re not confined by hours of operation of a brick and mortar site. You’re not confined by the availability of somebody being able to get transportation or be able to make it there. Many of the people in the population that we serve are on foot or they don’t necessarily want to travel outside of their comfort zone. I’ve met a couple of people that were definitely under the influence.” (SERVICE PROVIDER, HILLSBOROUGH COUNTY)

Other comments were mildly supportive, but suggested that a mobile van would not solve the issue of community acceptability, as noted by this interviewee:

“Maybe potentially [a mobile van could increase acceptability]. I just think that the big hang-up for a lot of people is the fact that they would be perceived as contributing to an individual’s bad habits.” (HARM REDUCTION PROFESSIONAL, HILLSBOROUGH COUNTY)

And still others thought a brick and mortar facility combined with a health center would be more acceptable than a mobile van:

“I think it would make a big difference. If you put something like that in a community health center, I think that it would be viewed much differently than if you put it in a rolling van.” (TREATMENT PROFESSIONAL, HILLSBOROUGH COUNTY)

Additional suggestions that emerged without prompts included stationing a police officer outside of the facility; integrating the SCS with an existing social service facility; contracting with the police to ensure immunity for PWUO; implementing it jurisdictionally and without public money; staffing the SCS with peers (i.e., those with lived experience) and having it run by a trusted organization (like a NEP); putting the SCS on a bus line; putting the SCS near a NEP and other services frequented by PWUO; and moving slowly toward implementation. Several key informants felt that time, above and beyond all else, would be the greatest facilitator, as evidenced but the growing acceptance of MT, naloxone, and NEP. As one professional summed up this idea:

“I could’ve said a few years ago that Narcan [naloxone] distribution wasn’t that feasible because no-one would be okay with it. Slowly, but surely, that’s becoming pretty accepted among most people. You know, police departments were refusing to carry it. I mean, ambulance crews are opposed to it. You know, even a couple of years ago, like I said, we had to use it on-site, and we got a call from one police chief, because we’re out in his township, saying, “No, we don’t want you using Narcan [naloxone] at your facility. Just call 911 and let them deal
with it when they come,” and we said, ‘No, we’re going to use it because we don’t want people to die,’ and he was like, ‘Oh no, but that enables people to use.’ So, I mean, that was just, like, a couple of years ago, and now, it’s this commonly accepted thing among a large chunk of the community.” (SERVICE PROVIDER, ASHTABULA COUNTY.)

Summary of SCS findings

Overall, key informants, many of whom were not initially familiar with SCSs, offered several reasons why they thought SCSs could effectively help address the opioid crisis, including preventing overdose and disease prevention, treatment linkage, a safe, judgment-free place for PWUO to use, and drug composition testing; however, many who spoke about positive attributes for both PWUO and the community also expressed reservations and described myriad reasons SCS implementation would not be currently feasible in their communities, including several practical barriers. Some key informants—PWUO in particular—believed SCSs would be a law enforcement trap for PWUO, would not be realistic for PWUO because of travel required after purchasing and prior to using, and that SCSs might be stigmatizing for PWUO. PWUO from a majority of focus groups thought SCSs would enable or perpetuate opioid use.

Many key informants who generally expressed support for SCSs also believed that their communities as a whole might not currently accept SCSs as a viable strategy for addressing the opioid crisis. Although this view was particularly salient among stakeholders from the rural counties, neither of which has NEP or adequate detox, treatment, or sober living facilities, even urban stakeholders felt that an SCS in their community was not currently their priority or a priority for their communities. Key informants suggested that putting funding into evidence-based programs that already have gained traction with community members would be a more prudent investment of limited resources. Moreover, key informants cited myriad reasons that SCSs might not be acceptable to community members, including conservative cultural landscapes, widespread lack of acceptance of a harm reduction approach, long-standing stigma and fear around addiction, and general “NIMBYism” around placing such facilities in areas that would be accessible to PWUO. Again, potential resistance was perceived as greater in the more rural communities, followed by Hillsborough County, and least in Cuyahoga County, which already has NEP and a plethora of services for PWUO.

Although several potential facilitators of implementation and community acceptability were explored, such as connecting the SCS to a medical facility, housing the SCS in a mobile van, or prohibiting the use of opioids by injection, stakeholders did not fully endorse any of these facilitators as sufficiently increasing acceptability. Stakeholders suggested that the only truly effective facilitators would be education and evidence: educating community members on the chronic nature of addiction, on any evidence and implementation data about SCS, and about the potential benefits of an SCS to outcomes for PWUO and the community.
In sum, while many key informants support SCSs and would embrace almost anything that would help stem the tide of the opioid crisis, lack of community support, lack of resources, and the need to choose the most effective, scalable solutions that are feasible to implement render SCSs as unlikely to be adopted by these communities in the near future, according to key informants. However, community acceptability could differ greatly by county, with implementation most likely in Cuyahoga County, which has more treatment resources and a long-standing NEP, better transportation, and is the most urban, and least likely in Carroll County, with the fewest treatment resources, no NEP, and poor transportation. Nevertheless, despite concerns about community resistance and lack of funding, key informants compared the rollout of SCSs to that of NEPs and MT, in that if there is evidence and it is ultimately rolled out, like NEPs and MT, it will be accepted in time by communities, albeit slowly and in the distant future.
6. Summary and Key Findings

Interviews and focus groups with key informants across four counties in two states with among the highest overdoses deaths in the U.S. suggest that both programs—HAT and SCSs—hold several potential benefits for PWUO, including reducing overdose deaths and keeping PWUO safe from infectious diseases; at the same time, each program gives rise to a range of concerns, chief among them enabling drug use and likely community resistance, both of which could limit implementation at the present time. Nevertheless, some key informants suggested this situation may change over time, particularly in more urban areas with relatively strong service provision. For SCSs, key informants in the urban counties noted similarities with the establishment of NEP, and thought that while the program might meet resistance among community members, in time, like the NEP, the program could be increasingly accepted. Key informants in rural counties suggested that their communities are unlikely to embrace these programs before the counties have established NEP and adequate treatment services for PWUO and noted practical barriers such as lack of anonymity for PWUO and poor transportation. Indeed, with regard to SCSs in particular, PWUO from all counties expressed practical concerns, such as not wanting to travel after purchasing opioids and viewing the SCS as a law enforcement trap, which could limit use of SCSs, especially in smaller communities. Professionals thought one aspect of HAT that might make it acceptable to community members is that it is a medical intervention, conceivably supported by the medical community. Interviewees and provider focus group participants alike almost unanimously indicated that more evidence and removal of legal hurdles is needed for either program to be accepted in any of the four communities and that successful implementation requires more education about substance use disorders and the need to address pervasive stigma against PWUO.

Key findings from the interviews and focus groups are as follows:

**Key Findings Applicable to Both HAT and SCSs**

1. All four jurisdictions reported major gaps in service provision for PWUOs. These gaps, while pronounced to a varying degree in each community, are primarily related to non-existence of some services, capacity constraints in existing services (and lack of immediate availability of services), and funding or insurance challenges. In this context, for communities with similar constraints, innovative programs like HAT and SCSs may not be policy priorities.

2. Across all four counties in this study, expanding the provision of services to PWUO continues to face resistance due to stigma associated with addiction. In key informants’ views, stigma-driven opposition could strengthen against programs that would either let PWUO use their own illicit drugs at an SCS or provide PWUO with heroin for HAT programs.
3. The severity and pervasiveness of the opioid crisis has resulted in greater awareness of opioid addiction as well as shifts in attitudes about addiction and PWUO on the part of some stakeholders in heavily affected communities. This may signal slightly higher potential acceptance of innovative solutions like SCSs and HAT among stakeholders and in communities that might not ordinarily accept them.

**Key HAT Findings**

1. **Interviewed professionals and provider focus group participants suggested that HAT programs could potentially improve outcomes for people who use opioids (PWUO), but expressed concerns about the program enabling opioid use.** Among the most frequently mentioned benefits of HAT were providing PWUO with a drug of known composition and that HAT may offer a suitable option for PWUO who have tried but have not succeeded with other treatments. With respect to perceived drawbacks, professionals primarily expressed concern that HAT programs would enable drug use and do little to address the individual’s underlying addiction problem.

2. **PWUO currently engaged with treatment services for their opioid use were more skeptical of the effectiveness of HAT than other key informants.** PWUO in focus groups expressed concerns that HAT would enable drug use and that street drugs would continue to be used alongside HAT. PWUO who were actively using opioids and not currently in treatment were the most open to HAT, particularly with respect to the fact that HAT clients would be prescribed a safe drug, although these PWUO also identified a series of potential drawbacks. PWUO in particular, along with some other key informants, also expressed concern that any gaps in continuity caused by capacity or insurance issues could result in being dropped from treatment and left with an active addiction, similar to the experience many had with prescription opioids.

3. **Despite potential benefits for some PWUO, both professional and PWUO key informants suggested that HAT implementation may not be feasible due to practical and legal concerns and potentially to community resistance.** The most frequently cited reason that HAT likely would be difficult to implement was the belief that potential implementation would be impeded by local community values and culture, as well as stigma toward PWUO, impediments that have been common in attempting to establish NEP and other programs for PWUO. Other, albeit less frequently mentioned obstacles to HAT acceptability included local opposition around siting of the program (referred to by key informants as “NIMBYism,” reflecting the acronym for the colloquialism “not-in-my-backyard,”) as well as concerns surrounding the diversion of prescribed heroin.

4. **Making evidence on HAT effectiveness available to community stakeholders is considered critical to any debate surrounding HAT.** Approximately a third of interviewed professionals expressed desire to learn about the evidence underlying HAT programs. Other key informants (both professionals and PWUO) suggested that community education about HAT and the evidence of its effectiveness (to the extent that it exists) would be required to even begin the argument for the implementation of HAT and to influence the corresponding policy debate. A related observation made by some interviewed professionals was that emphasizing the medical nature of HAT may be effective in addressing some concerns community stakeholders may have. Several interviewed professionals pointed out that a small-scale pilot program may be useful to
demonstrate how a HAT service operates and examine whether it can be effective in improving outcomes for PWUO, and whether it is acceptable to the community.

Key SCS Findings

1. **Both professional and PWUO key informants noted harm reduction benefits to SCSs, but also perceived drawbacks such as that it may enable opioid use, and practical barriers, including PWUO lack of desire to travel to an SCS after purchasing opioids.** Among the main benefits noted were preventing overdose and disease, and providing treatment linkage, a safe, judgement-free place for PWUO to use, and drug composition testing. Some professionals and PWUO also thought SCSs would enable or perpetuate opioid use. PWUO in all focus groups, rural and urban, saw SCSs as impractical due to the time needed to travel to an SCS after purchasing drugs, with rural PWUO emphasizing its impracticality due to overall transportation challenges. PWUO also worried SCSs would be a law enforcement trap for PWUO; this concern was also anticipated by professional informants. Some PWUO currently receiving MT noted that SCSs could provide a safe place to use while waiting to get into treatment.

2. **Despite supporting some benefits of SCSs, interviewees and focus group participants generally believed that their communities as a whole likely would not currently accept SCSs as a viable strategy for addressing the opioid crisis due to cultural, resource, and practical barriers.** Although this view was particularly salient among informants from the rural counties, neither of which currently has a NEP or adequate naloxone distribution, detoxification services, treatment provision, or sober living facilities, even urban informants who supported the concept felt that an SCS in their community was not the current priority for addressing the opioid crisis. Key informants generally believed that putting funding into evidence-based programs that already have gained traction with community members would be a more prudent investment of limited available resources. Moreover, key informants cited multiple reasons that SCSs likely might not be acceptable to community members, including conservative cultural landscapes, lack of endorsement of a harm reduction approach to opioid use disorder, long-standing stigma and fear around addiction, and general “NIMBYism” around placing such facilities in areas that would be accessible to PWUO.

3. **Despite cultural and policy-related barriers, implementation may be more feasible in more urban communities with existing (and perhaps more long-standing) harm reduction programs, greater treatment resources, and adequate transportation, particularly if there is evidence to support it.** Although some interviewees and focus group participants had reservations about SCSs and believed that their communities have other more pressing priorities, professionals in the two urban communities were more inclined to believe that with education and evidence, SCSs could eventually be accepted by community members, as NEP and MT have been accepted, at least by key stakeholders and policy makers. This was particularly the case in Cuyahoga County, where there has been a NEP since 1995, first legal through local emergency orders, and then legalized statewide in 2013.

4. **As with HAT, publication of evidence on SCSs and community education were seen as essential in fostering community acceptance of SCSs.** A number of key informants (both professionals and PWUO) expressed belief that more education around SCSs and more published evidence would facilitate acceptance and generate potential community
buy-in, assuming there is adequate evidence of SCS effectiveness. This call for more evidence was also made by key informants who were skeptical of SCSs or expressed reservations about the SCS model. Among other steps that could help address community concerns towards SCSs were integrating the service with an existing medical facility and introducing a mobile supervision service, with the perceived dual benefit of reaching PWUO who may not come to a fixed SCS and of minimizing neighborhood concerns associated with a fixed SCS location. However, neither of these steps was fully endorsed as adequate for addressing community concerns.


https://www.cdc.gov/nchs/data/databriefs/db329_tables-508.pdf#4


Fischer, B. and Allard, C. (2007). Feasibility Study on ‘Supervised Drug Consumption’ Options in the City of Victoria. Centre for Addictions Research of British Columbia (CARBC), University of Victoria. As of 5 August 2018:
https://dspace.library.uvic.ca/bitstream/handle/1828/4789/Feasibility%20Study%20Fischer%20Benedikt%202007.pdf?sequence=1


SAMSHA (n.d.) Medication and Counseling Treatment. As of 6 August 2018: https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat


Appendix A. Key informant interview questions

Questions about the nature and scope of local opioid problem

1. Could you briefly describe your role and responsibilities?
2. How would you describe the opioid problem in [JURISDICTION]? [prompts:]
   a. Who are the most affected populations?
   b. Estimated number of opioid users in the area?
   c. What are the most abused opioids? And what proportion of the problem users are injecting?
   d. How has the opioid problem evolved in recent years? What changes have you noticed over the past 5 years?
   e. What are the current trends? Are things getting worse/better?
3. Are there any factors that exacerbate the impact of the opioid issue in [JURISDICTION]? [prompts:]
   a. Resource-related factors (e.g. funding for treatment, human capacity)
   b. Geography-related factors (human and physical geography, transportation, weather)
   c. Policy-related factors (local, state, federal, e.g. zoning and licensing of facilities)
   d. Context-specific factors (e.g. high availability of fentanyl)
4. Are there any factors that mitigate the impact of the opioid issue in [JURISDICTION]? [prompts:]
   a. Resource-related factors (e.g. funding for treatment (e.g., Medicaid expansion?), human capacity)
   b. Geography-related factors (human and physical geography, transportation, weather)
   c. Policy-related factors (local, state, federal, e.g. zoning and licensing of facilities)
   d. Context-specific factors (e.g. well-integrated local services)

Questions about local service provision

5. Could you describe the services available to heroin or fentanyl users in [JURISDICTION]? [prompts:]
   a. Drug-treatment services
   b. Wrap-around services
   c. Naloxone? What is the policy/availability? (e.g., first responders only, OTC, take home, co-prescribing?)
   d. Needle exchanges?
   e. Replacement therapies? (Methadone clinics, licensed buprenorphine prescribers)
   f. Who is eligible for existing services?
   g. In your estimate, how large a share of the eligible population engages with available services?
   h. Any notable gaps in available services? Why do these gaps exist?
   i. If services are not available locally, can users visit other locations? Do they?
j. How are decisions about service provision made? Who are the relevant stakeholders?
k. Criminal justice-related interventions (e.g., drug courts, police amnesty)

6. In your opinion, what are the strengths and weaknesses of existing service provision in [JURISDICTION]? What are the drivers of these strengths and weaknesses? [prompts:]
   a. Resource-related factors
   b. Geography-related factors (human and physical geography)
   c. Policy-related factors (local, state, federal)
   d. Context-specific factors

7. What are the most important barriers to access to treatment in [JURISDICTION]? [prompts:]
   e. Could you comment on the following:
      i. Users’ awareness of available services
      ii. Costs of services and who bears these costs
      iii. Spatial distribution of available services
      iv. Cultural factors/stigma
      v. Any other?

8. What other measures are being taken in [JURISDICTION] in response to the opioid crisis?

Questions about a potential SCS program

9. How familiar are you with safe consumption sites that have been implemented in some international jurisdictions? [prompts:]
   a. SCS are places where users can consume already-purchased street drugs in the presence of trained staff (sometimes volunteers, sometimes health professionals), who monitor for overdose or risky injection practices. Clients can sometimes test their drugs, acquire clean injection supplies, and engage with social services.

10. I would now like to ask you a few questions regarding introduction of SCS in [JURISDICTION]. In your opinion, do you think an SCS program could help improve outcomes for people who use heroin or fentanyl? Why/Why Not? [prompts:]
   b. In what way do you think an SCS program could help people who use heroin or fentanyl?
   c. Thinking about the results of a potential SCS program, what do you think would be the biggest obstacles to the program being effective for people who use heroin or fentanyl? How could these obstacles be overcome?

11. In your opinion, how feasible would it be to implement an SCS program? By feasible I mean would it be practical, technically and politically possible to implement an SCS program in [JURISDICTION] Why/why not? [prompts:]
   a. Thinking about the implementation of a potential SCS program, what would be some of the biggest obstacles to a successful implementation of an SCS program? How can these obstacles be overcome?
12. In your opinion, how do you think ___ would respond to a proposal to create SCS programs in [JURISDICTION]? [prompts:]
   a. People who use heroin or fentanyl?
   b. Substance use disorder treatment providers?
   c. Neighbors?
   d. Local faith community?
   e. Business development groups?
   f. Policymakers?
   g. Other important stakeholders?
   h. What might be possible sources of opposition to this program? Why might there be opposition?
   i. How could the acceptability of these programs be enhanced among these different groups?

13. In each case, what reservations or concerns do you think any of these groups might raise? [prompts:]
   a. how strong might the opposition be?
   b. what would be the concerns or arguments against?

14. Do you think the perspectives of any of these stakeholders would be appreciably different if the SCS program were restricted to the taking of drugs other than by injection? If the service were provided via a mobile van vs. a fixed location? If a police officer were stationed outside the SCS during its hours of operation?

15. How do you think this would be portrayed in the media here in [JURISDICTION]?

16. On a scale from 1-10, how strongly would you recommend that an SCS program be implemented in [JURISDICTION]?

Questions about a potential HP program

17. How familiar are you with heroin prescription programs that have been implemented in some international jurisdictions? [prompts:]
   a. HP: intended for people who have failed treatment (e.g., methadone) multiple times. The premise is the same as for well-studied and long-accepted medication-assisted treatments such as methadone maintenance: substitute a legal, quality controlled, free or low-cost pharmaceutical opioid for expensive illicit market opioids whose potency and purity are not known to the seller or user.

18. I’d like to ask you a few questions regarding introduction of HP programs in [JURISDICTION]. In your opinion, do you think an HP program could help improve outcomes for people who use heroin or fentanyl? Why/Why Not? [prompts:]
   a. In what way do you think an HP program could help people who use heroin or fentanyl?
   b. Thinking about the results of a potential SCS program, what do you think would be the biggest obstacles to the program being effective for people who use heroin or fentanyl? How could these obstacles be overcome?
19. In your opinion, how feasible would it be to implement an HP program? By feasible I mean would it be practical and technically and politically possible to implement an HP program in [JURISDICTION]? Why/why not? [prompts:]
   a. Thinking about the implementation of a potential SCS program, what would be some of the biggest obstacles to a successful implementation of an SCS program? How can these obstacles be overcome?

20. In your opinion, how do you think ___ would respond to a proposal to introduce these programs in [JURISDICTION]? [prompts:]
   a. People who use heroin or fentanyl?
   b. Substance use disorder treatment providers?
   c. Neighbors?
   d. Local faith community?
   e. Business development groups?
   f. Policymakers?
   g. Other important stakeholders?
   h. What might be other possible sources of opposition to this program? Why might there be opposition?
   i. How could the acceptability of these programs be enhanced among these different groups?

21. Do you think the perspectives of any of these stakeholders would be appreciably different if instead of an HP program with injection it were a program that provided maintenance via opioid pills with no injection?

22. On a scale from 1-10, how strongly would you recommend that an HP program be implemented in [JURISDICTION]?

Closing questions

23. Do you have any recommendations for other ways to address the opioid crisis in [JURISDICTION]?
24. Are there any other individuals you would recommend we speak to?
25. Is there something else you would like to comment on?

Thank you very much for your time.
Appendix B. PWUO focus group questions

1. If you do not agree to participate in this group, you may leave at this time. How would you describe the opioid problem in [JURISDICTION]? [prompts:]
   a. What groups are the most affected the problem?
      i. Teenagers?
      ii. Men?
      iii. Women?
      iv. Certain racial groups, like mostly whites or blacks?
   b. Which opioids are causing the biggest problems?
   c. How has the opioid problem changed in recent years?
   d. Are things getting worse/better?

2. Tell me about the types of services available in [JURISDICTION] to help people who have problems with heroin or fentanyl [prompts:]
   a. Outpatient/day treatment?
   b. Inpatient/residential treatment?
   c. Help with housing?
   d. Help with other services?
   e. Needle exchange programs?
   f. Have other individuals or groups helped you or others you know with their OUD?

3. Tell me how helpful current treatment programs and other services are for people who want help with their heroin or fentanyl use.

4. What are some of the biggest barriers to people who use heroin or fentanyl getting treatment services? [prompts:]
   g. Distance to services?
   h. Long waiting lists?
   i. People don’t want treatment?
   j. Treatment isn’t effective?
   k. People need a lot of other kinds of help that isn’t offered?
   l. Cost of services?
   m. Stigma?

Next I’d like to talk with you about a couple of new programs that are being used to support people with heroin or fentanyl use problems that you may have heard about already. One is called a safe consumption site. I’ll call it an SCS for short.

5. Tell me what you’ve heard about SCS, if anything.
   a. SCS are places where users can consume already-purchased street drugs in the presence of trained staff (sometimes volunteers, sometimes health professionals). The staff monitor for overdose and, in the case of injected drugs, risky injection practices.
6. In your opinion, do you think an SCS program is a good way to help people like you? [prompts:]
   a. In what ways do you think an SCS program could be good for people who use heroin or fentanyl?
   b. Are there any reasons an SCS program could be bad for people who use heroin or fentanyl?
   c. What would be important for this program to do to be able to help people?

7. If [JURISDICTION] decided to implement an SCS program ...
   a. Do you think people who use heroin or fentanyl would use it? Why/why not?
   b. Do you think the community would support it? Why/why not?
   c. Are there any groups in particular who might be against this kind of program?

8. In your opinion, are there any variations on an SCS program that might make it more effective or more acceptable?
   a. if it excluded injection
   b. if the service were provided via a mobile van vs. a fixed location
   c. if it was co-located with other services
   d. if it was run by the city/county

Next I’d like to talk about the heroin prescription program. I’ll call it HP for short.

9. Tell me what you’ve heard about HP, if anything.
   a. In a HP program, heroin users who fail treatment (e.g., methadone) multiple times can be prescribed pharmaceutical-grade heroin as a substitute for illicit heroin in order to help stabilize their lives.

10. In your opinion, do you think an HP program is a good way to help people who use heroin or fentanyl in [JURISDICTION]? Why/Why Not?? [prompts:]
    a. In what ways do you think an HP program could be good for people who use heroin or fentanyl?
    b. Are there any reasons that HP program could be bad for people who use heroin or fentanyl?
    c. What would be important for this program to do to be able to help people?

11. If [JURISDICTION] decided to implement an HP program ...
    a. Do you think people who use heroin or fentanyl would use it? Why/why not?
    b. Do you think the community would support it? Why/why not?
    c. Are there any groups in particular who might be against this kind of program?

12. In your opinion are there any variations on an HP program that might make it more effective or more acceptable?
    a. Prescribe another type of opioid instead of heroin
    b. Require consumption on site so there are no take home doses
    c. Avoid using the term heroin
13. What are your recommendations for other ways to help people with heroin or fentanyl problems that we didn’t talk about today?

Thank you for your time. That is the end of the focus group.
Appendix C. Provider focus group questions

1. How would you describe the opioid problem in [JURISDICTION]? [prompts:]
   a. Who are the most affected populations?
   b. What are the most abused opioids?
   c. What changes have you noticed in recent years?
   d. Are things getting worse/better?

2. What do you think is driving the opioid problem in [JURISDICTION]? [prompts:]
   a. Unemployment
   b. Poverty
   c. Lack of services
   d. Too many Rx drugs
   e. Other things?

3. Tell me about the types of services available in [JURISDICTION] to help people who have problems with heroin or fentanyl [prompts:]
   a. Needle exchange programs?
   b. Outpatient/day treatment?
   c. Inpatient/residential treatment?
   d. Help with housing?
   e. Help with other services?

4. Tell me how helpful current treatment programs and other services are for people who want help with their heroin or fentanyl use.

5. What are some of the biggest barriers to people who use heroin or fentanyl getting treatment services? [prompts:]
   a. Distance to services?
   b. Long waiting lists?
   c. People don’t want treatment?
   d. Treatment isn’t effective?
   e. People need a lot of other kinds of help that isn’t offered?
   f. Cost of services?
   g. Stigma?

Next I’d like to talk with you about a couple of new programs that are being used to support people with heroin or fentanyl use problems that you may have heard of. One is called a safe consumption site. I’ll call it an SCS for short.

6. Tell me what you’ve heard about SCS, if anything.
   a. SCS are places where users can consume already-purchased street drugs in the presence of trained staff (sometimes volunteers, sometimes health professionals). The staff monitor for overdose or risky injection practices.
7. In your opinion, do you think an SCS program is a good way to help people who use heroin or fentanyl in [JURISDICTION]?
   [prompts:]
   a. In what ways do you think an SCS program could be good for people who use heroin or fentanyl?
   b. Are there any reasons an SCS program could be bad for people who use heroin or fentanyl?

8. If [JURISDICTION] decided to implement an SCS program ...
   a. Do you think people who use heroin or fentanyl would use it? Why/why not?
   b. Do you think the community would support it? Why/why not?
   c. Are there any groups in particular who might be against this kind of program?
   d. What would make an SCS program in [JURISDICTION] successful in helping people?
   e. E.g. mobile provision, co-location with other services, management by the city/county, exclusion of injections

Next I’d like to talk about the heroin prescription program. I’ll call it HP for short.

9. Tell me what you’ve heard about HP, if anything.
   a. In a HP program, heroin users who fail treatment (e.g., methadone) multiple times can be prescribed pharmaceutical-grade heroin as a substitute for illicit heroin in order to help stabilize their lives.

10. In your opinion, do you think an HP program is a good way to help people who use heroin or fentanyl in [JURISDICTION]? Why/Why Not?? [prompts:]
    a. In what ways do you think an HP program could be good for people who use heroin or fentanyl?
    b. Are there any reasons that HP program could be bad for people who use heroin or fentanyl? E.g. do you think people would join HP in order to get heroin that they would then resell into the black market?

11. If [JURISDICTION] decided to implement an HP program ...
    a. Do you think people who use heroin or fentanyl would use it? Why/why not?
    b. Do you think the community would support it? Why/why not?
    c. Are there any groups in particular who might be against this kind of program?
    d. What would make an HP program in [JURISDICTION] successful in helping people?
       i. E.g. allowing/not allowing take-home doses; avoiding the word ‘heroin’ in the title, management by the city/county

12. What are your recommendations for other ways to help people with heroin or fentanyl problems that we didn’t talk about today?

Thank you for your time. That is the end of the focus group.