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## The Adoption Of Harm Reduction By Abstinence Program Staff: A Qualitative Analysis

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The Adoption of Harm Reduction by  
Abstinence Program Staff:  
A Qualitative Analysis

A Thesis Presented  
by  
MORGAN COE

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The Adoption of Harm Reduction by  
Abstinence Program Staff:  
A Qualitative Analysis

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## ABSTRACT

THE ADOPTION OF HARM REDUCTION BY ABSTINENCE PROGRAM STAFF:

A QUALITATIVE ANALYSIS

MAY 2016

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Opioid overdose fatalities have quadrupled in the United States since the turn of the century, and are becoming increasingly recognized as a nationwide epidemic. While naloxone (narcant) has long been the standard treatment for overdose in clinical settings, it has not been issued to opioid users or their family members in the U.S. until relatively recently. As naloxone distribution and overdose training become more widespread, they are being incorporated into more and more abstinence-oriented settings including detoxes, halfway houses, and outpatient methadone and suboxone treatment programs. This qualitative study explored whether the staff at such programs found that training their patients to use naloxone was disruptive or controversial, and whether they found it difficult to reconcile these trainings' basis in harm reduction with their personal and organizational philosophies about substance use and recovery. Ten subjects from Eastern and Central Massachusetts were interviewed about their experience

introducing naloxone to their patients under the aegis of the Massachusetts Department of Public Health's Opioid Overdose Prevention Pilot Program, and their interviews were analyzed from a descriptive phenomenological perspective. This approach seeks to distill the essence of a phenomenon by analyzing the narratives of those who have experienced it, and has been found especially useful when exploring questions that have not yet been studied in depth. The analysis identified eleven recurring themes, grouped into four broad domains (What is overdose prevention training? What is narcan? What is harm reduction? What is the goal of treatment?). These themes suggested that while subjects overwhelmingly experienced naloxone distribution and overdose prevention training as positive additions to their workplace, this experience did not necessarily lead to more engagement with the broader concept of harm reduction.

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# CHAPTER I

## PROBLEM STATEMENT

Opiate users around the world have been found to have a mortality rate between 10 and 20 times that of the surrounding population (Hickman et al., 2003; Oppenheimer et al., 1994; Perucci et al. 1991). The single largest cause of that mortality is overdose, which accounted for 26% of user deaths in Frischer's (1993) Scottish study, 34% in Goldstein and Herrera's (1995) New Mexico study, and over half in Hickman's (2003) London study. In Portland, Oregon overdose was "a leading cause of death" in the year 1999 among *all* men aged 25–54 (Oxman et al. 2000). Just as disturbingly, Hall & Darke (1998) found a six-fold increase in Australian overdose mortality between 1979 and 1995. The Center for Disease Control and Prevention (CDC/NCHS, 2015) reported that from 1999 to 2014, the U.S. drug overdose fatality rate more than doubled (from 6.1 to 14.7 per 100,000 people), and the *opioid* overdose fatality rate more than quadrupled (from 1.4 to 5.6 per 100,000). However, not all overdoses result in death: 38% of Strang's (1999) study participants had previously overdosed, as had 44% of Green's (2008) and 48% of Ochoa's (2001). The rate at which participants had witnessed another user's (not necessarily fatal) overdose was considerably higher: 54% in Strang's (1999) first study, 86% in Darke's (1996), 95% in Tobin's (2009), and 97.4% in Strang's (2000) later study. Clearly the prevalence and potential consequences of opiate overdose represent significant public health concerns, and perhaps one growing more serious with time. In 2014, 1.9 million Americans suffered from prescription painkiller addiction, and approximately 586,000 were using heroin (SAMHSA, 2015)

There are many ways to decrease the likelihood and impact of opiate overdose. These options include: discouraging opiate use and increasing treatment and detox options,



decreasing concomitant risk factors (such as concurrent alcohol or benzodiazepine use) among opiate users, improving hospital and ambulance response to overdose, encouraging opiate users to adopt non-injection methods of opiate intake, providing safer injection facilities with medical staff, increasing the availability of maintenance treatment for opiate addicts, and providing take-home naloxone to opiate users (Darke & Hall, 2003; Sporer, 1999). While each of these options has certain advantages and disadvantages, the research proposed here focuses on of the newest and least well-studied alternative—providing take-home naloxone to opiate users.

## CHAPTER II

### BACKGROUND

Naloxone has been used as an effective treatment for opiate overdose in clinical settings since the early 1970s (World Health Organization, 1993). It functions as an opiate antagonist, blocking the drug's effects for a typical duration of 45-90 minutes. It takes effect within 1-2 minutes at the most, and is considered to have only a very small chance of adverse effects in patients (Baca & Grant, 2005; Galea et al., 2006; Kerr et al., 2008; Sporer, 1999). Although naloxone is the standard treatment for overdose, it has not been issued to opiate users (or their family members) for use outside of medical facilities until relatively recently. This practice was begun as a component of European and Australian anti-overdose interventions in the mid 90s, and was first adopted in the United States in 2001, when the San Francisco Department of Public Health sponsored a pilot research program. In the same year, the state of New Mexico implemented laws that freed physicians and private citizens from the legal liabilities involved in having a drug prescribed to one person with the expectation that they would use it on someone else, or have it used on them by someone else (Sporer & Kral, 2007). There are currently naloxone training and distribution programs active in at least 30 U.S. states, including Massachusetts (Wheeler et al., 2015).

In 2009, the greater Boston area led the nation in yearly drug- and heroin-related emergency room admissions per 100,000 residents (SAMHSA, 2011), and since 2005 opioid overdoses have surpassed automobile accidents as a cause of death in Massachusetts (Walley et al., 2013). In 2007 there were 9.9 opiate-related deaths per 100,000 state residents, compared to 5.2 in 1999 and 1.6 in 1990. In addition, there were 47 non-fatal hospitalizations for every death, and the total cost for hospitalizations related to opioid dependence and

overdose exceeded \$239 million in 2007 (BSAS, 2009). In response to these rising rates of fatal opiate overdose, the Massachusetts Department of Public Health created the Opioid Overdose Prevention Pilot Program (OOPPP, or “Narcan Pilot Program” colloquially) in order to implement and study the effects of providing Overdose Education and Naloxone Distribution (OEND) in 2006. The OOPPP works with existing treatment programs such as detoxes, inpatient treatment programs, and short- or long-term recovery housing, in order to provide training and naloxone to at-risk individuals and potential bystanders (BSAS, 2012; Doe-Simpkins et al, 2009).

In a 2010 survey conducted by the Harm Reduction Coalition, the OOPPP was one of 48 U.S. naloxone providers providing OEND at 188 sites (Wheeler et al., 2010). When the same agency conducted a similar survey in 2014, that number had risen to 136 programs serving 644 sites (Wheeler et al., 2015). Not only did the number of programs providing OEND nearly triple over this time span, the geographical area that they covered increased substantially as well: from 15 states and the District of Columbia in 2010 (Wheeler et al., 2010) to 30 states and the District of Columbia in 2014 (Wheeler et al., 2015). In other words, this four-year span did not just see naloxone become more accessible in states that had already embraced OEND—it also saw OEND adopted in many states that had previously resisted it. All together, these programs have distributed an estimated 150,000 naloxone kits and have tracked over 26,000 opioid overdose reversals (Wheeler et al., 2015).

### CHAPTER III

#### LITERATURE REVIEW

The concept of “harm reduction” has been applied to injection drug use in many ways, and encompasses a wide range of strategies. These include, but are not limited to, syringe exchange, street outreach, supervised injection facilities, promoting non-injection routes of drug administration, risk reduction education, “grass roots” organizing of drug-injecting peers, drug purity testing, and naloxone distribution (Ritter & Cameron, 2006). What these interventions have in common is that they aim primarily to reduce the harm associated with drug injection; while they may not exclude working towards (short- or long-term) abstinence or decreased use, these are not goals *in and of themselves* (Lenton & Single, 1998).

There is not much published research on the ways that naran-based overdose prevention has been incorporated into treatment and recovery settings, and a majority of published articles focus on naloxone distribution in syringe exchanges, by street outreach workers, and through peer recruitment channels.

In their discussion of a Wisconsin counseling program serving primarily substance using women, Ackerson & Karoll (2005) report that that “incorporating a harm-reduction philosophy within a traditional abstinence-based agency setting” was challenging for staff, both from a clinical standpoint and in terms of collaborating with outside agencies who continued to adhere to a strict abstinence-oriented framework. However, in this case “harm reduction” is conceptualized primarily in terms of staff’s being open to helping clients work towards goals other than full sobriety, and accepting the possibility of relapse as part of the recovery process—there is no mention of taking active steps like providing naloxone to current or past opiate users.

In an email questionnaire, Hofschulte (2012) investigated Minnesota social workers' attitudes towards harm reduction and towards substance users in order to determine whether positive or negative attitudes towards either or both were connected to the clinicians' demographic characteristics, professional history, or self-perception. She found that positive attitudes towards harm reduction were associated with having worked with substance using populations, having been trained on substance use and addiction, and perceiving this training as adequate. On the other hand, only past training on substance use and addiction was associated with belief in the efficacy of harm reduction-based treatment. None of the measured factors were associated with positive or negative perceptions of substance users.

Koutroulis (2000) conducted a small qualitative study that explored the ways that substance treatment staff understood and applied the concept of harm reduction. For the purposes of this research, "harm reduction" was conceptualized primarily in terms of staff's being open to working towards goals other than full long-term abstinence, and willing to provide education and resources that support safer substance use. She described an ongoing tension between clients (who generally entered the program with the intention of ceasing substance use) and staff (who often felt that it was safest to assume that their clients would not be able to maintain abstinence). Some staff found it conceptually challenging to negotiate the gap between ideal (abstinence) and reality (expected relapse), and therefore saw harm reduction as a tool to be used when they judged a particular client to be at risk for relapse, or unlikely to continue attending their program. Others saw no conflict between harm reduction and abstinence, and consistently provided harm reduction information and counseling as part of their baseline treatment. As with Ackerson and Karoll (2005), there is no mention of providing naloxone to clients potentially at risk for opiate overdose.

Maxwell et al. (2006) describe a Chicago-area naloxone distribution program similar to the one implemented in Massachusetts, and report that it appeared to be effective: not only did it result in 319 reported overdose reversals from 2001 to 2006, but the local rate of fatal overdose declined during the first 3 years it was implemented after rising steadily for a decade. This program provided naloxone via outreach vans, at fixed sites, and through a telephone pager system, but did not contact opiate users in treatment or recovery settings. However, the authors strongly advocate for expanding overdose prevention training and naloxone distribution into detoxes.

In their interviews with a treatment sample of methadone clinic patients who had little or no previous experience with naloxone, Strang et al. (1999) found strong support for naloxone distribution as a way to decrease overdose fatalities. While 70% of this population felt that distributing naloxone would be either a “good” or “very good” idea, only 13% felt that it would be a “bad idea. Within that dissenting minority, less than half of felt that it might encourage them to increase their opiate use. While this study did not address the views of methadone program staff, it does suggest that there may be substantial interest in naloxone among substance users who are in treatment or recovery.

Using data collected by the OOPPP’s programs in Massachusetts, Walley et al. (2013) described the program’s success in training and enrolling nearly 1,000 opiate users from methadone treatment and detox settings, which resulted in 33 reported overdose reversals from 2008 to 2010. These reversals were reported to staff by the trainees themselves after the fact, either when they returned for more naloxone, or when they were seeking other services from the OOPPP program that trained them. Therefore, this total would not count reversals performed by opiate users who had no subsequent contact with program staff—perhaps

because they stopped using, because they were able to obtain naloxone from other sources, or because they left the area. Furthermore, it is possible that even trainees who did return to an OOPPP program to get a naloxone refill might not have consistently reported overdose reversals. For instance, they may have felt obliged to “protect” the people or places involved, they may have believed that it was not their place to report the incident because they did not directly administer the naloxone, or they may have forgotten the incident (or decided that it “did not count”) because so much time had elapsed between the reversal and their next program contact.

Walley et al. (2013) also outline five different ways that overdose prevention training and naloxone were being provided to detox and methadone treatment patients:

1. Treatment program staff were certified to provide education and naloxone directly to their patients.
2. Treatment programs hosted outside certified trainers to provide education and naloxone to their patients.
3. Treatment program staff provided education, but referred their patients to one or more off-site programs in order to receive naloxone.
4. OOPPP program staff conducted targeted outreach in order to provide education and naloxone to detox or methadone program patients.
5. OOPPP program staff provided education and naloxone at sites not affiliated with treatment programs

Of these categories, the first two will be especially relevant to this research project.

## CHAPTER IV

### SIGNIFICANCE

As naran distribution becomes more accepted as an effective way to reduce opiate overdose fatalities, it seems likely that programs like OOPPP will expand. This is something that I observed firsthand while working at the Cambridge Needle Exchange—at times it seemed like the demand for naran training was so high that the availability of certified training staff was the only limiting factor. While naran appears to have been enthusiastically adopted as a life-saving strategy by state officials, harm reduction agencies, and opiate users themselves, there appears to be a lack of research and data on the ways that it has or has not been embraced by the staff of more traditional, recovery-oriented programs.

This is significant because these programs offer a valuable opportunity to reach opiate users in an environment that is more structured than a typical street outreach or drop-in center contact. Most detox, inpatient treatment, and recovery housing programs require their patients to attend a regular schedule of groups and classes, and integrating OEND into this schedule would ensure that the trainers have a physical space in which to conduct demonstrations and enrollments, a set time in which to conduct the training, and a regular time and place for trainees to participate—all of which may be lacking in more informal training settings. Furthermore, recovery-oriented programs serve a broader demographic that includes individuals who have stopped or intend to stop using opiates (Koutrolis, 2000), and who may not choose to visit the social and physical settings where active users are more likely to be found. However, a lack of staff buy-in may hamper efforts to expand naran training into these types of programs. Learning more about how these staff members assess the integration of naran training into their programs could improve the situation in two ways: first, by revealing areas where further



training or resources would benefit them, and second, by suggesting ways that the narcan distribution and training staff could improve their relationships with the programs that host them.

## CHAPTER V

### RESEARCH OBJECTIVES

In my experience as a needle exchange staffer and program manager I have encountered a broad spectrum of reactions to the idea of offering naloxone training in substance treatment settings. These reactions influence the ease or difficulty with which the initial training may be scheduled, the amount of interest or disinterest with which staff participate in the training, the extent to which they do or do not encourage patients to attend patient trainings if they are offered, and the ease or difficulty of organizing further trainings, naloxone distribution, or other follow-up meetings. I decided to explore this issue further by conducting a study that addressed the following research questions:

1. Was the integration of OEND into recovery-oriented programs disruptive or controversial? If so, why?
2. Did recovery-oriented program staff find it difficult to reconcile the harm reduction philosophy underlying OEND with their personal and organizational philosophies around substance use and recovery?

## CHAPTER VI

### METHODS

This research project used a qualitative methodology, based on the principles of descriptive phenomenology. This approach seeks to distill the essence of a phenomenon by analyzing the description of individuals who have experienced it, and it has been found especially useful when the phenomenon of interest has not been previously studied, or has been only incompletely analyzed (Wojnar & Swanson, 2007). Since there is currently very little published research on the integration of naran and overdose prevention into addiction treatment settings, the choice of descriptive phenomenology seemed appropriate here. This methodology is based on the assumption that “there are features to any lived experience that are common to all persons who have the experience” (Lopez & Willis, 2004, p.728), and this study will use the lived experience of addiction treatment program staff as a window to learn about the underlying phenomenon of integrating overdose prevention and harm reduction into recovery-oriented treatment programs. However, in light of the opiate overdose crisis facing many countries today, learning for its own sake is not the final goal of this study. Hopefully, its analysis will help to inform future research and program planning efforts as well—a goal to which descriptive phenomenology is well-suited (Wojnar & Swanson, 2007).

The integration of OEND into addiction treatment settings is experienced by at least two distinct populations: the staff of the programs in question, and their patients. However, conducting ethically sound research with patients (many of whom also belong to other vulnerable populations) is beyond the scope of this project. Furthermore, the Massachusetts Department of Public Health and OOPPP indicated that they would not support my attempting such research at this time. Therefore, this study’s subject population consisted of treatment

program *staff* only. Furthermore, since descriptive phenomenology dictates that researchers learn about a phenomenon through those who have experienced it, this study restricted its sample to treatment program staff who had themselves experienced the integration of OEND into their programs. In other words, subjects were drawn from settings falling under the first two categories of Walley et al.'s taxonomy (2013)—those in which the treatment program staff were trained to provide OEND directly to their own patients, and those in which they hosted outside trainers from OOPPP programs. It excluded treatment programs that exclusively referred patients to other locations for narcan distribution, and where OOPPP programs conducted outreach or recruitment, but did not actually provide OEND.

Since this study's research questions both addressed the issue of whether the experience of OEND integration was a positive one, it used a purposive deviant sampling strategy based on how smoothly OOPPP staff and trainers felt that the integration process went. This allowed the final analysis to incorporate perspectives from staff whose programs embraced OEND (on an operational level, at least), as well as those whose programs resisted it or found it logistically difficult to adopt. This approach allowed the study's analysis to develop a broader and richer understanding of the phenomenon, to "uncover [...] the boundaries of difference within [the] experience", (Polkinghorne, 2005, p.141), and to "illuminate subtle but potentially important differences" (Barbour, 2001, p.1116) between the purposive sample's sub-groups.

Although ideal qualitative sample sizes cannot be computed the same way that quantitative ones can, there does appear to be a general consensus that descriptive phenomenological studies can obtain useful data from relatively small samples (Maggs-Rapport, 2001; Omery, 1983). In fact, some research suggests that such studies may reach

saturation—the point at which adding more data does not help researchers to develop new categories, or to further refine the properties of those they have already identified—with sample sizes of a dozen or less (Guest et al., 2006; Starks & Trinidad, 2007). Morse (2000) states that studies with relatively narrow scopes may expect to reach saturation using smaller samples. With that in mind, this study’s planned sample size was to be ten individuals, interviewed one time apiece. Analysis of the interviews suggested that this was enough to achieve saturation: several important themes appeared in all or nearly all the interviews, and many themes were present in a solid majority of them. Even when themes encompassed different perspectives, there was enough overlap between the subjects’ experiences for them to confirm and complement one another. Based on this analysis, I would have expected that adding more data (without altering the study’s sampling or selection process, as discussed below) would have tended to confirm and reinforce the themes that were already appearing consistently.

The sample was assembled as follows: each OOPPP program was asked to list the treatment settings in which it conducts OEND trainings *or* where it has trained local staff to conduct them, rating each one on a 1-3 scale according to how smoothly it integrated OEND. The scale was intended to highlight the positive and negative extremes of the potential subject pool, in accordance with purposive sampling practice:

1. The program requested OEND and was supportive of OOPPP staff
2. The program did not actively request OEND but was not resistant to it
3. OOPPP staff had to reach out to the program several times before they agreed to host OEND, and/or found it challenging to collaborate with them

I then reached out to potential subjects in order to assemble a ten-person sample. The intent was to make sure that both extremes were represented in the study's sample, so I attempted to include at least three staff from programs that were rated "1" on the scale above, and at least three from programs that were rated "3." In practice, this was somewhat challenging as a majority of the contacts I was given by OOPPP staff fell under the first category, which made it difficult to schedule interviews with subjects from the second and third categories. In particular, only 3 programs were identified as "challenging," one of which did not respond to participate, even after I made several attempts to contact them. Ultimately, the sample consisted of 7 subjects from "supportive" programs (category 1), 1 subject from a "neutral" program (category 2), and 2 subjects from "challenging" programs (category 3). This may represent a limitation of the study, and will be discussed at more length in a later section.

## **Instrument**

This project's data collection instrument was an open-ended interview protocol. It consisted of 11 main questions; follow-up prompts were sometimes used depending on the depth and detail of the subject's initial answer. The questions were sequenced to begin with a background question, and then to proceed from concrete questions about the present, to concrete questions about the past, and finally to more reflective questions.

1. What kinds of experience have you had in the substance abuse and addiction field?
  - a) What positions have you held at [your program]?

2. How do narcan trainings happen at your program? [If the answer does not appear to fit into the five categories outlined in Walley et al., 2013 and cited in the Literature Review section, subject will be asked to elaborate]
  - a) How does [your program's] staff decide when to schedule a narcan training?
  - b) Which members of [your program's] staff and patients go to these trainings?
3. What do the outside trainers do when they run a narcan training at [your program]?
4. What is *your* role when a narcan training happens at [your program]?
5. Think back to the time before [your program] started hosting narcan trainings. What made [your program] decide to start hosting narcan trainings?
  - a) What did you see as the pros and cons of narcan training before it started happening at [your program]?
  - b) What did you expect from the first narcan training at [your program]?
6. How did the first few narcan trainings go?
  - a) What concerns did [your program's] staff have about those first few narcan trainings?
  - b) What benefits did they see in hosting narcan trainings?
  - c) How did your clients feel about those first few narcan trainings?
7. How are [your program's] narcan trainings going these days?
  - a) How would you say [your program's] staff feel about narcan training now?
  - b) How would you say your clients feel about narcan training now?
  - c) How have these trainings affected your program, either positively or negatively?
8. What are your goals when working with clients at [your program]?

9. How does harm reduction relate to your work at [your program]?
10. Think about different kinds of harm reduction, like safer injection training, encouraging drug injectors to switch to non-injection use, methadone and suboxone treatment, needle exchange, safer injection rooms, or drug decriminalization.
  - a) How do you feel about these things?
  - b) What differences do you see between them?
  - c) Which ones would you refer your clients to?
11. Is there anything that you would like to add about your experience integrating harm reduction and narcan training?

### **Analysis: Theory**

In addition to looking for shared elements and commonalities among these subjects' experiences, the analysis was alert for variations between them in order to explore the ways that overdose prevention training has been experienced differently among members of the subject population. The descriptive phenomenology approach was chosen because, in the absence of pre-existing research or analysis on this specific topic, it seemed most fitting to take an open-ended look at the conceptual landscape before committing to a more closed, quantitative methodology (Wojnar & Swanson, 2007).

One central element of descriptive phenomenology is the process of suspending or *bracketing* prior beliefs or understandings that the investigator attaches to the phenomenon being studied. This is done in order to help them remain open to whatever meanings emerge from their subjects' narratives, rather than forcing them to fit pre-existing theories or interpretations (Hycner, 1985). Bracketing must be an ongoing process throughout this type of



phenomenological investigation (Wojnar & Swanson, 2007). During the planning, interviewing, transcription, and analysis phases of this study, I maintained a reflective research journal in which I noted my own preconceptions and reactions concerning OEND, addiction treatment and recovery, ways that I might have influenced subjects' responses, and any other issues that arose.

### **Analysis: Process**

I digitally recorded the interviews. Immediately after each interview was complete, I used my research journal to record any significant information that might not have been captured on the audio recording—interruptions, time constraints, non-verbal communication, or deviations from the normal interview protocol. In addition, I made note of any of my own preconceptions or assumptions that may have come to light as a result of the interview. These journal entries were used to facilitate accurate transcription, to give a stronger sense of the meanings being conveyed, to improve my analysis of the narrative, and to ensure that bracketing remained an ongoing part of the process.

Next I transcribed each interview verbatim, appending any notes taken after the interview. When each transcription was complete, I re-read it as a whole, re-listened to the original recording, and re-read it while listening to the recording. At this stage the intent was to get a general sense, or “gestalt” (Hycner, 1985) of the meaning(s) being conveyed. I continued to record my observations and impressions in my research journal, along with any of my own preconceptions or assumptions that may have come to light.

Before starting the coding process, I entered the interview transcripts into the QDA Miner qualitative analysis package. I used this software to track and record codes, and to cross-

reference them between interview transcripts. I coded the interview transcripts using an iterative process, first by open-coding to look for recurring and salient themes, and then by re-coding them once I had developed a final list of coding categories (Hycner, 1985). As I created, combined, and eliminated categories I documented my decision-making process in my research journal. In doing this I focused on building a picture of how the subjects had experienced the process of incorporating naloxone distribution into their work. To do so, I used information that they provide explicitly (for instance, in response to questions 6 or 7), but I was sensitive to the language that they used when answering questions that addressed the topic less directly (such as 3, 4, 8 or 9).

### **Analysis: Establishing trustworthiness**

Guba (1981) suggests that the “trustworthiness” of qualitative research be assessed in terms of how well it fulfills four criteria: *truth value* (i.e. how accurately it depicts the experience of its subjects), *consistency* (i.e. the extent to which the study’s results would be similar if it were repeated with other subjects in a similar setting), *neutrality* (i.e. the extent to which the study’s results are a function of its subjects’ experience, and not its researchers’), and *applicability* (i.e. how well its findings can be used to understand the experiences of other subjects in similar settings). Some strategies for establishing trustworthiness along the first three axes include member checking and peer debriefing (for truth value), maintaining an “auditable” diary of research decisions (for consistency), and reflexively documenting the bracketing process (for neutrality) (Guba, 1981; Hycner, 1985; Moore et al., 2002; Wojnar & Swanson, 2007). The fourth axis, applicability, may be “more the responsibility of the person wanting to transfer the findings to another situation or population than that of the researcher of

the original study”—the original researcher’s job being to provide enough descriptive detail to make this transfer possible (Krefting, 1991).

I established this study’s truth value by debriefing and discussing category coding with a fellow researcher who has experience with qualitative research, in order to test my perceptions and open my interpretations to their questions (Guba, 1981; Hycner, 1985). The researcher in question was Jenn O’Neill, a licensed MSW and current PhD candidate at Lesley University. She has worked on qualitative research projects in the past, and was an AIDS Action Committee program manager during the time I was managing the Cambridge Needle Exchange. She served as interim supervisor for the needle exchange staff after my departure, and has a good deal of experience around opiate addiction and overdose.

In addition, I conducted member checks with two of the ten subjects after their interviews have been transcribed and coded, in order to make sure that the themes I have derived from their interviews have faithfully captured the essence of their experience (Guba, 1981; Hycner, 1985). In both cases, they reported that my summaries felt accurate to them. I established consistency and neutrality by maintaining a research journal to document the initial assumptions I had bracketed before beginning to conduct interviews, my subsequent reactions to the interviews themselves, and my decision-making process as I created, combined, and eliminated coding categories (Krefting, 1991). I also used this journal to document the feedback I received from peer researcher debriefings and member checks, and to track the ways I incorporated this feedback into my ongoing analysis.

Finally, I made sure that it was clear at all stages that my intent was not to “evaluate” the programs whose staff I interviewed, nor to report the material details of how they have implemented overdose prevention training. I discussed this with each subject before beginning

the interview, and with other staff or supervisors with whom I spoke in the process of scheduling the interviews. I emphasized that all data included in my final analysis would be stripped of personal and program names, as well as any details that might identify a particular individual or program.

When my analysis is finalized, I will present the results at a quarterly meeting of the Massachusetts OEND pilot program. I will also create a more streamlined write-up of my results that is suitable to be shared with the staff at the programs where my subjects work, or even with those working at other treatment programs with an interest in OEND.

## CHAPTER VII

### RESULTS

Ten subjects were interviewed. There were 7 women and 3 men, with 1-26 (average 9, median 5.5) years' experience working in the addiction field. The analysis process uncovered 4 broad thematic domains in the interview subjects' experiences, each of which encompassed several parallel or contrasting themes:

<b>Thematic domain</b>	<b>Themes</b>
What is overdose prevention training?	Overdose prevention training is education
	Overdose prevention training is a narrative
What is narcan?	Narcan undermines recovery
	Narcan is part of a regular life routine
	Using a narcan kit is frightening
	Narcan saves lives
What is harm reduction?	Harm reduction means using drugs more safely
	Harm reduction is a means to an end
What is the goal of treatment?	The goal of treatment is abstinence
	The goal of treatment is survival
	The goal of treatment is up to the client

When I have quoted them below, I have referred to them by number based on the order in which they were interviewed.

#### **Subjects' perception of overdose prevention trainings: Overdose prevention training is education**

This theme was the only one to be recorded at least once in every interview. Subjects generally mentioned it in a neutral, factual manner.

Clients leave here with [...] new information, upgraded information. -S10

I think that they appreciated, you know, the information. -S7

However, two subjects returned to this theme again and again, in one case 18 times in the course of the interview. For them, the notion of overdose prevention training as education is of great significance.

So I think *the biggest thing* is definitely the education the clients get. -S1, emphasis added

And for one particular subject, this kind of education is seen as a societal good that transcends the narrow setting of the training sessions and their specific audience of addiction treatment program clients.

And I think education is really important. And I'm glad to see, like I said, it's starting to come out on the TV and stuff like that. -S3

We need a lot of education. You know, I talked to one of the police officers—we went to [...] drug court graduation—and he says, you know, he's big on helping parents and educating them, which I think is wonderful. -S3

### **Subjects' perception of overdose prevention trainings: Overdose prevention training is a narrative**

In contrast, this theme was not as widely recorded, and was not mentioned as often among those subjects who brought it up. However, it elicited detailed responses from a few subjects:

We had one instance where [the client] left the facility, went right up to Dunkin Donuts, and used [a narcan kit]. Cause she found somebody in the bathroom. Right up the block. [...] So *that kinda hit hard* for the people that were sitting in the group, it was nice. -S8, emphasis added

[The trainer] really goes into detail, he's really good about: 'Let me get through all this information and then ask the questions after.' [...] Our clients, not that it's a bad thing, but some get very open, and they feel like they *need* to disclose information, so if he starts *getting off track* you have all these different conversations going on. -S8, emphasis added

The trainings are seen as proceeding along an educational “track,” but with the ever-present risk of being derailed by narrative and storytelling. While this can impede their educational function, it may also have positive value if it elicits an emotional response in the training participants.

The notion of narrative overlaid on top of education was articulated more explicitly by another subject:

I thought it was gonna be *just*: I'm gonna educate them, and it might be that I would be lecturing and they would be sitting, listening. And it's not like that at all. -S2, emphasis added

They don't *just* sit like they're bored—they wanna talk about the losses that they've experienced in their lives and the people they knew that have overdosed. -S2, emphasis added

This repeated use of the word “just” suggests a contrast between the overdose prevention trainings' baseline educational component, and the narrative component that allows them to rise above that baseline (and the boredom that it entails).

### **Subjects' perception of narcan itself: Narcan undermines recovery**

While this theme was recorded in a majority of the interviews, it was typically addressed obliquely and not as something that directly characterized the subjects' own current perception of narcan. For instance, for some subjects the idea that narcan might undermine recovery was relevant not primarily because *they themselves* thought it was true, but because they knew that other people did.

It's interesting to bring [narcan] into a program where people aren't supposed to be using drugs. But some do. So a lot of patients were like, 'Well why are you giving me this? I don't use drugs anymore!' -S7

I think the only negative thing is about, you know, just the perception of [narcan] and, you know, if it undermines their recovery or not. Some people think it might undermine it. -S1

Other subjects brought up this theme as something that had shaped their perception of narcan in the past, but that was not part of their current view.

I did think [before being directly exposed to narcan trainings], 'I wonder if this isn't a good program, because does it encourage them to wanna go out and use opiates with their friends, knowing that they have a way to bring back or resuscitate a friend that...overdosed?' Now that I know more about it and I'm more educated, and I talk to the clients weekly about it I realize that it's saving lives. I no longer feel ambivalent about it, I feel strongly that it should be in the hands of those that use drugs, and it should be back at the homes of their families, and I completely—now that I know more about it—am a total advocate for it. -S2

In fact, some of the subjects who mentioned that they had *previously* seen narcan as something that undermined recovery explicitly argued against this notion based on their *current* perception of narcan.

At first [...] you think you give [narcan] to 'em, you give them the okay to use. Well you know what, that's ridiculous. They're gonna use if they're gonna use. -S3

When we first started [narcan trainings] back in 2008, some of my behavioral health staff were a little leery about it because they felt that we were enabling people to use by making narcan available. ["And how did those first few trainings go?"] They went fine because once they got the information they opened their eyes to the flipside of it. And it's not, you know, we're not trying to—I mean, people are gonna use no matter what. People aren't thinking 'Oh gee, it's okay for me to use now because I know there's narcan hangin' around.' -S4

### **Subjects' perception of narcan itself: Narcan is part of a regular life routine**

When this theme appeared, it was often in very personal and immediate terms. In fact, nearly half of the interview subjects volunteered that they personally carried narcan with them outside of professional settings.

I carry it in my glovebox all the time. -S9

I even have narcan in my truck, I have narcan at my house. So if something happens I have narcan. -S10



For several subjects, this attitude carries over into their interactions with clients, who they also encourage to incorporate narcan into their lives whether or not they are actively using opioids.

I tell the clients that [...] 'if you can carry your drugs on you, why not carry the narcan?' -S1

At one point, before we knew much about it we didn't allow it but we definitely allow it now and [...] even if they don't wanna sign up we're kinda like 'You know, you might be at a stoplight, you could help somebody.' -S3

### **Subjects' perception of narcan itself: Using a narcan kit is frightening**

This theme was also fairly common, appearing in half the interviews—generally among the subjects who did not report carrying narcan on their person outside of work. The main source of fear and anxiety tended to be the narcan kit itself. This was partly because it superficially resembles a syringe, which the subjects strongly associated with injection drug use.

At first we were a little wary about it, cause it's new and it looks terrible. I mean it looks like a syringe. -S3

My first thought was, 'Oh, it's a shot? We're not gonna give a heroin addict needles!' -S8

In addition, some subjects saw the narcan kit as intimidating in its complexity, especially as they imagined trying to assemble it under the stressful conditions of a real overdose.

[The narcan kit] looks a little intimidating I guess—put yourself in a situation, you know. I think it could be a lot easier to use. ["How so?"] I just feel like there's a lot of little things you have to do, you know, put certain parts here [...] I just feel like maybe in a situation with something going on like that, myself I'd be really shaky, and like, you know, trying to rush. And, you know, if it all came together already I just think it would be a lot quicker. But I've never had to use narcan on anyone. So I don't know really how it is in that situation, it's just me imagining. -S6

I think in the back of everybody's mind even including myself: 'God forbid I have to use it,' and 'I'm not confident using it,' and you know, fear is there. Because, number one, because of how you have to put 'em together and everything—you have the mechanics of what's involved before ever hittin' somebody up with it. -S9

Not only is the narcan kit itself frightening due to its complexity and resemblance to a syringe, but several subjects were afraid that opioid users would react with anger or hostility after being given narcan.

I also let 'em know that when you take them out of that overdose, they can be angry. And they can be violent so you have to be careful with that. -S3

I have heard from clients before that when they're narcan-ed they get mad. Because their high goes away. -S6

### **Subjects' perception of narcan itself: Narcan saves lives**

This theme appeared frequently and in most of the interviews. In some cases it referred to specific, concrete events.

I saw a client on the outside and they told me, 'I died and like, I got brought back because of narcan.' -S5

I had a client this morning who was here prior, he got the narcan here and before he left the program he said he ended up using with a friend, actually somebody that he met here. The friend overdosed, he had the narcan on him, hit him with narcan, saved his life. [...] I also shared a story with a client: I know this lady who's a social worker, who was leaving the gym and she seen this lady in the parking lot, shaking her husband and he was overdosing. She had narcan on her cause she was recently trained, she had a narcan in her car—hit him with narcan, saved his life. -S1

At the narcan group yesterday when two clients raised their hands and said, 'Can I talk to you? That narcan you put in my suitcase, I saved my little brother.' -S2

It was notable that even when they described narcan saving a particular life, the subjects were speaking about an overdose reversal that had been performed by a client, a friend, a co-worker, or a casual acquaintance—none of them described a situation in which they were the one to use narcan on an overdose victim.

Several other subjects emphasized this theme with no reference to a particular life-saving incident. For them narcan saves lives, and has the potential to continue saving lives, primarily in the abstract.

[Narcan] saves lives. I mean it kinda speaks for itself, it's a no-brainer as far as I'm concerned: it saves lives. -S9

While you're in the program, you're gonna get this training, and you're gonna get this medication that you can use to save someone, or someone can use to save you. -S7

[Clients] leave here with the opportunity, even though they hope they don't have to use it, to save one of their peers' lives. -S10

### **Subjects' perception of harm reduction: Harm reduction means using drugs more safely**

Although this was a less common theme, it did appear in over half the interviews. Some subjects acknowledged it indirectly, by providing examples of the kinds of advice they give to their clients:

So I educate them as part of the narcan training, 'If this is not your last detox, and we hope to see you again—if this isn't it for you, there are things you can do to protect yourself from overdose before narcan might have to be used on you. Such as: don't use the amount that you used when you leave here. Use a tester shot. Know your drug dealer. Know that what you buy in the streets, what it is. Um, know and trust your drug dealer.' -S2

I'll let them know, 'You know you should have the non-emergency line in there. That way you're not having police involvement. [...] You know if you don't wanna call the police you can the ambulance instead. And if you do call the police you should just tell 'em that they're not breathing. That's it, you don't have to say anything else.' -S3

They may not explicitly tie these examples to a broader philosophy of harm reduction, but that philosophy is implicit behind their attempts to help their clients use opioids more safely, by avoiding hazards such as overdose and contact with police officers. Other subjects expressed

their views on this theme more directly, with one of them even using the harm reduction trope of “meeting people where they are at”:

I mean, I think that you have to meet people where they're at. So, some people aren't ready to stop using drugs, so if we can help them use in a safer way, then that's a step in the right direction. -S7

[Harm reduction] is just integrated into [the work we do here] because we realize that, that people are gonna, people are gonna relapse—it's gonna happen. And our responsibility is to provide 'em with the tools and the resources they need, that if they do relapse, they don't die. -S4

I just have come to see [harm reduction] as *an integral part of what we do*. I don't think we can do treatment without some degree of focus on, on harm reduction. -S4, emphasis added

### **Subjects' perception of harm reduction: Harm reduction is a means to an end**

This theme was even less common, but was interesting for being closely tied to the more direct and explicit endorsements of harm reduction described above.

Sometimes we use, we use the harm reduction model with patients who need to come to the clinic, and so we kind of use the suboxone program as a way to get them in here for their other care. You know, for patients who are HIV positive, who need to see an infectious disease doctor, who need medication adherence counseling. So we'll kind of use, use the program to our benefit in that way. [...] They wanna come for suboxone, cause they know they're gonna get the suboxone. They don't wanna come and see their infectious disease doctor, if they're not getting anything out of it. -S7

I think harm reduction has its place even in abstinence-based treatment cause the reality is, people relapse and we need to keep them alive. And *that's all we're trying to do at this point*: keep 'em alive so we can get 'em into treatment. -S4, emphasis added

Whether the end goal is a broad one like “get clients back into treatment” or a more specific one like “get clients connected to medical services that they wouldn't be motivated to seek out on their own,” here harm reduction is perceived as a tool that helps the subjects to achieve goals other than reducing the harm of opioid use. It was striking that this theme was most clearly

articulated by the same subjects who had most strongly expressed positive views of harm reduction in the broad, philosophical sense.

### **Subjects' perception of addiction treatment: The goal of treatment is abstinence**

This was a common theme, and appeared in nearly all the interviews. In many cases the subjects acknowledged that they saw the goals of treatment as being complex and multi-faceted, but went on to assert that abstinence occupied a privileged place as the most important goal, or the most consistent, or the one that had to be in place before others could be addressed:

I can't micromanage them but I can offer them all the support, aftercare in whatever community they live in—I will call veterans' groups if it's a veteran, I will call anyone I know with a contact anywhere to help them. Call someone at an AA meeting, 'Can you meet them at this group, cause they're afraid to go into a new group.' *The best call I ever get* is when someone calls back to say, 'Will you come see me get my [AA] medallion?' -S2, emphasis added

In the back of my mind, I don't know if this is wrong or right, but I *always* have the ultimate goal of total abstinence [...] But if it's not their goal, it doesn't fly. But that's *always* the hope: to have a drug free, um, dependence free lifestyle. -S9, emphasis added

I mean, the big picture is we want them to, you know, abstain from drugs and, kind of, become more active participants in the community. So we really encourage people, like when they're doing well, like, 'Well how about, you know, we start looking for employment, or volunteering, or, um...' You know, so those are our goals: for people to get clean, *and then*, like, be able to better themselves other ways. -S7, emphasis added

In some cases the subjects so strongly saw abstinence as the primary goal of treatment that they discouraged clients from seeking out harm reduction resources that they felt might undermine it:

I believe that if you're gonna be clean, be clean. But again, [suboxone] works for some people. Some people can do it and some people cannot. So...Again I'm open for anything that works for you. I would like you to try this road first, this clean road with nothing. Drop the suboxone, drop the methadone if you can—try that first, you know? -S3

I personally don't agree with teaching somebody, you know, different ways to, you know, shoot up or, you know, use needles like that. I don't agree with those things, I kinda feel like we're telling them, it's like an enabler I guess. -S6

There are places we refer clients to that are harm reduction programs, that they aren't as strict and structured and they don't get urine tested. And some clients wanna go out cause they figure, 'Oh I'll use but not as much.' And I hesitate to send clients to some of those programs, because I feel like I'm setting them up for failure rather than success. -S2

### **Subjects' perception of addiction treatment: The goal of treatment is survival**

Just over half the subjects saw the goal of addiction treatment as being, in part at least, to help clients stay alive even if they were not able to maintain abstinence:

But if they don't have [access to clean syringes], they may die. And let's give them something to keep them safe for that day, the next couple days, until they realize what they need. -S8

Keep 'em sober, keep 'em safe. Um, educate them. Let 'em know there's help, if they need it. Um, if they relapse it's not the end of the world. We can help. You know, come back, let us know, call us, tell us—we'll help you. They always worry that, you know, when they relapse we're mad at them. I'm like, 'We're not mad at you. You know? We wanna help you.' -S3

For most subjects, this theme appeared alongside the previous one (that the goal of treatment was abstinence). Some alluded to a hierarchy of goals in which abstinence was ranked more highly (as described above), but for others the two goals coexisted without either one being prioritized.

### **Subjects' perception of addiction treatment: The goal of treatment is up to the client**

Half of the interview subjects brought up this theme. As was the case with the previous theme, when the notion of client-set treatment goals was mentioned, it was usually contrasted with the subject's view that the proper goal of treatment was sobriety.

In the back of my mind, I don't know if this is wrong or right, but I always have the ultimate goal of total abstinence [...] But if it's not *their* goal, it doesn't fly. But

that's always the hope: to have a drug free, um, dependence free lifestyle. -S9, emphasis added

We're very client-centered in our treatment. So...*it's really about their goals, not ours*. Um...and what they're looking for. And the needs of the population that we serve are so complicated, so much more complicated than they used to be years ago. [...] I mean there's just like a whole laundry list of things, and the challenge in treatment and what we want to help clients do is to learn to prioritize what comes first, and tackle each piece step by step. Obviously we wanna encourage them to be abstinent but we can't make that decision for them, so it's really about, our treatment focus is really about personal empowerment. -S4, emphasis added

I think they're just different levels [...] Teaching someone to, you know, clean their needles is different, you know, that person's just at a different level than someone being on methadone or suboxone, ready to stop using drugs altogether. -S7

## CHAPTER VIII

### DISCUSSION

#### **What is overdose prevention training?**

Although they took place in a range of settings, involving different client populations and staff with widely varying degrees of experience, the overdose prevention trainings themselves were consistently experienced as an educational exercise first and foremost. This is not surprising, given the trainers' need to convey information and key concepts within the time and logistical constraints of treatment programs such as these. However, some subjects also experienced these training sessions as a space where clients and staff shared and processed their experiences surviving overdose, rescuing others from overdose, and losing friends and loved ones to overdose. Some subjects felt tension between the trainings' educational format and their clients' desire for narrative communication and emotional catharsis. However, even when they described this as filling a *need* that education alone could not, they did not discount the value of education. Rather, education was seen as the foundation of overdose training, and narrative as the element that strengthened and filled gaps in that foundation.

#### **What is narcan?**

Subjects perceived narcan itself in many ways, some of which appeared to be at odds with each other. For instance, the narcan kits themselves were intimidating and complex to many, and the process of using them was imagined to be frightening, but narcan was also seen as something that should be part of everyday life—carried not just by active injection drug users, but by anyone who might come across an overdose in any public location. Narcan is seen as life-saving, but also as something that can easily be misconceived as promoting drug use.



Significantly, compared to the other themes found in this study, the subjects experienced narcan through a lens of external and indirect factors—memories of their own past opinions, assessments of other people’s beliefs, hypothetical fears, and accounts of other people’s experiences. Their own direct experiences with the kits themselves, with overdose reversals or as overdose victims, were presented as a relatively small piece of the picture. Perhaps this theme’s inconsistencies are a result of this lack of firsthand experience administering or receiving narcan in an actual overdose situation.

### **What is harm reduction?**

When the interviewer mentioned a range of harm reduction strategies, some subjects responded in broad emotional terms, with little or no emphasis on their particular experience or reasoning. This general emotional reaction could be negative:

I am not a fan of it. –S5

I mean I just feel like when you're teaching them things like that, we're just showing them new ways, you know, do you understand what I'm saying? [...] I don't even know. I just, I don't know—I'm just not a fan of things like that. I feel *those are negative things* I guess. –S6, emphasis added

But it could also be positive:

[“What sorts of differences would you see between these different types of harm reduction strategies?”] I really don't see any differences, I'm seeing a lot of similarities. I mean, it's all like I said: it's all a form of reducing harm. *It's a beautiful thing*—nobody's out to hurt anybody, we're all trying to help keep folks alive. So it's a common bond and that's what stands out for me, is not—I don't see any differences. –S9, emphasis added

While some subjects painted harm reduction with a broad brush as “negative things” or “a beautiful thing,” others recounted a more specific experience of the concept as it related to their work. They understood and implemented harm reduction as a way to help their clients

remain safe (from physical harm, from incarceration) while they continued to actively use drugs. Even when this philosophy was not explicitly articulated, it was clearly implicit in the interactions that these subjects described having with their clients, both in and outside of overdose prevention training sessions. Keeping clients safe and alive was presented as the self-evident end goal of harm reduction, but sometimes it also served as a way to accomplish additional goals, such as getting clients back into treatment or connecting them with medical care. In other words, they experienced harm reduction as an integrated part of treatment, rather than as a discrete safety-providing mechanism that could be added or subtracted from their work.

### **What is the goal of treatment?**

Clients' abstinence from drug use was strongly felt to be the primary goal of treatment. However, many subjects also acknowledged other goals, such as helping clients to remain safe and alive, or supporting goals that the clients set for themselves. When subjects felt that these goals were in conflict, abstinence was often the priority. Even when they had otherwise expressed support for harm reduction, they did not see it as something that could be weighed against abstinence—the conflict was essentially one-sided, with abstinence the a priori winner. In a sense, they did not experience the conflict between goals as a “conflict” at all, since the outcome was a foregone conclusion. However, there were times when the goals of treatment were seen as less hierarchical, with clients' safety, sobriety, and self-determination as mutually complimentary rather than opposed to one another. *To some extent*, this perspective was more characteristic of subjects who had a more integrated view of the relationship between treatment and harm reduction (see “What is harm reduction?”, above), but the two themes did not overlap exactly.

## CHAPTER IX

### LIMITATIONS

When assembling a sample population, my original intention was to strike a balance between subjects who came from programs that seemed to be supportive and receptive to OEND, and those who came from programs for whom OEND had not been as smooth a fit—in other words, to sample purposively in order to capture a range of perspectives. This intention was to be implemented by asking the OOPPP contacts to place each of their partner programs (i.e. the sites where they conducted OEND training sessions, and from whose staff my sample population would be drawn) in one of the three following categories:

1. The program requested OEND and was supportive of OOPPP staff
2. The program did not actively request OEND but was not resistant to it
3. OOPPP staff had to reach out to the program several times before they agreed to host OEND, and/or found it challenging to collaborate with them

When I reached out to potential subjects, I attempted to include at least 3 from programs that were rated “1” on the scale above, and at least 3 that were rated “3.” Unfortunately this proved to be impossible, because a majority of the contacts I was given by OOPPP fell under the first category, while only a small minority (3 total) fell under the third. The final 10-subject sample included 7 subjects from the first category, 1 from the second, and 2 from the third.

Technically, this is very close to my stated goal: if a single subject from the first or second category was replaced by one from the third, the final sample would have met the criteria established at the outset. However, it is difficult not to see this sample as strongly skewed

towards programs supportive of OEND, according to the spirit as well as the letter of my sampling strategy.

I suspect this may have been caused in part by self-selection, whereby programs whose leadership and/or institutional culture were most supportive of OEND were more likely to host trainings more often and build relationships with OOPPP staff, which led them to be disproportionately represented in my pool of potential subjects. Conversely, programs that resisted OEND may have self-selected out of that potential subject pool by hosting trainings irregularly or infrequently, and failing to establish the kinds of relationships that would have led my OOPPP contacts to suggest them as interview subjects. It is also possible that programs which found OEND challenging for logistical reasons (such as understaffing or staff turnover) found participation in this study challenging for the same reasons—while no programs declined to participate outright, there were several with whom I was unable to make contact after repeated attempts, or with whom I was not able to schedule and conduct an interview even after establishing contact. In fact, this was the case with the one “challenging” program whose staff I did not interview. Finally, although I did my best to make it clear that I did not intend to judge or evaluate the programs they were putting me in touch with, it is possible that my OOPPP informants were reluctant to place an arguably negative label like “challenging” on a program with which they were collaborating. This could have resulted in a programs being described as more supportive than they actually were, and made it difficult to assess how well my purposive sampling protocol had actually been implemented.

In hindsight, there are several strategies that might have mitigated the above limitations of my study. For instance: I could have recruited subjects from programs that had previously hosted OEND but were no longer doing so, in the hopes that this would give me a larger pool

of potential subjects from challenging or OEND-resisting programs. I could have provided individual- and/or program-level incentives in order to make participation more attractive to programs facing staffing or organizational challenges. And finally, I could have framed my sampling strategy differently, in order to avoid making key informants feel less like they were passing judgment on their collaborators. Unfortunately, it was not possible to employ any of these strategies “on the fly” as I was conducting this study—the first would have represented a significant change in the study, the second would have required resources that were not at my disposal, and the third would not have been effective once my informants’ perception was colored by the (perhaps loaded) way the question was initially asked.

## CHAPTER X

### CONCLUSIONS

My first research question was “Was the integration of OEND into recovery-oriented programs disruptive or controversial?” Based on analysis of these interviews, I have concluded that these subjects have *not* experienced the introduction of OEND as disruptive. On the few occasions when they did mention disruption, the subjects felt that their clients’ need for catharsis and personal engagement were not being met by the trainings’ over-emphasis on strictly educational content. They did not experience this as a failure of the trainings (or trainers), or as poor conduct by their clients, but rather as an opportunity to *enhance* the trainings by strengthening their narrative component. Future OEND programs may benefit from explicitly acknowledging the importance of narrative, and creating space for staff and clients to share personal experiences and real-world examples to illustrate and complement their more traditional educational content.

The subjects also did not experience OEND training as a controversial topic. When they did allude to controversy, they situated it outside of their own current experience—either a thing of the past, or a characteristic of other people’s beliefs. These controversies were resolved by the subjects and/or their coworkers gaining a greater understanding of the issues around naran and overdose, or by conversations in which the subjects successfully defended OEND to skeptics. This suggests that even in situations where OEND seems controversial in the abstract, the controversy may dissipate once staff members have gained a better understanding of the underlying issues, and have seen the training and tools provided firsthand. Communities and programs that are considering the adoption of OEND can take comfort in the fact that whatever controversy they initially face is unlikely to be deep-seated or long-lasting.

My second research question, however, was more challenging: “Did recovery-oriented program staff find it difficult to reconcile the harm reduction philosophy underlying OEND with their personal and organizational philosophies around substance use and recovery?” Although they overwhelmingly supported OEND itself, and tended to speak positively of “harm reduction” in a non-specific sense, many subjects engaged with harm reduction (as a philosophy, but also as a set of strategies) in fairly limited ways, especially when it threatened to encroach on the notion of abstinence as the primary goal of treatment. In these situations, they tended to unilaterally prioritize abstinence. Some experienced this as an emotional conflict, and expressed negative views of harm reduction in this context; others simply took for granted that harm reduction would give way to abstinence, but did not hold any negative feelings towards it. In both cases, it seems that these subjects did indeed find it difficult to reconcile harm reduction with their personal beliefs about abstinence—or perhaps, that they did not feel as if the two needed to be “reconciled” at all, since it was a foregone conclusion that abstinence-oriented philosophies and practices would trump harm reduction.

For advocates of harm reduction, this finding has both positive and negative implications. On the one hand, it appears that OEND can be integrated into environments that are not receptive to harm reduction in a broader sense. In other words, OEND is an effective and widely acceptable way to reduce overdose fatalities *now*, without having to wait for a resolution of the larger philosophical questions around harm reduction. On the other hand, in spite of its effectiveness, OEND may not be a particularly good way to introduce harm reduction into settings that had previously resisted it—precisely because OEND is so concretely effective and uncontroversial, it is easy for staff to mentally separate it from the more abstract and challenging issues that make harm reduction unpalatable to them. If “bringing harm reduction into recovery-

oriented settings” is seen as a secondary goal of OEND, there may remain work to be done even if OEND is successfully implemented on a wide scale. Indeed, it might be useful to further investigate the way other harm reduction strategies are understood and experienced in settings like these, in order to learn whether it is realistic to expect that resistance to them can eventually be overcome the way resistance to naran was in this study (i.e. by exposure and education), or whether the relatively rapid acceptance of naran should be seen as a special case. In other words: is the growing acceptance of naran something that can eventually be replicated with other harm reduction strategies, and if so what will need to be done in order to make that happen more readily than it has among my subjects?

Although some subjects experienced harm reduction (aside from OEND) mainly in the abstract, others *did* describe a work environment where harm reduction had been reconciled with abstinence-based treatment philosophies. For them, harm reduction was more concrete than it was for the subjects mentioned above, with more clear and explicit connections to the ways they helped their clients. For instance, integrating harm reduction into their workplace might mean focusing on client-selected goals other than abstinence, or helping clients to more safely use drugs when they were not prepared to stop—in other words, they sometimes prioritized harm reduction over abstinence. They did not experience this as a negative thing, even though they felt that ultimately, abstinence remained at the core of their personal and organizational philosophies. Harm reduction was not viewed with suspicion, or mere tolerance, or as something that was only applicable in specific limited circumstances. Rather it was an integral part of their treatment landscape—a landscape that was too complex to be explored through a strictly abstinence-based lens. In the words of one subject:

I just have come to see [harm reduction] as an integral part of what we do. I don't think we can do treatment without some degree of focus on harm reduction. -S4



Because this study focused on its subjects' experiences, rather than issues of cause and effect, it does not show how these programs' acceptance of harm reduction was or was not a result of their implementation of OEND. Perhaps a future study could focus on this issue more specifically, and attempt to establish whether there are lessons that can be learned from programs like these. A prospective study might be especially useful here, in order to learn whether in addition to its primary goal of reducing overdose fatalities, OEND has had a positive effect on some program staff's willingness and ability to embrace other harm reduction strategies. If this does turn out to be the case, it would be *very* interesting to explore what makes these programs and staff different from the ones mentioned earlier, for whom the acceptance of OEND did not lead to a broader integration of harm reduction into the workplace.

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