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Healthcare and Substance Use Service Accessibility and Barriers for Syringe Service Program

(SSP) Participants in Manchester, NH

Faith Farnham

University of New Hampshire

Healthcare and Substance Use Service Accessibility and Barriers for Syringe Service Program
(SSP) Participants in Manchester, NH

Background

Opioid use is a prevalent topic in New Hampshire, as our state has one of the highest rates of death from opioid overdose in the country (CDC, 2018). The current literature surrounding people who inject drugs' (PWID) experiences and needs indicate a lack of access to preventative care and treatment resources. However, many of these inquiries are not specific to New Hampshire's PWID (Artenie, 2015; Al-Tayyib, 2015) but instead focus on the population as a whole. Decreased resources are even more prevalent due to COVID (Nolte et al., 2020). One of the goals of Syringe Services Programs (SSPs) is to engage participants in connecting with services and offering low barrier access to resources. SSPs offer sterile supplies, education, and support to PWID (CDC, 2016). SSPs demonstrate reductions in overdose deaths, communicable disease transmission (HIV and Hepatitis C), and infection rates such as endocarditis and abscesses (CDC, 2017). Fifty percent of participants who engage with an SSP reduce their use after engagement and are five times more likely to enter a substance use treatment program (CDC, 2017). SSPs also know how to engage PWID with compassion, as these persons face discrimination in the community (Kidorf, 2011). Although the benefits of SSPs are clear there is little knowledge about factors that enable or constrain SSP participants' healthcare engagement.

PWID often face discrimination in the inpatient setting due to their drug use and blood-borne diseases (Maffina et al., 2013). Effective engagement of PWID is even more critical given the greater physiological vulnerability to infectious disease including HIV and Hepatitis C (HCV). PWID are more likely to leave against medical advice (AMA) which often leads them to

not completing recommended treatment and therefore at higher risk for health issues to progress to a chronic or more life-threatening stage (Biancarelli et al., 2019).

Experiencing discrimination within healthcare can negatively impact engagement in care and receipt of effective treatment. When PWID feel as though they are being discriminated against they are less likely to honestly disclose information about their health and their drug use and are less likely to stay engaged in harm reduction services (Henwood et al., 2014). Some fear the loss of control over their prescribed opioid to the point of wanting to avoid the healthcare realm altogether, obtaining heroin and opioids from the street to achieve relief instead (Marie, 2014). Although multiple sources describe the difficulties, few effective interventions have been identified to integrate into the inpatient setting to address these concerns.

Community-based resources are often the healthcare setting of choice for PWID. Supervised injection facilities, rarely available within the US, provide non-judgmental treatment and a safer environment for PWID not only physically, but socially and emotionally. These facilities provide integrated care with access to counseling and social services, which is not typically found in the inpatient setting (Lang, et al., 2013). Use of harm reduction approaches, like supervised injection facilities, demonstrates to PWID that providers value, care for, respect, and dignify patients as individuals. Harm reduction strategies result in providers celebrating any positive change toward better health and used positive reinforcement as a building block in the patient-provider relationship (Rosenburg & Davis, 2013). In a harm reduction approach, providers recognize that PWID require support during any transition toward risk reduction. Evidence for harm reduction approaches has been primarily built up in community-based settings. Thus, connecting PWID to community programs increases the chance in continuity of care for these patients secondary to the support received in such settings.

The current literature outlines multiple factors that lead to negative interaction for PWID in healthcare. Firstly, PWID often feel that their pain is not well managed, which is associated with feelings of isolation, shame, humiliation, and poor communication with the healthcare team (Marie, 2014). Other PWID on chronic opioid therapy also reported fear of losing control of their prescribed opioid, wanting to hide treatment from others, and feeling stigmatized when receiving treatment for pain. (Marie, 2014).

Negative experiences for PWID with healthcare and are missed opportunities to support positive change. PWIDs report some service providers are unable to provide effective services due to a lack of resources and education (Maffina et al., 2009). In most cases, there is mutual mistrust between the provider and the patient, which creates a barrier for treatment and communication. PWID have cited poor interaction with service providers as the main reason for avoiding care (Maffina et al., 2013). PWID describe being denied access or resources as stigmatizing and embarrassing, leading to internalization and reaction to stigma (Paquette et al., 2018). PWID associated this stigmatization with delayed and substandard care of overdoses and injection-related infections (Paquette et al., 2018).

Positive interactions between healthcare professionals and patients are essential in engaging PWID in high quality care. When PWID feel welcomed in the hospital they are more inclined to connect to resources. Establishing rapport is important for healthcare professionals when communicating with all patients, but especially important with PWID due to the disproportion of health disparities they face. Patient outcomes are optimized when care is delivered in a non-judgmental and respectful manner (Paquette et al., 2018).

Although the majority of interactions PWID face within healthcare literature have been described as negative, this highlights the great potential to address and promote positive

interactions. Key factors in positive interactions include transparent and continuous honest communication between patients and their health caregivers (Marie, 2014). PWID value relationships with family, extended family, and their supports who they perceive view their circumstances optimistically (Small et al., 2009). Despite these findings, providers may be less likely to engage family and friends of PWID than other clients. Providers could benefit from recognizing the power they have and therefore remain and ally and advocate for their clients.

Once a provider-client relationship is established it is maintained. A key component of maintaining a positive provider-client relationship is by understanding that abstinence-only goals during recovery are not realistic for every PWID (Small et al., 2009). A critical time to show support for a PWID are during those times in which they may still be moderately using. Support being withheld during this transition time between moderate use and abstinence, could actually put the patient at risk for isolation from resources and support (Hawk et al., 2017). Instead, Hawk and colleagues (2017) recommend positive reinforcement to be rewarded as an encouraging incentive to continue to strive towards sobriety.

Community-based resources are preferred by PWID as a safe and welcoming place to receive care and connection to counseling and other social services (Lang et al., 2013). Needle exchange programs are becoming more prevalent here in NH as well as across the country and have been shown to incentivize clients to seek primary care (Lang et al., 2013). Although equitable care is often perceived more by patients in the outpatient setting, these strategies have also seen positive results when integrated into the inpatient setting. For instance, PWID found lower levels of using when they were offered multidisciplinary support services for substance misuse in the inpatient setting (Wakeman et al., 2017).

The primary aim of the study was to identify the health service needs of SSP participants in Manchester, NH. To answer this question more accurately, it was broken into five sub-questions:

1. What healthcare services are SSP participants accessing and what is their satisfaction with those services?
2. What substance use services are SSP participants accessing and what is their satisfaction with those services?
3. What barriers to accessing medical care do SSP participants face?
4. How did COVID affect this access to substance use services and healthcare services?
5. Is there an association between accessing substance use (SU) and healthcare services with length of engagement with an SSP?

Methods and Materials

This study was conducted between November 2020 and May 2021. The study was University of New Hampshire IRB approved (#8386) and funded by the UNH Collaborative Research Excellence (CoRE) program. A Qualtrics survey was administered to up to two hundred participants of four SSP in New Hampshire. Data collection is still ongoing at one site. This study focuses on Manchester subset of data that engaged Queen City Exchange participants. These surveys were completed in November and December 2020. Criteria for inclusion was being at least 18 years of age and actively participating in an SSP. The Qualtrics survey took approximately 15 to 20 minutes and was administered on a tablet. The survey included audio-

computer assisted self-interview (ACASI), as this is best practice to accommodate those who would prefer questions read for them, including low literacy individuals. The survey explored items including syringe access, use of safe supplies, healthcare services, substance use, substance use services, infection prevention, overdose/naloxone, and demographics. A \$20 gift card was provided for participation in the study. From January to April of 2021, data analysis was conducted on SPSS Statistics. Additional analysis and graphing were completed on Excel. A chi square test was utilized to test associations between SSP engagement and accessing services.

Results

Recruitment for this study yielded 81 participants (demographics listed in Table 1). The majority of our participants were 26-35 years old (n=26, 41.9%).

Table 1

| Demographic Characteristics of HealSS Participants: Manchester Subsample | | |
|--|-----------------------------------|----|
| | Manchester HealSS Participants | |
| | % | n |
| Age (n=62) | | |
| 18-25 | 11.3 | 7 |
| 26-35 | 41.9 | 26 |
| 36-45 | 22.6 | 14 |
| 46-55 | 16.1 | 10 |
| 56-65 | 6.5 | 4 |
| >65 | 1.6 | 1 |
| Gender: Male (n=57)* | 59.6 | 34 |
| Gender: Female | 40.4 | 23 |
| SSP Utilization of HealSS Participants: Manchester Subsample | | |
| | Manchester HealSS Participants | |
| | % | n |
| Utilizes a Unique ID at SSP (n=39)* | 73.2 (50.6) | 41 |
| Agreed to Allow Access to Visit Data | 48.1 | 39 |
| Who Utilizes Supplies You Receive (n=81) | | |
| Myself (only) | 35.8 | 29 |
| Myself and Friends/ Family | 33.3 | 27 |
| Family and Friends | 4.9 | 4 |
| Utilizing SSP For (n=64) | | |
| 1.5-3 years | 17.2 | 11 |
| 1-1.5 years | 15.6 | 10 |
| 6 months- 1 year | 28.1 | 18 |
| 3- 6 months | 15.6 | 10 |
| 1-3 months | 14.1 | 9 |
| < 1 month | 9.4 | 6 |
| When meeting with the needle exchange, I received information regarding: | | |
| Preventing overdose | 63 | 51 |
| Safe injecting practices | 49.4 | 40 |
| HCV testing | 43.2 | 35 |
| HIV testing | 34.6 | 28 |
| Vaccinations/ Immunizations | 33.3 | 27 |

The survey questioned participants regarding the healthcare services accessed (Table 2). The most utilized non-emergent service was primary care (n=46, 56.7%), while the most accessed emergent services with the emergency department (n=55, 67.9%).

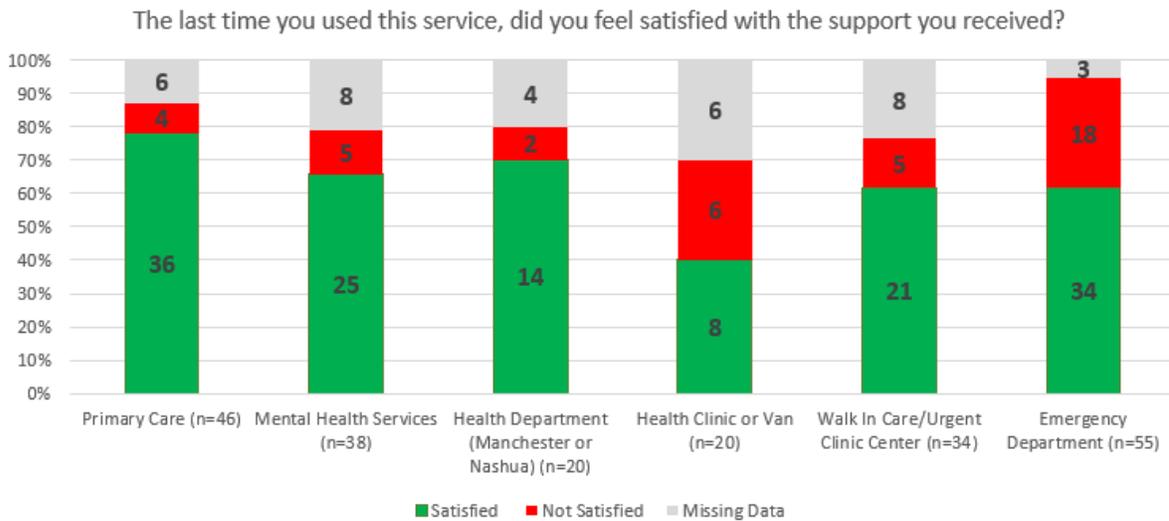
Table 2

| Healthcare Services Accessed (N=81) | % | n |
|---|-------|----|
| Accessed ANY Services | 91.3% | 74 |
| Accessed ANY Non-Emergency Care | 71.6% | 58 |
| Primary care | 56.7 | 46 |
| Mental health services (counselling, psychiatry) | 46.9 | 38 |
| Health department (Manchester or Nashua) | 24.6 | 20 |
| Health clinic or van (ie Healthcare for the Homeless) | 24.6 | 20 |
| Accessed ANY Emergency Care | 75.3% | 61 |
| Emergency Department | 67.9 | 55 |
| Walk in/ Urgent care | 42.0 | 34 |

The survey questioned participants if they felt satisfied with the support received by these services (Figure 1). Overall, participants were the most satisfied with the support received from primary care (n=36, 78.2%), and the least satisfied with health clinics or vans (n=8, 40%).

Despite being the most accessed, the ED had lower satisfaction with support received (n=34, 61.8%).

Figure 1



The survey also questioned participants regarding substance use services accessed and if they felt satisfied with the support received by these services. Table 3 describes Non-MOUD substance use services accessed by participants. For the non-medication-based group, these services were not utilized as much as healthcare services medical detox (n=34, 42%), peer-help groups (n=29, 35.8%), and counseling (n=28, 34.6%) were accessed the most.

Table 3

| Non-MOUD Substance Use Services Accessed (N=81) | % | n |
|---|------|----|
| Medical detox | 42.0 | 34 |
| Peer help groups (NA, AA, SMART Recovery, etc.) | 35.8 | 29 |
| Counseling one on one | 34.6 | 28 |
| Residential Programs (ex. 28 days) | 29.6 | 24 |
| Recovery residence/sober house | 21.0 | 17 |

Figure 2 represents the satisfaction rates of those using non-MOUD services. Overall, the percentages of those satisfied with these services is not extremely high, with each around 50-60%.

Figure 2

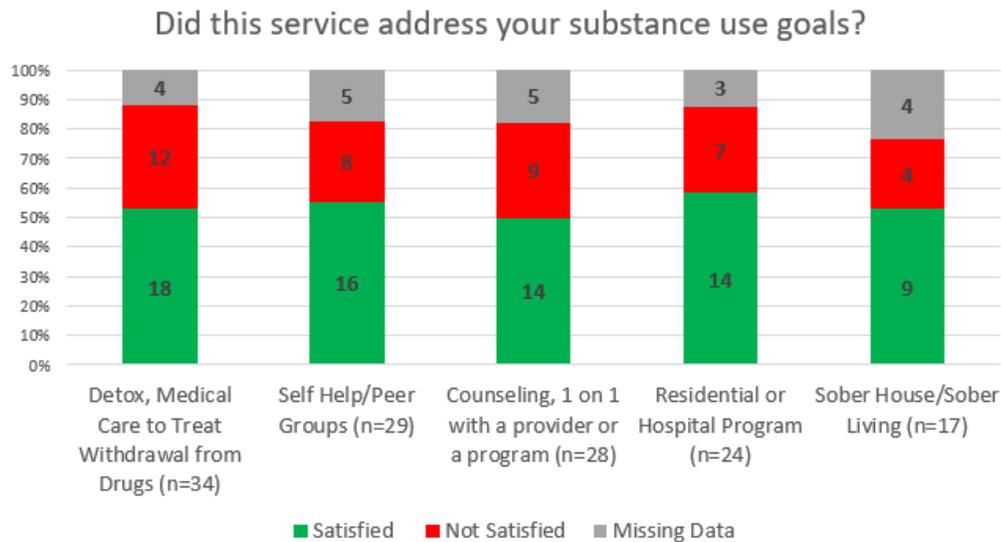
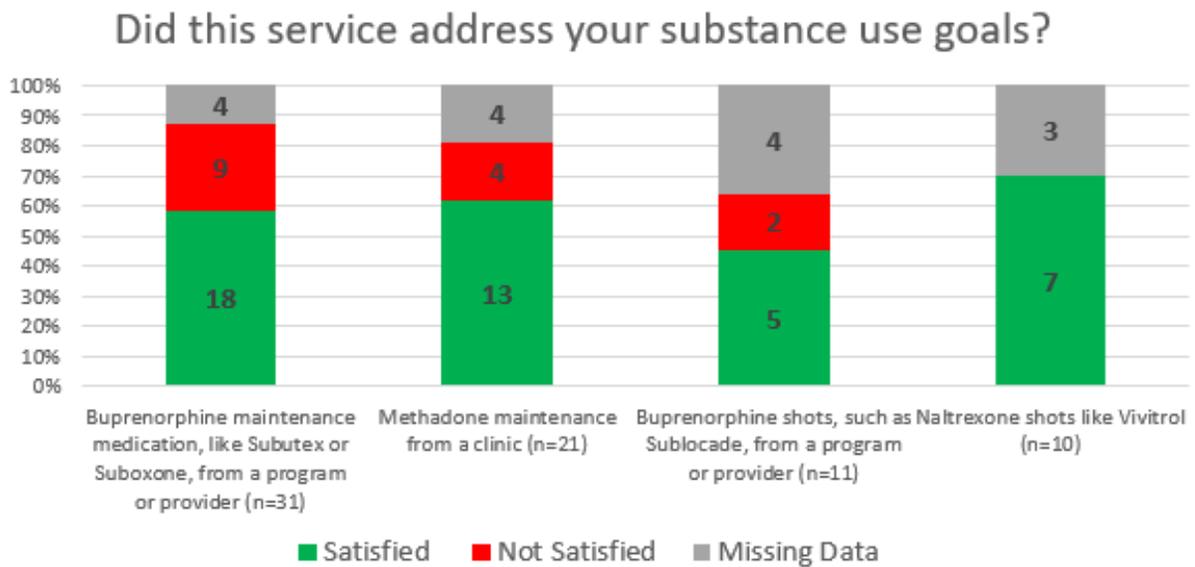


Table 4 describes MOUD substance use services accessed by participants. Prescribed MOUD has strong evidence in reducing illicit opioid use, mortality, drug-related HIV risk behaviors and crime and has been shown to be very cost-effective (Hall et al., 2021). 42 of 81 participants accessed any kind of medication, with buprenorphine pills (n=31, 35.8%) and methadone (n=21, 27.2%) being the more utilized options.

| MOUD Substance Use Services Accessed (N=81) | % | n |
|--|------|----|
| Buprenorphine (pills) from a prescriber | 35.8 | 31 |
| Methadone from a clinic | 27.2 | 21 |
| Buprenorphine (injectable) from a prescriber | 13.6 | 11 |
| Naltrexone (injectable) | 12.3 | 10 |
| Accessed ANY Medication | 51.9 | 42 |

Figure 3 represents the satisfaction rates of those using MOUD services. Overall, beside the naltrexone shots also known as Vivitrol, the satisfaction with these services is mixed (although there was a small sample size). We also have to consider that our SSP participants are engaging with an exchange potentially because these services did not lead to abstinence or desired control of their use.

Figure 3



The next portion of the results examines barriers SSP participants face when accessing medical care (Table 5). The 3 most common responses were a lack of transportation (n=27, 33.3%), being afraid of disrespect because of their drug use (n=24, 29.6%), and someone besides a medical professional treated their issue or they treated themselves (n=24, 29.6%).

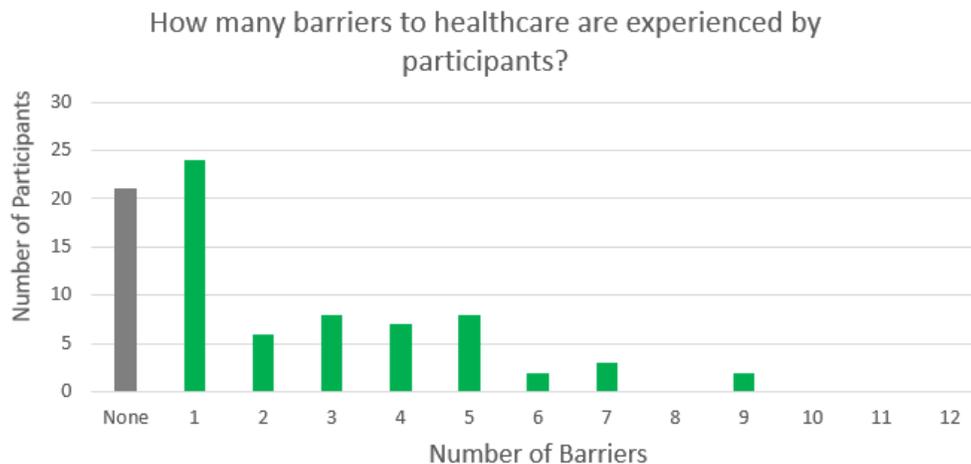
Table 5

| Number of Participants (N=81) | % | n |
|-------------------------------|------|----|
| No transportation | 33.3 | 27 |

| Number of Participants (N=81) | % | n |
|---|------|----|
| Afraid of disrespect because I use drugs | 29.6 | 24 |
| Someone else treated me (not a doctor or nurse) or I treated myself | 29.6 | 24 |
| Could not pay | 24.7 | 20 |
| Treated poorly in the past | 18.5 | 15 |
| Lack of trust in doctors and nurses | 16.0 | 13 |
| Don't care about taking care of myself at this time | 16.0 | 13 |
| Unsure where to go | 14.8 | 12 |
| Unable to get care because "to high or too drunk" | 14.8 | 12 |
| Did not want to be seen at clinic | 13.6 | 11 |
| Clinic hours inconvenient | 11.1 | 9 |
| Didn't have childcare | 2.5 | 2 |

Figure 4 shows how many barriers each participant faces. 21 of our 81 participants experience no barriers to healthcare. However, the majority of the participants have at least 1 barrier to accessing medical care, with some experiencing as many as 9 of the barriers.

Figure 4



Statistical analysis was used to see if there was an association between accessing healthcare services and months engaging with an SSP. Only 64 participants were used, as this was a fill-in answer and some of the responses were not specific enough to categorize. Access of non-emergent services was the focus, as it is well documented in the literature that PWID often utilize emergency service. To look for an association, a chi square test was performed despite this being a smaller sample size. There was not a relation between engagement in an SSP and accessing non-emergent care or primary care.

Statistical analysis was also used to see if there was an association between accessing substance use services and months engaging with an SSP. Overall, MOUD is utilized less than others. The literature documents this could be due to barriers such as negative MOUD perceptions, fear of experiencing stigma, cost and a perceived lack of flexibility. The chi square test found that there was not a relation between engagement in an SSP and accessing non-MOUD and MOUD services (Table 6).

Table 6

| Non Emergent Care * Length of Time at SSP | | | | | | | |
|---|---------|------------|---------|---------|---------|---------|-------|
| Observed | 0-1 | "1-3" | "3-6" | "6-12" | "12-18" | "18-36" | Total |
| Yes | 4 | 8 | 10 | 14 | 5 | 10 | 51 |
| No | 2 | 1 | 0 | 4 | 5 | 1 | 13 |
| Total | 6 | 9 | 10 | 18 | 10 | 11 | 64 |
| Expected | 0-1 | "1-3" | "3-6" | "6-12" | "12-18" | "18-36" | Total |
| Yes | 4.78125 | 7.17188 | 7.96875 | 14.3438 | 7.96875 | 8.76563 | 51 |
| No | 1.21875 | 1.82813 | 2.03125 | 3.65625 | 2.03125 | 2.23438 | 13 |
| Total | 6 | 9 | 10 | 18 | 10 | 11 | 64 |
| Chi Square Value | | 0.07553366 | | | | | |
| Non MOUD Care * Length of Time at SSP | | | | | | | |
| Observed | 0-1 | "1-3" | "3-6" | "6-12" | "12-18" | "18-36" | Total |
| Yes | 5 | 7 | 6 | 9 | 7 | 8 | 42 |
| No | 1 | 2 | 4 | 9 | 3 | 3 | 22 |
| Total | 6 | 9 | 10 | 18 | 10 | 11 | 64 |
| Expected | 0-1 | "1-3" | "3-6" | "6-12" | "12-18" | "18-36" | Total |
| Yes | 3.9375 | 5.90625 | 6.5625 | 11.8125 | 6.5625 | 7.21875 | 51 |
| No | 2.0625 | 3.09375 | 3.4375 | 6.1875 | 3.4375 | 3.78125 | 13 |
| Total | 6 | 9 | 10 | 18 | 10 | 11 | 64 |
| Chi Square Value | | 0.57232143 | | | | | |

| Primary Care * Length of Time at SSP | | | | | | | |
|--------------------------------------|--------|---------|--------|---------|---------|---------|-------|
| Observed | 0-1 | "1-3" | "3-6" | "6-12" | "12-18" | "18-36" | Total |
| Yes | 4 | 7 | 8 | 11 | 5 | 5 | 40 |
| No | 2 | 2 | 2 | 7 | 5 | 6 | 24 |
| Total | 6 | 9 | 10 | 18 | 10 | 11 | 64 |
| Expected | 0-1 | "1-3" | "3-6" | "6-12" | "12-18" | "18-36" | Total |
| Yes | 3.75 | 5.625 | 6.25 | 11.25 | 6.25 | 6.875 | 51 |
| No | 2.25 | 3.375 | 3.75 | 6.75 | 3.75 | 4.125 | 13 |
| Total | 6 | 9 | 10 | 18 | 10 | 11 | 64 |
| Chi Square Value | | 0.50811 | | | | | |
| MOUD Care * Length of Time at SSP | | | | | | | |
| Observed | 0-1 | "1-3" | "3-6" | "6-12" | "12-18" | "18-36" | Total |
| Yes | 3 | 5 | 4 | 8 | 5 | 7 | 32 |
| No | 3 | 4 | 6 | 10 | 5 | 4 | 32 |
| Total | 6 | 9 | 10 | 18 | 10 | 11 | 64 |
| Expected | 0-1 | "1-3" | "3-6" | "6-12" | "12-18" | "18-36" | Total |
| Yes | 3.9375 | 5.90625 | 6.5625 | 11.8125 | 6.5625 | 7.21875 | 51 |
| No | 3 | 4.5 | 5 | 9 | 5 | 5.5 | 13 |
| Total | 6 | 9 | 10 | 18 | 10 | 11 | 64 |
| Chi Square Value | | 0.58627 | | | | | |

We also included how participants felt COVID has affected their access to services (Table 7). The category least affected was naloxone, with 81.7% (n=58) stating there was no change in access. Syringes, healthcare services, and substance use services had similar results, with healthcare services having the highest percentage of participants reporting access becoming more difficult.

Table 7

| Since COVID-19 how has your access changed to access: | Harder to Access % | No Change % | Easier to Access % |
|--|---------------------------|--------------------|---------------------------|
| Sterile Syringes (n=61) | 21.3 | 63.9 | 14.8 |
| Healthcare Services (n=66) | 39.4 | 56.1 | 4.5 |
| Substance Use Services (n=67) | 32.8 | 58.2 | 9.0 |
| Naloxone (n=71) | 7.0 | 81.7 | 11.3 |

Discussion

Primary care is effective for addressing many of the complex health needs of PWID, as they can provide screenings, vaccinations, PreP, MOUD, and can foster a long-term relationship. PWID engaged in primary care are more likely to initiate and maintain MOUD-and abstain from drug use (Motavelli et al., 2021). This is consistent with our results, as these participants felt the most supported by primary care. However, emergency medical services are utilized more often, as we also saw in our data with 55 of 81 (67.9%) participants utilizing this service. In this study as well, the ED was utilized more, but participants were not as satisfied.- The literature documents that while emergency departments have developed innovative protocols to address the unmet needs of PWID accessing emergency services, they are not designed or resourced for

delivering preventive services, providing long-term management of SUD, or addressing social needs (Motavelli et al., 2021).

MOUD, especially methadone and buprenorphine, has strong evidence in reducing illicit opioid use, mortality, drug-related HIV risk behaviors and crime and has been shown to be very cost-effective. The most reported barriers overall were negative perceptions, fear of experiencing stigma, cost, and a perceived lack of flexibility around OST (Hall et al., 2021). The participants in this study were also not as satisfied with these services. As previously stated, one must also consider that the SSP participants are engaging with an exchange potentially because these services did not lead to abstinence or desired control of their use.

For barriers, 60 of 81 (74%) participants face at least one barrier to care, the most common barriers: Fear of judgement, lack of transportation, and self-treatment. COVID has also negatively impacted this population's access to resources (Nolte et al., 2020). Despite the lack of statistical relation between length of SSP engagement and access to non-emergent, primary care, non-MOUD and MOUD services, the sample size was small and therefore is not as reliable. The nature of this association and what it means for future research still needs to be further analyzed.

SSPs are in a unique position of interacting with PWID on a regular basis. These programs have the power to engage more participants in health services such as primary care, MOUD, and other resources. These referrals to primary care can result in better long-term management of their complex needs and a reduction in complications.

There are a few limitations to this study. The environment the surveys were taken in may have affected the results. Due to the COVID-19 pandemic data collection occurred outdoors, so participants may have spent less time on their answers in order to finish. Some participants also had to be excluded for incomplete surveys. The statistical analyses may also not be as accurate,

as only 64 participants could be included in the analysis due to some missing data. A larger sample size would have yielded more accurate results in the analysis portion of this study. While this was one of the largest groups for all the SSP sites surveyed, responses were still less than the preferred amount for the chi square test, as only 64 of the participants' responses for length of time were able to be deciphered.

Conclusions

This study effectively engaged SSP participants to assess factors that enable or constrain their healthcare involvement. Primary care was the most utilized non-emergent service in the study. PWID also felt the most supported by primary care services. It is recommended that PWID regularly engage with primary care for screenings, MOUD, and other long-term management. While the emergency department was used more frequently, emergency services cannot regularly provide long-term management of PWID's complex needs. While MOUD is documented in the literature to reduce illicit opioid use, these medications are underutilized. Common barriers to healthcare include fear of judgment, lack of transportation, and self-treatment. COVID-19 has also affected access to resources, which public health officials and SSPs should take into consideration for the future. In terms of association between length of SSP engagement and accessing services, more research is needed with a larger sample size.

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