

HOUSING STABILITY **FOOD AND SHELTER** **DRUG USE**
TREATMENT WITHDRAWAL **SYRINGE ACCESS** **TREATMENT OPIOID**
BASIC NEEDS OPIOID USE **PROGRAM** **SUBSTANCE USE DISORDER DENVER**
METHADONE DISORDER **PROGRAM** **MEDICATION ASSISTED TREATMENT**
EDUCATION **EDUCATION** **RECOVERY**
HEROIN **MEDICATION ASSISTED TREATMENT** **HEROIN WELLNESS**
BUPRENORPHINE **EDUCATION** **HEALTH**
EQUITY

OPIOID

DENVER NEEDS ASSESSMENT ON OPIOID USE

TREATMENT AND RECOVERY **EDUCATION** **MEDICATION ASSISTED TREATMENT**
RECOVERY **HARM REDUCTION** **WITHDRAWAL**
OVERDOSE **HEALTHCARE**
SYRINGE ACCESS PROGRAM **SELF-CARE** **HEALTH** **TREATMENT**
ACCESS **BASIC NEEDS** **EQUITY** **SUBSTANCE USE DISORDER** **WITHDRAWAL**
RECOVERY **OPIOID** **METHADONE** **HEALING** **WITHDRAWAL**



DENVER
PUBLIC HEALTH &
ENVIRONMENT

TABLE OF CONTENTS

ACKNOWLEDGMENTS.....	3
GLOSSARY.....	4
ACRONYMS.....	5
INTRODUCTION.....	6
METHODS.....	7
SEMI-STRUCTURED IN-DEPTH INTERVIEWS WITH PWUO.....	7
SURVEY OF SUD TREATMENT PROVIDERS.....	8
ANALYSIS.....	8
SEMI-STRUCTURED IN-DEPTH INTERVIEWS WITH PWUO.....	8
SURVEY OF SUD TREATMENT PROVIDERS.....	8
INTERVIEW FINDINGS.....	9
DEMOGRAPHICS.....	9
OVERDOSES.....	10
BASIC NEEDS AND SERVICES.....	10
TREATMENT.....	13
DISCUSSION.....	18
RECOMMENDATIONS.....	19
BASIC NEEDS AND SERVICES.....	19
TREATMENT AND RECOVERY.....	20
APPENDIX.....	21

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AUTHORS

MARION RORKE, MPH AND STEPHEN KOESTER, PHD

DENVER DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT STAFF

GRETCHEN ARMIJO

KERRA JONES

TRISH CASTILLO

MONDI MASON

JEANETTE COOPER

NATALEE SALCEDO

LINDSEY COULTER

TRISTAN SANDERS

JEAN FINN

LISA STRAIGHT

COMMUNITY PARTNERS AND AGENCIES

ACCESS POINT/DENVER
COLORADO AIDS PROJECT

COLORADO CONSORTIUM
FOR PRESCRIPTION DRUG
ABUSE PREVENTION

DENVER PUBLIC LIBRARY

DENVER RECOVERY GROUP

HARM REDUCTION
ACTION CENTER

MENTAL HEALTH CENTER
OF DENVER

Most importantly, thank you to the individuals who courageously shared their life experiences as a part of this assessment.

GLOSSARY

BUPRENORPHINE - A medication used to treat opioid use disorders. It is most commonly prescribed in combination with naloxone, called Suboxone.

CODING - The process of organizing qualitative data into categories relevant to the assessment's purpose. For example, a sentence from an interview transcript may be assigned a code representing a concept or theme. These are used as the first step in analyzing the data.

HEROIN - An illicit opioid that can produce a euphoric effect and can result in respiratory depression. In Denver, heroin is typically found as a sticky black substance known as "black tar", which is most commonly combined with a liquid, such as water, and injected intravenously.

INTER-RATER RELIABILITY - When two or more researchers are analyzing the same data set, they take steps to ensure that they are coding the data in a similar manner. This is achieved by independently coding a few transcripts, comparing them and then developing a set of agreed upon codes for use in coding the data.

MEDICATION ASSISTED TREATMENT (MAT) - The use of medications as a component of treatment for opioid use disorders that reduces cravings and decreases the effects of withdrawal. The two most common types are methadone and buprenorphine.

METHADONE - A synthetic opioid medication that is used to treat pain and opioid use disorders as a part of medication assisted treatment by reducing cravings.

METHADONE MAINTENANCE TREATMENT (MMT) - The use of methadone to treat an opioid use disorder.

METHAMPHETAMINE - A stimulant that impacts the central nervous system. While forms of methamphetamine are used to treat health conditions such as ADHD, for the purposes of this report the term refers to an illicit substance that can result in paranoia and hallucinations when used long-term.

NALOXONE (NARCAN) - An opioid antagonist medication that is used to reverse opioid overdoses by binding to opioid receptors and blocking the effects of other opioids. Forms are available that can be injected intramuscularly or sprayed into the nostrils.

NALTREXONE (VIVITROL) - A prescription medication used to treat some substance use disorders, including opioid use disorders. As an opioid antagonist, naltrexone blocks opioid receptors and prevents the euphoric effects of opioid use. It is most commonly administered in an injectable form once a month.

NATIONAL HIV BEHAVIORAL SURVEILLANCE (NHBS) - A Center for Disease Control and Prevention (CDC)-funded study that conducts anonymous standardized surveys with populations at increased risk for contracting HIV.

OVERDOSE - When a drug is taken in excessive amounts, injuring the body and potentially causing death. While some overdoses are intentional, most are unintentional. Opioid overdoses are typically characterized by stopped or limited breathing, unresponsiveness, and bluish fingertips and lips.

GLOSSARY

OPIOID - A chemical or drug that interacts with opioid receptors in the brain, impacting pain signals and other brain functions.

OPIOID USE DISORDER (OUD) - A substance use disorder in which the primary drug of misuse is an opioid.

PURPOSIVE SAMPLING - A sampling strategy used to identify information-rich cases, or in other words, to identify participants who can inform the questions driving the assessment.

SUBSTANCE USE DISORDER (SUD) - The continued use of a substance despite negative consequences. SUDs can range from mild to severe and are characterized by impaired control, social impairment, risky use, tolerance and withdrawal.

SYRINGE ACCESS PROGRAM (SAP) - Legally sanctioned programs that provide new, sterile syringes in exchange for used syringes. SAPs also provide other safer injection supplies such as water, alcohol pads and cottons to ensure that the injection process does not facilitate the transmission of diseases, such as HIV and HCV.

URINARY ANALYSIS (UA) - The process of screening the urine of treatment clients to identify use of additional substances and confirm use of treatment medications.

WITHDRAWAL - Symptoms that occur after the abrupt discontinuation of use of a certain drug. For some drugs, withdrawal can be life threatening and should be medically monitored.

ACRONYMS

DCAP - ACCESS POINT/DENVER COLORADO AIDS PROJECT

CDPHE - COLORADO DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT

DDPHE - DENVER DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT

HRAC - HARM REDUCTION ACTION CENTER

HCV - HEPATITIS C VIRUS

HIV - HUMAN IMMUNODEFICIENCY VIRUS

OME - DENVER OFFICE OF THE MEDICAL EXAMINER

PWID - PEOPLE WHO INJECT DRUGS

PWUO - PEOPLE WHO USE OPIOIDS

INTRODUCTION

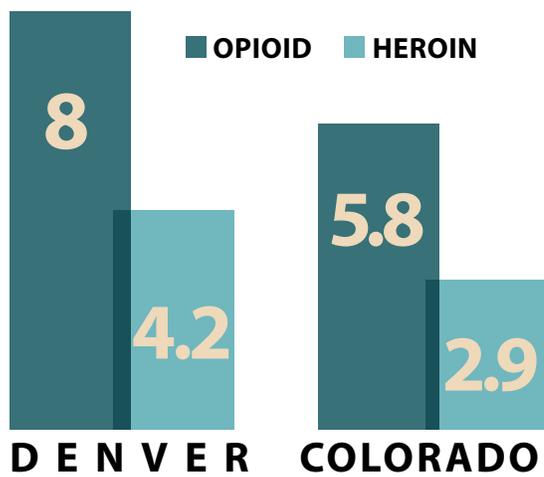
SCOPE OF THE PROBLEM:

Drug overdose is now the leading cause of accidental death in the United States, with opioid use driving this epidemic. Rates of drug-induced death have consistently increased nationally over the past 15 years, and Colorado is no exception. According to the Colorado Department of Public Health & Environment (CDPHE), 10,552 Coloradans died from drug overdoses between 2000 and 2015, with opioid-related overdoses tripling during this period.¹

In 2015, Denver County rates of opioid- and heroin-related deaths were statistically higher compared to the rest of the state. Denver experienced eight opioid-related deaths per 100,000 residents and 4.2 heroin-related deaths per 100,000 residents.

In 2015, Colorado experienced 5.8 opioid-related deaths per 100,000 residents and 2.9 heroin-related deaths per 100,000 residents.¹

2015: OPIOID-RELATED DEATHS PER 100,000 RESIDENTS



In 2016, 173 overdose fatalities were reported by Denver's Office of the Medical Examiner (OME). Of those deaths, 103 involved opioids — 50 of which included heroin. As of Nov. 13, 2017, the OME reported 140 fatal overdoses in Denver during 2017 — 83 of those overdoses were attributed to opioids, with 35 specifically indicating heroin as a substance involved in the overdose.²

The largest syringe access program (SAP) in Colorado, Harm Reduction Action Center (HRAC) in Denver, reported that at least five of its clients died of an overdose in 2016. In a two-week period during January 2017, six HRAC clients died of an overdose.

- In 2016, clients of HRAC reported reversing 187 overdoses.
- In the first 10 months of 2017, clients reported reversing 234 overdoses.³

Reports on opioid overdoses nationally and locally illuminate the importance of being able to respond to and reverse an overdose and the speed with which overdose deaths are increasing.

PURPOSE OF THE ASSESSMENT:

The purpose of this assessment was to better understand the opioid crisis in Denver from the point of view of people who use opioids (PWUO),

¹Colorado Department of Public Health & Environment, "Examining Opioid and Heroin Related Drug Overdose in Colorado," <https://www.cohealthdata.dphe.state.co.us/chd/Resources/pubs/Colorado-Opioid-and-Heroin-Overdose.pdf>

²Denver Office of the Medical Examiner, www.denvergov.org/MedicalExaminer

³Harm Reduction Action Center, www.harmreductionactioncenter.org

specifically heroin. The assessment aimed to understand people's lived experiences using heroin, and their experiences accessing and engaging in treatment. An additional goal was to gain a better understanding of the post-nonfatal overdose experience as it relates to treatment initiation. A key component of overdose prevention is providing supportive services, including drug treatments that improve the lives of PWUO and reduce their risk of overdose. This report examines the availability and accessibility of those services.

Denver's Department of Public Health & Environment (DDPHE) recognizes that there are many types of substance use disorders (SUDs). While the public health care system has been slow to respond to behavioral health diseases, many public health agencies are now working to normalize all aspects of discussion around these issues.

Furthermore, historically, both locally and nationally, there has been a disproportionate response toward SUDs between public health officials and law enforcement officials. The criminalization and stigmatization of mental health and people who use drugs has perpetuated societal and institutional racism.

Due to the importance of equity and the history of criminalization of people who use substances, the researchers prioritized interviewing populations most stigmatized and disenfranchised in the community: people who inject drugs (PWID) and were experiencing homelessness at the time of the interview.

METHODS

SEMI-STRUCTURED IN-DEPTH INTERVIEWS WITH PEOPLE WHO USE OPIOIDS:

Qualitative, semi-structured interviews were conducted with individuals who self-reported current opioid use, specifically heroin. Interviews were conducted by two experienced qualitative researchers — Marion Rorke, MPH, and Steve Koester, PhD., — between June 2017 and August 2017.

A purposive sampling strategy was employed to ensure the sample was composed of current opioid users. Most participants were recruited through the city's two community-based agencies serving people who actively use substances: HRAC and Access Point, a program of the Colorado AIDS Project. Both agencies operate SAPs. Additional participants were recruited through other organizations and agencies serving community members who use drugs. Due to the increases in EMS calls and overdoses in the area surrounding Civic Center Park and the adjacent Denver Central Library, interviews with individuals in this area were prioritized. Therefore, it is important to note that these individuals' experiences may differ from those of people who do not congregate in this geographical area.

The interview method provided participants the opportunity to give detailed responses and allowed the interviewers to ask additional questions and gather further information.

All interviews were confidential and no names or other identifying information were collected. Demographic information collected was limited to age, ethnicity, gender and current housing status. Drug-use information collected was limited to current drugs used, previous treatment experience(s) and whether or not the interviewee had ever experienced an overdose. The purpose of the interviews was explained to all participants and each was asked to give verbal consent to participate prior to the interview. Participants received \$20 gift cards as compensation for their participation. Interviews were audio-recorded, and the two interviewers also took field notes. Interviews were transcribed and coded at the conclusion of data collection.

SURVEY OF SUD TREATMENT PROVIDERS:

Due to the barriers experienced by PWUO when attempting to access treatment, an additional component of the assessment was a survey targeted to SUD treatment providers in the Denver area. Survey questions were initially based on a similar assessment conducted in New Mexico.⁴ These questions were then modified to better reflect circumstances specific to Denver. Input on survey design was provided by staff from a local harm reduction agency, a social worker from the Denver Public Library, a methadone treatment provider and a staff member from the Colorado Consortium for Prescription Drug Abuse Prevention.

At the time, comprehensive lists of Colorado treatment providers or of Denver treatment providers were not available. Therefore, to identify as many agencies and providers as possible, the researchers contacted multiple agencies and individuals that work to place clients in treatment programs. Four separate listings of providers were combined, totaling 62 agencies or individual SUD treatment providers. Those agencies and individuals were then contacted by phone to obtain an email address to which to send the survey.

Survey responses were collected via SurveyMonkey between Sept. 18, 2017 and Oct. 2, 2017. At the completion of data collection, survey responses were compiled into an Excel spreadsheet.

A N A L Y S I S

SEMI-STRUCTURED IN-DEPTH INTERVIEWS WITH PWUO:

In qualitative research, the first stage of analysis occurs while the interviews are being conducted. This enables interviewers to compare notes and to incorporate emerging findings into subsequent interviews. Coding is the process of identifying and categorizing the collected data. To ensure inter-rater reliability, meaning consistent agreement on the interpretation of the data, the two interviewers — as well as two DDPHE staff members trained as qualitative researchers — independently coded transcripts, compared codes and developed a common coding scheme. Codes included pre-set and emergent codes that were identified during the analysis of the transcripts. The final stage of analysis consists of merging codes into themes. Finally, these themes were presented to a focus group of HRAC clients for confirmation and feedback.

SURVEY OF SUD TREATMENT PROVIDERS:

For the purpose of this assessment, analysis consisted of examining the distribution of treatment services and requirements among service providers. Aggregate information was tabulated to show the number of agencies providing a given type of treatment. Wait times, restrictions, and other barriers to treatment access reported by providers were compared with the interview responses from PWUO regarding experiences with and perceptions of treatment access.

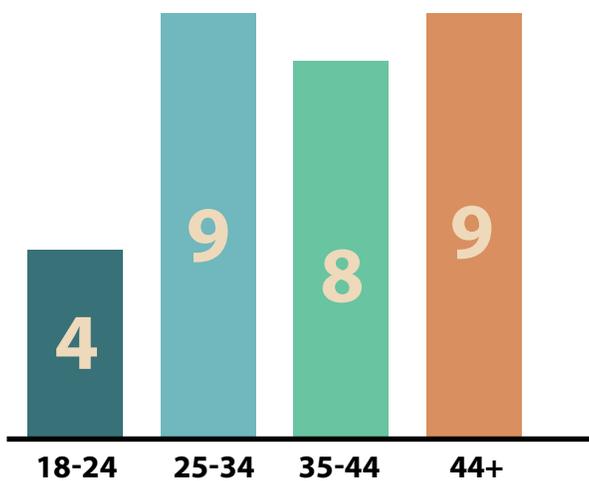
⁴City of Albuquerque, "Opioid Needs Assessment." <http://www.cabq.gov/mayor/documents/opioidneedsassessmentnms.pdf/view>

INTERVIEW FINDINGS

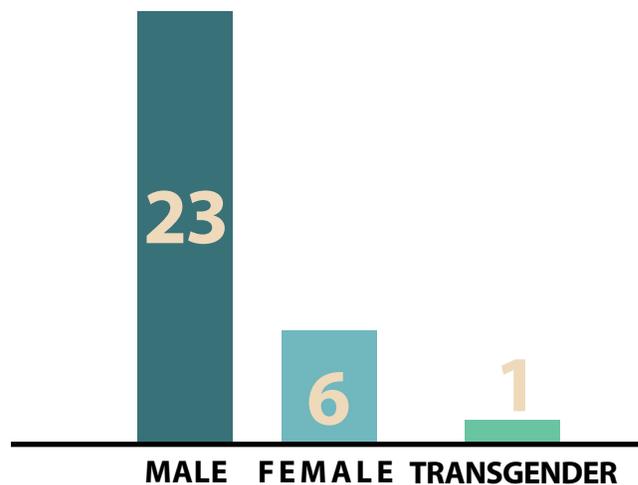
DEMOGRAPHICS:

Thirty individuals were interviewed as a part of this assessment. Participant ages ranged from 20 to 60. Twenty-three participants identified as male, six as female. One participant identified as transgender. Most participants identified as white, but participants also identified as black, Hispanic and Native American, and race/ethnicity choices were not mutually exclusive. All participants that reported currently using an opioid were injecting heroin, other than methadone prescribed for treatment. Additionally, most participants also reported injecting methamphetamine, and almost all reported regularly using more than one substance. While no participants reported current prescription pain pill use, most reported that their first experience with any opioid was in the form of a prescription pain pill. Since the only opioid that participants reported currently misusing was heroin the remainder of the report will refer to heroin unless otherwise indicated.

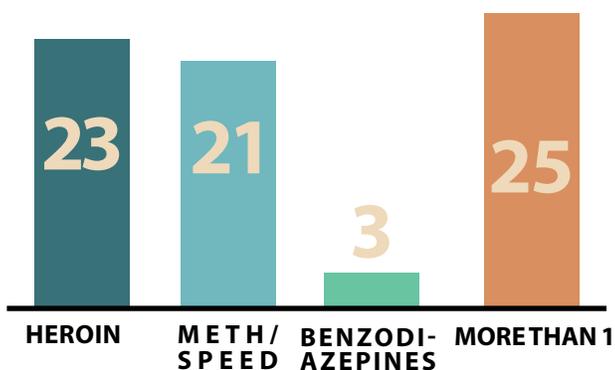
AGE



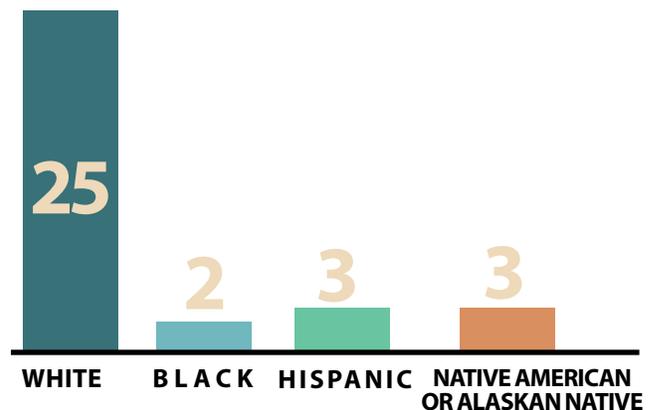
GENDER



DRUGS USED



RACE/ETHNICITY



OVERDOSES:

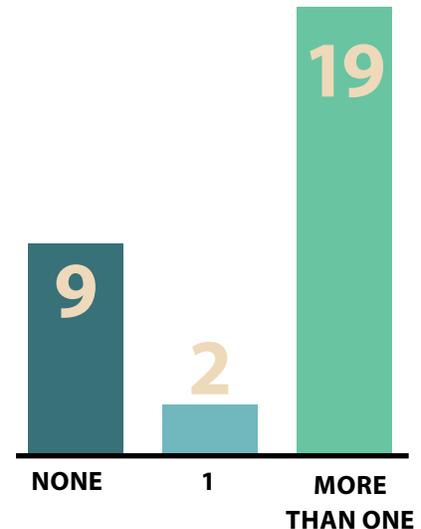
Most participants had firsthand experience with overdoses and reported both personally overdosing and observing overdoses. More than two-thirds of participants reported having overdosed. Of those, nearly all reported overdosing multiple times. While the majority reported having personally experienced overdose, the experience did not appear to directly influence participants' decisions about seeking drug treatment.

Most participants were clients of one of the two SAPs previously mentioned, both of which provide naloxone along with training on responding to an overdose and expressed the importance of having naloxone in the hands of PWUO.

“KEEPING THE [SAPS] OPEN IS ESSENTIAL. THREE WEEKS AFTER I WAS TRAINED AT HRAC I WAS THERE WHEN SOMEONE WAS OVERDOSING AT THE 16TH STREET MALL.”

— ASSESSMENT PARTICIPANT

OVERDOSE EXPERIENCES



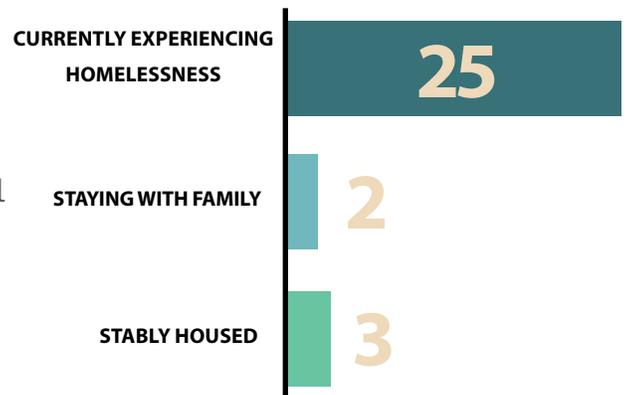
BASIC NEEDS AND SERVICES:

Housing and Shelters

Most participants were part of Denver's burgeoning homeless population. For these participants, homelessness was an ever-present reality that compounded all the other challenges in their lives, including their drug use. Participants who were experiencing homelessness and those who had previously been homeless were persuasive in describing the multiple, interconnected challenges that homelessness presented, including taking care of personal hygiene, maintaining clothing and other personal property, meeting treatment schedules and having hope that their lives were improving.

Several of the participants experiencing homelessness who also inject heroin reported injecting methamphetamine as well. Some of these participants described their methamphetamine use as a response to the need to stay awake at night to stay safe. They explained that staying awake and vigilant reduced their risk of being victims of violence and theft, as well as reduced the risk of unwanted police encounters for curfew, trespassing and unauthorized camping violations. Participants also described the many ways that homelessness significantly created and/or exacerbated barriers to treatment.

HOUSING STATUS



Nearly all participants were currently experiencing homelessness or housing instability. *Note: As this information was self-reported, definitions of homelessness varied. Several participants reported currently staying with family, but did not feel as though they could call it their home.*

Shelters were recognized as critical resources in extreme emergencies. As one participant stated, “Shelters save lives in the winter.” However, most participants did not see shelters as a viable solution to homelessness, even for short periods of time. Participants reported not regularly using shelters for the following reasons:

- Shelters don't accommodate couples.
Participants in relationships reported feeling uneasy about being separated from their partner at shelters, especially because they shared important resources like cell phones.
- Shelters are overcrowded and unsanitary.
Participants reported that in inclement weather shelters are often full, and that it is not uncommon for people to sleep on the floor “shoulder to shoulder.” They described the overpowering odor in shelters and complained that the bathrooms (toilets and showers) were filthy.
- Shelters have strict rules and requirements.
Participants reported having to be at a shelter at a certain time and being forced to leave the shelter early in the morning. Additionally, shelters often require sobriety and identification.
- Shelters are considered unsafe.
Participants mentioned that personal possessions are frequently stolen at shelters, and some mentioned a fear of sexual predators.

Hygiene

Participants explained how homelessness turned daily activities, like brushing one's teeth and going to the toilet, into major time-consuming tasks, and noted that homelessness has had a negative impact on their sense of personal dignity. Due to the limited availability of public restrooms, finding a place to relieve oneself was mentioned as a constant challenge. Participants reported difficulty in finding sanitary toilets and expressed frustration with their inability to use bathrooms in stores and businesses based on negative perceptions of homelessness and people who use drugs. Participants commented that the recent availability of mobile restrooms provided by the City was helpful, but not sufficient.

Participants explained that finding places to bathe is also very difficult. Places to shower are limited and access is constrained by hours of operation and long waiting times, as well as distance from other services. The shower facilities that do exist are typically unable to accommodate both men and women, and rarely provide much privacy.

Possessions

Without housing, participants described the difficulties they experienced in protecting personal belongings, such as clothing, phones, mementos, identification and important legal documents. Most people kept these belongings in small backpacks, which were frequently lost or stolen.

Identification

Lack of formal identification posed a problem for many participants. Without an ID, seeking services and taking care of daily tasks — such as finding places to sleep, qualifying for treatment services and obtaining employment — become increasingly difficult.

Participants described the process of obtaining an ID as a daunting exercise, particularly for people who have never had an ID in Colorado and/or have no other identifying information such as a birth certificate. Although there are some organizations that assist people in getting IDs, including covering the associated costs, it is still a lengthy process. This in turn delays access to services, including treatment.

Accessibility of Services

The cost of transportation and the distance between services were reported as major barriers to accessing services. Participants suggested making transportation affordable for people experiencing homelessness and people with SUDs through a program providing discounted fare or tokens, similar to programs that exist for other special populations. The location of services creates an additional barrier. Participants mentioned that while social services provided in Denver were generally good, getting to them was difficult and time consuming.

“It’s hard to go hungry in Denver. It’s just that...you have to go all the way over here to take a shower, and all the way over here to find clothes, and hopefully they have something, and then you have to be over there to eat, so it takes away from your possibilities of going out and looking for work...

...BY THE TIME YOU’RE
CLEAN AND PRESENTABLE
YOUR DAY IS PRETTY **GONE.**”

Obtaining Accurate Information

Participants said that it can be difficult to find out about services. There is no centralized resource for learning about available services. Participants reported receiving inaccurate information about services, and several said their best source of information was from other PWID or were experiencing homelessness. One participant mentioned that this was how she learned about the social workers at Denver Public Library and about a potential housing program.

Health Care and Insurance

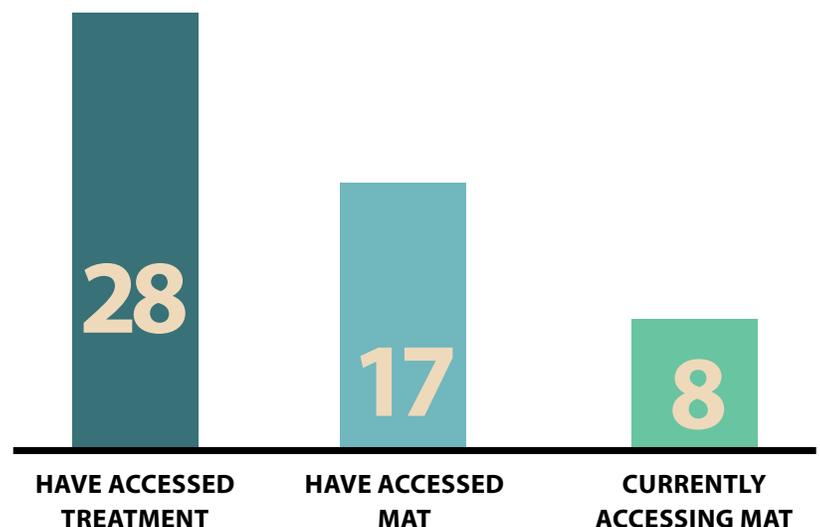
Several participants mentioned Medicaid expansion as a significant and beneficial change, explaining that having staff from social services available at HRAC to provide enrollment assistance was particularly helpful. Importantly, one participant who was seeking treatment worried about starting a Medicaid-funded methadone program for fear that Congress might eliminate the Affordable Care Act. As a result, she was afraid to begin treatment, explaining that she didn't want to become dependent on methadone and then lose her coverage. While participants mentioned they were able to access basic health care services, the lack of coverage for a wide variety of treatment options under Medicaid impacted the effectiveness of Medicaid in providing treatment for participants.

TREATMENT:

An underlying assumption of this assessment was that accessible drug treatment is a critical component in combating opioid overdose. A variety of treatment options exist, including outpatient, intensive outpatient, inpatient and residential services. The most common treatment of opioid use disorder (OUD), including heroin, is medication assisted treatment (MAT). All but two participants had some experience with treatment for a SUD. More than half reported experience with MAT and more than 25 percent were currently engaged in MAT.

Nearly all participants reported previous experience with drug treatment, including MAT. Of those with MAT experience, previous treatment was with methadone or buprenorphine. None had been in treatment using naltrexone. Experiences with other types of treatment (non-MAT) also varied by participant. While inpatient and residential treatment was mentioned, most reported it was inaccessible due to cost.

EXPERIENCE WITH TREATMENT



WHAT IS MEDICATION-ASSISTED TREATMENT?

Medication-Assisted Treatment (MAT) is typically provided as an outpatient service, but is often combined with other services. MAT uses different medications to mimic the effects of an opioid and/or to block opioid receptors, enabling people to return from a physiological “deficit,” therefore allowing them to **TAKE CARE OF DAILY ACTIVITIES** rather than seek out heroin or other opioids to stave off cravings and symptoms of withdrawal.

It is important to note that while some people’s **RECOVERY GOALS** may include eventually tapering off of MAT, for others, MAT may be a **LIFELONG** component of their recovery. There are three different types of medications that can be used for MAT: methadone, buprenorphine (Suboxone) and naltrexone (Vivitrol), each with different dosing and eligibility requirements.

Methadone, also known as methadone maintenance treatment (MMT), is the most widely known form of MAT. With MMT, clients are initially required to visit a clinic daily (in the mornings) to receive an administered a dose of methadone. Clients start out on low levels of methadone and gradually **WORK WITH THEIR PROVIDER** to increase the dose until they reach a “therapeutic level” — a dose that is sufficient to stop or **REDUCE THE CRAVING** for additional opioids. Over time, clients who demonstrate compliance with a program’s requirements may receive “privileges” allowing them to “take home” doses so that they do not need to visit the clinic every day. The number of “take-homes” or daily methadone doses increases as the **CLIENT DEMONSTRATES COMPLIANCE**. While it varies by provider, the most common reason clients are denied “take-homes” or lose privileges is continued substance use.

Buprenorphine is similar to methadone in that it is most commonly taken daily. However, there are some differences. Buprenorphine is typically prescribed in forms combined with naloxone, such as Suboxone. Since naloxone blocks opioid receptors, there is less likelihood clients will use other opioids on top of it, thus **REDUCING THE POTENTIAL FOR OVERDOSE**. Typically, buprenorphine treatment does not require daily clinic visits for dosing. Instead, clients are usually provided with a few daily doses at a time. As they become more stable, the number of doses they receive may increase.

Naltrexone (Vivitrol) is different in that it is an injectable form of MAT and only needs to be administered once a month, rather than daily.

Barriers to Treatment

While some participants found MAT accessible, many did not. Problems with or obstacles to obtaining MAT caused some participants to abandon attempts to obtain treatment. Barriers to accessing and remaining on MAT identified by participants included:

- Treatment costs.
- Finding a treatment provider willing to accept insurance (Medicaid).
- Providers' requirement that the client provide proof of identification.
- Differences in eligibility requirements (particularly for those who had previously accessed MAT in a different state).
- Dosing requirements:
 - The amount of time needed to reach a therapeutic dose.
 - Requirement to visit a clinic daily at a specified time (which added many additional barriers).
 - The inability to move up phases due to the use of other substances, indicated by a positive urinary analysis (UAs).
- Accessing treatment on demand.

Participants complained that often there is an extended wait period between the time they ask for treatment and commencing treatment. A two-week lag was frequently mentioned. This may be the most significant barrier or disincentive for initiating treatment. As participants explained, deciding to enter treatment is a major decision that is often fraught with doubt and fear. Participants reported that waiting to begin treatment leaves them little recourse but to continue using drugs in the interim and often results in abandoning their decision.

- Additional concerns regarding MAT:

- The requirement of MAT programs that clients do not use any drugs.

Participants were wary of MAT because treatment programs routinely test for all drug use and may impose consequences for signs of use. For participants this was particularly troublesome in the case of marijuana, a legal substance in Colorado and one that many reported using regularly.

- The lack of supportive services.

MAT programs rarely offer assistance regarding other facets of people's lives that have direct impact on their drug use, including everyday needs like housing, coping mechanisms and employment.

- The limited amount of counseling and therapy that MAT clients receive.

Some participants described their drug use in terms of self-administered medication for underlying emotional and psychological problems, suggesting the need for more intensive counseling than some MAT programs typically offer.

"WHEN YOU WALK IN AND
WANT HELP NOW
YOU SHOULD BE ABLE
TO GET IT...
WISH I COULD GO TO
A PLACE AND GET
ON SUBOXONE
RIGHT AWAY,
PERSONALLY.
WITHOUT QUESTIONS.
I CAN'T GO HOME,
NOT DO ANYTHING FOR
THREE DAYS AND COME
BACK... IT WON'T WORK."

- Fear that methadone is difficult to withdraw from.

Participants were apprehensive about becoming dependent on methadone and then being in a situation where they would be unable to dose — a concern based on experience and exacerbated by homelessness. Currently Denver County is the only county in the five-county metropolitan region that provides methadone to MMT clients who are arrested and jailed.

- Stigma around MMT.

For some members of the public and for some of the participants, MMT remains controversial. A few participants expressed the sentiment that methadone was essentially “substituting one substance for another,” and that some people who are on MMT use it “to get well” rather than to stop using heroin.

Successful Engagement with MAT

The few participants who were on MAT at the time of the interview were asked why they felt their current engagement with MAT was more successful than previous attempts. They explained that their most recent treatment attempt had been motivated by some sort of realization. For example, one participant said he wanted to be around his kids more often. A younger participant described recent bouts of homelessness and a growing awareness that he did not want that to be his future. The most significant reason for several participants, however, was that treatment was accompanied by stable housing. These participants explained the difference that housing made in their daily lives, and how it provided an incentive to stop using heroin.

“I’m at 220 (mmg of methadone) and I’m staying there for a while. I don’t know when it’s going to be time for me to stop, but I’m just going to continue doing what I’m doing. I’m proud of myself, though. I’m not living the way I used to live anymore. I’m actually out in the community now helping people.”

— ASSESSMENT PARTICIPANT

Ideal Treatment Components

While individual perspectives varied, there was some consistency among participants regarding the important components of treatment for OUDs. These include:

- Humane withdrawal and treatment on demand.
- Marijuana use not being a reason for being unable to “move up phases.”
- Long-term inpatient and residential services.
- Individualized treatment plans that address the underlying causes of a client’s SUD.
- Peers/people with lived experiences as a part of the treatment staff.

SUD Treatment Provider Survey

Valid email addresses were retrieved for 43 of the 62 treatment programs identified. Twenty completed treatment provider surveys were received. One of the respondents represented a facility that had recently closed but hoped to re-open soon, and another organization responded twice. This resulted in a total of 18 unique responses by treatment organizations currently operating. Not all the providers were in the Denver area, but all were located in Colorado.

A few of the programs were oriented toward residential and recovery services. As indicated in the Appendix, most providers treated more than one substance, if not all. Five of the programs only treated OUDs, and one treated others but required OUD as the primary use disorder. It is important to note that the survey did not specifically ask about heroin treatment, but about the treatment of OUDs in general. Five of the programs provided long-term residential treatment (exceeding 28 days). None of the responding organizations provided short-term residential treatment.

In terms of other services provided, seven of the 18 offered some type of withdrawal management services. Half had the capacity to treat people with dual diagnoses (SUD and mental health). Seven programs provided MMT, five provided buprenorphine and five provided naltrexone. Fewer than half of the programs offered case management as a treatment component.

WAIT TIMES FOR TREATMENT VARIED CONSIDERABLY, FROM NO WAIT TIME TO UP TO FOUR MONTHS FOR SOME TYPES OF TREATMENT. ONLY FOUR OF THE RESPONDING PROGRAMS DID NOT REQUIRE FORMAL IDENTIFICATION TO ACCESS SERVICES, AND HALF ACCEPTED MEDICAID.

While only two of the programs reported being at capacity at the time they completed the survey, 14 reported that they were trying to increase capacity. This indicates the recognition of providers that there is an unmet need for treatment of OUDs.

For more information on the survey, see appendix D.

Staying in Recovery

Participants described a variety of factors, both positive and negative, that affected recovery. One theme that was repeated by many participants was the importance of a support system. Those without friends and family nearby to support them said this makes recovery extremely difficult.

Another important theme was finding ways to occupy time. Participants suggested that getting a job or finding other things to do throughout the day was helpful in remaining in recovery, although participants also mentioned issues with obtaining employment due to criminal records.

**“IF YOU HAVE NOTHING TO DO,
YOU DO DRUGS.”**

Participants identified additional challenges that made it difficult to stay in recovery. These included:

- Failure of treatment programs to teach coping mechanisms.
- Lack of change in other life circumstances (i.e., housing and employment).
- Associating with the same group of people or being in environments where other people are using drugs.

DISCUSSION

The purpose of the assessment was to gain an understanding of the availability and accessibility of treatment services and the potential of a nonfatal overdose to serve as an intervention point to initiating treatment. However, the researchers found that while there are people actively seeking treatment, the number of other daily concerns and difficulties related to securing shelter, food, transportation, and medical and social services resulted in a lack of urgency and/or interest in SUD treatment. While overdoses were not considered a deterrent to drug use, or a gateway to treatment, many described the importance of recognizing and responding to overdoses. Overdose education and training including the distribution of naloxone is perhaps the most successful strategy to date for reducing overdose.

AS OF SEPTEMBER 2017, HRAC HAS TRAINED 1,800 CLIENTS ON NALOXONE USE, AND CLIENTS HAVE REVERSED 730 OVERDOSES SINCE THE PROGRAM STARTED IN 2012.⁵

When addressing homelessness and SUDs, it is important to emphasize that not all people experiencing homelessness use drugs (including opioids). The opposite is also true; not all PWUO are experiencing homelessness. However, to impact OUDs and overdoses among PWID, homelessness must also be addressed.

The challenges presented by homelessness create enormous barriers to meeting basic human needs, accessing services, and initiating and remaining in treatment. For the people interviewed for this assessment, homelessness as well as policies aimed at the homeless influence every aspect of their lives including their comfort, health and dignity. To encourage more PWUO to access treatment, additional services must also be available and accessible, including toilets, shower facilities and transportation.

While treatment was not one of the most important daily considerations for most participants, some were already on MAT. Others had previously tried to access MAT or were interested in starting treatment, but described a multitude of barriers, including cost, requirements and stigma. As mentioned earlier, MMT has often provoked a bit of controversy among PWUO and the public at-large. Research has largely dismissed the former critique, and a 1999 study conducted in Denver demonstrated that MMT is an effective form of harm reduction for the minority of clients who continue to use heroin.⁶ This finding has been confirmed by several subsequent studies.

⁵Harm Reduction Action Center, 2017 Third quarter report, www.harmreductionactioncenter.org

⁶Substance Use and Misuse, "Active Heroin Injectors' Perceptions and Use of methadone Maintenance Treatment: Cynical Performance or Self-Prescribed Risk Reduction?" <http://www.tandfonline.com/doi/abs/10.3109/10826089909039442>

Aside from basic needs and services, participants mentioned other things that were conducive to treatment. These included programs that were accessible on demand, focused on the whole person, included staff with similar lived experiences and provided supportive services to address contributing factors to their OUD.

There were several limitations to this assessment. First, the assessment focused on a specific sub-population of PWUO. Therefore, the barriers and experiences described in this report may not reflect that of all PWUO, particularly those with stable housing and private insurance or PWUO who use prescription opioids instead of heroin. Secondly, the assessment utilized a convenience sample of people from local SAPs and service providers. However, the demographics and characteristics of assessment participants mirror the client data collected by the two SAPs located in Denver, and the participants in the 2015 wave of the CDC-funded National HIV Behavioral Surveillance (NHBS) study. Non-Hispanic white males are the primary demographic served by HRAC. Approximately 50 percent of recent HRAC clients report using both heroin and methamphetamine.⁷ Similarly, non-Hispanic whites and males in general were the most heavily represented groups among NHBS study participants (n=592), accounting for 58.8 percent and 71.4 percent, respectively. Approximately 50 percent of NHBS participants reported using both heroin and methamphetamine.⁸ Homelessness is endemic among HRAC clients with 70 percent reporting unstable housing at intake. Likewise, the majority of NHBS participants reported experiencing homeless at the time of the interview.

⁷Harm Reduction Action Center, www.harmreductionactioncenter.org

⁸Substance Use and Misuse, "Heroin and Methamphetamine Injection: An Emerging Drug Use Pattern." <http://www.tandfonline.com/doi/full/10.1080/10826084.2016.1271432>



RECOMMENDATIONS

DDPHE is committed to advancing health equity.

This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to quality education and housing, safe environments, health care and good jobs with fair pay. DDPHE will not seek to advance recommendations that can be expected to widen racial or ethnic disparities in health, access to services, income or justice system involvement.

Based on participant and treatment provider responses, the researchers created recommendations for Denver to consider while addressing the current opioid epidemic.

Basic Needs and Services (in no particular order or priority)

- Harm Reduction:
 - Increase knowledge of SAPs by advertising their services to people who inject heroin who are not connected with harm reduction programs.
 - Support the expansion of SAPs to allow for extended hours and additional components to reduce the harms associated with injection drug use.
- Identification:
 - Explore ways to expedite the process of obtaining and replacing personal IDs.
 - Work alongside state agencies to remove the barrier of formal identification to initiate treatment, similar to processes currently in place for special populations, such as pregnant women.
- Transportation:
 - Support efforts to expand access to transportation with reduced transit fares for low-income riders, including people with SUDs and/or people experiencing homelessness.
 - Investigate, promote and support programs for other forms of transportation to get individuals to appointments and service agencies.
- Hygiene:
 - Increase the number of restrooms accessible to the public and explore innovative ways to reduce the possibility of overdose and improper disposal of injection devices in public restrooms.
 - Work with community-based organizations to identify locations where showers could be provided to people experiencing homelessness.
- Housing:
 - Support programs that prioritize housing, with an emphasis on making them low-threshold and supportive, including affordable housing plans.
 - Facilitate collaboration between treatment agencies and housing providers to reduce the number of people returning to homelessness following inpatient treatment services.

RECOMMENDATIONS

Treatment and Recovery (in no particular order or priority)

- Work in collaboration with state initiatives to increase the availability of a wide variety of low-barrier treatment options accessible on demand.
- Identify ways to provide funding to treatment agencies to employ people with lived experiences surrounding SUDs and homelessness.
- Identify and encourage the development of treatment programs that address polysubstance use, rather than focusing specifically on one drug.
- Encourage other counties in the Denver Metro Area to provide MAT in jails.
- Support the funding of treatment programs that address contributing factors to substance use, such as previous traumas.
- Facilitate conversations between treatment providers and recovery agencies to support long-lasting recovery for clients.
- Identify innovative funding opportunities to increase the amount of recovery-support services.

APPENDIX

A. INTERVIEW GUIDE

B. CONFIDENTIALITY AGREEMENT FORM

C. INFORMED CONSENT

D. SUD TREATMENT PROVIDER SURVEY

E. PRELIMINARY FINDINGS INFOGRAPHIC



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