

# Direct Relief Naloxone Access Program Evaluation

Final Report

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harder  co | community  
research

 Direct Relief

*Pfizer*

# Executive Summary

Direct Relief is a humanitarian aid organization, active in all 50 states and more than 80 countries, with a mission to improve the health and lives of people affected by poverty or emergencies. Direct Relief's medical assistance programs equip health professionals working in under-resourced communities to meet the challenges of diagnosing, treating, and caring for their patients. In response to the opioid epidemic, Direct Relief partnered with Pfizer to develop a naloxone access program that has distributed more than 1 million doses of naloxone at no cost to nonprofit, community-based organizations across the United States and Puerto Rico. Through surveys completed with various experts, community clinics and similar settings, Direct Relief found that primary healthcare settings were more frequently dealing with opioid-related overdoses. This evidenced the need for expanded distribution of naloxone outside of existing primary care networks and reaching various healthcare and community health settings.

With support from Pfizer and Direct Relief's longtime partner BD, to date Direct Relief has distributed over 1 million doses of no-cost naloxone as well as needles, syringes, and alcohol prep swabs to community health centers, free community clinics, public health departments, harm reduction organizations, and other opioid overdose prevention and treatment organizations.

## Evaluation Goals

Direct Relief partnered with Harder+Company Community Research (Harder+Company) to conduct an evaluation of Direct Relief's naloxone access program.

The key goals of the evaluation were to:

- Identify the **methods and approaches for prevention and treatment of opioid addiction** across various health care settings;
- Understand the **impact of having a surplus of naloxone** available across various health care settings;
- Understand how **having naloxone available in primary care settings has influenced primary care providers' approach to treating opioid addiction.**

Harder+Company conducted a total of 20 interviews with providers and field experts across various health care settings to understand the impact of Pfizer's donation of one million naloxone doses and the reach of the naloxone access program in communities across the United States and Puerto Rico over the past four years. The data collected includes representation from the following health care settings across the United States and Puerto Rico:

- 9 Harm Reduction Organizations (HRO)
- 8 Federally Qualified Health Centers/Look-Alikes (FQHC)/Free and Charitable Clinics
- 2 Public Health Departments (PHD)
- 1 Field expert

## Program Successes and Impact

Data from donation recipient interviews were analyzed to understand the successes and impact of the naloxone access program in supporting primary healthcare settings respond to the opioid crisis. The interviews revealed that:

**At the organization level, interviewees highlighted the immense impact increased access to naloxone through Direct Relief's donations has had on their programs, including the ability to reprioritize resources and integrate more opioid overdose prevention education and naloxone distribution in their work.** Interview participants emphasized the importance of Direct Relief's no-cost approach to naloxone distribution; receiving naloxone at no-cost has allowed programs to subsidize funding or free up money to be used for other program costs. With an increase in supply of naloxone through Direct Relief's donations, harm reduction organizations, nonprofit safety-net health clinics, and Public Health Departments (PHD) now have the means to reprioritize resources and facilitate more opioid overdose prevention, naloxone education and trainings, and kit distribution. Additionally, increased access to naloxone has allowed for programs to strengthen their street outreach programs, expand their reach, and create systems of access for communities at high risk for overdose who may not have access to naloxone elsewhere.

**At the community level, interviewees highlighted that having increased supply of naloxone through Direct Relief has saved thousands of lives.** One interviewee from a PHD noted that over the last three years, they have collected almost 6,000 reports that people's lives were saved. Interviewees could not stress enough how important the Direct Relief program and having access to naloxone are, and how many lives they have been able to save with an increased supply of this medication. Programs like Direct Relief's have also given hope to family members of people who use drugs and who feel like they are at a loss of resources. Having more naloxone available gives families peace of mind that they have something to help their loved one stay alive.

**More organizations have been able to embrace a harm reduction model to address drug use and addiction, implementing strategies that put individuals at the center of intervention.** Several interview participants also emphasized that since receiving naloxone from Direct Relief their programs have been able to focus their efforts on harm reduction practices and needs-based naloxone distribution, which has saved lives. Direct Relief's program has allowed numerous organizations, clinics, and health departments to implement programs that engage people who use drugs, empower them, employ them, and redirect their lived experiences to benefit this work, which has made a tremendous impact in the death rates in their communities. Harm reduction practices center genuine relationship-building experience and build mutual aid networks of peer-support for people who are affected by substance use. Harm reduction challenges the belief that drugs are the issue and instead, addresses lack of resources, stigma, racism, and criminalization at the center of drug crises.

## Key Learnings and Recommendations

The naloxone access program implemented through Pfizer's partnership with Direct Relief has yielded positive results beyond quantification. The interviews conducted through this evaluation highlight the impact of having naloxone available in multiple healthcare settings, and how giving organizations the freedom and trust to leverage all the resources possible can support communities in combatting the

opioid crisis. Specifically, having a surplus of naloxone in primary healthcare settings, harm reduction organizations, and public health departments supports:

**Opioid overdose prevention through trainings, education, and outreach.**

Organizations are better positioned to develop and implement overdose prevention services because a surplus of naloxone allows resources to be allocated to other important activities, such as trainings.

**Reducing reliance on first responders and empowering friends and family members to attend to suspected opioid overdoses.** Providing naloxone donations to organizations that work in communities, allow for family members, neighbors, and friends to become the first responders. This increases the likelihood of a timely response and in turn, reduces the chances of fatal overdoses.

**Incorporating harm reduction models across healthcare settings.** Harm reduction models are centered on relationship building and developing a mutual aid network of peer support for people affected by substance use, addressing lack of resources, stigma, racism, and criminalization that are at the center of the opioid crisis.

Based on the data collected, recommendations for Direct Relief to make an even greater impact include the following:

- **Prioritize outreach and simplify the application process.** Many organizations do not have resources or connections to learn about opportunities like the Naloxone access program. Consider expanding outreach and simplifying the process to apply for the program to support more under-resourced communities.
- **Promote leveraging and coordination to build on the expertise and capabilities of each type of healthcare setting.** Each healthcare setting has its own strengths and limitations and coordination between the types of organizations can leverage resources and capacities, filling gaps and saving lives.
- **Explore availability of NARCAN donations.** Providing the nasal spray rather than the injection supports the reduced reliance on first responders and enables friends and family members to more easily respond to suspected overdoses.
- **Promote the incorporation of the harm reduction model across healthcare settings.** Consider prioritizing grantees who incorporate harm reduction in their settings to shift the culture of overdose treatment to a user-centered approach.

The need for naloxone in communities across the United States continues to rise as drug overdoses are fueled by the growing opioid epidemic. Through its access program, Direct Relief has been able to directly save the lives of thousands of individuals affected by the opioid crisis. The innovative idea of donating a surplus of naloxone to various healthcare and community health settings has created an opportunity to combat the epidemic by allowing the experts at Health centers, HROs, and PHDs to allocate resources to strengthen their prevention and treatment programs. Organizations who have participated in the access program recognize the unparalleled impact of having a surplus of naloxone, and hope that similar partnerships continue and expand across the communities that need it the most in order to contain, and eventually help end, the opioid epidemic.

# Background

## The Opioid Epidemic

In 2019, reported deaths from drug overdose in the United States reached an all-time high of almost 72,000, with opioids involved in more than two-thirds of the total deaths.<sup>1</sup> In America, 130 people die every day from an opioid overdose, a crisis of epidemic proportions.<sup>2</sup> Overdose deaths involving opioids, including prescription opioids, heroin, and synthetic opioids (like fentanyl), have increased almost six times since 1999.<sup>3</sup> As of July 2020, deaths from drug overdose in the United States rose by an estimated 13% in the first half of the year compared with 2019, according to data compiled from several local and state governments. In some states, drug-related deaths climbed by over 30%.<sup>4</sup> The COVID-19 pandemic has exacerbated an already difficult situation by reducing access to life-saving treatment, harm reduction, and recovery support services, while pandemic-related stress and isolation increase the risk of addiction and substance use disorders (SUDs).<sup>5</sup>

Tangible and systemic factors that have contributed to the opioid overdose crisis involve the increasing use of combination drugs; introduction of fentanyl into drug supplies; higher poverty rates, homelessness, diagnosed mental health situations and trauma; and increasing rates of national despair.<sup>6</sup> The opioid overdose crisis has been compounded by polysubstance use. In the first half of 2018, nearly 63% of opioid overdose deaths in the United States also involved cocaine, methamphetamine, or benzodiazepines, signaling the need to address polysubstance use as part of a comprehensive response to the opioid epidemic.<sup>7</sup> Fentanyl, a highly potent synthetic opioid, has been identified as a driver of overdose deaths involving other opioids, benzodiazepines, alcohol, methamphetamine, and cocaine.<sup>8</sup> As a result, drug use still proves to be very challenging to most medical establishments; most health professionals and mental health care are confounded by drug use, which continues to carry stigma and misinformation.<sup>9</sup> As a policy issue, the opioid epidemic must be addressed through education, improved access to coverage and quality care, and combating the stigma of addiction while not impeding patients' access to medications needed to treat chronic pain.<sup>10</sup>

## Opioid policies and use of naloxone in the United States

Naloxone is a prescription medication that reverses overdoses caused by opioids such as heroin, Vicodin, and OxyContin; it is not a controlled substance and does not have potential for misuse.<sup>11</sup> As of January 2017, 47 states and Washington, DC have expanded access to naloxone through legislation that permits prescriptions to people who are likely to encounter someone who might overdose (i.e., third party prescriptions) or standing orders by health care providers.<sup>12</sup> Additionally, to encourage people to seek out medical attention for an overdose or for follow-up care after naloxone has been administered, 40 states and the District of Columbia have enacted some form of a Good Samaritan or 911 drug immunity law.<sup>13</sup> These laws generally provide immunity from arrest, charge or prosecution for certain controlled substance possession and paraphernalia offenses when a person who is either experiencing an opiate-related overdose or observing one calls 911 for assistance or seeks medical attention. States and communities can further expand access to naloxone through education, training, and distribution programs that reach drug users and their families and friends as well as efforts to ensure that all



first responders, including EMTs, firefighters, and law enforcement officers, are trained and authorized to administer naloxone.<sup>14,15</sup>

However, despite the recent legislative changes that have addressed some of the reported implementation challenges since 2018, stigma and drug criminalization, the cost of naloxone, and access to treatment remain significant barriers. Just one in five people with opioid use disorder in the United States are able to access treatment at the time they need it, and fewer than half of community health centers in the country have the capacity to provide medication-assisted treatment (MAT).<sup>16</sup> MAT is the use of medications in combination with counseling and behavioral therapies, which is effective in the treatment of opioid use disorders (OUD) and can help some people to sustain recovery.<sup>17</sup> Additionally, public health infrastructure that helps prevent and treat addiction has been chronically underdeveloped and underfunded in the United States, creating additional challenges for combating the opioid epidemic.<sup>18</sup>

Policies related to drug use often do not uphold health and wellness. Instead, these policies promote stigma and exclusion of people who use drugs.<sup>19</sup> The opioid epidemic is a policy issue, disproportionately impacting low-income, houseless, and marginalized communities of color. In lieu of treatment and mental health support, the response to the opioid crisis has been one that frames addiction as a crime.<sup>20</sup>

Although the Good Samaritan law is in effect in almost all fifty states and a substantial number of people who use drugs are generally aware of the law and its protections, individuals often do not perceive it as a safe option.<sup>21</sup> Various Harm Reduction Organizations interviewed highlighted the ongoing criminalization of low-income individuals who use drugs as a consequence of systemic inequities and institutional racism. Because of continuing targeting and marginalization of these communities, often at the hand of law enforcement, people have become distrustful and fearful that even if acting under the Good Samaritan law, that they might still be charged of a crime for being involved in an overdose situation. A comprehensive solution that includes reductions in criminalization and over-policing practices, inappropriate opioid prescribing, increased access to evidence-based treatment and de-stigmatization of addiction is likely necessary to create large-scale, lasting change.<sup>22</sup>

## Direct Relief's Naloxone Access Program

In response to the opioid epidemic, Direct Relief partnered with Pfizer to develop a naloxone access program that has distributed more than 1 million doses of naloxone at no cost to nonprofit, community-based organizations across the United States and Puerto Rico. Through surveys completed with various experts, community clinics and similar settings, Direct Relief found that primary healthcare settings were more frequently dealing with opioid-related overdoses. This evidenced the need for expanded distribution of naloxone outside of existing primary care networks and reaching various healthcare and community health settings. Specifically, Direct Relief targeted donations to primary healthcare settings who met the following criteria:

- Be a 501(c)3 non-profit community health center or free/charitable clinic, charitable pharmacy, public health department, harm reduction organization, or other nonprofit organization providing substance abuse treatment;
- Comply with State Board of Pharmacy regulations in storing and dispensing medications;

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**“There is a policy problem: that's the epidemic, it's a lack of access to services. Not the opioid, not the Fentanyl, not the overdose, that's not the epidemic. The epidemic is lack of adequate health care services in the United States. That's the epidemic.”**

Harm Reduction Organization  
Fajardo, Puerto Rico

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- Have a Medical Director or Pharmacist with a valid state license; and
- Dispense donated products to patients within the United States and its territories.

Throughout the course of the access program, Direct Relief has continued to see an increase in the need for naloxone in various healthcare and community health settings, as well as an increase in number of requested doses. Direct Relief has responded to this growing need by filling more orders, relying on the existing partnership with Pfizer to be able to meet the higher demand on a more frequent basis. Having a steady supply on hand enabled Direct Relief to fulfill and complete more requests to both existing partners and new organizations enrolling in the program. In turn, this has allowed for partner organizations to provide broader distributions of naloxone within their communities and has put this life-saving medication in the hands of many more people.<sup>23</sup>

With support from Pfizer and Direct Relief’s longtime partner BD, to date Direct Relief has distributed over 1 million doses of no-cost naloxone as well as needles, syringes, and alcohol prep swabs to community health centers, free community clinics, public health departments, harm reduction organizations, and other opioid overdose prevention and treatment organizations. Exhibit 1 offers a detailed description of each healthcare setting type who has participated in the donation program.

**Exhibit 1. Health Care Setting Types**

Health Care Setting	Description
<b>Harm Reduction Organizations (HROs)</b>	Community-based programs that use the harm reduction model; a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction programs incorporate a spectrum of strategies that include safer use, managed use, abstinence, meeting people who use drugs “where they’re at,” and addressing conditions of use along with the use itself. Harm reduction programs include syringe exchange programs, safer injection facilities, overdose prevention programs and policies, and opioid substitution treatment.
<b>Nonprofit safety-net health clinics</b>	Free and charitable clinics are organizations/community clinics that utilize a volunteer/staff model to provide a range of medical, dental, pharmacy, vision and/or behavioral health services to economically disadvantaged individuals. Such clinics are 501(c)(3) tax-exempt organizations or operate as a program component or affiliate of a 501(c)(3) organization. Entities that otherwise meet the above definition, but charge a nominal/sliding fee to patients, may still be considered free or charitable clinics provided essential services are delivered regardless of the patient's ability to pay. Free or charitable clinics restrict eligibility for their services to individuals who are uninsured, underinsured and/or have limited or no access to primary, specialty or prescription health care. These clinics are generally developed because of a primary care gap – where low income, uninsured people need more access to care. They are truly their community’s response to the health care needs in their area.

## **Public Health Departments**

Local or state government agencies in the U.S. that serve as the frontline for delivery of various basic public health and “population based” services. Most public health departments provide the following core services: adult and childhood immunizations; communicable disease control; community outreach and education; epidemiology and surveillance; environmental health regulation such as food safety services and restaurant inspections; emergency planning activities; and tuberculosis testing.

## **Puerto Rico’s Opioid Crisis**

Direct Relief’s naloxone access program distributed hundreds of doses to organizations in Puerto Rico. In many ways, the challenges present in Puerto Rico regarding the opioid crisis mirror those in the United States. However, there are some unique factors given Puerto Rico’s impacted health care system, poor infrastructure, and challenges faced with recovery from the devastating 2017 hurricane season and 2019/2020 earthquakes that have exacerbated mental health needs, substance misuse, and overdose deaths on the island. Two important factors unique to Puerto Rico were identified through the two interviews completed with organizations in Puerto Rico:

**Limited Access to Traditional First Responders.** As a result of Puerto Rico’s several bankrupt systems, specifically their emergency response 911 system, community members cannot rely on first responders (police, EMS, fire departments) for opioid overdose response, let alone other emergencies.

**Lack of Education and Health Resources.** The lack of education and health resources approved by fiscal oversight boards in Puerto Rico hinders the ability to practice health care in a robust, public health, and individualized way, which often leads to the reliance on outside support from U.S. intervention and humanitarian organizations, like Doctors without Borders or Direct Relief.



# Evaluation Goals and Methods

## Evaluation Goals and Design

Direct Relief partnered with Harder+Company Community Research (Harder+Company) to conduct an evaluation of Direct Relief's naloxone access program. Harder+Company conducted a series of interviews with providers across various health care settings (i.e., primary care, public health departments, free community clinics, harm reduction organizations, etc.) to understand the impact of Pfizer's donation of one million naloxone doses and the reach of the naloxone access program in communities across the United States and Puerto Rico over the past four years.

The key goals of the evaluation were to:

- Identify the methods and approaches for prevention and treatment of opioid addiction across various health care settings;
- Understand the impact of having a surplus of naloxone available across various health care settings;
- Understand how having naloxone available in primary care settings has influenced primary care providers' approach to treating opioid addiction.

## Methods

### Data Collection and Analysis

The evaluation team conducted a total of 19 interviews with donation recipients and 1 interview with an expert in the field. The data collected includes representation from the following health care settings across the United States and Puerto Rico:

- 9 Harm Reduction Organizations (HRO)
- 8 Federally Qualified Health Centers/Look-Alikes (FQHC)/Free and Charitable Clinics
- 2 Public Health Departments (PHD)
- 1 Field expert

The interviews were recorded and transcribed, and the evaluation team conducted *thematic analysis* on the text of the transcripts to elicit feedback and recommendations from the stakeholders that participated in the interviews.

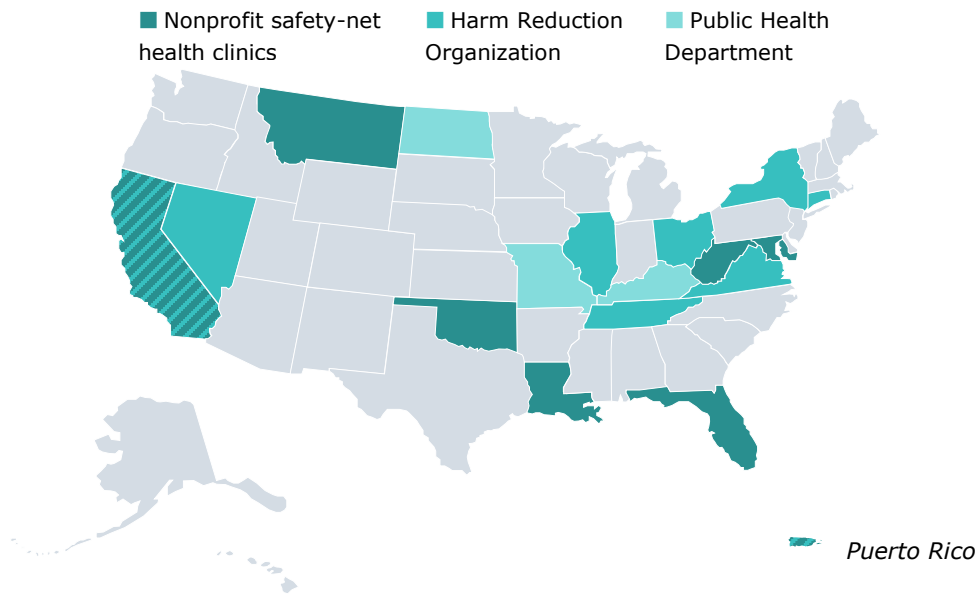
Thematic analysis is a systematic approach for organizing, analyzing, and interpreting narrative data. Our process involved two researchers working closely together through a *sense-making session* to discuss emerging themes, corroborate findings, and organize those themes into narrative form. This evidence-based iterative process enabled us to:

- Ensure nuances in the data are captured accurately;
- Incorporate multiple perspectives and ensure a balanced and reliable interpretation of the content; and

- Create a consistent process to ensure high degree of agreement among the research team on the main takeaways from the interviews.

Interviews were conducted virtually via video conference or phone. As shown in Exhibit 1, the primary data collection activity was conducted with donation recipients across five geographical regions within the United States and Puerto Rico. Exhibits 2 and 3 show the location and characteristics of the health care settings that received naloxone distributions from Direct Relief.

**Exhibit 2. Completed Interview Distribution Map**



**Exhibit 2. Health Care Setting Characteristics**

Location	Type of Setting
St. Louis, MO	Public Health Department
Rolla, ND	Public Health Department
Roanoke, VA	Harm Reduction Organization
Rock Island, IL	Harm Reduction Organization
San Francisco, CA	Harm Reduction Organization
Las Vegas, NV	Harm Reduction Organization
Knoxville, TN	Harm Reduction Organization
New York, NY	Harm Reduction Organization
Fajardo, Puerto Rico	Harm Reduction Organization
Granville, OH	Harm Reduction Organization
Hartford, CT	Harm Reduction Organization

Stigler, OK	FQHC
New Orleans, LA	FQHC
Missoula, MT	FQHC
Oakland, CA	FQHC
Dunkirk, MD	Free and Charitable Clinic
Miami, FL	FQHC
Morgantown, WV	Free and Charitable Clinic
Caguas, Puerto Rico	FQHC

### Limitations

**Uniqueness of donation recipients.** Given that donation recipients are unique with respect to health care setting, type of services offered, and geographic location, the evaluation team ensured that findings generally spoke to the successes and challenges experienced across all donation recipients, as well as providing insight into the experience shared by subsets of recipients when similarities exist.

**COVID-19 pandemic crisis response.** Due to the unprecedented challenge of the COVID-19 pandemic and the impact of the crisis response work on healthcare providers, interview response rate was slow. Despite delays, the evaluation team prioritized and ensured active follow-up and accommodations to meet demands of healthcare providers schedules and a diverse group of voices across geographical regions and healthcare settings. 🏥

# Impact of COVID-19 Pandemic on the Opioid Epidemic

## Colliding Crises

In January 2020, the first COVID-19 case was confirmed in the United States. The rapid spread of novel coronavirus necessitated federal, state, and local government responses that in many instances included shelter-in-place or quarantine orders. Being in the face of a global pandemic has affected everyone, and opioid users and organizations that work to combat the opioid epidemic have in no way been spared as the ongoing spread of COVID-19 collides with the opioid epidemic. During 2019, drug-related deaths in the United States reached record numbers.<sup>24,25,26</sup> This crisis is further complicated by the challenges brought on by the COVID-19 pandemic, including many factors that can fuel substance abuse, such as economic downturns, stress, and isolation, among others.<sup>27</sup> The impact of the coronavirus pandemic seems to be twofold: organizations who work to provide prevention and treatment services have had to pivot their strategies to respond to the pandemic, and the individuals they serve who are opioid users are faced with higher levels of isolation and the challenges of accessing treatment during a time of social distancing.

With the pandemic continuing to spread throughout the U.S., it is important to understand the implications for healthcare settings and for opioid users in order to adapt future overdose prevention strategies, including naloxone donations, to meet the current context. Through conversations with interviewees in different healthcare settings, we learned some of the initial challenges and adjustments that service providers had to make to meet the needs of the communities they serve.

In response to the pandemic, organizations that provide opioid preventive and overdose treatment services, found themselves pivoting strategies to continue delivering their life-saving services to the community. Specifically, most organizations halted or significantly reduced in-person service delivery, at least temporarily, while developing strategies that would work for this population and honor the COVID-19 shelter-in-place requirements. Although there is a variety of functions served by each of these healthcare settings, many of the shifts that happened at the onset of COVID-19 were similar. These include:

- Providing Personal Protective Equipment (PPE) to the communities they serve.
- Distributing information about COVID-19, including best practices around social distancing, washing hands, etc.
- Providing basic hygiene products, such as hand sanitizer, toiletries, etc.
- Testing and contact tracing for COVID-19, including swab and antibody testing.

**The social isolation resulting from following COVID-19 public health guidelines is triggering increased drug use and difficulty building relationships with patients.** Interviewees from all healthcare settings shared both concerns and opportunities from trends that have started to surface since the

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**“Social distancing to our people is just social isolation. Our communities are already extremely isolated. That’s one of the factors that puts them at such high risk for overdose deaths. And so basically the public health order to reduce the transmission and spread of COVID are completely paradoxical to the strategies we use to prevent overdose.”**

*Harm Reduction Organization  
San Francisco, CA*

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COVID-19 pandemic. Everyone experiences the effects of isolation and social distancing in a different way; however, according to interviewees, for opioid users, the measures to combat COVID-19 seem to be resulting in increased drug use, overdoses and relapses. The effects of isolation, financial concerns, and prolonged feelings of uncertainty in this population can increase anxiety and depression that can trigger relapses. Interviewees also shared the challenges of building relationships with patients and community members using the new virtual modes of service delivery.

**The pandemic's disruption of the drug supply chain presents as an opportunity to turn opioid users toward treatment.** One opportunity identified by at least one interviewee that has resulted from the measures that have been implemented to fight the spread of COVID-19 is the disruption of the drug supply chain. While in some cases this seems to be turning drug users to alternative drugs (for example, from heroin to synthetic opioids) it has also resulted in an opportunity to get individuals into treatment because of withdrawal symptoms stemming from the drug supply disruption. One interviewee's department is being strategic about this opportunity, sharing,

*"as we surveillance the landscape of addiction and illicit substances, we're noticing that the drug supply chains are impacted by the current pandemic, and so a lot of our eyes and ears have really been trying to focus on getting people into treatment because of the drug supply disruption, which can be causing really severe withdrawal symptoms, especially when it comes to opioid use disorder, so we're using this opportunity to really engage clients around change talk, and motivating them that this might be the right time to get treatment. And using this as a momentum to get folks into care."*

**The shift to Telehealth services must be considered in the context of each community as it can help expand reach for some and further isolate others.** Finally, one of the pandemic's mitigation strategies – the use of Telehealth – has highlighted some of the existing inequities within the healthcare system. Interviewees shared that being able to shift to providing services remotely through Telehealth, really helped them ensure a safe continuation of services for their patients. However, many patients do not have access to the technology or reliable internet required for Telehealth. This is especially true in rural areas, where high speed internet and strong cell phone signals are not always available. As the confirmed COVID-19 cases across the United States continue to rise, the opioid crisis seems to be overshadowed by the pandemic; this has created a need for organizations to continuously adapt their strategies to address the unfolding challenges brought on by the collision of the two crises.

## COVID-19 Responses

While many of the shifts made in response to COVID-19 were similar across organizations, each type of healthcare setting implemented changes more tailored to the services they provide. The following are specific shifts healthcare settings made in response to the COVID-19 pandemic:

### Harm Reduction Organizations

- Create and deploy harm reduction and overdose prevention protocols and policies in activated hotel sites where individuals who are houseless were placed temporarily.
- Adapt to higher requests for naloxone from partner organizations while working from home.

### Public Health Departments

- Developing and deploying street outreach to make naloxone available in the communities they serve

### Nonprofit Safety-net Health Clinics

- Health centers are considered essential businesses and have stayed open throughout the pandemic.
- Implemented distribution of multiple naloxone kits at a time to increase access and use.
- Responded to an increased demand for services by operating on additional days during the week.

# Program Successes and Impact

Prior to Direct Relief's naloxone access program, programs either had to find the funds to purchase naloxone through their health departments, state, or buyer's clubs, or had little to no consistent supply. Many programs were resigned to distribute expired naloxone. Because purchasing naloxone can be very expensive, many programs, predominately harm reduction organizations, often found themselves rationing their supplies and unable to give all their community members the naloxone kits they needed. Lack of access to financial resources continues to be a barrier for harm reduction organizations and clinics (i.e. community clinics, free clinics), who do not receive federal funding. Prior to receiving support from Direct Relief, these programs needed to get creative in their community fundraising strategies and grant applications in order to receive the supplies and resources they needed to meet their communities' needs. The lack of access to naloxone weighed heaviest on small grassroots harm reduction programs as the cost of sourcing the nasal spray or the auto injector was prohibitive for these small community organizations.

Many programs, before receiving donations from Direct Relief and without the necessary resources, were limited in the work they could do and focused on safer use supplies, overdose education, and distributing naloxone when they could. When programs that had established themselves as a safe resource for people who used drugs in their community ran out of their naloxone supplies in each week, it elicited panic and fear and had heartbreaking effects on the community. Without naloxone and the tools and training about overdose response, programs were seeing higher numbers of preventable deaths.

**At an organizational level, all interview participants highlighted the immense impact increased access to naloxone through Direct Relief's donations has had on their programs: the ability to reprioritize resources and integrate more opioid overdose prevention education and naloxone distribution in their work.** Interview participants emphasized the importance of Direct Relief's no-cost approach to naloxone distribution; receiving naloxone at no-cost has allowed programs to subsidize funding or free up money to be used for other program costs. One HRO in San Francisco, CA, shared that,

*"And so Direct Relief offering no cost naloxone, Pfizer having the program of low-cost naloxone allowed us to subsidize our funding so that we could increase access and training. And now it's completely interwoven into the culture of our city. And so now a lot of those providers will staff someone with a syringe full of naloxone because they've just gotten used to it...We never would have been able to do that on the scale that we did without Direct Relief."*

With an increase in supply of naloxone through Direct Relief's donations, harm reduction organizations, health center programs, and public health departments now have the means to reprioritize resources and facilitate more opioid overdose prevention, naloxone education and trainings, and kit distribution. Additionally, increased access to naloxone has allowed for programs to strengthen their street outreach programs, expand their reach, and create systems of access for



communities at high risk for overdose who may not have access to naloxone elsewhere. Interview participants also voiced how grateful they are, not only that Direct Relief provided naloxone medication, but also additional supplies such as personal hygiene and other health care products and crisis response supplies.

Lastly, interviewees highlighted that one significant difference between Direct Relief's program and other donation programs is that Direct Relief respects and values on-the-ground program knowledge, experience, and expertise. As one interviewee said, *"Direct Relief understands that the organizations know what's best for their community and what the best methods of distribution are, and what the best programs are to get it to who needs it. Other donation programs often carry some conditions. Like, 'Okay, here's your naloxone, but you have to only give it to these people, or you can only use it this way, or that way.'"*

**At the community level, interview participants highlighted that having increased supply of naloxone through Direct Relief has saved thousands of lives.** One interviewee from a PHD noted that over the last three years, they have collected almost 6,000 reports that people's lives were saved. Interviewees could not stress enough how important the Direct Relief program and having access to naloxone are and how many lives they have been able to save with an increased supply of this medication. Of the 19 interviewees, 16 highlighted at least once during their conversations that through Direct Relief's programs they have been able to save lives. Some shared the impact in numbers:

*"The naloxone has saved countless lives and has allowed us to provide naloxone to people in 87 of Ohio's 88 counties. (Mercer County, we're coming!)"*

*"We've been relying on that as a very steady source for it, and we've been able to save literally thousands of lives with it. We've given out thousands of doses."*

*"I just got a text from one of our secondary distributors earlier today that said that there were 12 overdose reversals just this month from the Naloxone we sent. So, that's 12 human lives. I mean, those texts happen regularly and it just wouldn't be possible without the Direct Relief Naloxone."*

*"February was 12, March is 10, April is six, May is nine, June is 21, July is 15, and August is 15. So these are the ebbs and flows I'm talking about. These are saved lives. These are reversals."*

*"We're saving a lot more lives. I know in Peoria, they've had a 41% increase in overdose deaths, and we have really not had an increase in overdose deaths here locally because we are seeing so many of our participants take extra naloxone and take care of each other."*

*"In the first seven months of this year, 452 overdose reversals have been reported to us. The actual number is, I'm sure, much higher."*

Several interviewees also shared the impact beyond numbers. Some highlighting long term benefits and lives saved from building a network of care, trust, and empowerment and reducing reliance and burden on already impacted hospital and EMS systems:

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**"I mean, all I can say is that I have no doubt that these donations will be responsible for saving tens of thousands of lives through [program's] harm reduction specifically, just through one program, just through our program. The amount of distribution of intramuscular naloxone, we've been able to do things through Direct Relief. It is going to have a significant impact in reducing opioid overdose mortality nationally."**

*Harm Reduction Organization New York, NY*

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*"The people we work with have little contact with the medical system and rarely have insurance. We work heavily through homeless outreach programs and people in recovery who have access to and are trusted by people who use drugs in their communities. Naloxone not only saves lives directly, but it helps start a conversation with a person by showing an act of love and concern that can lead to long-term benefits."*

*"I think the impact that this program will have is that it's making Naloxone accessible to those who didn't have it before, which saves lives and hopefully will continue, as Naloxone is more readily available, will continue to bring down overdose rates and give people the chance to stay alive, so that they have the opportunity to find recovery."*

*"We were just able to give people more and that, yeah, that helps contribute to them being able to just continue to save people's lives in the moment. I would also say it directly impacted our EMS system because people were calling less and our hospital systems, all of those things were just impacted less as we increased access because people were needing to count on them less. They have the resources they needed."*

*"I think just extending my gratitude for this program. It really does, like I said earlier, provide hope for people and saves lives every day."*

Programs like Direct Relief's have also given hope to family members of people who use drugs and feel like they are at a loss of resources. Having more naloxone available gives families peace of mind that they have something to help their loved one stay alive. A harm reduction organization highlighted that they work heavily with people who have little contact with the medical system and rarely have insurance. They collaborate with homeless outreach programs and with people in recovery who have access to, and are trusted by, people who use drugs in their communities. Not only has the naloxone provided by Direct Relief saved countless lives, but it has allowed programs that work directly with the community to start conversations with people who use drugs by showing love and concern, building relationships, and through that connection creating long-term benefits.

*"And so that's why it's just so important for us to be able to distribute this Narcan to the people who are essentially boots on the ground. They live these lives every day, and they're most familiar with the needs of their own community. So really what we're doing by providing Narcan, as well as the education, is just empowering folks to be able to go on and care for their communities and care for themselves."*

**More organizations have been able to embrace a harm reduction model to address drug use and addiction, implementing strategies that put individuals at the center of intervention.**

Several interview participants also emphasized that since receiving naloxone from Direct Relief their programs have been able to focus their efforts on harm reduction practices and needs-based naloxone distribution, which has saved lives. Direct Relief's program has allowed numerous organizations, clinics, and health departments to implement programs that engage people who use drugs, empower them, employ them, and redirect their lived experiences to benefit this work, which has made a tremendous impact in the death rates in their communities. One harm reduction organization noted that it is no coincidence that the only places where death rates have gone down in their state are in places where their harm reduction team operates. Another HRO in Roanoke, VA, described how they have been able to shift the conversation and support individuals, saying,

*"And what I've seen...is the trajectory of somebody who comes in here and volunteers with us, who takes naloxone out into their social circle and distributes it and gives it to their friends and uses it on them if they need to. You're looking at somebody who has nothing most of the time. You're looking at somebody who hasn't ever had anything most of the time. And all of a sudden, you've empowered them with the ability to save a life and make a difference. And the trajectory of those individuals, whether or not they choose any sort of substance use treatment, whatever we want to call that, is huge. I've seen lives change from this, from people just coming in and saying, 'Hey, what can I do? I want to volunteer.' Saying, 'Yeah. You using naloxone?' 'Nope.' 'All right. Well, let's talk about that.' And like I said, it's changed the conversation here in Roanoke doing that, and one individual at a time."*

Harm reduction practices center genuine relationship-building experience and build mutual aid networks of peer-support for people who are affected by substance use. Harm reduction challenges the belief that drugs are the issue and instead, addresses lack of resources, stigma, racism, and criminalization at the center of drug crises. Harm reduction is a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.<sup>1</sup> Some of the harm reduction practices interviewees highlighted that need to be integrated in opioid overdose prevention, response, and treatment strategies include:

**Involve people who use drugs in decision making for their own care, with clear understanding that they know what's best for them.** Harm reduction practices emphasize the importance of centering services around the people who are at the highest risk for overdose, because they're also at the highest risk for witnessing overdoses. Harm reductionists operate under the belief that if care providers/people who work with the community listen and ask questions, people will tell them what they need and if people who are at risk are given access to the resources that they need, they can and will take care of themselves.

**Focus is on relationship-building, non-judgmental safe spaces, and meeting people where they are at and where they're going.** Harm reduction moves away from treating people who use drugs as less-than or disposable and instead seeks to build relationships with them, understanding why they use drugs, what it does for them, how to help them use safely, and eventually how to help them reduce their use. "The work is much more than just giving people naloxone. It's about making sure that people who use drugs know that they're seen that they're people, that they're loved, that they're cared for, and that the world's better with them in it. And the world is not the best at showing them that. Harm reduction programs do that."

**Understanding the systemic racism and criminalization of drug use and recognizing power and privilege.** Harm reduction practices require people working with communities that use drugs to actively reflect on their own positions of power and privilege and how they engage with their patients from a trauma-informed, racial-equity, and whole-person lens. Although the people who use drugs cross racial lines, it is the communities of color who have experienced the most harm and structural/state violence, generationally living in poverty and still experiencing the repercussions of the war on drugs and criminalization at the hands of the medical establishment. By acknowledge racial discrimination, harm reduction practices work to try to

break down those barriers.

# Opioid Addiction Prevention and Treatment Methods and Approaches

Across HROs, nonprofit safety-net health clinics, and PHDs, all engage in various methods of prevention, education, and distribution of naloxone.

**Interview participants across all three healthcare setting types acknowledged the high need for more opioid addiction prevention in the field and the importance of centering harm reduction strategies in the work.** Although interview participants identified the need for more opioid addiction prevention work, several expressed that they are limited in their capacity to integrate it due to ongoing pressure to meet the need for opioid overdose response and naloxone distribution, education, and trainings. This limits the funding, bandwidth, and/or tools and resources to engage in prevention practices and education. One Public Health Department, however, shared that prevention is embedded into their department's practices through active use of state campaigns, street outreach flyers, and other materials to increase the capacity and awareness in their service area. They also engage in extensive education and engagement programs with youth and families on harm reduction, HIV/AIDs, Hepatitis, safer sex and IV drug use practices. Two health centers acknowledged capacity for youth education and engagement around drug use through presentations at local high schools and through dialogue with teens about their own, or their parents', drug use at their well-child visits. Several Harm Reduction Organizations emphasized that if they had the money, they would be running prevention programs at all the schools in their communities. Some of the prevention strategies interviewees shared they would employ through a harm reduction lens include working with youth and families to discuss safer sex practices, substance use, proper disposal of unused drugs, risks associated with opioid misuse, multiple drug use, and addiction.

**The two main practices interviewees emphasized in their work around opioid overdose prevention education and naloxone distribution were opioid overdose prevention trainings and street outreach.** Although Harm Reduction Organizations were most often to cite the use of these practices in their programs, several Health centers and PHDs similarly acknowledged the importance of, and use of, these distribution approaches.

Several interview participants highlighted the importance of using comprehensive opioid overdose prevention education and naloxone distribution in tandem. Integrating overdose prevention education and distribution ensures that the individuals given the resources and tools are also taught how to use naloxone correctly, building their capacity to save lives. Several Health centers have integrated harm reduction programs into their clinics with the sole purpose of providing opioid overdose prevention and education trainings and distributing naloxone kits out in the community and within the clinic. Several Health centers who have both harm reduction and treatment programs on-site highlighted the value of being able to provide internal referrals and offer multiple services for patients, regardless of where they are in their healthcare journey. Specifically, one health center in Morgantown, WV, shared,

*"I realized that we had this opportunity to create and strengthen our naloxone training initiatives. And so I've come up with our training models and implemented our standing biweekly naloxone training. And also community-based naloxone training. And those are for folks who are people who are interested in becoming opioid overdose responders or who may know people who are using opioids. [...]. And also supporting other harm reduction services through the greater department and integrating that into the work we're already doing."*

Across all three healthcare settings, programs provide both group and one-on-one opioid overdose prevention and education trainings for first responders who are community members, general public, or laypeople interested in becoming opioid overdose responders (e.g. people who use drugs, family members, friends, loved ones of people who use drugs, local businesses, libraries, churches, nightlife spaces, bars, homeless service providers, shelters, and schools) as well as providers and crisis response professionals (e.g. law enforcement, Emergency Medical Services, other healthcare providers, syringe exchange programs, etc.). Through these trainings, people become versed in administering naloxone, and receive training certificates and naloxone kits in preparation for future crisis response.

Many programs also use street outreach as a means of direct distribution of naloxone into the hands of the communities with less access to primary care, prescriptions, pharmacies, and other resources, and those who can't afford or feel stigmatized by accessing naloxone (e.g. rural, low-income/uninsured communities). Through these direct naloxone kit distributions, organizations, clinics, and public health department programs can distribute the following resources that several organizations would not be able to access otherwise:

- gloves;
- syringes;
- vials of naloxone;
- breathing barriers;
- alcohol swabs;
- instructional materials for administering naloxone; and
- resource cards with treatment agency partners, clinics, or local harm reduction organizations.

Harm Reduction Organizations highlighted the importance of prioritizing naloxone distribution specifically to laypeople, especially if funding is provided via public health funds. Many organizations believe the general public should be prioritized to receive the naloxone, as law enforcement and medical providers have access to naloxone through their own avenues and their own training schools and academies.

In addition to clinical services, naloxone distribution, and/or outreach programs, one organization noted the importance of having other integrative harm reduction services accessible to their patients and community: Hepatitis C testing and treatment, women's services, reproductive services, syringe exchange programs, and safer use supplies services.

Although many clinics, Harm Reduction Organizations, and public health departments have continued using and/or returned to some version of in-person services since the onset of COVID-19 in response to their communities' needs, several programs have also introduced virtual overdose prevention trainings as an additional resource. One program has leveraged their online form since the onset of the pandemic, as both a registration/sign-up for overdose prevention trainings and a place for naloxone donation requests.



**Opioid treatment approaches include Medication Assisted Treatment (MAT), counseling, and peer recovery support programs.** Health centers are the primary health care setting with the resources and funding to provide treatment. The majority of HROs and PHDs do not have the infrastructure and system in place, nor medical team on staff, to implement treatment practices. Several harm reduction organizations and public health departments experience regulatory hurdles in becoming qualified to provide treatment and get reimbursed by Medicaid. It requires a large organization and team of staff to surpass those regulatory hurdles and requires specialized knowledge and resources that harm reduction groups or small public health departments often do not have.

All health center programs interviewed highlighted their implementation of behavioral health services, some more comprehensive than others, including both counseling and medication assisted treatment services. Seven of the eight interview participants from health centers mentioned their use of Medication Assisted Treatment (MAT) programs and addiction medication management. One health center program recently started a COAT clinic, a Comprehensive Opioid Addiction Treatment program, some have long-standing suboxone programs, and others have statewide collaborative MAT programs where primary care providers and nurse practitioners become certified in treating opioid use disorders. A few clinics also have on-site residential treatment facilities and if not, several have strong ties to community partners with local residential treatment facilities who they refer patients to. One FQHC also has an intensive outpatient program.

Several health centers provide one-on-one and group counseling services with providers trained in harm reduction, trauma informed care, and motivational interviewing practices. All of the interviewees who mentioned having the resources to provide counseling emphasized the importance of using an interdisciplinary team, addiction counselors, psychologists, clinical social workers, psychiatry, care management, and primary care services and if possible, housing each of these resources in one location. A few health centers have also integrated peer recovery support teams into their harm reduction and treatment programs. Several harm reduction programs center their work around the peer-support model and believe programs are the most effective at engaging people who use drugs when they meaningfully involve people who use drugs. An HRO in Las Vegas, NV shared that,

*"Primarily service people in, or seeking recovery from, either a substance use or mental health disorder. We are a community grassroots organization, so all of the staff members and the leadership and the founders, we are all also people who are in recovery from substance use disorder or mental health disorders. So we provide nonclinical services to whom we call our peers. So we're very reflective of the populations we serve because we have very similar life experience as the people who come through our doors looking for services."*

Therefore, programs are often founded and led by peer-support staff who have used drugs. One HRO interviewed has challenged the structure of treatment work by providing nonclinical peer support services for people in or seeking recovery, as a community grassroots organization with all staff members, leadership team, and founders who identify as in recovery from substance use disorder or mental health disorders. They provide one-on-one and peer recovery support specialist coaching sessions and recovery planning with other people either in or seeking recovery. Prior to COVID-19, sessions would be conducted in-person at their drop-in center and community members would also have access to various amenities and resources, like a computer lab, a clothing closet, and a safe place to relax; they've been able to continue providing peer support virtually through online video sessions.

## **Innovative Harm Reduction Strategies**

One grassroots harm reduction organization, the country's first online and mail-based harm reduction program, has established innovative ways to distribute naloxone through an online and mail-based system that addresses these inequities and stigma associated with drug use and addiction by mailing naloxone directly and discreetly to their homes.

### **Harm Reduction Coalition | - New York, NY**

Another harm reduction organization created a portable unit called a Rover, which allow individuals to incorporate harm reduction best practices into a variety of settings with minimal disruption to service delivery. Similar to a repurposed toolbox that has everything a person would see in a syringe exchange, it is a locked and secured unit with syringes, wound care supplies, IBU kits, safe sex kits, safe crack kits, and naloxone kits. This organization is able to supply these units in 16 different areas around the state. Through Direct Relief's naloxone donations, they have yet to run out of naloxone at any of their sites and have been able to make sure these units are adequately stocked with a combination of products. **Harm Reduction Coalition | Hartford, CT**

A third HRO has integrated another unique resource into their program; their involvement in various training, technical assistance, and agency support for different communities that might not have existing recovery support infrastructures available yet. Their trainers provide guidance, consultancy and toolkits, and trainings for communities who would like to start their own peer support programs, set up their own nonprofits, or improve their program work. **Foundation for Recovery | Las Vegas, NV**

# Naloxone Access Program Improvement

Naloxone access programs, according to interviewees, traditionally have many conditions attached to them. One consistent theme of appreciation from interviewees across healthcare settings was the ease with which they could choose how to use the naloxone donations they received through Direct Relief's program. While most of the feedback gathered through interviews was praise for the program and Direct Relief as an organization, interviewees shared some suggestions on how the program could improve. These include increasing the supply of Narcan (nasal spray), further streamline the application process to make it more accessible to organizations with less resources and expand their outreach so that more under-resourced communities learn about the access program.

**Availability of NARCAN® (nasal spray).** The most frequent suggestion for program improvement was the need to make NARCAN® (nasal spray) available.<sup>28</sup> Currently, the naloxone access program provides the intramuscular (IM) injectable version of the overdose reversal drug which, according to interviewees, is the most effective for reversing overdoses. However, most interviewees pointed to the fact that the IM version of naloxone requires additional training to ensure individuals know how to administer it, which includes assembling a kit and learning how to draw naloxone into a syringe. This can be problematic since time is such an important factor in reversing an overdose. This can also be cumbersome for organizations with less resources to train, and further exacerbated in the time of COVID-19 where in-person trainings can be unsafe for community members. Similarly, an interviewee at a Harm Reduction Organization in Illinois shared that "especially for non-clinical people, putting a vial of medication into a syringe and injecting somebody is a very scary thing for a lot of people that have never done that."

An interviewee highlighted the fact that family members, especially children, would have an easier time and higher level of comfort delivering the nasal spray than an injection. Another interviewee from a Harm Reduction Organization in Tennessee shared that their program has been trying to partner with local jails in their region to make sure naloxone is available when individuals are released, and how the donation program has made that possible. One interviewee from a Public Health Department in Missouri further highlighted the need for having both versions of the overdose reversal drug, sharing that "that allows us to kind of reserve some of the Narcan we're getting through our grant for agencies like jails, where they won't let us bring in the intramuscular version for concern about having needles in those areas."

The evidence is mixed on whether one is more effective than the other. A recent study found that the nasal spray is as effective as the IM injection when delivered within the first 15 minutes of a suspected overdose.<sup>29</sup> However, other studies have found that because current available doses of the nasal spray result in longer response times for improved respiration and consciousness, this version is not as effective.<sup>30</sup> The desire for availability of the nasal spray, according to interviewees, is driven by the ease of delivery and the comfort level that individuals feel with administering the nasal spray versus the IM injectable version of the drug. Additional suggestions that interviewees shared are:

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**"So, the nasal, people have said that time and time again, you have any more nasal naloxone... I think gives even more feelings of comfort... if it came down to it, I would feel comfortable using that syringe in injecting somebody where I wouldn't have had before I had the training or the education sessions. But even think of kids that maybe are at home with a parent or something. So, if I could say anything that I would like to see in the future, it would be more of the nasal administered naloxone."**

*Federally Qualified Health Center - Stigler, Oklahoma*

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- Provide face shields for administering rescue breathing (CPR) during an overdose along with the other materials provided like alcohol swabs, etc.
- Assembled kits to minimize the hours that smaller organizations need to spend putting kits together.
- During COVID-19, having masks and gloves available to more safely serve the community, especially to be able to safely reach people experiencing homelessness.

**Streamlining Application Process.** The application process for requesting naloxone through Direct Relief’s donation program came up through various interviews. Most interviewees recognized several improvements in the process from the first time they applied. However, some noted opportunities for improvement in two specific areas of the application process: approval times and follow-up. In some cases the approval process can be very long. Specifically, one Harm Reduction Organization in New York shared that “honestly, it took us six or eight months to get our Direct Relief application approved”, also recognizing some improvements, stating “but something happened last year. It seems like they just started offering it more regularly.” This highlights the initial challenges of the application process and the improvements it has made.

Additionally, one Harm Reduction Organization in San Francisco, CA, shared that while the application process may be easy for larger or more well-resourced organizations, “for less resourced programs it’s really challenging because most of them don’t have doctors or anybody willing to sign for them.” Any improvements in the application process can really support smaller organizations, especially, organizations that do not have doctors on staff and, organization in rural areas, where there are additional challenges to access technology and internet.

Another opportunity for improvement is communication about the delivery time once an order of naloxone has been placed. One interviewee from a FQHC in Miami, FL, shared that not knowing when they will receive the naloxone order they placed from Direct Relief is very challenging, because it forces them to “backfill that with something they get from the pharmacy”. This can be especially cumbersome for smaller organizations, who may depend on the Direct Relief naloxone donation for their entire naloxone supply. To this end, interviewees suggested that it would be helpful to receive an estimated shipping and delivery time from Direct Relief in order to incorporate that into their planning.

**Increase promotion of the Naloxone Access Program.** The donation program, according to interviewees, has been more impactful than many other programs they are part of. All interviewees recognized the importance of having naloxone available in multiple healthcare settings so it can be put into the hands of those closest to people who are at high risk of experiencing an opioid overdose. Many organizations that participated in interviews shared that they are currently partnering with other smaller organizations in their regions to expand the availability of naloxone in their communities. This highlighted the opportunity for Direct Relief to expand their promotion of the program, to ensure that all organizations who provide opioid overdose prevention or treatment services know about the donation program. Specifically, a Harm Reduction Organization in Las Vegas, NV, shared that “I don’t know how much they do on their end, as far as like public information services or getting word out about this program into other communities. But if anything, if they could do any work in that area, then maybe start doing that. Like help get the word out to more organizations that exists.” Raising awareness about the program can really expand its reach and have an even broader impact in more communities across the country.

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**“I mean, I hope that through the donation program, naloxone continues to become more accessible. Not just to professional organizations, but to people who actively are using drugs and harm reduction agencies. We’ve been able to funnel a lot of our Direct Relief naloxone to harm reduction agencies, and they get it out. They get it to people who are going to use it and save a life. More so than I feel, from my perspective, because I see from every organization, I kind of get to see the gamut from law enforcement to treatment providers to friends and family, we get the most reports from the people who are using drugs and their friends and family members.”**

*Public Health Department  
St. Louis, MO*

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**Focus on partnerships with harm reduction programs.** Several interview participants pushed for Direct Relief to partner with more harm reduction organizations. Interviewees hope to see that through this program, naloxone continues to become more accessible to people who are actively using drugs, not just clinics, public health departments, or other professional organizations. Harm reduction organizations put the naloxone directly into the communities' hands. It is the people who use drugs, and their friends and family members who are there when naloxone needs to be used and the ones who need access to the tools.

**Continue supporting organizations to help break down stigma.** Across all healthcare settings, interviewees addressed the continued stigma around drug use and naloxone. Several highlighted the need for more harm reduction trainings and knowledge-building around stigma with pharmacies. Interviewees mentioned several instances where people who request naloxone through pharmacies report gatekeeping systems and barriers to access. Even though most states have now implemented policies that allow naloxone to be available through pharmacies without a prescription, people still have difficulty accessing it at their pharmacies, likely due to lack of knowledge and training. To address this, one harm reduction organization has been able to expand their naloxone distribution with support from Direct Relief's donations so that they can work in tandem with their pharmacy technician students. This education is vital not just for clients seeking medication, but for the folks that will be working with this population in the future. Several harm reduction programs similarly mentioned that, although they witnessed a large shift in perception over the last several years, there is still stigma around drug use and the use of naloxone amongst those unfamiliar with it, especially in small, rural, and more conservative communities. With continued stigma, people are less likely to call an ambulance or seek medical care, and therefore more likely to die from overdose.

One organization highlighted the hope that, with high enough volume of naloxone distributions through programs like Direct Relief's, injectable naloxone can be normalized and perceived as a very cheap, very effective medication and delivery system. Additionally, the increase in drug use over the last several years continues to be very challenging for most medical establishments. Both primary and mental health care institutions are confounded by drug use, which continues to carry stigma and misinformation. Harm reduction programs are challenging traditional medical establishments to reflect on their fear and lack of understanding around drug use and the harm caused by the tendency to label people who use drugs, especially low-income or houseless communities of color, as resistant to care, disposable, with personal or moral failure, or unable to care for themselves. Instead, they could center their care with the holistic understanding of the person's lived experiences, understand the social and societal inequities at play, and ask people what they need with the belief that they know what is best for them.

# Conclusion & Recommendations

The naloxone access program implemented through Pfizer's partnership with Direct Relief has yielded positive results beyond quantification. The interviews conducted through this evaluation highlight the impact of having naloxone available in multiple healthcare settings, and how giving organizations the freedom and trust to leverage all the resources possible can support communities in combatting the opioid crisis. Specifically, having a surplus of naloxone in primary healthcare settings, harm reduction organizations and public health departments supports:

**Opioid overdose prevention through trainings, education, and outreach.**

Organizations are better positioned to develop and implement overdose prevention services because a surplus of naloxone allows resources to be allocated to other important activities, such as trainings.

**Shifting reliance on first responders to attend to suspected opioid overdoses.** Providing naloxone donations to organizations that work in communities, allow for family members, neighbors, and friends to become the first responders. This increases the likelihood of a timely response and in turn, reduces the chances of fatal overdoses.

**Incorporating harm reduction models across healthcare settings.** Harm reduction models are centered on relationship building and developing a mutual aid network of peer support for people affected by substance use, addressing lack of resources, stigma, racism and criminalization that are at the center of the opioid crisis.

From the interviews conducted through this evaluation, we learned of the impact of the naloxone donation program in different healthcare settings as well as in organizations with different program size, budget, staff, etc. In order to further the impact of this program in the future, we offer the following recommendations to Direct Relief and its partners.

**Prioritize outreach and simplify the application process.** Many organizations who were able to participate in the donation program did so because someone within that program was able to go through the application process and ensure that they were considered. However, many organizations across the country, especially those in more rural areas, often do not have the resources or connection to know about these opportunities. Expanding the outreach and simplifying the process to ensure smaller, rural organizations are accounted for can really support and further increase the impact of naloxone surplus across more under-resourced communities.

**Promote leveraging and coordination to build on the expertise and capabilities of each type of healthcare setting.** This evaluation focused on three specific types of healthcare settings, each with different capabilities and reach. Understanding the strengths and limitations that each organization has can help develop a collaboration network. For example, Health centers could work hand in hand with HROs and PHDs by leveraging services and coordinating to fill the gaps in their communities based on the services they are able to provide. Because HROs and PHDs often do not have medical staff, they are unable to provide some



services that Health centers can; however, working collaboratively can help leverage the resources and services each provides for the community, especially those affected by substance abuse. This could help increase treatment and prevention across communities.

**Explore availability of NARCAN donations.** Most organizations highlighted the need for NARCAN (nasal spray) due to the ease of use of this overdose reversal drug. While the effectiveness of nasal spray compared to IM naloxone is still being debated, interviewees all agreed that having the nasal spray version available supports the shift to making family members, friends and neighbors the ones who first respond to suspected overdoses, as individuals generally feel more comfortable with this delivery method.

**Promote the incorporation of the harm reduction model across healthcare settings.** While various healthcare settings have a specific approach to prevention and treatment of drug use, there is a clear shift in the treatment of drug use that embraces the harm reduction model that builds on understanding the needs of drug users and prioritizes meeting them where they are at. To this end, Direct Relief could prioritize in grantee selection healthcare settings who use this model as part of their approach. Doing so can promote the incorporation of the harm reduction model more consistently across other healthcare settings that currently rely on more traditional approaches that are often not user centered.

The need for naloxone in communities across the United States continues to rise as drug overdoses are fueled by the growing opioid epidemic. Through its donation program, Direct Relief has been able to directly save the lives of thousands of individuals affected by the opioid crisis. The innovative idea of donating a surplus of naloxone to various healthcare setting types has created an opportunity to combat the epidemic by allowing the experts at Health centers, HROs, and PHDs to allocate resources to strengthening their prevention and treatment programs. Organizations who have participated in the donation program recognize the unparalleled impact of having a surplus of naloxone, and hope that similar partnerships continue and expand across the communities that need it the most in order to contain and eventually help end the opioid epidemic.

# Endnotes

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<sup>1</sup> NCHS, National Vital Statistics System. Estimates for 2019 and 2020 are based on provisional data. Estimates for 2015-2018 are based on final data (available from: [https://www.cdc.gov/nchs/nvss/mortality\\_public\\_use\\_data.htm](https://www.cdc.gov/nchs/nvss/mortality_public_use_data.htm))

<sup>2</sup> Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Opioid Overdose: Understanding the Epidemic. <https://www.cdc.gov/drugoverdose/epidemic/index.html>

<sup>3</sup> Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Opioid Overdose: Data Overview. <https://www.cdc.gov/drugoverdose/data/index.html>

<sup>4</sup> Katz, Josh, et al. "In Shadow of Pandemic, U.S. Drug Overdose Deaths Resurge to Record." *New York Times*, 15 July 2020, [www.nytimes.com/interactive/2020/07/15/upshot/drug-overdose-deaths.html](http://www.nytimes.com/interactive/2020/07/15/upshot/drug-overdose-deaths.html).

<sup>5</sup> Wen, L. S., & Sadeghi, N. B. (2020). The opioid crisis and the 2020 US election: crossroads for a national epidemic. *Lancet (London, England)*, 396(10259), 1316–1318. Advance online publication. [https://doi.org/10.1016/S0140-6736\(20\)32113-9](https://doi.org/10.1016/S0140-6736(20)32113-9)

<sup>6</sup> DOPE Project: National Harm Reduction Coalition. *Harm Reduction Coalition*, Harm Reduction Coalition, 16 Sept. 2020, <https://www.harmreduction.org/our-work/action/dope-project-san-francisco/>.

<sup>7</sup> Gladden, R. M., O'Donnell, J., Mattson, C. L., & Seth, P. (2019). Changes in Opioid-Involved Overdose Deaths by Opioid Type and Presence of Benzodiazepines, Cocaine, and Methamphetamine - 25 States, July-December 2017 to January-June 2018. *MMWR. Morbidity and mortality weekly report*, 68(34), 737–744. <https://doi.org/10.15585/mmwr.mm6834a2>

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