OHIO INJURY PREVENTION PARTNERSHIP

Ohio Overdose Prevention Network

Harm Reduction Subcommittee

Harm Reduction Survey Results

Executive Summary

Table of Contents

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Key Takeaways

- In May and June 2021, harm reduction programs in Ohio were surveyed about issues of sustainability and aspects of their syringe services programs (SSPs) (if applicable). Harm reduction programs provide services that prevent adverse outcomes from substance use, which could include the distribution of naloxone, fentanyl test strips, sterile syringes, etc.

Sustainability Survey

- While barriers still exist, all respondents reported distributing **naloxone** and most utilized one or more stable funding sources for this service. However, programs based in **metropolitan counties** cited lack of available naloxone funding opportunities as one of their top sustainability barriers.
- A minority of programs reported distributing **other harm reduction services** like fentanyl test strips, sterile syringes, safe smoking, and safe snorting kits. These other services relied more often on internal or local (e.g., ADAMH or MHAR Board) funds, or less stable sources like donations.
- The leading reported **barriers** to sustaining harm reduction programs were community perceptions/buy-in, limited staffing, and lack of support from local leadership and organizations. These barriers were cited at even higher proportions among programs based out of **non-metropolitan counties**.

Syringe Services Program Survey

- Of the 90 individual respondents who were involved in running a harm reduction program, only 34 reported their program as being an SSP (distributing sterile syringes).
- Offering **hepatitis C virus (HCV) testing** continues to be a large challenge for SSPs, with the leading barriers being staffing and lack of funding. One third of responding SSPs stated no HCV testing was offered.
- A one-for-one syringe exchange model was the most common service model reported by SSPs in this sample, **despite not being recommended by the CDC.** A needs-based model is considered best-practice.
- The leading **administrative barriers** SSPs face were reported as data collection, followed by data reporting.

Background

According to a preliminary report, 2020 had the highest number of unintentional overdose deaths in Ohio history (5,018 as of August 31, 2021).[1] Harm reduction services like naloxone, fentanyl test strips, and syringe services programs (SSPs) help prevent overdoses, infectious disease, and other adverse outcomes from substance use.[2-4] SSPs specifically can offer a variety of services, including provision and disposal of sterile syringes and injection supplies, vaccination, testing, and linkage to care for infectious diseases.[4] SSPs protect the public and first responders, save lives, reduce the impact of drug use on the community, and help people who use drugs get the support needed to regain a health.[4] They also are an effective way to engage with stigmatized populations and connect participants with resources like treatment.[4]

To learn more about this landscape in the state, the Ohio Overdose Prevention Network's (Ohio OPN) Harm Reduction Subcommittee (HRSC) developed a survey to assess issues of sustainability among harm reduction programs and issues specific to SSPs. Ohio OPN is an action group of the Ohio Injury Prevention Partnership (OIPP), and the HRSC aims to promote harm reduction practices and policies.

Methods

On May 24, 2021, a REDCap survey was sent to members of Ohio OPN, Project DAWN programs, and other known harm reduction contacts via email. REDCap is a secure web application for building and managing online surveys and databases. Recipients were encouraged to share the link with those who might not have received it from the state contact lists. Anyone involved in running a harm reduction program in Ohio was eligible to participate in the Program Information and Sustainability portions of the survey, while only those who indicated distributing sterile syringes could take the SSP Survey. Responses were anonymous unless an email was volunteered at the end of the survey. The survey closed June 4, 2021.

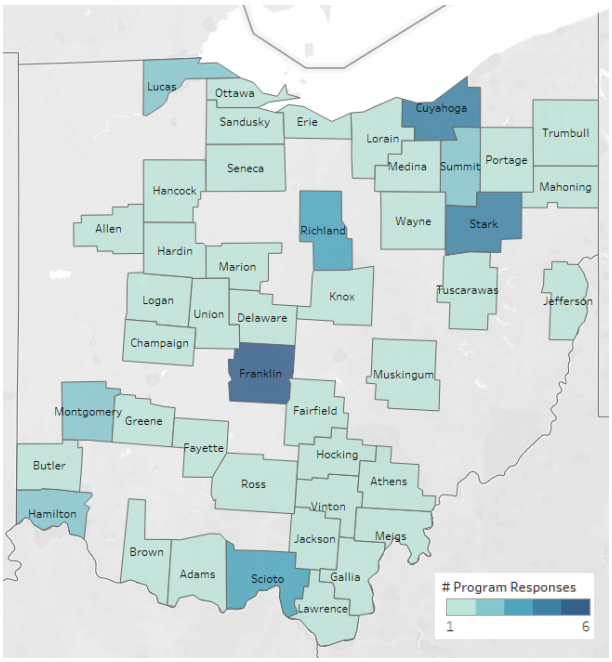
Results

The Harm Reduction Survey received 100 responses in REDCap. Of these, 90 unduplicated individuals involved in running a harm reduction program completed the initial Program Information part of the survey. Full survey results are available in the Harm Reduction Survey Full Report.

Sustainability Results

Program Information

Figure 1. Counties of Responding Programs



The survey received complete responses from 77 individuals representing 64 unique harm reduction programs in Ohio. Programs were based out of 45 of Ohio's counties (Figure 1). Most programs (n=40, 62.5%) were based out of counties classified as metropolitan, while 37.5% (n=24) were in non-metropolitan counties (using 2013 NCHS Urban-Rural Classification Scheme for Counties).[5]

Most programs were local health departments (70.3%), followed by SSPs (29.7%), and nonprofit organizations (14.1%) (agency types were not mutually exclusive).

Hospital systems, behavioral health organizations, and other agency types were represented as well.

Table 1. Services Provided by Programs (n=64)	
Naloxone	100.00%
Linkage to care (referrals)	57.81%
Fentanyl test strips	40.63%
Basic resources (personal care items, hygiene, etc.)	40.63%
Peer support services	39.06%
STI/HIV/Hepatitis prevention services	35.94%
Sterile syringes	29.69%
Other	15.63%
Safe smoking kits	6.25%
Safe snorting kits	3.13%
Missing	0.00%

All programs reported distributing naloxone, followed by nearly 58% providing linkage to care, and 40.6% distributing fentanyl test strips and basic resources like personal care items (Table 1).

Programs reported delivering harm reduction services most frequently at local health departments (65.6%), treatment/recovery settings (48.4%), and via street outreach (39.1%). Other settings included but were not limited to community access points, quick response teams, SSPs, corrections/court systems, online mail-order, lay distribution networks, and various health settings.

Sustainability

Funding Sources

Naloxone: Of the 64 programs that reported distributing naloxone, 78.1% obtained naloxone kits from the Ohio Department of Health (ODH) General Allocation, over 56% from the Integrated Naloxone Access and Infrastructure (IN) Grant, [1] and 46.9% from the Ohio Department of Mental Health and Addiction Services (OhioMHAS) grant for County Health Departments to equip law enforcement and first responders. Most programs (over 95%) provided Narcan Nasal Spray, while mucosal atomization devices or intramuscular naloxone were both reported by only 6.25% of programs.

Sterile Syringes: Among programs that reported distributing sterile syringes (n=19), the two leading sources were donations and the GRF Harm Reduction Surge Materials funds (both reported by 31.6% of programs). These were followed by their organization's general funds, county mental health and addiction recovery (MHAR) or Alcohol, Drug Addiction and Mental Health (ADAMH) boards, and buyers' clubs (all reported by 26.3% of programs).

Fentanyl Test Strips: The most common sources of fentanyl test strips among distributing programs (n=26) were MHAR or ADAMH boards (34.6%), their organization's general funds (30.8%), and buyers' clubs (26.9%).

Infrastructure: Most programs (n=64) funded their infrastructure, which could include staff salaries, travel, and other costs outside of harm reduction supplies, through their organization's general funds (over 59%). Half utilized the IN Grant, and 23.4% used federal grant funds.

Barriers

Programs (n=64) reported a range of barriers to sustaining their harm reduction programs. The leading barriers were community perceptions/buy-in (50%), limited staff to implement programming (40.6%), and lack of support from local leadership or organizations (34.4%) (Table 2). Other barriers included limited capacity to apply for grants, funding restrictions, and lack of funding opportunities for various supplies.

Table 2. Barriers to Sustaining Harm Reduction Programs (n=64)

Community perceptions/buy-in	50.00%
Limited staff to implement program	40.63%
Lack of support from local leadership/organizations	34.38%
Limited staff capacity or resources to apply for grants (e.g., need for a grant writer)	25.00%
Restrictions pertaining to existing funding sources	25.00%
Lack of available fentanyl test strip funding opportunities	23.44%
Lack of available naloxone funding opportunities	23.44%
Lack of available safe smoking kits funding opportunities	23.44%
Lack of available safe snorting kits funding opportunities	23.44%
Lack of available sterile syringe funding opportunities	21.88%
Available funding is not enough to cover program costs	20.31%
Cost of naloxone	20.31%
Lack of available infrastructure/operational cost funding opportunities	20.31%
Legal barriers	15.63%
Organization is ineligible for certain types of funding	7.81%
Other	7.81%
Unable to bill client insurance for naloxone	4.69%
Missing	10.94%

When comparing metropolitan versus non-metropolitan counties, the leading two barriers were the same but programs in nonmetropolitan counties reported these at higher proportions (Table 3). They were also more likely to cite lack of support from local leadership or organizations. Programs in metropolitan counties were more likely to cite lack of naloxone funding opportunities as a barrier.

Table 3. Leading Three Barriers to Sustainability by County Type

Metropolitan (n=40)		Nonmetropolitan (n=24)	
Community perceptions/buy-in	42.50%	Community perceptions/buy-in	62.50%
Limited staff to implement program	37.50%	Limited staff to implement program	45.83%
Lack of available naloxone funding opportunities	30.00%	Lack of support from local leadership/organizations	45.83%

[1] The ODH General Allocation is supported by state general revenue funds (GRF); the IN Grant is supported by federal (State Opioid Response) funds administered by ODH in partnership with OhioMHAS.

Billing

Only 9.4% of the 64 programs said they had billed or considered billing insurance for naloxone or other services (e.g., SBIRT) (Figure 2). Of those who had (n=6), 33.3% reported no challenges while 66.6% reported barriers including clients not being able to afford copays, finding personnel who can prescribe naloxone, adding provider(s) to insurance panels, submitting claims and receiving reimbursement, and clients not wanting naloxone on their insurance record (Table 4). One participant also described that it *"creates an additional barrier to effectively sending a patient/individual home with a Narcan kit in hand rather than a prescription that will go unfilled."*

Figure 2. Programs that bill or have considered billing insurance for naloxone or other services (e.g., SBIRT) (n=64)

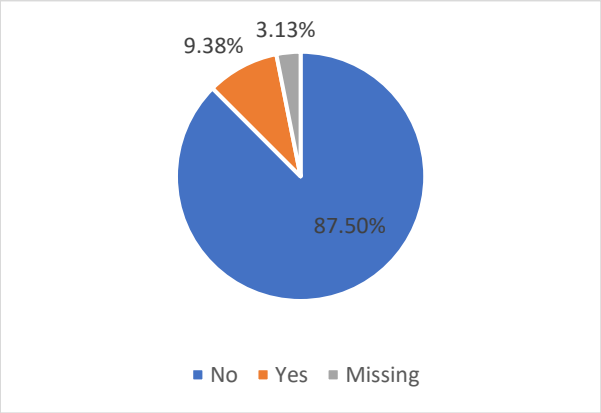


Table 4. Challenges Encountered Billing Insurance (n=6)	
Clients can't afford copays	33.33%
No challenges	33.33%
Other	33.33%
Finding or retaining personnel who can prescribe naloxone	16.67%
Difficulty adding provider(s) to insurance panels	16.67%
Challenges submitting claims and receiving reimbursement	16.67%
Clients don't want naloxone prescription on their insurance record	16.67%
Missing	0.00%

Staffing

Among individual respondents (n=77), just over half (53.3%) said their program had a coordinator or manager who dedicated 0.5 full time equivalents (FTE) or more to the program, while 42.9% said they did not. Most individual respondents said they had adequate staffing to effectively operate their program (66.2%), but nearly 30% said they did not have adequate staffing.

Disrupted Funding

When asked if they had a plan for how their program would continue if their primary source(s) of funding were unexpectedly cut, only 18% of the 77 individual respondents said they did, while 74% did not have a plan (Figure 3).

Figure 3. If your primary source(s) of funding was unexpectedly cut, do you have a plan for how your program would continue? (n=77)

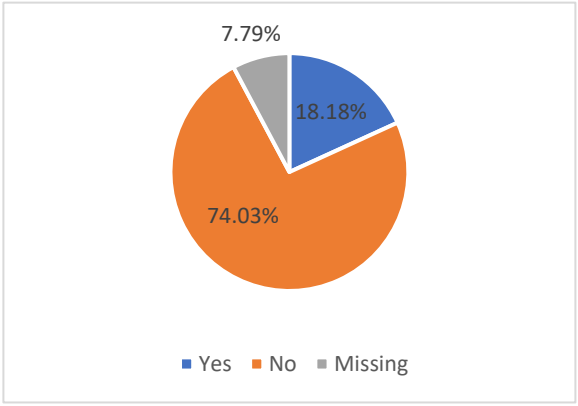


Table 5. Strategies Programs Found Helpful for Sustainability (n=64)	
Community partnerships	67.19%
Utilize grants	54.69%
Integrate naloxone into existing programs to reduce need for additional personnel	35.94%
Diversify funding	18.75%
Donations	15.63%
Fundraise	9.38%
Bill for naloxone and/or other services	7.81%
Purchase less expensive forms of naloxone (e.g., nasal atomizer spray, injectable naloxone)	6.25%
Other	1.56%
Bill for SBIRT and/or counseling	0.00%
Bill for wound care and/or other health services	0.00%
Missing	14.06%

Strategies

Programs (n=64) also reported a variety of strategies they found helpful for making their harm reduction programs more sustainable. The most frequently reported strategies were community partnerships (67.2%), utilizing grants (54.7%), and integrating naloxone into existing programs to reduce the need for additional personnel (35.9%) (Table 5).

Syringe Service Program Results

The SSP Survey received completed responses from 34 individuals representing 18 unique (unduplicated) Syringe Service Programs (SSP) in Ohio. Programs were based out of 17 counties in Ohio (Figure 4).

SSP Operation Schedule

Of the 18 responding programs, 39% reported operating their SSP one day a week while 44% operated 2 or more days a week (Figure 5).

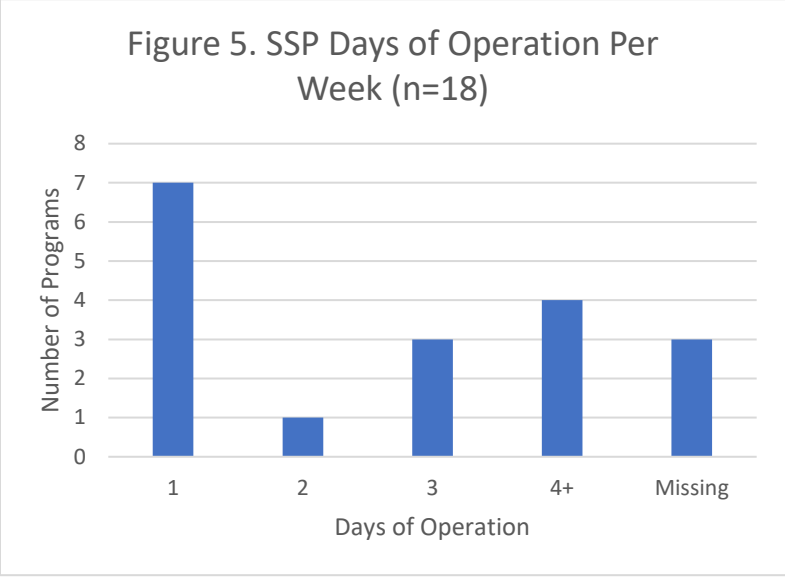
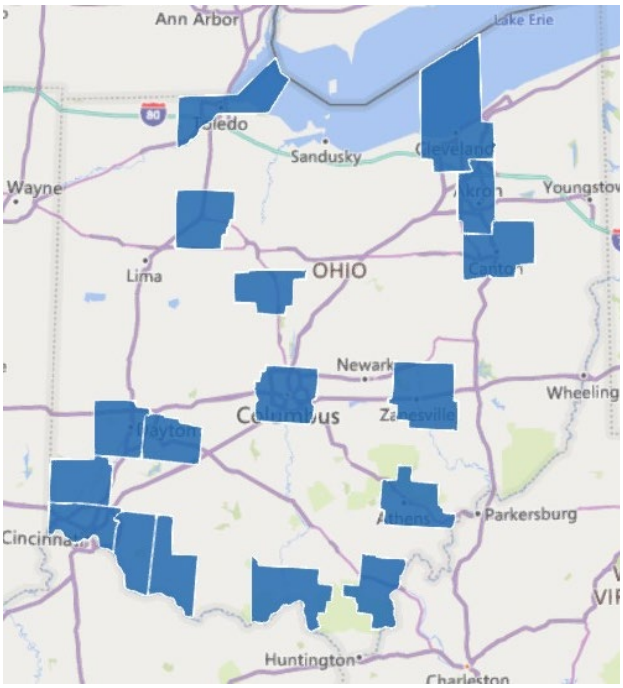


Figure 4. Counties of Responding SSPs



Services Provided via SSPs

When asked about services provided, 100% of SSPs (n=18) reported naloxone is offered, followed by 94.4% offering linkage to care and 83.3% offering fentanyl test strips, among other services (Table 6).

While each SSP offers services in a different capacity, listed in the table below are basic descriptions of these services. In no way does the below description completely encompass what might be available through the SSPs who responded that these services were provided.

Table 6. SSP Services Provided (n=18)

Survey results		Description of services
Naloxone	100.0%	Naloxone (commonly known as NARCAN®) is a medication that can reverse an overdose caused by an opioid drug (heroin, illicit fentanyl, or prescription pain medications). When administered during an overdose, naloxone blocks the effects of opioids on the brain and quickly restores breathing. (ODH, 2021)[6]
Sterile Syringes	100.0%	Sterile syringes, or needles, are used to inject substances and come in a variety of gauges and sizes.
Linkage to care (referrals)	94.4%	Linkage to care allows clients to be provided alternate care that might not be available through a certain agency or program (i.e., a warm hand-off to HIV treatment)
Fentanyl test strips (FTS)	83.3%	FTS can be used to determine if drugs have been mixed or cut with fentanyl, providing people who use drugs and communities with important information about fentanyl in the illicit drug supply so they can take steps to reduce their risk of overdose. (CDC,2021)[8]
STI/HIV/Hepatitis prevention services	77.8%	Sexually transmitted infection prevention aims to reduce the prevalence of STIs by interrupting their transmission through utilizing education and providing resources like condoms. (CDC, 2021)[7]
Basic resources	66.7%	Basic resources could include assistance with food, housing, transportation, personal hygiene, etc.
Peer support services	61.1%	Peer support workers are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. (SAMHSA, 2021)[9]
Safe smoking kits	22.2%	Safe smoking supplies provide safe and sterile supplies to people who use drugs (i.e., clean smoking pipe, plastic hose, alcohol swabs, foils, etc.)
Safe snorting kits	16.7%	Safe snorting supplies provide safe and sterile supplies to people who use drugs (i.e., clean straws and occasionally an object like a razor blade which could be used to chop and break up large particles before using)
Other resources	22.2%	Below are the other resources that respondents noted within the SSP survey results: • *Wound care.* • *Snacks, water, sterile water, antibiotic ointment, alcohol pads, cottons/filters, tourniquets, cookers, pregnancy tests.* • *Drug treatment, social service, health and mental health referrals; Distribution of condoms and lube; offer pregnancy tests; assist with Medicaid enrollment; Wound care; information on gambling addiction.*

Syringe Transaction Model

Participants were asked about the type of syringe transaction model their program offered (Table 7). Of the responding SSPs (n=18), the most reported model was one-for-one exchange (44.4%), followed by exchange (27.8%), and needs-based (11.1%), with 16.7% not offering a response. Below is a basic description of the traditional service models for SSPs as well as the Center for Disease Control and Prevention (CDC) recommendation and guidance.

Table 7. Syringe Transaction Model (n=18)		
Survey Results		**Description of Services**
One-for-one	44.4%	Sterile syringes are provided in exchange for the same number of used syringes. According to the CDC, a one-for-one model is defined as *"a practice of restricting syringe access by providing a participant only the number of syringes that the participant returns to the SSP for disposal (not a recommended practice)."* [10]
Exchange	27.8%	Sterile syringes are provided in exchange for any number of used syringes. According to the CDC, an exchange model is defined as *"less preferred by some because of its focus on needle distribution (less accurate than syringe distribution) and implication of 1:1 exchange (not a recommended practice)."* [10]
Needs-based	16.7%	Sterile syringes are provided based on need, not requiring the return of used syringes. According to the CDC, a needs-based model is defined as *"a syringe distribution practice that allows participants as many syringes as they say they need, regardless of how many syringes they return to the SSP for disposal (A best practice)."* [10]

Testing Services

Human immunodeficiency virus (HIV) and Hepatitis C (HCV): Offering HIV and HCV testing services through SSPs is proven to be effective in decreasing the prevalence of blood-borne pathogens and other infectious diseases as well as increase treatment rates (CDC, 2021.) [4] Respondents were asked about testing services provided, and almost 28% of participants responded that HIV testing (Table 8) is available at every shift. On the other hand, the next highest reported testing frequencies were no HIV testing offered at all and testing less than once a week (16.7% for each).

Respondents were also asked about HCV testing. One-third of participants reported that HCV testing (Table 9) is not available at all (33.3%). Only 16.7% of programs offered HCV testing at every shift, while 33.3% offered it between less than once a week to more than once a week (but not every shift).

Table 8. HIV Testing Frequency (n=18)	
No testing	16.7%
Less than once/week	16.7%
Once/week	11.1%
More than once/week	11.1%
Every shift	27.8%
No Response	16.7%

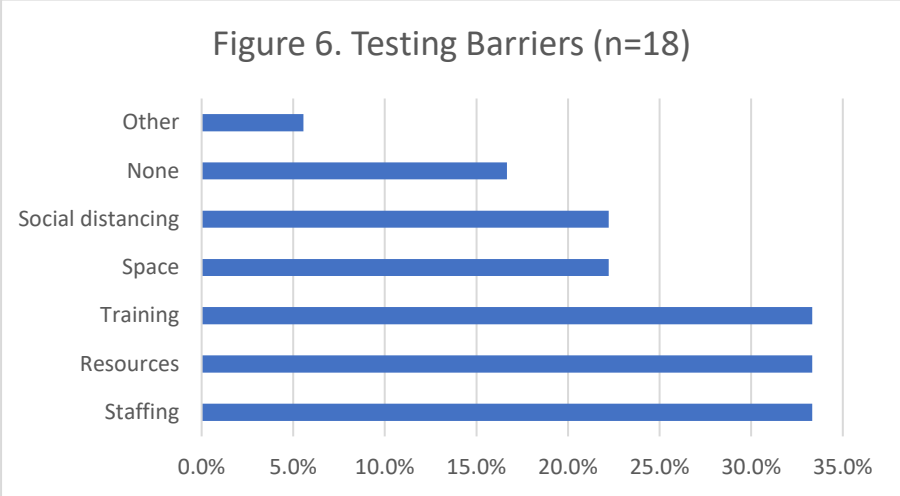
Table 9. HCV Testing Frequency (n=18)	
No testing	33.3%
Less than once/week	11.1%
Once/week	11.1%
More than once/week	11.1%
Every shift	16.7%
No Response	16.7%

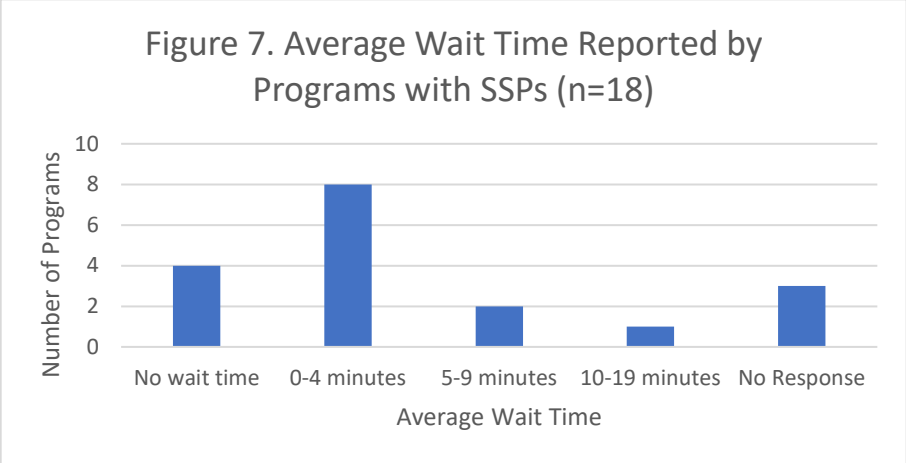
Some respondents also left comments regarding offering testing services, below are comments that offered more insight as to why testing services were or were not offered:

- *"We have the capability to [provide testing], but not the funding to purchase test kits."*
- *"We did offer [testing] at every shift but we currently do not have HCV kits."*
- *"HCV testing is not being conducted at this time due to COVID. We are working on a set up so that we can conclude with testing safely."*

Barriers and Challenges

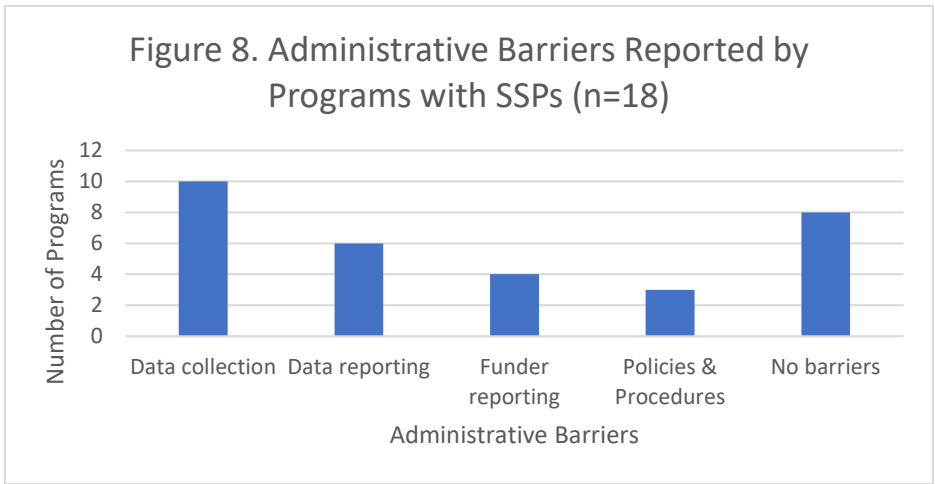
Testing barriers: Respondents were asked about barriers to HIV and HCV testing (Figure 6) and the leading barriers were staffing, resources, and training (33.3% for each), followed by space and social distancing (22.2% for each).





Client wait time: Respondents were asked about average wait time that clients face (time from when participant arrives at program location to when they interact with services) (Figure 7) and 44% of programs reported a wait time of 0-4 minutes, followed by no wait time (22.2%).

Administrative Barriers: Lastly, respondents reported on administrative barriers (Figure 8). Of the barriers, data collection was identified as the largest barrier (55.6%), followed by no barriers (44.4%), and data reporting (33.3%).



Funding

As part of the Sustainability Survey, respondents were asked how their program obtains or purchases sterile syringes. The 18 SSPs that also responded to the SSP Survey reported obtaining syringes from a variety of sources (Table 10). The leading three funding sources were the Ohio Department of Health (ODH) GRF Harm Reduction Surge Materials funds, donations, and organizational general funds (all reported by 27.8% of programs).

Table 10. Purchasing Sterile Syringes for Distribution (n=18)

ODH GRF Harm Reduction Surge Materials funds	27.8%
Donations	27.8%
Your organization's general funds	27.8%
County Mental Health and Addiction Recovery (MHAR) or Alcohol, Drug Addiction and Mental Health (ADAMH) board	22.2%
Buyers' clubs (e.g., NASEN, DanceSafe)	22.2%
Local/county foundation	16.7%
Other organizations within community/other funding	11.1%
Crowd sourcing and mutual aid (e.g., social media resource sharing, transfers from other programs)	5.6%
Fundraising events	0.00%
NEXT Distro	0.00%
Missing	0.00%

Additional Feedback

The end of the Harm Reduction Survey offered a chance for participants to provide additional thoughts. Six individuals responded to this prompt, and three that reflected themes in the rest of the data are shown below.

- *"Making [intramuscular] IM naloxone available to Project DAWN, recognition of SSP and harm reduction programs as medically necessary services potentially fundable through other state funding channels like Medicaid."*
- *"Funding for syringes is currently our largest hurdle. Since we cannot purchase syringes with federal grant funds, we must write grants to other funders. While the number of SSPs in Ohio and the nation have increased, this also means that the funders are more competitive and often exclude governmental operations. Having a secured and sustainable path for syringe purchasing is essential for the continuation of the program."*
- *"If spacing would allow, we would likely build a harm reduction program within our LHD, but we have no space to house another staff person. I am open to applying for ODH harm reduction grant funding beyond the 2 sources we use for Naloxone currently. A grant would have to fund the personnel costs."*

Limitations

The survey results should be considered with some limitations in mind. First, the sample may not be representative of all harm reduction programs and SSPs in Ohio. Many programs were through local health departments (LHDs), which have different experiences compared to other agency types like non-profit, grass-root, and "underground" programs. The latter were likely underrepresented due to not being on state contact lists and because of perceived confidentiality concerns. The HRSC tried to address this by making the survey anonymous unless participants volunteered an email address and encouraging sharing of the survey to better reach unknown programs.

In addition, because the survey was open to anyone involved in running a harm reduction program, some individual respondents (n=77 for the Sustainability Survey; n= 34 for the SSP Survey) worked for the same program. Because some questions would be more meaningful when considered by unique programs, responses that were highly likely to be from the same organization were combined and unduplicated (resulting in n=64 for the Sustainability Survey; n=18 for the SSP Survey). Responses were only combined if 1) they had matching organizational email domains OR 2) the agency type was an LHD, and that county only had one LHD. If participants did not volunteer an email or fall into the second category, it is possible they were incorrectly considered unique programs. However, results did not vary greatly between these datasets.

Conclusion

Sustainability Survey: The harm reduction programs in the Sustainability Survey sample reported a range of funding sources and experiences with sustainability. Every program reported distributing naloxone, and respondents frequently obtained naloxone from more stable funding sources like the ODH General Allocation, IN Grant (federal State Opioid Response funds administered by ODH in partnership with OhioMHAS), and OhioMHAS funds for first responders. However, lack of available naloxone funding opportunities was still the third most frequently reported barrier among metropolitan counties.

Provision of other harm reduction services like fentanyl test strips, sterile syringes, safe smoking and safe snorting kits were less common. These relied more often on organizational general funds, donations, and local sources like ADAMH and MHAR boards. This suggests these other services are more reliant on local levels of support, which can vary greatly across Ohio. Similarly, the first and third leading barriers reported were community perceptions/buy-in and lack of support from local leadership/organizations, respectively. These barriers were reported at even higher proportions in nonmetropolitan counties.

Finally, while about two-thirds of programs reported having adequate staffing, limited staffing was the second most reported barrier and nearly 43% said they did not have a coordinator/manager who dedicated 0.5 FTE or more to their harm reduction programming. Based off these results, while there have been advances in the support of harm reduction in Ohio, there are still gaps and barriers to sustainability.

Syringe Service Program Survey: The syringe service programs in the survey sample reported a range of services offered, challenges and barriers, and experiences. Every program reported providing naloxone via the SSP but other services like testing services (HIV and HCV) were somewhat lacking. The respondents report the structure of Ohio SSPs were mostly a one-for-one exchange, which is not best practice. This could be due to lack of community or leadership buy-in for an exchange type like needs-based. In addition, one conclusion is that of the 90 individual Harm Reduction Survey respondents (not all took the Sustainability Survey), less than a third of those were from programs who operate an SSP, pointing to how few SSPs there are in Ohio. Lastly, results show that many programs rely on less sustainable funding sources like donations, which was reported as often as ODH Harm Reduction funds and agency general funds.

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