## Funding Priority 2: Reduce Overdose Risk and Mortality, Especially Among Individuals at Highest Risk and Highest Need with Linkage to Treatment, Naloxone, and Harm Reduction

**Rationale**

Although opioid-involved non-fatal overdoses in Connecticut have been recorded in the thousands and every municipality in the state except for two have experienced fatalities, the burden falls mostly heavily on specific cities and specific underserved and marginalized groups of Connecticut residents. Reviewing the scientific literature and state-specific data, we conclude that efforts to reduce overdoses will have the greatest possible impact if strategies are focused on individuals who:

- have recently experienced a non-fatal overdose
- use opioids alone
- have a history of OUD and have lost tolerance to opioids
- are opioid-naïve or have low opioid tolerance and are purchasing stimulants, anxiolytics, or other non-prescribed drugs from the illicit market, inclusive of counterfeit medications, that are contaminated with fentanyl
- are unhoused or marginally housed

There are a significant number of people who fall into one or more of these groups residing in the state. Recommendations in this section focus on how to reduce overdoses among these groups beyond increased access to MOUD, as addressed in Priority 1.

The substantial impact of the criminal legal system on people who use opioids and those with OUD presents a formidable barrier to preventing overdose fatalities when considering these high-risk groups. People who are arrested, incarcerated, or otherwise exposed to the criminal legal system often find that opportunities to increase their wellbeing are diminished by restrictions of community supervision and repeated incarceration.[1] Return to substance use often precipitates re-incarceration, prompting concealment of use and using alone, resulting in unwitnessed, potentially fatal overdoses. Since return to use frequently occurs shortly after release from custody, people in the month after their release have demonstrably high overdose mortality.[2]

The unregulated stimulant (i.e., cocaine and methamphetamine) supply is increasingly contaminated with fentanyl, leading to overdoses in people who use stimulants (and not opioids). Harm reduction programs can offer fentanyl test strips or other forms of drug checking to alert stimulant users to fentanyl-contaminated drugs. It is important to fund programs that link at-risk individuals to naloxone, drug supply testing, syringe service programs, and education about fentanyl contamination of the stimulant supply.

Housing instability exacerbates an individual's risk of overdose in myriad ways that are compounded by de jure criminalization of substance use and de facto criminalization of homelessness. Programs and initiatives that recognize low-barrier, stable housing as a critical measure to reduce harm and promote

treatment engagement and retention have the potential to address a litany of overdose risk factors among people who use drugs and those with a SUD.

**Evidence**

Connecticut currently has several community-based organizations (CBOs) that have extensive experience implementing harm reduction services, engaging with people who use drugs, and collaboration with state and municipal government to produce harm reduction-focused activities. DMHAS, DPH, and DCP have made significant efforts to increase distribution of naloxone in the state including direct distribution of naloxone to CBOs[3] and, since 2015, efforts to support naloxone prescribing by pharmacists who have received training through a program operated by the DCP.[4] Importantly, in 2023, the FDA approved sale of naloxone without a prescription (aka "over the counter"), a promising step towards expanding naloxone access. The ability of the DCP to accurately track pharmacy sales will be limited moving forward, given uncertainty in how much naloxone will be dispensed via prescription versus over the counter.

Since 2016, DOC has also increased efforts to provide naloxone to people released from prisons and jails. The Connecticut legislature has also made several changes to increase naloxone access and, in the latest legislative session, a law (Public Act No. 23-97) was enacted to pilot harm reduction centers in the state.[5,6] This logistical and policy environment puts Connecticut in an advantageous position to implement and enhance harm reduction efforts.

Public Act No. 23-97 does not include language on provision of overdose prevention centers (OPCs), locations where a person can use their drug(s) of choice under supervision of trained personnel, within these harm reduction centers. Given current interpretation of state and federal statute that would prohibit provision of OPCs, our report does not include recommendations to fund them. However, if state or federal statute, or their interpretation, were to change, these types of interventions should be considered given growing evidence on their efficacy in preventing overdose deaths. Two overdose prevention sites opened in New York City in November 2021 and have since witnessed thousands of substance use episodes and more than 700 potentially fatal overdoses without a single fatality. OPCs operate in other countries, without experiencing a single fatal overdose to date.[7] The legality of these services in the United States is evolving as a lawsuit within the federal judicial system is currently pending regarding provision of these services in Philadelphia. Rhode Island and Minnesota have passed legislation aimed at opening OPCs and Rhode Island has allocated opioid settlement funds to support these services.[8] These examples demonstrate efficacy of this unique, pragmatic if controversial approach to reducing overdose mortality. They also provide a blueprint for what might be offered in Connecticut harm reduction centers beyond supervised consumption, as OPC models typically offer expedited addiction treatment access, other medical services, and wraparound support services.

**Potential Impact**

Improving access to services that reduce overdose risk in individuals at the highest risk via linkage to treatment, naloxone, and harm reduction services has significant potential to reduce overdose deaths in the near term. Several models comparing different community-based interventions to address the overdose crisis have demonstrated that increased naloxone access has the greatest potential and is the most cost-effective intervention to reduce overdose deaths.[9-12] As noted above, the recent change making naloxone available over the counter complicates tracking and reporting on distribution since there is no formal or informal monitoring system for over the counter drugs. Efforts to determine if the state is

achieving naloxone saturation will need to include novel methods to estimate over the counter naloxone sales.

**Strategies**

**Strategy #1:** Increase use of naloxone, drug supply testing, and syringe service programs by people at high risk of overdose.

**Goal:** All at-risk individuals using opioids and those near them will have to access naloxone, drug supply testing, syringe service programs.

- **Tactic #1:** Fund initiatives that directly distribute naloxone to high-risk individuals or people around them including families, friends, and caregivers. This can include community groups that work directly with people who use drugs (e.g., harm reduction, substance use treatment and behavioral health programs, NA/AA groups) or who interact with those who are experiencing an overdose (e.g., EMS, police officers, crisis response teams), targeted outreach interventions for people who use opioids specifically, or novel naloxone distribution methods such as vending machines.
- **Tactic #2:** Fund targeted naloxone distribution in high-risk locations (public locations associated with opioid use or past overdoses) and other efforts to ensure at-risk individuals using opioids are near someone who can administer naloxone if needed. Mechanisms to expand access at such locations could include those listed under Tactic #1, posted QR codes to link to digital harm reduction information, or vending machines in court houses.
- **Tactic #3:** Fund outreach, education, and harm reduction service linkage efforts targeting people who are inadvertently exposed to illicit fentanyl when seeking other substances (e.g., stimulants, benzodiazepines).
- **Tactic #4:** Fund initiatives that provide community-tailored, culturally responsive, socially and racially concordant initiatives to increase access to and use of harm reduction services in populations at high risk of overdose who are currently accessing harm reduction services at lower rates. This should include a focus on funding organizations that have a proven track record of reaching these populations.
- **Tactic #5:** Fund initiatives to create and track metrics on naloxone provision, use of naloxone to reduce overdoses, and geographic access to naloxone in the state reported in a timely fashion via merging and linking relevant existing data from treatment providers, pharmacies, state agencies, and other entities. Metrics can be used by stakeholders and policymakers to guide funding, policy, and agency efforts to improve naloxone provision.
- **Tactic #6:** Fund initiatives that support near real-time reporting of fatal and non-fatal overdoses that include geographic, contextual, and other granular data and partner with jurisdictions to support targeted public health responses to reduce overdoses.[13-15]

### **Strategy #2:** Create harm reduction centers that provide ancillary support services for people using drugs.

There is evidence that centers that provide a range of harm reduction services reduce overdose death and other complications of opioid use from studies in Canada, Western Europe, Australia, and most recently in New York City.[16] During the 2023 legislative session Public Act No. 23-97 was enacted which allows the establishment of three harm reduction centers in Connecticut municipalities.[17] The final bill did not include language allowing for the provision of supervised consumption or overdose prevention centers. As such, we do not recommend funding of services not legal under current interpretation of federal and state statute in this report. Nevertheless, we do recommend that Connecticut learn from model overdose prevention centers (OPCs) regarding what and how *other* services can be provided in these harm reduction centers. The facilities will also supplement currently DMHAS and otherwise state-supported harm reduction services. The following tactics are recommended to ensure that the centers have the greatest chance of reducing overdose mortality and can more broadly inform provision of harm reduction services in the state.

**Goal:** All individuals at-risk of an opioid overdose will have to access harm reduction centers.

- **Tactic #1:** Fund initiatives that develop, create guidance for, and facilitate community consensus on a minimum package of services for harm reduction centers and the staffing needs to deliver services.

- **Tactic #2:** Fund needs assessment activities, education, and consensus-building efforts to support selection of harm reduction center locations that are acceptable to both people who use drugs and other community stakeholders.

- **Tactic #3:** Fund the establishment of harm reduction centers in all areas where the density of drug use maximizes their impact.

- **Tactic #4:** Fund evaluation of the performance and effectiveness of harm reduction centers. This can include generating metrics and analyzing data for harm reduction centers to assess volume of use, overdose fatalities averted, referrals to and entry into treatment for substance use disorders, referrals to and utilization of medical and social services, and changes in community attitudes regarding the harm reduction centers. Evaluation should be linked to demonstrable process improvement.

- **Tactic #5:** Fund initiatives to assess and respond to community attitudes regarding OPCs, akin to those being run in New York City and proposed in Rhode Island and Minnesota, in anticipation of changes in federal or state statutes.

### **Strategy #3:** Reduce solitary opioid use.

Individuals who use drugs alone are at greatest risk for fatal overdose since there is no one around to recognize and respond to the overdose, either by summoning help or administering naloxone. Reducing solitary drug use can greatly reduce opioid overdose deaths, but this will require tactics that promote informing others when using.

**Goal:** Decrease the number of individuals using drugs alone.

- **Tactic #1:** Fund creation and evaluation of initiatives designed to decrease the number of individuals using drugs alone such as a safe drug use hotline. Components needed would include a 24-hour telephone or smartphone accessible service that will monitor callers while they use and send help if not alerted that the caller is fine.[18,19]

- **Tactic #2**: Fund community education about the risks of using alone. Such efforts need to focus on destigmatizing drug use and promoting safer use strategies.

While Tactic #1 is promising given evidence that a high percentage of overdose deaths occur during solitary opioid use[20,21], evidence for specific interventions to address this issue is scant. Existing hotlines have not been evaluated, and people's willingness to use a system that keeps tabs on them while in the act of using has not been formally assessed.[22] Efforts to determine the benefits of promoting use of such services are worth funding as a near-term tactic. Changing community attitudes around substance use and reducing stigma (Tactic #2) are long-term undertakings.

**Strategy #4:** Reduce unanticipated exposure to opioids among opioid-naïve individuals who use drugs.

Fake prescription opioid pills that contain high potency synthetic opioids such as fentanyl are increasingly prevalent. Opioid-naïve individuals are at high risk for fatal and non-fatal overdoses if they use these illicitly manufactured pills. In addition, the unregulated stimulant (i.e., cocaine and methamphetamine) supply is increasingly contaminated with fentanyl. Drug testing services, a growing presence in the state, are reporting cases of cocaine mixed with high potency fentanyl and occasionally other synthetic opioids. As a result, Connecticut has witnessed multiple clusters of fatal stimulant-involved opioid overdoses with survivors claiming that they were seeking cocaine, not opioids. Drug testing can reduce exposure to unwanted contaminants and has seen some limited effectiveness in preventing the consumption of adulterated drugs.[23,24] A recent study in Connecticut found that among those who sought to consume cocaine but not opioids, only 13% used a fentanyl test strip in the last year while 45% felt that the risk of contaminants in their cocaine was always a possibility.[25] Reaching these at-risk individuals will require expanding the harm reduction work force and this, too, should be supported with settlement funds.

**Goal**: Decrease fatal and non-fatal overdose among opioid-naïve individuals

- **Tactic #1:** Fund provision of real-time testing of opioids, including fake opioid pills and stimulants, as the drug supply and the technology for point-of-use testing evolves. Current approaches to consider include using fentanyl testing strips or supporting more sophisticated technology like Fourier transform infrared spectroscopy.

- **Tactic #2:** Fund expansion of harm reduction outreach staff who are trained to inform people who use drugs, as well as parents and guardians of youth who use drugs, of the prevalence and persistence of fentanyl in opioids, including fake opioid pills and stimulants, and instruct on appropriate harm reduction measures.

- **Tactic #3:** Fund efforts to collect, report, and disseminate real time data on the drug supply in Connecticut. Potential data sources can include overdose events, drug seizures, or voluntary

- testing of drugs. Dissemination might include local efforts to engage and report to communities or networks of people who use drugs on status of the illicit drug supply.

- **Tactic # 4:** Fund initiatives to examine and address overdose risk among youth including infants. These efforts should be commensurate with the documented prevalence of these events and relative risk compared to other poisonings. Specific caution should be taken to avoid disincentives for parents who use drugs interacting with treatment or social service organizations.

**Priority 2 References**


1. Marotta P HA, Viera M, Doernberg M, Barbour R, Grau LE, Heimer R. Technical violations and infractions are drivers of disengagement from methadone treatment among people with opioid use disorder discharged from Connecticut jails 2014-2018. *Substance Abuse Treatment, Prevention, and Policy.* 2023.
2. Seaman SR BR, Gore SM. . Mortality from overdose among injecting drug users recently released from prison: database linkage study. . *BMJ.* 1998;316:426-428.
3. Opioid Overdose Prevention/Naloxone (Narcan) Initiative. Connecticut Department of Mental Health and Addiction Services https://portal.ct.gov/DMHAS/Programs-and-Services/Opioid-Treatment/Naloxone. Published 2024. Accessed.
4. Naloxone Prescribing By Pharmacists. Connecticut Department of Consumer Protection. https://portal.ct.gov/DCP/Drug-Control-Division/Drug-Control/Naloxone-Prescribing-By-Pharmacists. Published 2024. Accessed.
5. N D. *Connecticut's Opioid Drug Abuse Laws.* Connecticut General Assembly;2022.
6. T H. CT bill takes aim at opioid crisis and fentanyl overdose deaths by supporting plan for 'harm reduction centers. *The Hartford Courant.* May 31, 2023, 2023.
7. J. I. One Year Inside a Radical New Approach to America's Overdose Crisis. *The New York Times.* February 2, 2022, 2023.
8. *Opioid Settlement Funded Project Annual Report.* Executive Office of Health and Human Services, State of Rhode Island; December 27, 2023 2023.
9. Ballreich J MO, Hu E, Chingcuanco F, Pollack HA, Dowdy DW, Alexander GC. . Modeling mitigation strategies to reduce opioid-related morbidity and mortality in the US. *JAMA Network Open.* 2020;3(11):e2023677.
10. Linas BP SA, Madushani RW, Wang J, Yazdi GE, Chatterjee A, Walley AY, Morgan JR, Epstein RL, Assoumou SA, Murphy SM. Projected estimates of opioid mortality after community-level interventions. . *JAMA Network Open.* 2021;4(2):e2037259.
11. Rao IJ HK, Brandeau ML. Effectiveness of policies for addressing the US opioid epidemic: a model-based analysis from the Stanford-Lancet Commission on the North American Opioid Crisis. *The Lancet Regional Health - Americas.* 2021;3:100031.
12. Stringfellow EJ LT, Humphreys K, DiGennaro C, Stafford C, Beaulieu E, Homer J, Wakeland W, Bearnot B, McHugh RK, Kelly J. Reducing opioid use disorder and overdose deaths in the United States: A dynamic modeling analysis. *Science Advances.* 2022;8(25):eabm8147.
13. Davis CS GT, Hernandez-Delgado H, Lieberman AJ. . Status of US state laws mandating timely reporting of nonfatal overdose. . *AJPH.* 2018;108(9):1159-1161.
14. BE. H. Opioid overdose surveillance: improving data to inform action. *Public Health Rep.* 2021;136(S1):5S-8S.

15. Canning P DS, Ali S, Logan SB, Alter A, Hart K, Coler R, Kamin R, Wolf SC, Soto K, Whiteman L. . Using surveillance with near–real-time alerts during a cluster of overdoses from fentanyl-contaminated crack cocaine, Connecticut, June 2019. *Public Health Rep.* 2021;136(S1):18S-23S.
16. Chalfin A dPB, Mitre-Becerril D. Overdose prevention centers, crime, and disorder in New York City. *JAMA Netw Open.* 2023;6(11):e2342228.
17. An Act Concerning Health and Wellness for Connecticut Residents. In. Committee PH, trans. 2023 ed2023.
18. Park JN GT, Rich JD. . Overdose Detection Technologies—A New Frontier in Preventing Solitary Drug Overdose Deaths. *JAMA Psychiatry.* 2023;80(7):657-659.
19. Lombardi AR AR, Rosen JG, Thompson E, Welwean R, Tardif J, Rich JD, Park JN. . Overdose detection technologies to reduce solitary overdose deaths: a literature review. . *International Journal of Environmental Research and Public Health.* 2023;20(2).
20. JM. W. Dying alone: The sad irrelevance of naloxone in the context of solitary opiate use. *Addiction.* 2019;114(3):574-575.
21. Mattson CL ODJ, Kariisa M, Seth P, Scholl L, Gladden RM. . Opportunities to prevent overdose deaths involving prescription and illicit opioids, 11 states, July 2016-June 2017. . *MMWR Morb Mortal Wkly Rep.* 2018;67(34):945.
22. Loverock A MT, Viste D, Safi F, Rioux W, Sedaghat N, Kennedy M, Ghosh SM. . Electronic harm reduction interventions for drug overdose monitoring and prevention: A scoping review. *Drug Alcohol Depend.* 2023(110878).
23. Betzler F HJ, Viohl L, Ernst F, Roediger L, Gutwinski S, Ströhle A, Köhler S. Drug Checking and Its Potential Impact on Substance Use. *Eur Addict Res.* 2020;27(1):25-32.
24. Fregonese M AA, Covino C, Gili A, Bacci M, Nicoletti A, Gambelunghe C. Drug Checking as Strategy for Harm Reduction in Recreational Contests: Evaluation of Two Different Drug Analysis Methodologies. *Front Psychiatry.* 2021;12:596895.
25. Quijano TAG CJ, Eggert K, Clark K, Grau L, Heimer R. . Xylazine in the drug supply: emerging threats and lessons learned in areas with high levels of adulteration. . *International Journal of Drug Policy.*120(104154).