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Qualitative Study of Local Health Department Programs to Prevent Opioid Overdose in **North Carolina**



Department of Population
Health Sciences

Duke University School of Medicine



NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

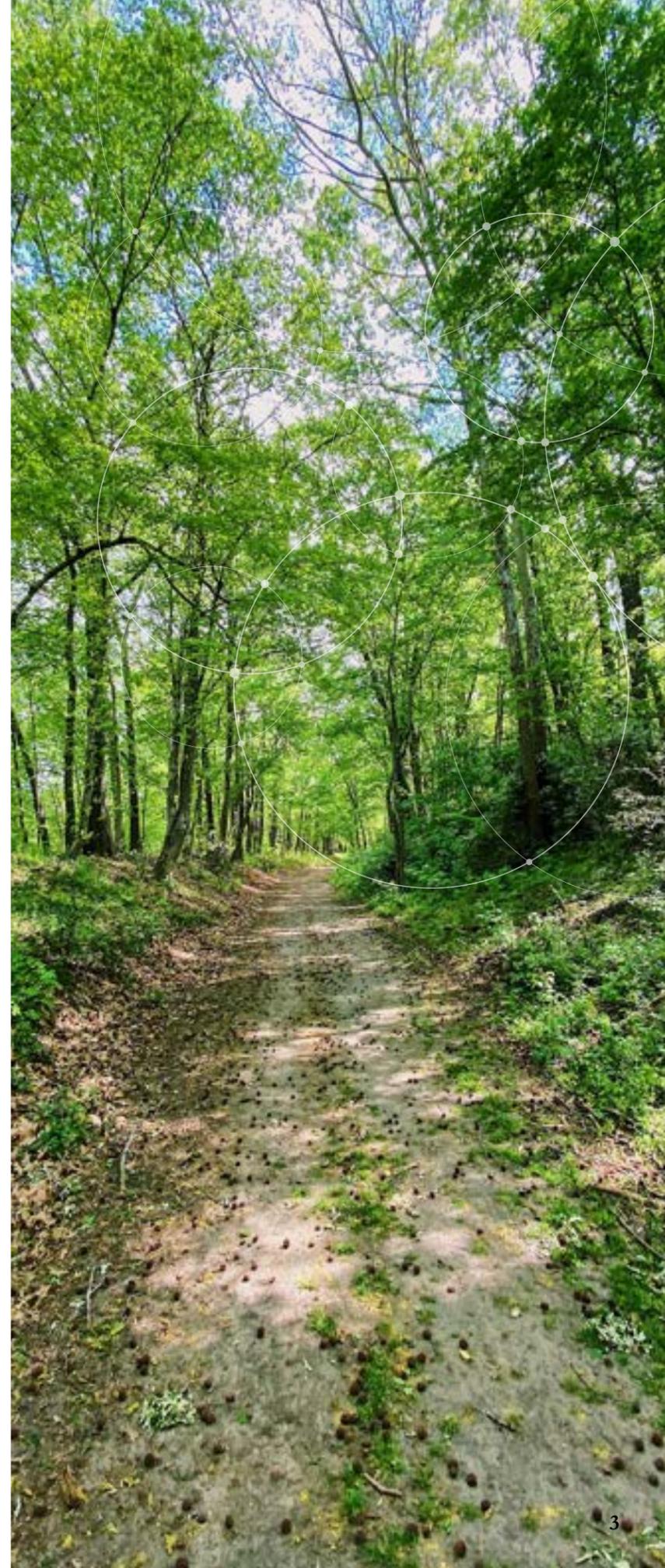
Appreciations and Acknowledgments

Thank you to all our local health department colleagues and community partners for your compassionate efforts to prevent overdose in North Carolina; and for your willingness to share your thoughts, opinions, and experiences with the evaluation team. We are especially grateful to those who have been directly impacted by the deadly war on people who use drugs and have shared their wisdom with us so we can all move towards a world more kind, equitable, and safe for everyone.

Questions?

Email HarmReduction@duke.edu

This project is included as part of the Duke School of Medicine Opioid Collaboratory, grant-funded by the Duke Endowment and administered through the Duke Department of Population Health Sciences, which is designed to save lives and reduce the harmful impact of opioids in North Carolina through the development, implementation, and/or evaluation of system-level interventions. populationhealth.duke.edu/research/opioids



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Executive Summary

Context

The North Carolina Division of Public Health's Injury and Violence Prevention Branch (NC DPH IVPB) funded 22 NC local health departments and districts (LHD) from November 2018 through October 2019 to advance one or more strategies identified in NC's Opioid Action Plan: (1) Establish or expand syringe services programs (SSPs); (2) Connect justice-involved persons to harm reduction, treatment, and recovery services; and (3) Establish post-overdose response teams (PORTs). In 2019, the IVPB partnered with Duke University School of Medicine's Department of Population Health Sciences to evaluate these LHD efforts.

Methods

The Duke team conducted 49 semi-structured, in-depth interviews with 72 LHD representatives and community stakeholders involved in implementation of funded strategies. Interviews were transcribed, coded line-by-line, and analyzed to identify themes. Program, organizational, individual/team, process, and contextual features that facilitate effective planning and implementation, as well as challenges to implementation, were identified.

Results

PROGRAM FEATURES

- **Formal collaboration** across sectors helped communities apply for funding and implement strategies. However, interviewees observed that challenges include difficulties in arranging periodic meetings, obtaining active engagement, and sometimes partner burnout from too many meetings.
- **Buy in** from key stakeholders, cultivated by communication and advocacy work, is crucial to effective implementation. Obtaining such buy-in was a key barrier in many communities, as was converting professed support into active engagement.
- **Community resource** shortages, such as a lack of accessible or affordable treatment facilities or providers, were named as a key barrier to treatment in both urban and rural locations, especially for uninsured people.
- **Structural challenges**, especially poor transportation, low housing accessibility, and lack of Medicaid expansion were named as major barriers to helping the individuals served by interviewees.
- **Rural and urban counties** reported similar barriers, even though rural counties often felt that structural challenges were more common in their communities. Rural counties also saw themselves as more tightknit and politically conservative, and suggested that "smallness" can help build close networks but lack of anonymity can be a barrier to seeking services.
- **Stigma** against people who use drugs was widely reported. It was most commonly related to syringe services programs and naloxone distribution, which some may see as "enabling."

ORGANIZATIONAL CHARACTERISTICS

- **Funding** helped expand hours, purchase supplies, and formalize volunteer-based programming by supporting paid staff positions. The most commonly reported funding challenges were not enough paid staff, lack of sustainable funding, and restrictions on purchasing syringes and naloxone.
- **Human resources** practices that benefited programs included hiring staff with lived experience or related backgrounds, removal of background checks and drug screening requirements, providing supportive supervision, and enabling self-care through updated leave policies.
- **Location of services** was key. Facilitating characteristics include public transit access, locating services where people who use drugs already spend their time, and co-location with other services. Challenges included finding and maintaining a stable space that feels comfortable and safe for participants.
- **Faith-based** organizations are often well positioned to provide harm reduction services alongside other services, such as food pantries or shelters. However, stigma can be rampant and may limit the ability of faith-based programs to gain trust of people who use drugs.

INDIVIDUAL AND TEAM CHARACTERISTICS

- **Champions of the work** were described as integral to advocating for overdose prevention, building rapport with people who use drugs, and facilitating programs effectively.
- **Hiring staff with lived experience** facilitates building trust with the population served, and can result in better understanding of the services and support that people need.
- **Stress and burnout** came up frequently as a challenge in overdose prevention work. Boundary-setting and supportive work environments are crucial to preventing burnout.

PROCESS CHARACTERISTICS

- **Advocacy** was essential to building buy-in, and consisted of choosing an effective messenger, framing the message for the specific audience, and committing to continued communication.
- **Meaningful engagement with people who use drugs** was facilitated by hiring people with lived experience, as well as a more informal process of getting feedback from program participants.
- **Building trust** was achieved by making participants feel respected, heard, and not judged. Hiring staff with lived experience can help, as can informal dress codes and welcoming spaces.
- **LHD involvement** is helpful in securing funding and initiating partnerships and collaboration through efforts such as coalition building.
- **Data management** can be time-consuming, and many expressed a desire for better data systems.
- **Naloxone** distribution challenges were particularly noted, due to funding restrictions and stigma.
- **Referrals from EMS** to PORT programs were frequently a challenge due to confusion about HIPAA compliance, interruptions to EMS workflow, and trouble getting consent forms signed in the field.
- **Stigmatizing language** was used by some interviewees when describing their work with people who use drugs, which could negatively affect project implementation.

SUMMARY OF COMMONLY MENTIONED FACILITATORS AND CHALLENGES

FACILITATORS	CHALLENGES
Establishing formal collaboration	Difficulty obtaining buy in/Resistance
Stakeholder buy in	Funding challenges
Funding	Inadequate human resources / staff
Hiring staff with lived experience,	Stigma
LHD involvement	Structural challenges
Appropriate human resources	Scarce community resources
Advocacy	Finding a good location to provide services
Building trust	Insufficient formal collaboration
Hiring staff with related backgrounds	Getting referrals from EMS
Convenient location of services	Data management / tracking

OTHER SUGGESTIONS FROM INTERVIEWEES

Avoid duplication of efforts; pick partners and lead organizations carefully; identify champions of the work; and build collaborative partnerships, even if they take time to build.

In addition, prioritize building trust with the people served, by treating them with respect and by being willing to listen; educate everyone on harm reduction; and hire the right people – including those with lived experience.

Key Themes and Takeaways

1

Hire people with **lived experience** and directly impacted people

2

Prioritize the establishment of **formal collaborations** to get buy in from diverse stakeholders

3

Provide **more funding** for overdose prevention efforts, with longer timelines

SAFER ALTERNATIVES WHEN YOU HAVE NOTHING ELSE TO USE



COTTONS	TOURNIQUETS
<ul style="list-style-type: none"> • Using 100% Cotton Q-Tips or cotton balls is the safest thing to use • Filter paper and tampons are another safe alternative • You can use pocket lint if it is all you have to use • You can skip altogether if you have nothing. • NOTE: You can still get an infection using alternative solutions other than 100% sterile cotton balls • NEVER USE CIGARETTE FILTERS. Cigarette filters are not safe to use. They contain tiny pieces of glass and if already have been smoked, contain tiny pieces of tobacco and harmful substances from the smoke. • REMEMBER: Fungi + Bacteria live in old cottons. Cooking up old cottons puts you at risk of infection. 	<ul style="list-style-type: none"> • Ties from hospital are best. • Lubricated condoms work well • Socks or panty hose • Note: Using leather or leather belts can be rougher on the skin and is not recommended.
	SYRINGES
	<ul style="list-style-type: none"> • Always use a clean needle and never share • Reusing needles get dull and barbed. This damages the vein • IF you must re-use, flush with cold water several times and make sure all blood matter is gone. Bleach out the syringe if you can.
	COOKERS + SPOONS
	<ul style="list-style-type: none"> • If using a spoon, try to find one that is rounder and deeper than an average teaspoon or Table spoon - closer to the shape of a ladle - You can bend handle so it won't tip over. • Bottle caps can be used. Make sure to remove the plastic lining or paper lining without scratching the polished surface. • Never: share your cooker with anyone. • Note: What ever you use always make sure your cooker is as clean as possible.

Table of Contents

2	Appreciations and Acknowledgments
3	Evaluation Team
4	Executive Summary
10	Background
15	Evaluation Methods
16	Study Findings and Conclusions
17	Contextual Characteristics
20	Organizational Characteristics
24	Individual and Team Characteristics
26	Process Characteristics
29	Summary of Common Facilitators and Challenges
30	Other Suggestions from Interviewees

Case Studies

32	Cabarrus County (Syringe Services Program)
34	Mecklenburg County (Syringe Services Program)
36	Appalachian District: Alleghany, Ashe, and Watauga Counties (Programs for Justice Involved Persons)
38	Guilford County (Post-Overdose Response Teams)

Background

In North Carolina (NC) nearly 6 people died every day in 2018 from unintentional medication or drug overdose, largely related to opioids. That same year, the Injury and Violence Prevention Branch (IVPB) under the NC Division of Public Health (DPH) was awarded funding via the Centers for Disease Control (CDC) Cooperative Agreement for Emergency Response: Public Health Crisis Response.¹

With this funding, IVPB released a “Request for Applications (RFA) on Emergency Overdose: Local Mitigation to the Opioid Crisis for Local Health Departments and Districts” to prevent fatal and non-fatal opioid overdoses, increase access and linkages to care services for the most vulnerable populations, and build local capacity to respond to the opioid epidemic in NC.

IVPB funded 22 NC local health departments and districts (LHD) from November 2018 through October 2019 to advance one or more strategies identified in NC’s Opioid Action Plan:

1. Establish or expand syringe services programs (SSPs)
2. Connect justice-involved persons to harm reduction, treatment, and recovery services
3. Establish post-overdose response teams (PORTs)

The intervention strategies supported at the county or district-level are briefly outlined below. Although programs were focused on opioid-related harm reduction and opioid use disorder (OUD) treatment, actual services could reach other populations.

¹ Division of Public Health, Injury and Violence Prevention Branch, November 2019. <https://www.injuryfreenc.ncdhhs.gov/DataSurveillance/StatewideOverdoseSurveillanceReports/CoreOverdose-SlideSet-November2019.pptx>

Intervention Strategies

1

Syringe services programs

Establish or expand SSPs through local health or human services departments, faith communities, pharmacies, community-based non-profit organizations, or other potential host organizations with experience of working with people directly impacted by drug use.

- Build a referral network with SSPs for all required services under North Carolina law (G.S. 90-113.27), including naloxone access, hepatitis/HIV testing services, and mental health and substance use treatment such as medication assisted treatment (MAT) if needed
- Train SSP leaders, staff, and participants in first aid, CPR, wound care, syringe hygiene, and related harm reduction and disease prevention practices.
- Use funds to cover staffing, supplies, and related costs, either through subcontracts with local or regional SSP(s) or in-house.
- Safely dispose of syringes and biohazard materials collected through SSP(s).

2

Justice-involved persons

Connect justice-involved persons to harm reduction, social/health services, treatment, and recovery services.

- Establish policies and protocols to universally screen people for substance use disorders (SUD) on intake at jails and prisons.
- Educate people who are incarcerated and their families or loved ones on harm reduction strategies before release, including but not limited to training on overdose recognition and response with naloxone and overdose prevention planning.
- Distribute take-home naloxone upon release to those identified with opioid use disorder (OUD) and to others who request it.
- Establish reentry programs to link or refer people to care services once released from incarceration, and provide care service referrals to those individuals identified with SUD upon their release.

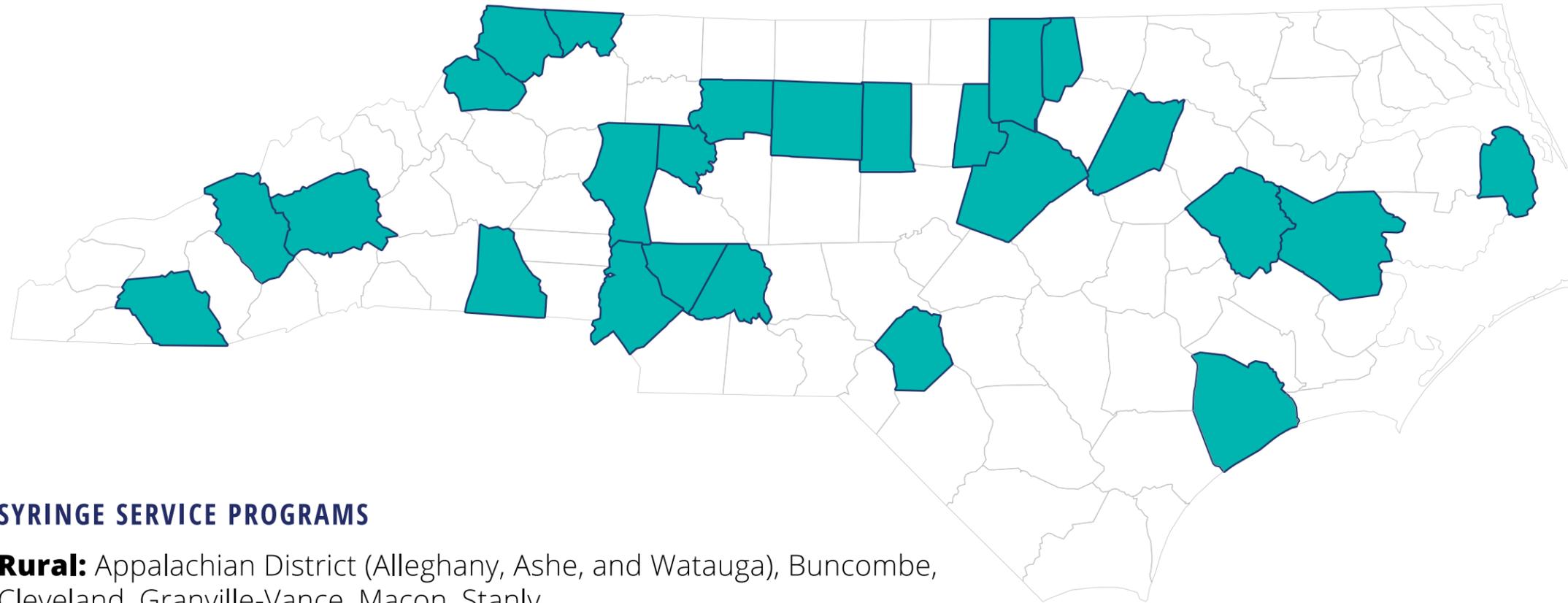
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Post-overdose response teams

Establish PORTs led by EMS and/or a harm reduction community-based organization to prevent repeat overdose, and connect those who have had a non-fatal overdose to harm reduction, care, treatment and recovery supports, including housing or employment.

- Engage with persons with lived experience with drug use or in recovery from drug use and other harm reduction specialists when developing post-overdose response teams, by including them throughout planning, implementation, and evaluation of the program.
- Follow-up with patients who have experienced an overdose within 72 hours of the non-fatal overdose event.

Funded Counties



SYRINGE SERVICE PROGRAMS

Rural: Appalachian District (Alleghany, Ashe, and Watauga), Buncombe, Cleveland, Granville-Vance, Macon, Stanly

Urban: Alamance, Beaufort, Dare, Forsyth, Guilford, Hoke, Mecklenburg, Nash, Pitt

JUSTICE-INVOLVED PERSONS

Rural: Appalachian District (Alleghany, Ashe, and Watauga), Beaufort, Cleveland, Davie, Granville-Vance, and Macon

Urban: Cabarrus, Dare, Durham, Guilford

POST-OVERDOSE RESPONSE TEAMS

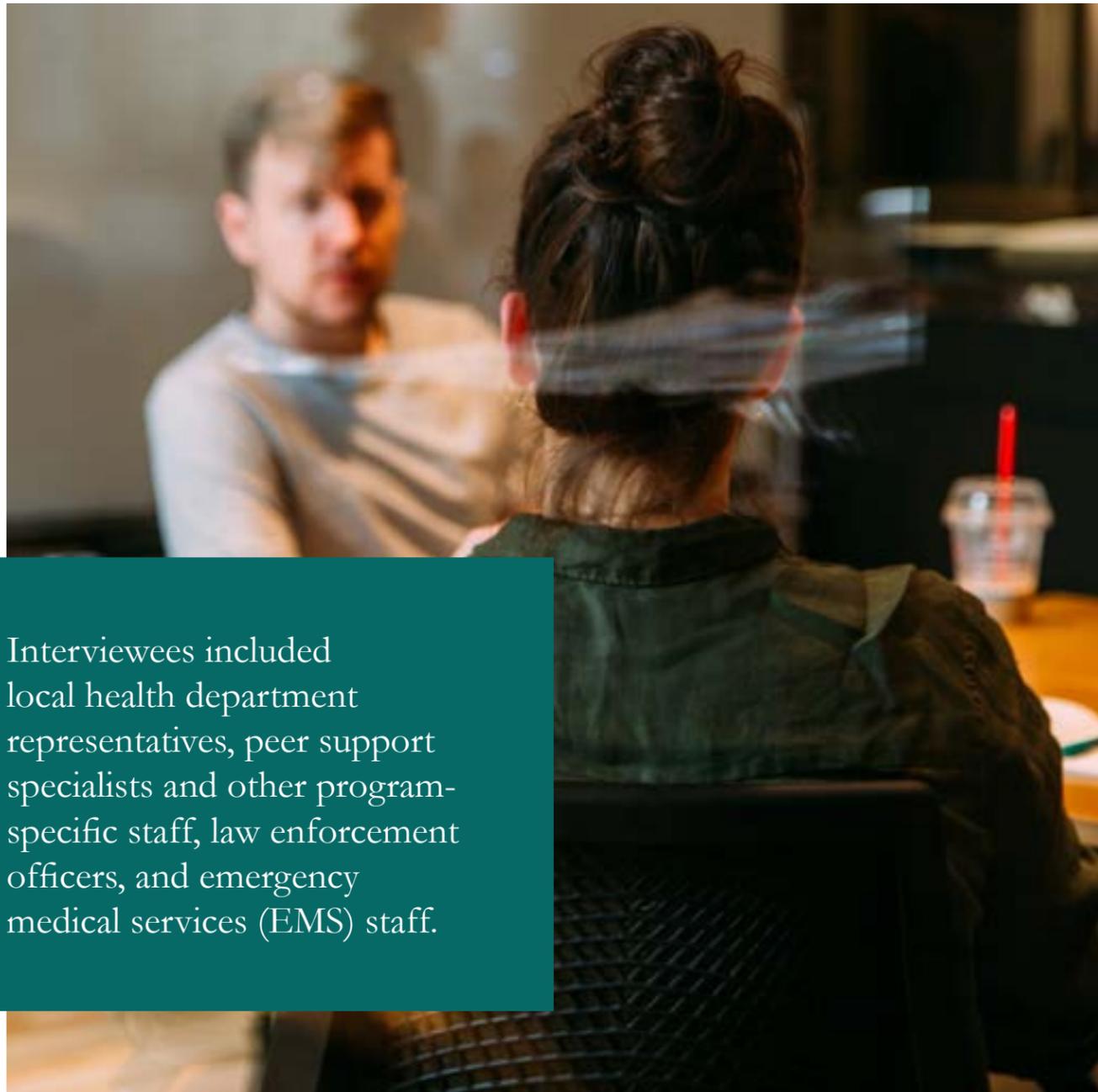
Rural: Granville-Vance, Haywood, Macon, and Stanly

Urban: Alamance, Dare, Durham, Iredell, Nash, Onslow, Wake

Evaluation Collaboration

In 2019, IVPB partnered with the **Department of Population Health Sciences (DPHS)** at Duke University's School of Medicine (SOM) to evaluate LHD efforts to mitigate the opioid crisis. Funding via the CDC Cooperative Agreement for Emergency Response represented the first time that significant DPH resources (up to \$100,000 per grantee) were routed to LHDs to address the opioid crisis, and IVPB considered it important to learn from the experience. Additionally, the interventions funded are somewhat new (e.g., SSPs have been legal in NC only since 2016), and some counties implemented the intervention strategies in relatively novel ways (e.g., by implementing PORTs with a focus on emergency medical services rather than law enforcement). IVPB was simultaneously developing its own capacity to provide technical assistance to counties, and was preparing a second RFA to provide longer term overdose prevention funding for LHDs.

For all these reasons, IVPB felt it was important to conduct a detailed evaluation of the funding and implementation process. Synergistically, Duke SOM had previously received extramural funding, and part of this funding was made available by DPHS to conduct this evaluation in partnership with IVPB.



Interviewees included local health department representatives, peer support specialists and other program-specific staff, law enforcement officers, and emergency medical services (EMS) staff.

Evaluation Methods

The Duke and IVPB evaluation team developed an interview guide based on the Consolidated Framework for Implementation Research (CFIR). The CFIR consists of five overarching domains: outer setting, inner setting, program characteristics, characteristics of the individuals involved, and the process of implementation. Open-ended questions explored program planning and implementation, focusing especially on facilitators and challenges.

To recruit interviewees, the study team worked with each grantee to identify the individuals best suited to discuss project planning and implementation of funded strategies in the county or district. The team conducted in-person, semi-structured, in-depth, one-on-one or small group interviews with LHD representatives and community stakeholders in 21 of the 22 funded counties, conducting a total of 49 interviews with 71 individual participants. Interviewees included local health department representatives, peer support specialists and other program-specific staff, law enforcement officers, and emergency medical services (EMS) staff.

Each interview was audio recorded and transcribed. Transcriptions were uploaded to NVivo version 12 software for data management and analysis. The Duke evaluation team used a thematic analysis approach to categorize and understand the information collected and summarized the findings in this report.

A case studies for each of the three intervention strategies, including implementation barriers, and facilitators at the specific location are provided through case studies at the end of the document. North Carolina counties differ in many ways and implementation is often tailored to the local conditions. These brief case studies are intended to be illustrative only, and highlight programs that are effective in their specific contexts.

INTERVIEWS BY RURAL/URBAN

Rural	26
Urban	23
Total	49

INTERVIEWS BY REGION

Mountains	12
Piedmont	27
Coast	10
Total	49

Study Findings and Conclusions

The study team's main findings and conclusions are discussed below. Program and contextual features that facilitate effective planning and implementation, as well as challenges to implementation, are identified.

Program Features

The characteristics that facilitate or potentially impeded effective program implementation are organized and presented in the following categories.



Contextual

The physical, cultural, and political environments in which local organizations are operating



Organizational

Characteristics of the implementing organizations or partners, and of the program itself



Individual and Team

People who are managing and implementing the program



Process

Practices undertaken to implement the program



Contextual Characteristics

Formal collaboration: Active collaboration among stakeholders through coalitions and other established efforts to engage with partners helped bring people to the table, leverage resources, and facilitate buy-in. Communities that had already established collaboration across sectors were well positioned to apply for funding and to implement the approved strategies, and cited this as a facilitator to building a successful program. However, several interviewees mentioned that while progress was made during the collaborative meetings, addressing action items only during periodic meetings was not enough to keep projects moving forward. Interviewees reported that some key stakeholders who reported being on board were not actively engaged or able to regularly attend collaborative meetings – most often EMS and law enforcement – which was a challenge for program implementation. Also, it was noted that burnout can occur when partners are asked to engage in too many coalitions and meetings.

One interviewee expressed concern that when organizations partner with law enforcement but officers are not held accountable for improving the way they treat people who use drugs, the program is prioritizing partnerships over improving the wellbeing of people who use drugs.

So, law enforcement agencies...the leadership is vocally supportive. And then, there are officers working or arresting everyone, even folks with syringe exchange participation cards, and taking them, and shredding them, and confiscating naloxone, and doing all kinds of awful things, and just being mean in general.
– Peer Support Specialist

BUY-IN: Buy-in prior to funding was especially important, with specific groups including (1) law enforcement, (2) local government, and (3) EMS. Counties that had established buy-in before receiving funding discussed how this benefitted the implementation process, and counties that started this process under the present funding mechanism noted the importance of strong communication and advocacy work to get leadership and decision-makers on board.

Getting buy-in was a significant challenge in many counties, and in a few instances, prevented implementation of planned programming. Interviewees described having the most difficulties bringing law enforcement stakeholders on board, especially with SSPs and providing naloxone and medications for opioid use disorder in jails. This resistance was often attributed to stigma, lack of training on harm reduction, having other priorities, and confusion around the legality of SSPs. County commissioners were also noted as key gatekeepers who were frequently not on board with harm reduction due to stigma and re-election pressures. Interviewees explained that resistant hospital and EMS staff sometimes had stigmatizing views of people who use drugs, were experiencing burnout, or had not bought-in to the program enough to make time for referring patients to the programs. Moving stakeholders from professed 'buy-in' to active support was a commonly reported challenge, with many stakeholders stating their support but not committing the needed

“I mean, it took me six-plus years to change my mindset to instead of go out and arresting everybody is going to fix the problem to finding the root cause.”

-Law Enforcement Representative

funding, or attending preliminary meetings but not showing up to continue the work.

I've gotten a lot of verbal buy-in from other agencies. More, I suppose, specifically the town police department. They say they understand, they're on board. And then, that's it... I invited them to our meetings and stuff, and they'll show up, and they nod their head, they agree. And then, we don't ever see them again. Law enforcement as a whole... we're resistant to change. I mean, it took me six-plus years to change my mindset to instead of go out and arresting everybody is going to fix the problem to finding the root cause. – Law Enforcement Representative

COMMUNITY RESOURCES: Lack of accessible or affordable treatment/recovery facilities, transitional homes, and providers who prescribe medication for opioid use disorder were barriers to treatment in many counties. Although urban counties generally have more community resources, shortages of services were cited in both urban and rural communities, with options particularly limited for uninsured people.

That has been the No. 1 barrier, just not being able to find people beds. Just not being able to get them in. If we can't get them into a place like [the local in-patient treatment facility], then their only other option is to claim suicidal or get put on lockdown for 72 hours, and then hope they can get the

treatment afterwards... And then, if we can't get them into an actual treatment facility, then what we recommend is you go to the ER. And a lot of them do not want to do that. So, they won't. – Peer Support Specialist

STRUCTURAL CHALLENGES:

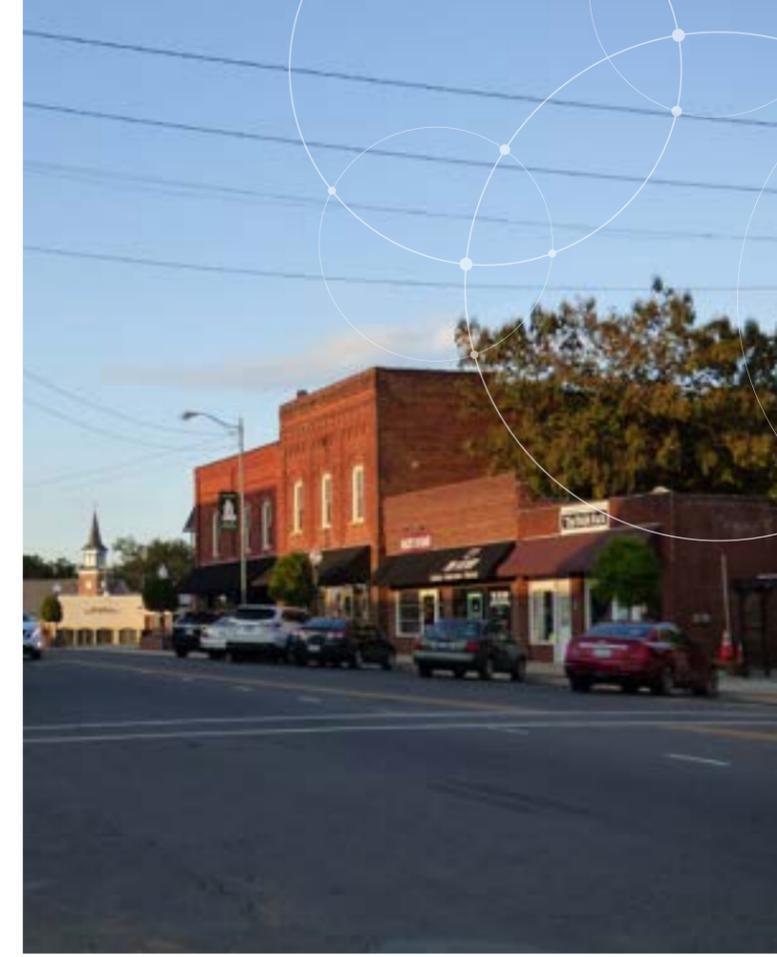
Transportation was the most consistently mentioned structural barrier statewide and was considered extremely impactful on people's ability to access services. Interviewees also explained that lack of affordable housing is an increasing issue, especially for individuals recently released from incarceration. Not having a valid ID can be a barrier for accessing homeless shelters and other needed services. In addition, lack of health insurance and NC's decision not to expand Medicaid make it difficult for individuals to access quality health care, including medication for opioid use disorder.

Much of the counties that we serve are very rural. Or their transportation shuts down over the weekend. So, if somebody is required to pick up their methadone seven days a week, they don't have access on Sundays. Or if someone decides that they want to get enrolled in an opioid treatment program [and in their county] if it's not a Wednesday, there's not a doc at the primary clinic that we refer to...so how do we get them transported to another [county's clinic]? – Program Representative

RURAL AND URBAN: Rural counties differentiated themselves from urban counties as being very close knit and often politically conservative, which has an impact on how overdose prevention services are provided. As a positive feature, rural local health departments were often able to tap into strong existing networks and relationships across county agencies since 'everyone knows everyone' and many have been living there for their whole lives. However, this 'smallness' can also produce a lack of anonymity, which can pose a challenge to reaching people who use drugs who may feel uncomfortable being seen by people they know accessing services.

STIGMA: Stigma against people who use drugs was mentioned in many of the interviews, most commonly related to establishing SSPs and naloxone distribution. Many interviewees described the stigma that program participants face from the community, including from law enforcement, health care providers and staff, and EMS. Interviewees noted that sometimes these negative beliefs are influenced by compassion fatigue. Some interviewees reported that people with negative beliefs about syringe services and distribution of naloxone see them as 'enabling' drug use. Stigma was not just an external force, however. Interviewees also explained that many program participants have internalized stigma and shame.

Some people come in and they're super embarrassed and disappointed, and they'll say, "I just can't believe I'm here. I can't believe I'm having to do this." Something we'll always say to them is, "This is amazing. You're taking the first step. You should not be embarrassed at all. You should not be disappointed in yourself. You care about your health, you care about your family, your loved ones, you care about everyone else. This is the first place that... you feel like you can come to, and we're happy that it's here. – SSP Representative



Rural local health departments were often able to tap into strong existing networks and relationships across county agencies since 'everyone knows everyone' and many have been living there for their whole lives.

“This kind of funding is so critical to our being able to do anything, especially in local bureaucracies [...] that don’t change easily, that have so much need.”

- LHD Representative



Organizational Characteristics

FUNDING: Funding helped expand program hours of operation, increase availability of supplies, and formalize volunteer-based programming by supporting paid staff positions. Community partners often noted securing funding as one of the important roles for their county’s LHD. The most common funding limitation noted by interviewees included inability to pay for enough staff to adequately support programs, lack of sustainable funding to continue paying current staff, and grant restrictions around purchasing syringes and naloxone. Many described leveraging several different funding sources including grants, donations, and in-kind support from local organizations to support programs, and noted that they need to continuously apply for grants. Stigma around harm reduction services can make it difficult to obtain county funding, especially for SSPs.

I do want... DPH to hear the message that this kind of funding is so critical to our being able to do anything, especially in local bureaucracies in general conservative

communities, that don't change easily, that have so much need. This goes a long way. I'd rather see it longer and bigger money, but it really has enabled us to do a lot of good stuff. - LHD Representative

HUMAN RESOURCES: Organization-level policies regarding human resources had important effects on the ability to implement the programs. Interviewees explained the importance of hiring staff that are the “right fit” for this work, often individuals with lived experience. Focusing on sufficiently staffing and engaging volunteer support at the organization level, supporting staff with lived experience by providing formal supervision, and establishing policies that encourage self-care means that staff are better able to serve the community.

Supervision is very important for this particular peer support position. Carrying a lot of heavy weight and not a lot of success stories, a lot of people still using. So, they get there at 9:00. At 9:00 we do check-in for 30 minutes, just kind of informal

supervision. How is your day going? How is life going? How is recovery going? Is there anything I can do to help out, and so on? - Peer Support Coordinator

Insufficient staff capacity was a common issue expressed by interviewees. Many emphasized the need to hire more paid staff to cover current program activities adequately, and explained that engaging volunteers is not a long-term solution as it is difficult to find individuals who are dependable and able to provide support consistently. Interviewees note the need for hiring more permanent staff, which will allow programs to serve more people, offer more hours, and have coordination oversight.

Some LHDs and agencies have policies requiring background checks and drug testing, which could prevent hiring individuals with lived experience (See Case Study 1: Establish or expand syringe services programs (SSPs) in Cabarrus County, NC). Some programs hired staff with lived experience through community partners to avoid such restrictions.

LOCATION OF SERVICES: Interviewees explained that SSPs should be located where people who use drugs already spend time or in spaces that are easily accessible without a car to address issues with transportation, and that it is important for spaces to be comfortable and inviting for all participants. Using mobile exchange can also help address transportation barriers, which interviewees reported throughout the state. Some interviewees discussed the benefit of choosing a SSP location based on other services that could be accessed in close proximity. For example, positioning an SSP near or within a health department facilitated linking participants to hepatitis C, HIV, and STI testing, or positioning an SSP in a church allowed participants to access co-located group sessions or food pantries and clothing banks. Finding an appropriate

space for SSPs was often noted as a challenge because of stigma from the surrounding community or other organizations sharing the building. It can be difficult to find spaces that feel comfortable and welcoming for PWUD and that are accessible to those with transportation limitations. Locating SSPs within health departments or other governmental buildings may prevent people from accessing the services or feeling safe in the space, especially if the spaces have law enforcement presence. Some interviewees also mentioned trouble maintaining a stable location.

I think there was nervousness. Like, “What are we opening ourselves up to?” And I think people go into worst-case scenario. “Are we going to find someone overdosed in the bathroom?” And, “Are we gonna find someone wandering around over in the pediatric clinic?” “Are we going to find people using in the parking lot?” “How many needles are we gonna find in the parking lot?” ...When [participants] join, we always remind them, “We’re very fortunate to have a program like this. We just ask that you respect the space so that we can make sure that we can continue to provide services to you.” And usually people self-police, because they want us to still exist here. - LHD Representative

FAITH-BASED: Faith was mentioned only in the context of Christian ministry and faith-based harm reduction services, and only in the context of SSPs. This is likely because PORTs and programs for justice-involved populations are more tightly aligned with government organizations. Interviewees described faith-based support or services as important to this work and common, but not always aligned with harm reduction principles. Churches have clout and strong networks throughout communities, especially in rural areas. The altruistic and service-oriented missions of churches may well position them to support marginalized

populations, including people who use drugs, and they may be already providing services to these populations through soup kitchens, food pantries, and shelters. Additionally, churches usually have a physical space and access to volunteers and often a formal LLC or nonprofit status. This gives them a platform to start service programs, like SSPs, without common financial and human resource challenges. Though churches may be well positioned to do this work for these reasons, interviewees made it clear that stigma can be rampant and may limit the effectiveness of faith-based programs. This can make it difficult for them to gain the trust of people who use drugs.

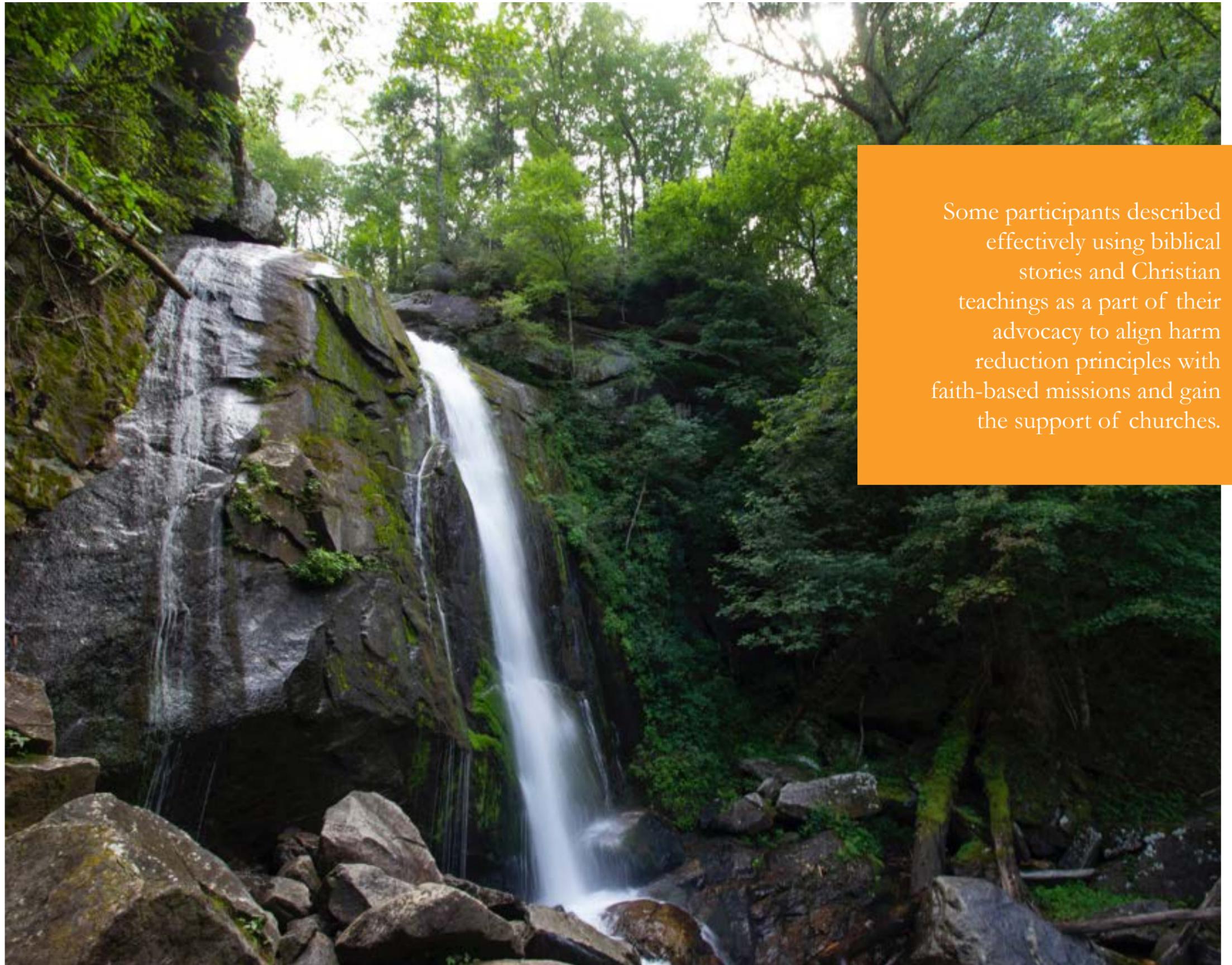
The issue that we have come across being in this community is even when people know that, they still hold tight to that morality argument, because they're convinced that there was a failure somewhere, that they didn't pray enough, they weren't going to church. That's why. If we all just pray a little harder, it will fix the problem.

– SSP Representative

However, some participants described effectively using biblical stories and Christian teachings as a part of their advocacy to align harm reduction principles with faith-based missions and gain the support of churches.

I gave a presentation about naloxone at a church the other day, and a guy came up to me afterwards, and he was like, "You know, you're right about this." He said, "But it's so hard, because these people, sometimes they're overdosing five or six times, and how many times?" And I said, "Well, what did Jesus say, 70 times seven?" And he's like, "Oh, yeah." And I was like, "Yep." And he's like, "You're right." And he just kinda walked off, and you can't argue with that.

– SSP Representative



Some participants described effectively using biblical stories and Christian teachings as a part of their advocacy to align harm reduction principles with faith-based missions and gain the support of churches.



Individual and Team Characteristics

CHAMPIONS OF THE WORK: Many programs identified champions of the work, who were described as integral to advocate for overdose prevention, build rapport with people who use drugs, and facilitate programs effectively. Champions often have strong connections to the communities they serve and large networks to tap into, a result of being from the community or having lived there a long time. This allows them to connect with more people and work efficiently, already knowing where to go and whom to talk to.

She's a walking encyclopedia for [this] county, just let me tell you. She will read a name on a chart and be like, "That's such and such's baby brother's nephew's cousin's third sister, and you know what, she left her husband because he was doing this, and this." And I'm like, "What? How?" And she knows where to find them, where we couldn't find them. – LHD Representative

Champions of the work were also described as assertive 'go-getters' who worked independently and were passionate about the positions they were in. Many of the passionate champions had lived experience using drugs and wanted to help others at risk of overdose. Champions were described as integral components to the work, to the point where they are irreplaceable.

One of the things that [the peer support specialist] does really well is storytelling. He builds a lot of community around that. And he's been able to knock down some barriers that I found to be hard to be believed...We presented to [the county commissioners]

a couple weeks [ago]...And we had a 75- or 80-year-old commissioner come up who said, 'I am from a highly conservative area, but you just sold me on this. Now, whether I can sell everybody else, I don't know. But I like the way that you framed that.' And I think those become very powerful conversations. – EMS Representative

HIRING STAFF WITH LIVED EXPERIENCE: Staff with lived experience are able to build trust with people they are serving and better understand the services and support people need because of their personal experiences. Interviewees repeatedly highlighted the vital importance of hiring staff with lived experience (e.g., with substance use, incarceration, or housing insecurity); and, expressed enthusiastic gratitude for their contribution to program successes.

I refer a lot of people to [the peer support specialist] if they're not comfortable talking to me about substance use... [They've] been a huge asset for me. And... if they don't wanna hear from me as a law enforcement officer, I can say, "Call [the peer support specialist]. Let them tell their story to you. They're not a cop, and they can help you better than I can...So, they've really been a great asset, to have somebody in recovery that has been through it all. – Program Representative

I think that because she is a peer support specialist, she's gone through the struggles that the people that she serves have gone through. She's been in and out of our detention center. She's made her way through navigating, accessing, trying to use the services that are available in the community... she's able to build a relationship or a rapport with them like probably nobody else, or very few people, could do... She can speak their language... she knows her stuff. – LHD Representative

"I think that because she is a peer support specialist, she's gone through the struggles that the people that she serves have gone through...she's able to build a relationship or a rapport with them like very few people could... She can speak their language...she knows her stuff."

– Program Representative

HIRING STAFF WITH RELATED BACKGROUND: Choosing staff based on their related background and job experience was considered important for successful hiring. Some of the background that interviewees looked for in candidates included employment experience with case management, mental health, substance use, and homelessness or having worked with justice-involved populations or in jails; and, being from the community or having investment in the community through previous employment or social connections.

STRESS AND BURNOUT: Stress came up frequently as a challenge in overdose prevention work. Some interviewees described feeling pulled in too many directions when they could not afford to hire enough staff. Setting boundaries is important for peer support specialists as the job can be emotionally heavy and require being available outside of work hours to provide support. Without boundaries, interviewees describe being vulnerable to burnout.

I think people who are in recovery and helping others get to recovery – it's really hard, because they just know how hard it is. And they want to help them so much that they really have to have that boundary of you can only do so much... – EMS Representative

I knew when they walked out of this building, if they did not get care within a week, I'd

probably be looking at their death certificate pretty quickly... So, knowing that, it drove me crazy that I was sending them out the door and the parents knew it – they would just be bawling and I had nothing else to do for them except hand them over to some partner agencies that may or may not be able to get some sponsorships from community members... I cried a lot. It was really hard. I didn't sleep a lot for about four weeks. – LHD Representative

It is beneficial for organizations to have supportive structures built in to support staff in recovery and staff who are engaged in work that may cause direct or vicarious trauma. Interviewees acknowledged that is important to recognize the trauma that first responders can experience around overdose.

We have dedicated time to having officers or EMS who have [experienced trauma come together], and any non-first responders leave the room... I think the county's done a good job of working towards that being not that stigma on vicarious trauma. – EMS Representative

Some interviewees noted that implementing harm reduction services could help address compassion fatigue among EMS and law enforcement, by providing services that can support better outcomes in people who use drugs.



Process Characteristics

ADVOCACY: Educating the community and local agencies, including EMS and law enforcement, on funded program efforts was identified as vitally important, with success contingent on 1) choosing an effective messenger, 2) framing the message for the specific audience, and 3) committing to continued communication. Interviewees noted that organizations are more receptive to hearing messages from someone who has experience in their field and is able to “speak the same language.” For example, EMS was more likely to find common ground with a messenger they felt understood their job and daily experiences. Acknowledging that different messages will resonate with different audiences was identified as key, with interviewees expressing the different impacts they could highlight – cost saving, public safety, lower disease transmission – based on the audience’s specific values. They described using metaphors such as wearing a seatbelt, comparisons between substance use disorder and other chronic conditions like diabetes or heart disease, or comparison between opioid use and other less stigmatized substances like tobacco to help audiences understand the importance of harm reduction. Interviewees noted that keeping partners informed on services they were planning to offer or any program changes helped manage potential pushback.

Now, we did have [a community stakeholder] – who’s wonderful and also supportive – who said on his way out the door of our last meeting, “Now, I believe in that naloxone stuff. I’m glad you’re doing it. But once people have had it three times, I don’t know that you should give it to them a fourth or fifth.”... And I just had to very politely and diplomatically say, “I know, but

if someone were having a heart attack, we wouldn’t stop giving CPR. So, we just gotta keep saving these lives. It’s hard.”
– LHD Representative

[Syringe use is] like smoking cigarettes. One person may only need 20, and we tell them they can take what they need. Another person may need far more than 100. It’s just like buying a pack. Some people go through two packs a day, some people only have a cigarette when they drink. There’s just a different dynamic. – SSP Representative

MEANINGFUL ENGAGEMENT WITH PEOPLE WHO USE DRUGS (PWUD): When interviewees were asked about meaningful engagement with PWUD, some talked about involving people with lived experience in the planning of the program and decision-making around services offered. Engaging people actively using drugs was expressed as a more informal process of asking individuals participating in the programs what their needs were regarding the services offered. Some interviewees mentioned changing the types of supplies they offered, services they had available, or hours of operation due to feedback from participants to ensure that the program fit the needs of the community served.

We ask them questions all the time. We pose things to them. When we looked at wound care kits, and the cost of wound care kits, we’re like, “What are you typically using in the wound care kits?” And they’re like, “We never use saline.” “Okay, well, what are you using?” “Oh, if we could get more of the big bandages.” So, we try and engage them and make sure that what we’re supplying is helpful. – SSP Representative

BUILDING TRUST: Success of programs is contingent on establishing trust with individuals being served. To build trust, interviewees explained that individuals accessing programming need to feel

respected, heard, and not judged, and that having staff with lived experiences helps make individuals feel more understood.

I feel like that’s so important. To be able to connect with them that way. But know I can make that person feel better about being here and like they’re doing the right thing. Even if they’re still using, they can leave here with their pride. And I love that. Because of that connection...It’s so weird – I feel like I’ve talked about the connection so much. But I feel like that’s a huge part of it. I know what that feels like to walk into a needle exchange. Or not walk into a needle exchange and use sort of a dirty needle. I know what that’s like. And I just want people that come here to feel really good about who I am and that I’ve been honest with them, open with them, and made them feel comfortable so much so that they will feel comfortable to come back.
– SSP Representative

Interviewees also explained the importance of offering services in welcoming spaces and making sure staff are dressed in ways that are approachable and not overly formal.

LHD INVOLVEMENT: Counties that described positive relationships between community partners and the LHD explained that the LHD is helpful in securing funding and initiating partnerships and collaboration through efforts like coalition building. Interviewees also expressed that when LHDs routed funding through community partners, components of the implementation process such as hiring and day-to-day spending were under fewer bureaucratic restrictions.

So, our perspective – my perspective here at the Health Department is our job is not to be the solution for everybody. It is to be the catalyst for the solutions in the community so we’re not the dictators of all that’s happening. We’re helping to initiate and funnel in resources to help provide

support...I tell our partners all the time, “We’re not doing the hard work. You’re doing the really hard work.” We’re going and getting the resources so you can keep doing your work. – LHD Representative

DATA MANAGEMENT: For SSPs, data management can be time consuming, as many programs still use paper tracking sheets that are later entered digitally. Having a more streamlined, electronic process to track SSP participant and supply data would be beneficial.

We have so much data and we don’t have that many people who can put it in, so we have – we probably have at least 300 hours’ worth of data entry that needs to be done.
– SSP Representative

Support is also needed for developing systems to manage data, especially for PORT referrals, SSP participant and supply tracking, and following up with individuals who have been released from incarceration.

NALOXONE: Challenges related to naloxone distribution were particularly noted. Stigma around naloxone is still commonly reported, with interviewees describing some partners and communities feeling that naloxone distribution enables drug use. One interviewee expressed concern that because they are giving out naloxone, not as many people will call 911, and in turn will not be linked up with PORT or additional case management follow up. In addition, difficulty obtaining funding for naloxone and tracking naloxone use and community reversals were reported challenges.

REFERRALS FROM EMS: For PORT programs, trouble getting referrals from EMS and hospitals when patients have experienced an overdose is a common challenge. Interviewees explained that this is often because it can require an extra step in the workflow for EMS and hospitals and

“Syringe use is like smoking cigarettes. One person may only need 20, and we tell them they can take what they need. Another person may need far more than 100. It’s just like buying a pack. Some people go through two packs a day, some people only have a cigarette when they drink.”

-LHD Representative

there is confusion around HIPAA compliance and what information can be shared. For PORT programs that include responding to the overdose in the field, it can be difficult to get consent forms signed when the patient is still in a crisis situation. It is reasonable that someone who recently had this experience would not want to engage with a stranger or have the capacity to go through a full evaluation at that particular crisis moment. Combing through EMS reports after the fact to identify individuals who have experienced overdose can be time consuming, as overdoses are not always documented clearly, thus requiring close review of case notes.

STIGMATIZING LANGUAGE: As a factor that could negatively impact project implementation, many interviewees used stigmatizing language when describing their work or PWUD. Stigmatizing language was most commonly used by law enforcement and EMS representatives. Statements tended to involve overgeneralizations, the belief that people using drugs do not care about their lives or their health, that there is something inherently “bad” about

people who use drugs, and that having an addiction was because of “bad” behavior choices. Interviewees who used stigmatizing language used phrases such as “addict”, “gang banger”, “bad guy community”, “crackhead”, “no moral compass”, “gangster”, and “low levels of society.”

They just don’t see – they don’t have any goals, that’s the whole thing. They don’t have any pride in their own selves. You can tell. Their shoulders are slumped, they don’t have any pride in themselves. They go around and they don’t have their GED, they have nothing. They steal for – just to be stealing. And then they puff themselves out. They’re in little gangs, and a gang is nothing. It’s ridiculous. And you look at them, and they’re just puffed all out. It’s really sad. And here they are, they’re 13, 14 years old and you’re thinking, “13, 14 years old, I was doing – I was outside playing and doing stuff and whatever.” It’s sad. – Law Enforcement Representative

Study Findings and Conclusions

Summarizing, interview data from the intervention strategies implemented in the 21 counties of NC helped the study team identify the following list of most commonly reported facilitators and challenges to implementation.

FACILITATORS	CHALLENGES
1. Establishing formal collaboration	1. Difficulty obtaining buy in/resistance
2. Stakeholder buy in	2. Funding challenges
3. Funding resources	3. Inadequate human resources/staff
4. Hiring staff with lived experience	4. Stigma
5. LHD involvement	5. Structural challenges
6. Appropriate human resources	6. Scarce community resources
7. Advocacy	7. Finding a good location to provide services
8. Building trust	8. Insufficient formal collaboration
9. Hiring staff with related backgrounds	9. Getting referrals from EMS
10. Convenient location of services	10. Data management/tracking



Additional Suggestions from Interviewees

The evaluation team asked interviewees for their top suggestions for other similar programs. The following were mentioned most often:

- **Avoid duplication of efforts** – contract to organizations in your county who are already engaging in the work, or, if the program does not already exist in your county, connect with organizations in other parts of the state who are engaging in the work.
- Think carefully about **which organization or partner is best suited** to implementing the program.
- Find individuals who can **champion the work** and advocate effectively.
- Understand that getting people on board and implementing these programs **takes time**.
- Building **collaborative partnerships** is key. Make sure you bring everyone to the table from the beginning – law enforcement, public health, EMS, partners, and especially the community.
- Educate everyone on **harm reduction**.
- Hire the **right people** – consider their related backgrounds and lived experiences.
- Involve **directly impacted people** and people with lived experience in every aspect of implementation.
- Prioritize **building trust** with the people you are serving, treat them with dignity and respect, and have a willingness to listen.

Key Themes and Takeaways

Finally, a few notable themes emerged repeatedly across the interviews:



1

Hire people with lived experience. Having people with lived experience on staff can help build trust with participants and better understanding of participant needs. Many programs identified a person with lived experience as the champion of the work that was key to program success. Hiring such individuals directly to LHDs may require revising personnel and leave policies, in particular relaxing background checks and drug testing.

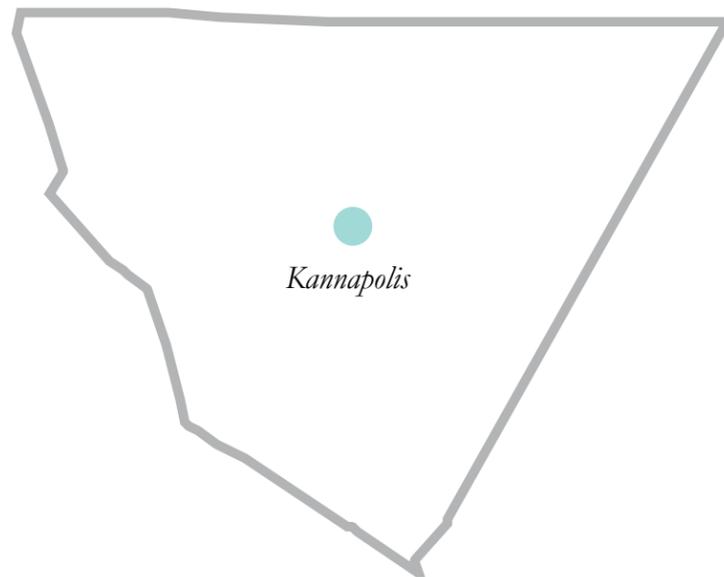
2

Prioritize the establishment of formal collaborations to get buy in from diverse stakeholders. Successful collaboration lays the groundwork for obtaining funding and successfully implementing programs.

3

Provide more funding for overdose prevention efforts, with longer timelines. One interviewee observed that they never have to worry about HIV funding, but they have only about 30 people living with HIV in their community, whereas they felt they were constantly seeking funding to address overdose, which affects many more in their community.

Establish or Expand Syringe Services Programs in Cabarrus County



I don't think people take the time to ask, "Are we really right for this?" Like, sure, we can open up a door and have a cabinet and carry syringes and let people come in, but [if you] don't have good collaborations with treatment providers, law enforcement [...]. Think about the dynamics of those relationships, and don't enter a space that's not appropriate for you to enter.

CONTEXT

Cabarrus County is a suburban county outside of Charlotte, NC with a population of about 216,500. The Cabarrus Health Alliance (CHA) is the public health authority in Cabarrus County. The Cabarrus County Health Department, the CHA, was incorporated as an LLC in 1997. Although CHA receives about 1/3 of their funding from the county, their LLC status allows them to make decisions independent of county leadership and apply for grants with non-profit LLC eligibility.

In 2017, CHA started a syringe services program (SSP) on site through local funding. They set up the program by leveraging a public health associate, paid through the CDC, to organize the program, and relying on volunteer time to staff the program. This allowed CHA to start the program without asking for any funds from the county.

PROGRAM

The CHA Syringe Exchange Program is a fixed-site SSP located in downtown Kannapolis. At the time of our interview, the CHA SSP was open Monday, Wednesday, and Friday. They had recently opened a second location on Tuesdays at a progressive church in Concord, the county's largest city. Both programs are staffed by volunteers and health department employees. Expanding to the church was an important step for the CHA to expand participation and geographic spread:

We're in Kannapolis on the Rowan County line, so I would say about 60% of our participants are Rowan County. So, we felt like we needed to move into Concord, just because we needed to continue [supporting Cabarrus County]. With the church, we met with [the] Reverend. He was interested in being a site because they serve anyone, and they open doors. They have a gay pride flag, they do racist anonymous groups, they have a lot of NA groups there, soup kitchen... They just try their hardest to reach different populations, and so they felt like this aligned with their mission.

The CHA SSP is unusual because its main site is located in the health department. Participants must enter through the main door and go to the syringe services program office. The office is set up in a location meant to make participants feel comfortable while entering a government related building. The office is close to the front entrance and does not require check-in to access. There is no law enforcement presence at the CHA and the

front desk receptionist is highly supportive of the program and treats participants with warmth and respect. The SSP office has a private waiting room where participants can access services.

The CHA hires staff with lived experience for its overdose prevention programs. Staff with lived experience may have a history of incarceration or need additional mental health or substance use benefits, the CHA changed organizational policy to accommodate the needs of peer support specialists and to the benefit of all CHA employees.

Our peer support did have a criminal history. He had shared that with us. We disclosed that to HR, and so they knew that coming into it. They knew that we were posting, and that this was going to be the situation. We also paid a peer support a lot more than most people pay peer supports, because we felt like we need to pay them a living wage. And so, we had to look at classifications for jobs.

We're now hiring someone who we are asking to be in recovery, so we need to be equipped and knowledgeable to what we need to do, so we talked about Family and Medical Leave policy. I think they reviewed that to make sure the language was appropriate to include not just for medical reasons - medical reasons include if they were to have a relapse and need to go to treatment, if they needed to take time off, or whatever that may be. We changed our sick leave policy to include if you're taking a mental health day, basically. That included mental wellness as well.

SERVICES PROVIDED

The SSP offers all types of injection drug supplies, including syringes, cookers, sterile water, cotton filters, fentanyl test strips, vitamin C, and naloxone kits. Staff and volunteers elicit informal feedback by asking participants about what types of supplies they need and ordering based on their usage and needs. Participants are encouraged to take as many supplies as they need.

The CHA also provides education on safe injection practices. They also offer connections to care at the CHA, including Hepatitis C and HIV testing, along with prenatal care and any other services the health department may offer.

TAKEAWAYS

Understanding the community context and which partners already provide services to people who use drugs was important for CHA syringe services management. They knew that they should not start a program that would be better positioned at an existing organization. Since an SSP did not exist in the county and there was not an existing community based organization better positioned to support the work, the CHA has filled a need that did not already exist in the county.

 Department of Population Health Sciences
Duke University School of Medicine



Establish or Expand Syringe Services Programs in Mecklenburg County

CONTEXT

Mecklenburg County is an urban county with a population of over 1.1 million. Charlotte is the county's seat and a sprawling city with a very transient population, which can make it challenging to provide comprehensive services and follow up.

In 2016, the Queen City Needle Exchange (QCNE) officially registered as an SSP in Charlotte, NC. At the time, the exchange was underfunded and not well supported by the community, leading to challenges in implementation. In 2018, QCNE became a program of the Center for Prevention Services (CPS) and cultivated relationships with other local SSPs, the health department, and other groups to start the Charlotte Regional Harm Reduction Coalition. The Mecklenburg County Health Department (MCHD) identified the NC Division of Public Health funding as a mechanism to provide more resources for QCNE, and staff from CPS and MCHD collaboratively developed the proposal. CPS, a local non-profit already serving people who use drugs, was well suited to manage QCNE.



The wonderful health department contracted us, CPS, to run the Queen City Needle Exchange Program, which allows us to just build infrastructure. Staff employees have supplies apart from what we couldn't purchase. And they've been an incredible fiscal agent. They've been supportive, but not in an invasive way so that our participants, our program members have really effectively been served.

PROGRAM

The QCNE operates in two locations: a small church and a private office space. The two sites provide participants options in where they access services.

At the church, syringe services are offered during other weekly programming that serves people who use drugs, including meals, clothing, and haircuts. While the community-oriented space allows for a more relaxed experience, it is more difficult to have a private conversation. The office space allows for more private discussions. Here, participants have as much time as they need to talk to SSP staff.

At the time of the interview, QCNE also operated a mobile van at a recovery center location. However, staff discovered that it was difficult for people to feel safe completing testing or picking up supplies in this location. Not wanting to discourage people from maintaining recovery or to place them in an uncomfortable situation, they have since discontinued this site.

Participants can take supplies for others if they report the number of people to whom they are distributing supplies. The peer network reaches more than double the number of registered participants (340 registered at the

time of the interview). Participants also help collect used syringes and return them to QCNE. Mobile exchange is challenging given the sprawling city layout and transient nature of the population.

SERVICES PROVIDED

QCNE distributes all types of injection drug supplies along with naloxone, peer support, and information on community resources and treatment options when appropriate. Since the funding they receive is flexible, they also help participants with emergency housing support and transportation.

She called me the other day about a woman who I think is getting forced out of one of the rooms that she's staying in. And I'm like, okay, ask her if she would accept a stipend, and we'll see how long we can cover her stay for. [...] Even participants who are like, I want to go to detox today, it's like cool, done, Uber. I can't take you, but I'll make this happen. You just gotta make it happen when they're ready, and that can be challenging, but we can do it.

TAKEAWAYS

By contracting with a local non-profit, health departments can provide funding to organizations who are already effectively engaging people who use drugs, ensuring greater success. The

Mecklenburg County Health Department allows QCNE to do the work, without taking credit. You can support on the back end, you can offer people testing and other linkages to care that the county health department offers. But you don't have to say that you're running syringe exchange because none of the people that we know are gonna want to come in your doors anyway.

Critical to the success of harm reduction programs, CPS is also experienced and adept at hiring and supporting staff with lived experience. Health departments may not be positioned to do this well.

I'm very supported. And if I'm going through life experiences that are very challenging for me, I have the safe space to talk about it with my employer. I'm compensated fairly. Our staff as a whole is compensated very fairly. We allot support stipends and otherwise for people who also deserve that that we might not be able to take on full-time. And I think that if you really honor and you really respect the voice of who you're trying to serve, and mine is one of millions and I'm also not one of the more marginalized, you need to create the platform and the safe space for them as well and treat them just as fairly.



Connect Justice-involved Individuals to Harm Reduction Services in Appalachian District (Alleghany, Ashe, and Watauga Counties)



CONTEXT

The Appalachian District Health Department covers three rural counties in Western NC, Alleghany, Ashe, and Watauga, and covers a combined population of around 94,400.

Efforts to connect justice-involved individuals to services in Appalachian District began with DHHS Department of Mental Health, Developmental Disabilities, and Substance Abuse Services Opioid Action Plan funding for a social work intern hired through the Sheriff's Department to provide case management support in the jail. The Sheriff and County Commissioners were supportive of the program; however, funding was a challenge for sustainability.

With additional funds from the Division of Public Health, the Appalachian District Health Department hired two peer support specialists (PSS) with lived experience to provide support for funded programming, including connecting justice-involved individuals to services.

PROGRAM

PSS in Appalachian District who connect justice-involved individuals to services offer support both while individuals are incarcerated and after they have been released from jail. The Appalachian District PSSs are a resource that jails can refer people to, and are also physically present at the jail for individuals to connect with about their needs on site.

At the outset of the program, the PSS provided a two-day training with corrections officers to educate them about the program and ensure there was awareness about services they could offer. While individuals are in the jail, they correspond about their service needs with the PSS via letters or connect in person when the PSS is in the jail communal space about twice weekly. The PSS is also able to use a phone application to track when new individuals arrive at the jail, which allows them to plan their visits on days when there are individuals they have not yet connected with.

The PSS works with individuals to set up a plan for reentry, for example by helping complete paperwork to get placement in housing or a treatment center or organizing a safe ride upon release. They also provide a card with their contact information to individuals who are incarcerated so that they have someone to connect with for any needs.

SERVICES PROVIDED

PSSs offer a range of services based on the expressed needs of individuals they work with in the jails. This can include education on naloxone, providing naloxone to the individual's family, following

up with legal representation, setting up a reentry plan while the individual is incarcerated, and upon reentry can include provide linkages to housing, treatment centers, medication for opioid use disorder, harm reduction services including syringe services, and transportation support. Appalachian District also offers a program through the National Fatherhood Initiative program called "The Inside out Dad's Guide to Family Ties" that aims to reestablish or build on family relationships, especially between fathers and their children.

TAKEAWAYS

Hiring individuals with lived experience with substance use and/or incarceration who are from the local community was particularly important for building trust with individuals involved in the justice system and better understanding the types of needs individuals have.

They're already involved in plenty of systems that tell them that they're [bad] and that they don't know how to navigate. Don't be another one of those systems... Be some place that they can come and at least know, all right, I'll get through the door... They're gonna give me what I need, and it's not gonna be another time where I'm sitting in somebody's office where they're telling me all the things I should do. This is their health.

Buy-in from the County Sheriff is key for implementing a program to support individuals involved in the justice system and important for establishing buy-in among corrections officers at the jail.

The sheriff was our in-road to it. He was very open to anything because he was tired – because these are his – these are people he grew up with. He knows their parents, or he knows them. And he's concerned about them. He's not like, "Lock them up. Don't ever let them out or anything." He's like, "What can we do for these people?"

Department of Population Health Sciences

Duke University School of Medicine



Establish Post-Overdose Response Teams in Guilford County



We've really started to leverage the university community. It's pretty special to be in the School of Social Work where you're getting BSW students and MSW students, many of which have lived experience as an opportunity to go out and do the work that we've started to really do.

CONTEXT

Guilford County is an urban county with a population over 500,000. In 2016/2017, Guilford County Emergency Medical Services (EMS) received funding from the NC General Assembly to address increasing opioid overdoses and opioid related deaths in the county and establish The Guilford County Solution to the Opioid Problem (GCSTOP).

In 2017 GCSTOP, housed under the University of North Carolina at Greensboro's School of Social Work, established a post-overdose response team (PORT). The goal of the PORT is to help prevent repeat overdose and counsel individuals with persistent opioid use to connect with services.

PROGRAM

When EMS responds to an overdose, they ask the individual if they would like to have a peer with lived experience follow up to help link them to care, treatment, or harm reduction services. Individuals who are interested sign a HIPAA release form so their contact information can be shared with peers at GCSTOP. For individuals who decline to sign the release, EMS provides naloxone and information on resources available in the community.

Most of the time, I tell my guys if they're gonna have a refusal, establish capacity, get an informed refusal, do it with a cop present. But before you start to have a conversation with them about post-overdose follow-up, etc., get them away from the cop. Because most of our cops in this system have body cameras, and we like that for establishing capacity and informed refusal. But we need to remove that once we move into a conversation about, 'Here's a kit. Here are some resources in the community.'

Once GCSTOP receives contact information for the individuals who sign a HIPAA release, a peer calls or texts the individual within 72 hours to set up an appointment to build rapport and discuss what services the individual is interested in being referred to.

If an individual cannot be reached by phone after several attempts, a peer from GCSTOP will visit the address listed from the EMS referral, accompanied by an off-duty deputy from the Sheriff's Department. Because mistrust of law enforcement is common among individuals who use drugs, it is critical that the peer takes the lead in establishing trust during these home visits while the deputy remains in the vehicle or elsewhere to minimize any

feelings of anxiety related to law enforcement presence.

Once an individual has received a referral to treatment or supportive services, the GCSTOP peer will follow up again after 1 week, 2 weeks, 1 month, and so on, until the individual no longer wishes to receive follow up, or they are consistently not able to be reached.

SERVICES PROVIDED

The Guilford County PORT distributes naloxone, information on community resources, and provides peer support to help link individuals with local resources including treatment options, medication for opioid use disorder, syringe services, recovery or Harm Reduction Works or Any Positive Change groups, and health and supportive services including distribution of condoms, basic wound care, and linkages to care for hepatitis C. The program collaborates actively with the local SSP to refer individuals to the fixed site where they can consistently receive harm reduction services in a space intentionally designed to be welcoming and safe. The SSP also provides food and social support. PORT also refers to the mobile syringe services in Guilford County, which typically provides services based on overdose mapping, traveling to parts of the county where there are higher occurrence of overdoses and lower access to services.

TAKEAWAYS

Actively collaborating with and referring to the local SSP has been a particularly important part of the PORT program in Guilford County because it allows individuals to consistently access a range of services through a space that has established trust among individuals who use drugs.

It became very evident to us that there was more to this - that we needed to actively participate in syringe exchange. We had one running here that was licensed and authorized and etc. It was a patient population that we were not seeing. If you're gonna be successful in having conversations about life change with folks, there's gotta be trust between them and a person. And when we're dealing with folks that use IV drugs, they're typically disenfranchised and marginalized, and therefore trust is one of the things that's very difficult to obtain. So, the SEP has really kind of become then our primary referral, although we're still actively referring. And so, I think they've got 200, 250 that - this year that we've referred, but they've got another 1,000 that they've probably seen through SEP.

The partnership between EMS and GCSTOP highlights potential benefits of partnering with a community organization based at a local University. Because GCSTOP is housed in the School of Social Work, they are able to more easily bring on staff who have both formal training in case management and lived experiences with substance use.

We've really started to leverage the university community. It's pretty special to be in the School of Social Work where you're getting BSW students and MSW students, many of which have lived experience as an opportunity to go out and do the work that we've started to really do.

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