ISSUE BRIEF
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Harm Reduction in the Commonwealth: Analysis of Opportunities to Save Lives

Traci C. Green, PhD, MSc
Brandeis University, The Heller School, Opioid Policy Research Collaborative

Katherine Nace, MPP
Brandeis University, The Heller School, Opioid Policy Research Collaborative

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Executive Summary

Every year, over 100,000 Americans die from drug overdoses, the majority of which are caused by opioids like fentanyl. In Massachusetts, an estimated 2,125 people died from opioid overdoses in 2023.[1] To address this enormous and preventable loss, people affected the most—people who use drugs—fought for the adoption of Harm Reduction approaches and policies. The Massachusetts state legislature is in the process of considering key opioid-related legislation that includes Harm Reduction protections. This legislation will build on a strong record of public health successes in the Commonwealth and is an opportunity to take additional steps necessary to save lives. This issue brief analyzes initiatives based on the latest research on effects of a range of Harm Reduction interventions. It provides promising approaches for consideration for current and future legislative action.

Harm Reduction responses include a set of specific substance use, infectious disease and health interventions such as syringe service programs, naloxone, low-barrier medication for addiction treatment, wound care, HIV prevention, and community drug checking. In addition to extensive scientific evidence of the effectiveness of these responses, Harm Reduction supports people who use drugs with respect, safety, and resources without judgement to reduce the harm of drug use. Massachusetts has advanced Harm Reduction through collaborative efforts of various stakeholders, bringing together local coalitions, members of the Harm Reduction workforce, healthcare providers, state agencies, legislators, and people with lived experience. More actions are needed to address the current complex opioid crisis driven by fentanyl and protect the progress in Harm Reduction to date.

Elevating Harm Reduction is warranted because it is evidence-based, human-centered, cost-effective, stigma-reducing, and it saves lives. A preliminary analysis undertaken for this report using city- and town-level overdose statistics and community drug checking data reflective of the illicit drug supply suggests that recent declines in overdose deaths may be driven by changes in the drug supply and associated with the existence of accessible Harm Reduction services. Communities with Harm Reduction services may be nimbler and more responsive to changes in the drug supply and can more efficiently reach people at high risk of drug-related harm than communities that lack Harm Reduction programming. For a strong healthy future, all residents in Massachusetts deserve these essential services, information, supplies, and capacities.

This report recommends ten **Actions for a Harm Reduction Commonwealth, including imminent actions that the legislature can take to expand Harm Reduction state-wide.** A more thorough rationale and accounting of the actions are contained in the body of the report. The 10 initiatives are based on analysis of the literature, review of other state efforts, and interviews with over 50 local and national experts and Harm Reductionists:

1. Ensure sufficient and equitable access to safe use supplies statewide	
Massachusetts allows individuals and organizations to distribute syringes and safer use supplies freely, yet Department of Public Health (DPH)-funded syringe service programs face unnecessary barriers requiring local board of health approval. Repealing or amending this provision would eliminate delays, enhance public health responses, and ensure equitable access to life-saving supplies and services across the Commonwealth.	This unnecessary and perverse impediment should be removed. • Repeal Mass. Gen. Laws Ann. ch. 111, § 21. • Alternatively, revise language of (OS 65) OUTSIDE SECTION 65, Effective 7/1/16 as suggested
2. Authorize community drug checking statewide.	
Community drug checking is a proven harm reduction strategy that enables individuals to identify the contents of substances before use, reducing risks and informing public health responses. Authorizing statewide drug checking programs in Massachusetts would protect both individuals and program operators, expand access to this life-saving service, and position the state as a leader in harm reduction innovation, technology, and drug trend data.	• Authorize community drug checking statewide as part of the "Opioid bill", since both Senate and House versions approved this as a strategy. Future legislative sessions should consider further supports of community drug checking: • Remove the criminal penalty for the sale of drug checking equipment (e.g., fentanyl test strips) • Include drug checking equipment use as a mitigating factor for reduced sentencing of any drug related crime
3. Pilot overdose prevention centers (OPCs).	
Public and health professional support in Massachusetts to implement overdose prevention centers (OPCs) is strong. Evidence from multiple reports and existing programs indicate their effectiveness in reducing overdose deaths, slowing disease transmission, and improving public order and safety.	• Address legal uncertainties and enact legislation that permits and funds both stationary and mobile OPCs, ensuring flexibility to meet community needs while protecting operators and clients from legal and zoning challenges.
4. Expand and protect access to medication for opioid use disorder (MOUD).	
Incorporating easy-to-access, low-barrier MOUD is Harm Reduction. Receipt of MOUD is proven to reduce overdose risk and improve health outcomes,	• Decriminalize nonprescribed buprenorphine possession. • Improve MOUD access through targeted changes, including

yet access remains limited because of geographic, financial, regulatory, racial, and system barriers.	removing cost sharing requirements for buprenorphine products • Expand and extend telehealth permissions and parity with in-person care and remove barriers to receiving ongoing telehealth care • Amend permissions to increase MOUD access through pharmacies and mobile units to improve access to different geographies and demographic groups
5. Support and protect the Harm Reduction workforce.	
The Harm Reduction Workforce is a diverse and evolving sector, deeply rooted in compassion, peer-led initiatives, and lived experience, yet faces significant challenges in sustainability, equity, trauma management, and support.	• Strengthen this vital workforce by addressing burnout and barriers to employment • Ensure equitable compensation and training. • Support the growth of affinity groups and advocacy organizations for this workforce
6. Nurture youth & family with Harm Reduction.	
Most students don't have ready access to naloxone and other Harm Reduction tools in schools or at home. Harm Reduction policies in schools and community organizations can interrupt the school-to-prison pipeline by replacing punitive measures with supportive, evidence-based interventions. Universal, comprehensive education can promote a safe, equitable and supportive environment for students and staff but long-standing punitive and abstinence-only models dominate. Such outdated approaches link to negative outcomes: more stigma, increased drug use, and death.	• Expand access to naloxone, fentanyl test strips, and comprehensive mental health services in schools • Adopt Harm Reduction-focused educational curriculums to reduce overdose, problematic drug use, and improve safety outcomes for youth and families.
7. Rethink criminal legal system and police response to overdose.	
Massachusetts' response to substance use reflects a tension between public health and criminalization with policies like the Good Samaritan Law, Section 35 commitments, and naloxone access illustrating progress but also gaps in the approach that	• Limit punitive measures and expand equitable access to lifesaving resources like MOUD and naloxone at release and in the courts

prioritizes public safety over public health. At the same time, crackdowns on visible and chronic homelessness lack protections for help-seeking in an overdose.	• Reform Section 35 involuntary civil commitment • Re-evaluate practices such as police-led housing sweeps and forced relocations since these exacerbate risks for vulnerable populations. If known in advance, preparation and swift community notification could be helpful in advance.
8. Apply Harm Reduction in housing settings.	
Implementing Harm Reduction in housing settings, alongside Housing First principles, can improve housing stability, decrease substance use in public spaces, and increase health outcomes, including for highly vulnerable populations.	• Expand low-barrier housing options, integrate Harm Reduction supplies and services therein, and align state and local policies with evidence-based practices.
9. Addressing health-related social needs and social determinants of health is Harm Reduction.	
Systemic inequities and structural barriers exacerbate overdose risks, especially in economically disadvantaged and marginalized communities. Discrimination is a social determinant of health and can be a factor in health-related social needs.	• Extend income supports • Commit to provision of culturally relevant treatment and care • Involve people with lived and living experience in the design of assistance programs • Apply and enforce the Americans with Disabilities Act (ADA) to protect people with substance use disorder from discrimination in care, housing, education, and the workplace.
10. Act to expand protections for overdose safety and reduce disease transmission.	
Massachusetts can strengthen public health by enshrining a right to Harm Reduction services. Building on recent healthcare advancements and the Harm Reduction evidence base, this initiative aligns with global human rights standards and addresses the ongoing overdose crisis while reducing health disparities and infectious disease transmission for everyone, statewide.	• Pass a law to secure the right to access Harm Reduction services, supplies, facilities and information because they save lives, mitigate harm, and reduce the risk of infectious disease transmission for all in Massachusetts.

Harm Reduction *is* public health. Its central role is preventing diseases like HIV and Hepatitis C, empowering wound care, and saving lives from overdose. To expand and enhance these benefits statewide and create a more equitable and sustainable Commonwealth, further investments and bold legislative action on Harm Reduction are needed today. Such actions will benefit Massachusetts, align scientific evidence with policy, and demonstrate national leadership at this critical time in history.

Disclaimers

This report does not represent the views of any of the sponsors, reviewers, or associated institutions but are the views of the authors based on original research and data collection. Statistical analysis related to changes in overdose rates represent preliminary findings that have not been subject to peer review. The analysis performed on state laws and local ordinances does not represent formal legal advice or guidance and further consultation with legal counsel may be necessary. We note that some municipalities in Massachusetts have local ordinances that are more strict or more permissive than state laws that are discussed in this report.

How This Report Is Organized

This report is organized to provide a comprehensive overview of ten distinct initiatives related to Harm Reduction. Sections for each initiative include background information, key challenges, supporting data, action items, and additional opportunities for impact. Appendices offer valuable insights into the historical context of Harm Reduction in the Commonwealth and expand upon background information for specific initiatives. Throughout the report, call-out boxes highlight examples of promising and innovative programs, policies, and laws associated with each initiative, serving as practical illustrations of the potential approach.

Introduction

Among the over 100,000 Americans dying every year from drug overdose, we lose our friends, family, neighbors, coworkers, and loved ones. Massachusetts residents who died of overdose on opioids—primarily due to the illicitly manufactured opioid fentanyl—numbered 2,125 in 2023.[2] Efforts to intervene and investments across the state are multi-faceted and involve laws and policies, prevention, treatment, recovery, harm reduction, and the criminal-legal system. Harm Reduction is one of the bright spots of the opioid crisis as it has been for the HIV epidemic because it represents more than just evidence-based services, supplies and information. Harm Reduction is both a movement and framework for action. It is effective and powerful because it is social justice.[3] As a framework, Harm Reduction empowers people who use drugs (PWUD) with agency, respects bodily autonomy, creates safe space to seek help and guidance without judgement, and respects an individual's decisions around substance use with a focus on reducing harm. Open conversations about substances, substance use, and how to stay safe are

fundamental to Harm Reduction but so too is lifting up the experiences, concerns, and innovations of PWUD. Taken together, Harm Reduction works and persists because it addresses stigma directly and is powered by grassroots advocacy not just laws and scientific evidence.[4]

There have always been many existential threats to Harm Reduction because of its link to social justice, equity, and the stigma of drug use.[5] The long-fought-for achievements to date in the Harm Reduction community--like syringe service access and broad naloxone availability--and the public health investments in the state of Massachusetts are stand-outs in the region and the country. These Harm Reduction efforts happened in response to and alongside the devastating HIV epidemic, the crisis of opioid-related harm, and now into new waves of an evolving, increasing complex drug supply.[6] We see enormous progress in Massachusetts and the opportunity to do even more to protect Harm Reduction here and serve as inspiration for other states across the country.

Centering Harm Reduction, as this report asserts, recognizes the fundamental contributions that the Commonwealth has made to advancing Harm Reduction in modern history, protects and invests in the human ingenuity of Harm Reduction, and suggests next-step actions for the future of Harm Reduction in Massachusetts.

Methods and Analysis

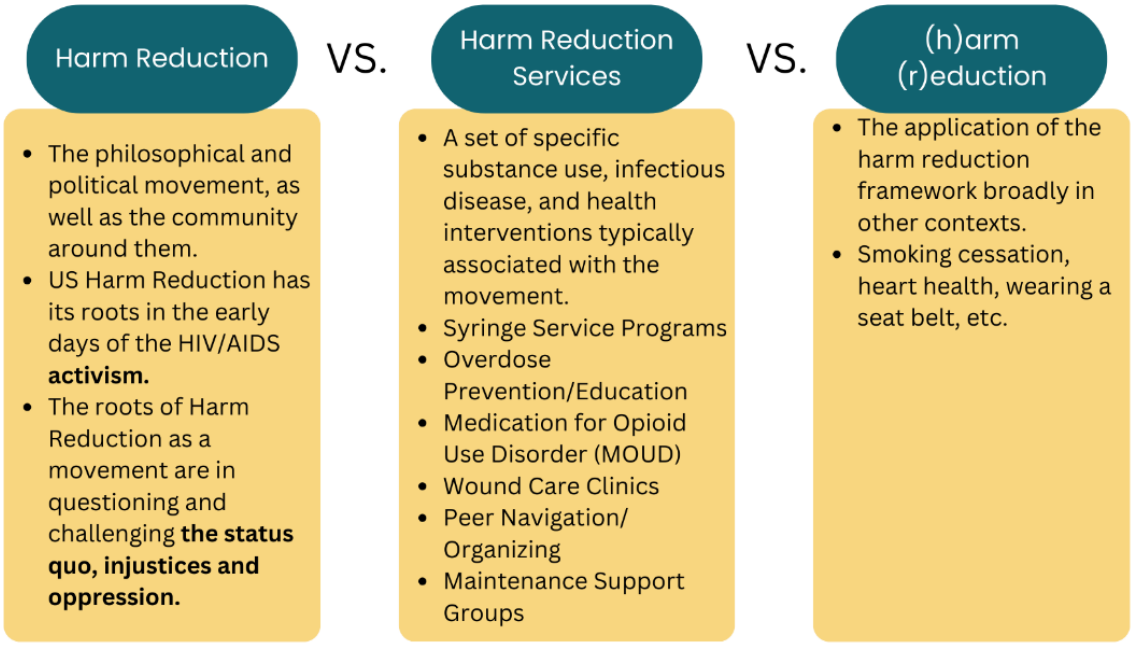
This report was conducted through scans of the literature, conference reports, and legislative reviews on harm reduction and related public health initiatives. We interviewed over 50 individual practitioners and leaders from a variety of fields and expertise including in harm reduction, people with lived and living experience, health and social policy, public safety, pharmacy, and medicine. We learned about Harm Reduction in practice, current challenges, gaps, future directions, and places and programs of inspiration. We also conferred with the statewide Harm Reduction Advisory Council (HRAC) on similar topics and met with members of the Massachusetts Legislature to inform our report's structure. During the preparation of this report, new statewide overdose statistics were released showing the largest reduction since 2006 in overdose deaths. Based on the research conducted by scientists at the Opioid Policy Research Collaborative at Brandeis University and the interviews performed for this report, we explored three hypotheses explaining these changes. We conducted statistical analyses comparing cities and towns with reductions to those without a change or an increase in deaths during the period of 2022 to 2023 and examined differences by Harm Reduction service status and notable changes in the drug supply. Results further informed the report's content.

A Harm Reduction-Centered Approach

Centering Harm Reduction creates a more wholistic approach to health and healthcare that can further the wellbeing of all people in Massachusetts. Research shows the benefits that can come from Harm Reduction, which includes reducing health and safety issues, providing broader public health benefits due to decrease in disease transmission, reducing visits to the emergency room

which can otherwise incur expensive costs, and reducing stigma.[7] The U.S. Department of Health and Human Services has recently recognized these benefits and includes many Harm Reduction components within its Overdose Prevention Strategy: promoting evidence-based research, expanding sustainable funding, and increasing public and user education.[8] Rooted in activism during the HIV/AIDS epidemic, Harm Reduction emphasizes dignity, bodily autonomy, and pragmatic risk mitigation, exemplified by services like syringe service programs (SSPs), naloxone distribution, and low-barrier access to medications for opioid use disorder (MOUD).

Figure: Harm Reduction vs. Harm Reduction Services vs. harm reduction. *Source:* National Harm Reduction Coalition[9]



See **Appendix A** for more on a Harm Reduction-Centered Approach, and **Appendix B** for the General Principles of Harm Reduction.

The Origins of a Harm Reduction Commonwealth

The Harm Reduction movement has evolved significantly over the past few decades, both nationally and in Massachusetts. Starting from grassroots local and regional efforts and growing to national policies, Harm Reduction is an impactful framework and has become a crucial component of public health strategies addressing drug use and its associated harms. The history of Harm Reduction advancements in Massachusetts is compelling because its chapters interweave outreach, protest, coalition building, pilot projects, commissions, lawsuits, but most importantly, invaluable contributions of local and national key figures who shaped the landscape of Harm Reduction and advocated for the health and rights of PWUD. Knowing these contributions is critical to advancing any additional policy efforts in the Commonwealth. Two exceptional and informative curated collections of Harm Reduction history can be found at the

Voices of Harm Reduction in Massachusetts oral history project and the compiled zine entitled, Harm Reduction Historia – A Collection of New England Harm Reduction Legacies.

Among the many historical documents worthy of review in this research brief, we call special attention to the report and related materials produced by the Harm Reduction Commission of 2018. This Commission, established by law by then Governor Charlie Baker, was charged with "reviewing and making recommendations regarding harm reduction opportunities to address substance use disorder."[10] We drew inspiration and direction from the work of the Commission, and many of their final recommendations are referenced throughout this report. These recommendations include fostering a culture of harm reduction throughout the state, supporting drug checking and fentanyl test strip access, piloting supervised consumption sites (aka overdose prevention centers), ensuring legal protections for staff and individuals accessing services, and acknowledged barriers with federal law.[11] A result of this Commission was increased state funding of more than $5 million to support Harm Reduction measures, including syringe access and naloxone expansion.[12]

A summary of the History of Harm Reduction: Nationally and in Massachusetts, can be found in Appendix C.

Racial Equity & Impacts of Stigma

Like too many other states, Massachusetts exhibits profound differences by race and ethnicity in overdose[13], treatment receipt, and Harm Reduction services uptake.[14] Communities that are disproportionately experiencing negative impacts of overdose and other drug-related harm deserve focused attention and support. In this report, we point out disparities by race, ethnicity, and geography, including rurality, to consider how stakeholders and lawmakers can act to reduce their impact.

Despite seeing overall reductions in overdose deaths last year, many communities still suffer. The Commissioner of the Department of Public Health, Robbie Goldstein, acknowledges the need for an equity-aware approach when saying, "To sustain these hard-won gains, we must focus even more deeply on the populations that have not yet seen such dramatic improvements. This means doubling outreach efforts in communities of color, particularly for Black residents, and people living in our most rural communities, who, as the data show, are disproportionately impacted by overdose deaths."[15]

Stigma of drug use is a universal theme across communities, academics, clinicians, PWUD, and certainly the interviews and discussions that informed this report.[16, 17] The impacts of stigma are deep and far-reaching, from fear of asking for help, calling 911 after an overdose, carrying naloxone, staying on medication treatment[18], reuniting with one's children, and many more everyday experiences for PWUD. Reducing stigma includes efforts to address misinformation and how we talk about drug use and PWUD. Networks such as *Changing the Narrative*, are working to do this through bringing diverse perspectives and experiences to their reporting,

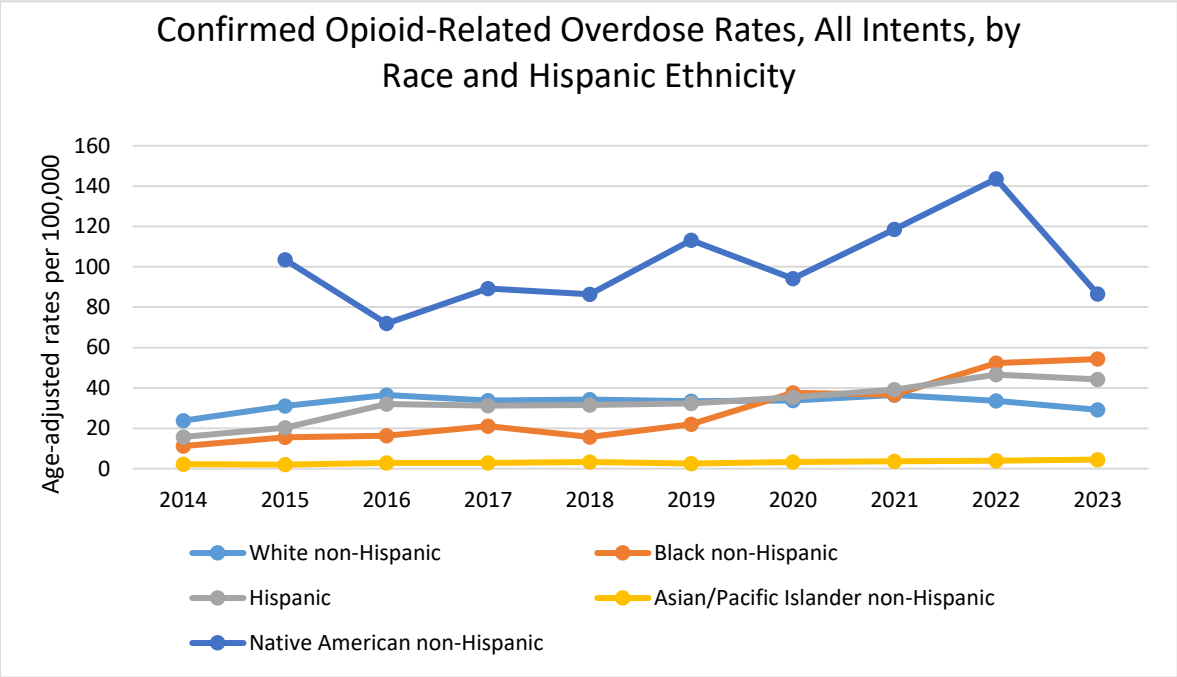
highlighting the importance of responsible reporting and evidence informed journalistic research.[19] Fighting off stigma and its legal consequence, discrimination, are essential in a Harm Reduction Commonwealth, and this report contains reminders of this necessity.

What is driving the decline in overdose deaths in Massachusetts?

Overdose statistics

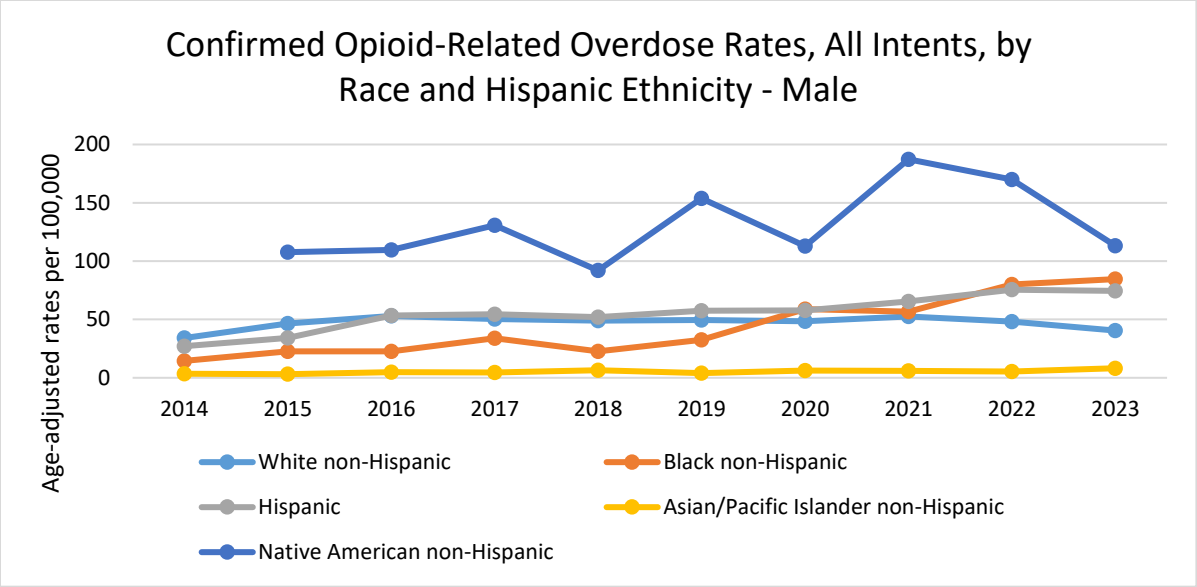
From 2022 to 2023, deaths from overdose fell from a record high of 2,357 to an estimated 2,125 opioid-related deaths, representing a 10% reduction in mortality. The prior year saw a slowed increase of 2.5% in overdose deaths from 2021 to 2022, but this year's decrease appears more encouraging and may harken a much-fought-for shift in the overdose crisis in Massachusetts and elsewhere. Still, so many premature, preventable deaths in any one year are far from tolerable and demand renewed efforts to save lives.

The reductions in opioid-related overdose deaths were not uniformly experienced. Demographically, disparities in overdose rates have widened and, geographically, many locations sustain dauntingly high numbers of overdose deaths.



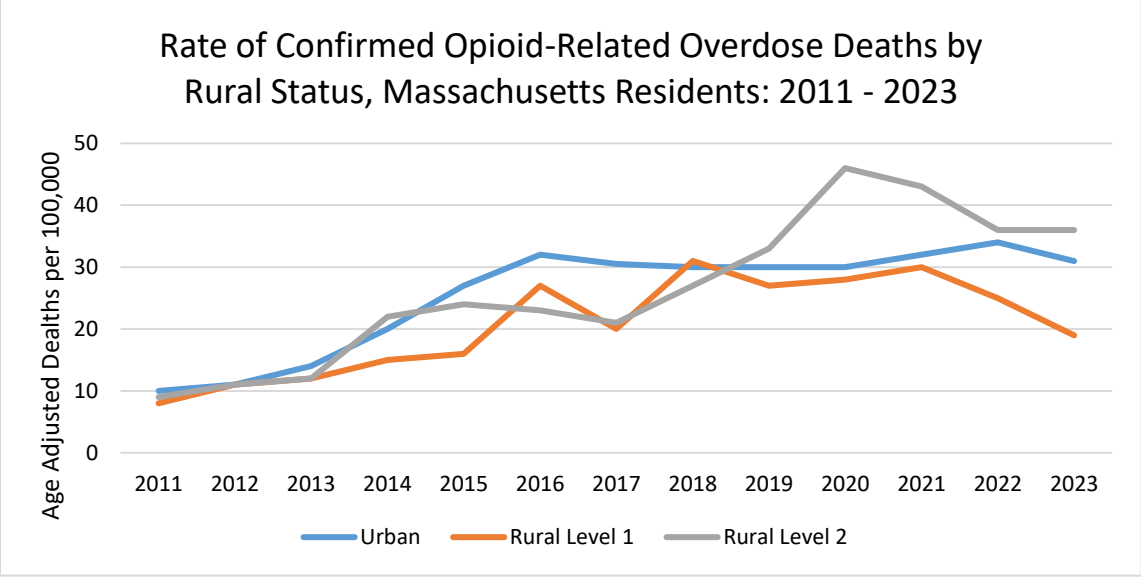
Source: *Massachusetts Department of Public Health*[20]

The decline in opioid-related overdose deaths from 2022 to 2023 was significant among White non-Hispanic men, whose overdose death rate declined 16% from 48.2 to 40.4 per 100,000 people. But Black non-Hispanic residents continue to be disproportionately impacted by fatal opioid overdoses: among Black non-Hispanic men, the rate of opioid-related overdose deaths *increased* from 80 per 100,000 in 2022 to 84.6 in 2023. American Indian non-Hispanics, along with Black non-Hispanic men and women, had the highest opioid-related overdose death rates in 2023 among all racial/ethnic groups.



Source: *Massachusetts Department of Public Health*[21]

Geographically, the most rural areas of Massachusetts continue to experience the highest opioid-related overdose death rate at 35.6 per 100,000 residents compared to urban, suburban, and less rural areas.



* Communities classified as rural level one meet fewer rural criteria than Communities considered rural at level two. Though communities in level one and two are both rural, communities in level two are less densely populated and more remote and isolated from urban core areas.

Source: *Massachusetts Department of Public Health*[22]

A Closer Look at Changes in Overdose Deaths in Massachusetts

Preliminary analysis of recent overdose trends points to the importance of drug supply monitoring and of Harm Reduction programs—especially SSPs— as informational tools and interventions that protect local communities and save lives. Overall, the experts identified a range of possible explanations including those below with further analysis in **Appendix D.**

- Recent larger reductions in overdose deaths in Massachusetts occurred in communities with active SSP and Harm Reduction service presence, suggesting their actions, local support, and advocacy in local communities are part of the story of reduced overdose mortality.
- Changes in the drug supply appear to have influenced the recent reductions in overdose deaths in Massachusetts. In particular, the veterinary sedative xylazine may be contributing to a reduction in fentanyl overdose deaths. Places experiencing increases in overdose deaths had less xylazine in their drug supply, and therefore less exposure and use of xylazine.
- Changes in the drug supply also appear to have influenced places experiencing ongoing or increased overdose deaths. Some specific communities had higher percentages of para-fluorofentanyl, a potent fentanyl analog, in addition to the fentanyl drug supply which may have compounded risk and contributed to the rise in overdoses there.
- Combining these findings, communities with SSPs and Harm Reduction services have tools, supplies, and a knowledgeable workforce able to respond and adapt quickly to drug supply changes to support risk reduction and prevent overdose deaths in their local areas. Communities lacking such capacity, or that hinder existing SSP and Harm Reduction service operations, are less efficient and able to respond to rapid drug supply changes with timely provision of prevention and intervention tools.
- Overall, fentanyl continues to contaminate the drug supply but the *concentration* of fentanyl present in the opioid supply appears to be declining. Reduced fentanyl concentrations in a given opioid drug may explain the observed reductions in overdose deaths in some communities.

Actions for a Harm Reduction Commonwealth

1. Ensure Sufficient and Equitable Access to Safe Use Supplies Statewide

Background:
The possession and free distribution of syringes and other safer use supplies is not illegal in Massachusetts. As of August 19, 2024, 90 cities/towns have local Board of Health (LBOH) approval to operate SSPs. The Bureau of Infectious Disease and Laboratory Services (BIDLS) funds 65 SSPs in 57 cities and towns across Massachusetts. Several programs are not BIDLS-funded, and several cities and towns have more than one SSP program operating within their borders. A brief history of SSP programs in the Commonwealth is in **Appendix C** with additional relevant background in **Appendix E**.

The Challenge:

While state law allows any individual or private organization to distribute syringes and other safer use supplies without impediment, local board of health approval is required for state-funded programs to be implemented in a community. This requirement takes time to document and creates a significant impediment to public health and safety demands. The pace of drug supply changes and the need to prevent transmission and spread of infectious disease and infection warrant a data-driven approach. If the Massachusetts Department of Public Health (DPH) identifies, for example, a need for syringe distribution in a community, such services should be permitted based on the health and safety needs of the community, not stigma or local political persuasions.

The Data:

Since 2016, Massachusetts has experienced three major HIV outbreaks related to injection drug use and the rapid emergence of fentanyl in Lawrence, Lowell, and Boston, with the Boston area outbreak still ongoing.[23, 24] Data consistently find that broad access to syringes for people who inject drugs significantly reduces the risk of transmission of HIV[25] and other blood borne viruses[26,27], reduces risk of infection and abscess[28], and increases entry into drug treatment[29,30] and MOUD[31], without increasing drug use or crime[32]. SSPs are a cornerstone of overdose prevention[33,34]. Syringe services are needed now, warrant implementation without barriers, and save lives.[35]

What's Needed:

This unnecessary and perverse impediment should be removed.

Drug User Health Hubs in New York State

The state of New York is taking an innovative approach to improve the access to resources for PWUD. The NY State Department of Health has Drug User Health Hubs, which are "expected to improve the availability and accessibility of an array of appropriate health, mental health, and medication assisted treatment services for PWUD, especially but not solely injection drug users (IDUs)." These hubs use frameworks of the Harm Reduction movement and focus on the prevention and response to opioid overdoses. These Hubs provide services either on-site or connections with other community resources that can refer people to culturally competent care, a critical component of care in a harm reduction setting. The hubs rely on creating connections and relationships with PWUD as a means of referral but also to establish trust that can provide support for the individual.

Suggested Actions: Repeal Mass. Gen. Laws Ann. ch. 111, § 21.

Alternatively, **revise language of (OS 65) OUTSIDE SECTION 65, Effective 7/1/16, adding the red text**

Chapter 111 of the General Laws is hereby amended by striking out section 215, as so appearing, and inserting in place thereof of the following section, containing possible expansions:

- Section 215. The department of public health may implement needle exchange programs for the exchange of needles in cities and towns. Prior to implementation of a needle exchange program, notification shall be made to or approval shall be obtained from the board of health in the hosting city or town. The city or town shall, in a manner determined by the department, document the acknowledgement of the notification or provide official approval to the department.
- Not later than 1 year after the implementation of a needle exchange program, the department shall report the results of the program and any recommendations by filing the same with the senate and house chairs of the joint committee on health care financing and the house and senate chairs of the joint committee on public safety and homeland security.

What else can be done?

Broader access to non-syringe safer use tools and education, such as safer smoking, snorting, and boofing (anal) materials and supplies should be provided across the Commonwealth. Any health department or community program providing naloxone and/or test strips should supply safer use materials and promote safe monitoring. If a program provides the ability to detect fentanyl and the medication to reverse a fentanyl overdose, they should also provide sterile materials other than syringes.

A Model State: Minnesota and the Legalization of Drug Paraphernalia

The state of Minnesota is leading the way in legislative action to improve harm reduction efforts, decrease punitive response, and truly prioritize health and wellness. In May 2023, Minnesota Governor Tim Walz signed an expansive public safety law. This bill included legalizing the possession of paraphernalia, even if there is any drug residue in it. Additional measures included:

1. Allowing people to possess hypodermic syringes or needles regardless of their intended use
2. Removing the cap on number of syringes pharmacists can sell to people without a prescription
3. Ending the ban on possession of products to test controlled substances, such as fentanyl test strips and devices for more comprehensive drug checking
4. Allowing community-based public health programs to provide sterile needles, syringes, and other equipment, in addition to providing education on overdose prevention and safe injection practices

Research supports this effort in that it shows that having access to these supplies supports broader public health and reduces the harm related to substance use that commonly happen from contaminated injection supplies. Minnesota is the first state to pass such an expansive measure that aligns with the principles of harm reduction, and should serve as a model for other states, including Massachusetts.

2. Authorize Community Drug Checking Statewide

Background:
Information about the drug supply is the single most important datapoint to calibrate our response to the opioid crisis—yet it is virtually a black box. The street drug supply is unregulated and unpredictable, leading to unprecedented overdose deaths, an undermining of the medication treatment options, and complex health needs. Between emerging threats, synthetic substances, veterinary medicine additives, and other contaminants being added to the drug supply, what is in a drug is changing frequently.

Community drug checking programs are services that operate in community settings where PWUD can learn the contents of a substance so that preventative and Harm Reduction actions can be taken. These services are essential to inform PWUD about possible risks and to inform our public health response. Drug checking is not a new invention or unique to the Commonwealth. Community drug checking is a standard component of drug supply surveillance used in most European countries, Canada, Australia, and New Zealand and programs operate all over the world.

It is imperative that both health officials and PWUD to know when, where, and in what form a change to the drug supply is occurring. Does the drug supply change increase risk, reduce risk, or represent a shift of limited or no-risk impact? This vast information gap demands attention and resources that can be filled by expanding a cornerstone of modern Harm Reduction: community drug checking. A brief history of drug checking in the Commonwealth is included in **Appendix F.**

Both the Massachusetts House and the Senate versions of the "Opioid bill" (S. 2898/H. 4758) authorize drug checking statewide.

The Challenge:
People fear arrest because the status of drug checking in Massachusetts is not explicit and because they worry about being in possession of even the remnant drug amounts needed for testing. Currently, drug checking programs operate in some Massachusetts communities under signed agreements with individual law enforcement agencies, so access to community drug checking is limited just to the patchwork of locations with agreements. For rural areas with many police departments, for programs operating mobile health vans, and for people who live far from a Harm Reduction organization, drug checking services are inaccessible. Clients or others who are concerned and may seek these services must take a risk in possessing and transporting controlled substances to use the available drug checking services. Mobile health van staff who conduct drug checking in one community but need to drive to another to provide health services run similar risks. For these occupational and personal liabilities and risks, the criminalization of this life-saving service is harmful and counterproductive.

The Data:

Community drug checking helps PWUD better understand what substances are in the drugs they use. The process of community drug checking involves allowing community members to donate remnant drug samples to be tested in a standardized way to determine their contents. Providing people with information about what's in their sample prior to use can help them make informed decisions about dose, route of administration, and overdose prevention strategies.[36]

When people drink alcohol, it is possible to know how much alcohol is in a beer or a bottle of wine, but for PWUD, the contents are unknown and may only be determined by trying it first. Drug checking is preventative, proactive, and community-centered: rather than waiting for a hospitalization, arrest, or death to learn about what is in a drug, community drug checking invites people to know the contents of a substance before bad outcomes happen, anonymously. Also, unlike data from hospitals, arrests and deaths, drug checking data are tested quickly, compiled, and accessible in real-time to the individual and shared with the community. In this way, data about the drug supply that is aggregated at the program and community/state level can inform service provision, health communication strategies, and health intervention and responses at local levels.

Case in Point:

In late 2020, drug checking data from the MADDS program identified the veterinary sedative xylazine as an additive in the opioid supply and informed communities of its presence and potential to cause painful wounds.[37] By 2022, the increase in xylazine prompted broader alerts to the public, making it possible to ramp up and adapt mobile health van and Harm Reduction resources, and raise awareness among public safety partners.[38] Xylazine presence in the drug supply is tracked interactively on the StreetCheck.org website.

The Opportunity:

Emerging testing technology requires incredibly small levels of substance, and some drug checking devices like immunoassay test strips have been mainstreamed into public health responses for fentanyl awareness. In many states, fentanyl test strips are available over the counter at retail pharmacies, accessible online for purchase, and, in

How are Drug Checking Data Used?

Data are used in many ways, including:

- *to inform if, what, when, how much, and where someone may use the substance*
- *to craft local responses to "spikes" in overdose or other health problems*
- *to identify emerging threats and substances, combinations, or types of use that are concern to health and safety*
- *to educate policy makers, community organizations, and other stakeholders about trends in your community*
- *to provide more accurate health communications, including informational briefings vs. risk-oriented messaging*
- *to prioritize public safety strategies*
- *to better align supplies and resources provided by harm reduction organizations with drug supply trends*
- *for opioid settlement fund planning and prioritizing*
- *to inform treatment conversations*
- *to advocate for specific treatment plans, treatment entry, wound care, etc.*

Massachusetts, can be obtained for free through the health department and community organizations. Test strips are safe for home, personal use and encouraged as a public health strategy by the Centers for Disease Control and Prevention (CDC), the Office of the National Drug Control Policy (ONDCP), the Substance Abuse and Mental Health Services Administration (SAMHSA), and trialed in National Institutes of Health (NIH) funded studies where use has been documented as feasible and effective by lay public and PWUD. But test strips are limited in that they test only for presence of one component (e.g., fentanyl, benzodiazepines), and substances that people use typically are mixtures of multiple substances—not just fentanyl. Portable, new analytic devices are non-destructive and require similarly small (or smaller) amounts of substance to determine possible contents of a drug.

Massachusetts is home or host to many cutting-edge technology companies and innovators whose products and tools are used in drug checking—or may be adopted in the future. Authorizing drug checking in the state elevates Massachusetts as a leader in Harm Reduction, will encourage more advanced technological innovations, and holds promise for business development in this field.

What's Needed:

- Legislators should authorize community drug checking statewide as part of the "Opioid bill" by ensuring that both drug checking programs and individuals that bring drug residue to be tested are immune from state drug possession laws for possession of the small amounts of drugs being tested.

- The Legislative Analysis and Public Policy LAPPA created a model drug act for fentanyl/xylazine test strips and other drug checking equipment. It provides model language to establish and prote6ct these services, the staff who operate drug checking services, and the patrons who may use the service. A future law should contain such clear protections.

What else can be done?

The legislature should also consider:

- Removing the criminal penalty for the sale of drug checking equipment
- Including the use of drug checking equipment or services as a mitigating factor for reduced sentencing of any drug related crime
- Investing in the operational aspects of this program is crucial: budgetary considerations should support ongoing training, technical support, and additional staffing of technicians.

3. Pilot Overdose Prevention Centers

Background:

Overdose prevention centers provide an indoor area, typically in a healthcare or community-based facility, where individuals can consume substances in a setting that is safe, monitored, and hygienic.[39] These facilities have trained staff that can provide intervention and overdose reversal medication, if necessary.[40] They usually extend other services that can decrease harm related to substance use, such as safer use materials, education, and drug checking. Some larger and more comprehensive sites also include supports like counseling, primary care, MOUD treatment, pharmacy services, reproductive care, employment supports, and laundry facilities.

In December 2023, The Healey administration released a feasibility report on Overdose Prevention Centers (OPC). This report, in conjunction with the findings of the 2018 Harm Reduction Commission, shows the benefits of moving forward a strategy around OPCs as a part of the Healey broader Opioid Epidemic Strategy.[41,42]Additionally, in March of 2024, the Boston Public Health Commission released a report supporting the research that shows the impact, safety, and cost-effectiveness of OPCs.[43] Following this, in April of 2024, three unions in Massachusetts of health care workers, educators, physicians and interns, and human care workers shared their support for OPCs.[44] In May of 2024, the Boston Public Health Commission released a public brief discussing support for OPCs in Boston.[45] Massachusetts residents overwhelmingly support OPCs (70%).[46]

The Challenge:

The legality of OPCs at the federal level is unclear. A federal law, 21 U.S.C. 856, forbids having space that is open, leased, rented, used, or maintained for the purpose of using a controlled substance.[47] However, it is not clear whether this law would apply to an OPC in Massachusetts. However, other states, including Rhode Island and Vermont, have authorized OPCs at the state level, and two OPCs have operated in New York City for years.

Rhode Island's Opioid Prevention Center (OPC) Legislation

Rhode Island enacted legislation on July 7, 2021, to establish an Opioid Prevention Center (OPC), which could serve as a valuable model for Massachusetts. The two-year pilot program, funded by opioid settlement funds, is guided by an Opioid Settlement Advisory Committee within the Executive Office of Health and Human Services. The legislation created a regulatory framework, empowering the Department of Public Health (DPH) to develop regulations for OPCs, which must receive local approval before opening. This initiative is part of the broader Prevent Overdose RI effort, aimed at ending the opioid epidemic in the state. Massachusetts can look to Rhode Island's regulatory approach and success in integrating harm reduction strategies at the local level as a potential framework for addressing the overdose crisis. Additionally, including a variety of overdose prevention materials accessible for the public can aid in building knowledge about what the OPCs are, help visualize the sites with a virtual tour, address frequently asked questions, and dispel myths.

State authorization in Massachusetts could take several forms. In addition to removing potential criminal and civil liability for OPC operators and clients, legislation may also need to preempt local land use and zoning laws.[48] As with early SSPs, legislation could require that OPCs be approved by the local board of health for the locality in which they would operate. However, also requiring city or town leadership approval is excessive and would risk turning what should be a decision driven by health considerations into one driven largely by politics.

The Drug Policy Alliance connected with almost 200 people across the U.S. who are doing advocacy around expanding access to an OPC. Their findings show that the design and implementation of OPC programs and policies should be based on what the community needs and should provide for flexibility and innovation.[49] Legislation that does not allow for this could stifle the ability to address community needs and concerns in a way that enhances the acceptance of OPCs and helps ensure their success.

The Data:

A large body of research has shown the effectiveness of OPCs in a variety of settings, operating as brick-and-mortar or mobile programs.[50] Research suggests that OPCs can be impactful in limiting the overdose risk for individuals that are unhoused, since substance use in public spaces put these individuals at a higher risk of feeling stigmatized, robbery, and interactions with police, all of which an rushed injections, the immediate disposal of syringes, and other unsafe practices.[51] The analysis of the OPC effects in New York City, one of which is located across from a school, found a reduction in violence, crime, public disorder and 311 calls in the neighborhoods with OPCs compared to demographically comparable areas of the city with other social service programming.[52]

Data indicate that OPCs mitigate the risk of infections including blood-borne infections like viral

hepatitis, HIV, and bacterial and fungal infections.[53] At OPCs, people can be provided with a safe space to consume substances, supplies for safer use, self-care (e.g., period products, condoms) and wound care that could decrease infections, speed healing, and reduce emergency department visits or hospitalizations for infection complications. lead to

The Opportunity:

The Massachusetts Harm Reduction Commission of 2018 found that OPCs decrease disease transmission and reduce drug-related overdose deaths.[54] Legislation provides an opportunity to ease the barriers to creating OPCs and creates the best legal protection in light of prohibitive state and local laws.[55]

During the 2023 – 2024 legislative session, a bill was put forward in the Massachusetts' legislature to establish overdose prevention centers and fund a pilot study of their effectiveness. The legislation did not make it through the chambers and was sent to conference committee for ongoing negotiations before the end of the session.

What's Needed:

Legislation can clearly permit the operation and use of both stationary and mobile overdose prevention centers in Massachusetts, and direct communities and the state to fund, through opioid settlement or other monies, this initiative.

Protections should specifically extend to providers with lived experience, allow for tailoring the level and type of services offered to community and population needs, ensure allowances for different types of drug use (including inhalation spaces), and provide language to ensure privacy and reduce barriers to service.[56]

What else can be done?

Policies and actions to reduce public drug use and support safer use and observation can occur right now, without legislative intervention.

Innovative Harm Reduction: Mobile Consumption Sites

In addition to Overdose Prevention Centers, other innovative models are emerging to address similar needs, such as the mobile consumption sites operating in rural British Columbia. These mobile sites aim to prevent overdose deaths, reduce public drug use, and connect individuals to essential services in underserved rural areas. Two mobile units were deployed to serve two areas and evaluations showed generally positive experiences, though there were calls for longer operating hours to improve accessibility. Community members largely supported the initiative, recognizing its value in harm reduction. This model could be considered for a pilot program in Massachusetts to test its effectiveness before scaling. Key to success, however, is community engagement, which is essential to ensuring the successful implementation of OPCs.

- Encourage the use of SafeSpot, the virtual consumption observation service funded by DPH. The peer-operated, confidential service stays on the phone line during use and calls for help in the event of an emergency.
- Create spaces for safe observation and monitoring, such as Boston Healthcare for the Homeless Program's SPOT, where people left or found outside can be safely monitored and observed
- Support Harm Reduction housing models and policies that equip low-barrier housing locations with Harm Reduction supplies and personnel (see Initiative #8)

4. Expand and Protect Access to Medication for Opioid Use Disorder (MOUD)

Background:
MOUD are already used widely across the Commonwealth. Buprenorphine is a prescribed medication that is filled at community pharmacies; methadone can only be dispensed by a specially regulated clinic or a hospital. In other countries and some specialized settings in the US, pharmacies dispense both medications by acting as a satellite medication unit of an existing opioid treatment program (methadone clinic). There are also injectable forms of buprenorphine (lasting one week or one month) and the injectable medication extended-release naltrexone that can be administered by a trained provider monthly. The network of community health centers in Massachusetts as well as mobile health vans in some cities[57] are places where integrated buprenorphine treatment is available and where a nurse-case manager model of care[58] was pioneered.

The Challenge:
While access to medication treatment in Massachusetts is available, barriers still remain for many due to the location and geography, cost, racial and ethnic disparities and stigma.[59, 60] These barriers are especially poignant for pregnant or parenting PWUD and PWUD who are incarcerated.

Racial and ethnic disparities in MOUD uptake exacerbate overdose risk and contribute to poor health outcomes for people who identify as Black and Latine with OUD. So-called "treatment deserts" point to the need for more accessible care hubs, inviting and sustaining a more diverse workforce, and "thinking outside the box."

Methadone is highly regulated at the federal and state levels, and clinics face local challenges when looking to cite new programs or bring on mobile methadone programs. While a growing service, mobile methadone programs operate in only a few locations around the state. Medication units (satellites of OTPs) are uncommon, and no pharmacies in Massachusetts are medication units of an OTP.

Administrative challenges to buprenorphine care imposed by insurers such as prior authorizations and cost-sharing impede access. Methadone clinics are too few and challenging to get to, posing geographic and practical limitations on who can engage in their services. While

community health center and clinic-based access to MOUD are fundamental, it is insufficient and inconsistently implemented across the state, creating gaps in access to care that too often magnify inequities.

Gaps in treatment access likely contribute to alternative markets for buprenorphine, which is frequently diverted from people with a prescription to people without a prescription. Studies show that people use nonprescribed buprenorphine primarily to prevent opioid withdrawal symptoms to avoid fentanyl or heroin use[61,62], and most would prefer to have their own prescription[63]. Prior use of nonprescribed buprenorphine is common among people in MOUD treatment, suggesting that nonprescription use may have a role in treatment uptake. But possession of medication that is not prescribed to you is illegal and thus poses increased risk of criminal justice contact.

According to the Maternal Mortality Review Committees, between 2017 – 2019, the leading cause of death for pregnant people was mental health conditions.[64] This includes death by suicide and overdoses related to SUD. Further, the fear of prosecution can serve as a barrier. The Child Abuse Prevention and Treatment Act (CAPTA), as well as other similar laws, could create barriers to MOUD since this act requires health care providers to notify protective services if caring for a child that has been "identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure".[65] This means a person with OUD that is on MOUD while pregnant because it is safe and effective could be reported for child abuse at the time of the delivery.[66] Massachusetts has a "priority access" law in place, that is meant to give access to pregnant and postpartum people in public drug treatment facilities. Access to this treatment is shown to increase positive outcomes for both the birthing people and the infants.[67] However, Massachusetts has additional punitive laws in place that require reporting to child welfare agencies, which could include being on MOUD.[68] Due to the existing disparities of MOUD enrollment by race, this could especially impact Black, Indigenous, People of Color (BIPOC) pregnant people. There is currently work on a dual pathway reporting system that would allow those with no concerns of abuse or neglect to be de-identified for CAPTA reporting and only those who meet the criteria for harmful patterns of substance use to have child welfare involvement.

The Massachusetts Department of Correction and Houses of Correction have been expanding access to MOUD for incarcerated individuals, particularly for individuals without prior treatment history. However, gaps still remain in the education around MOUD and implementation. Inconsistent practices between facilities that may result in the slower increase in dosage can lead individuals receiving the MOUD to not be satisfied with the medication and want to discontinue the use and are currently only doing maintenance medication rather than induction to start people on MOUD care. Additionally, doctors are not always directly involved with the patient care for MOUD. Finally, MOUD is controlled by a different provider and challenges in the connection between the healthcare services and the MOUD services can cause barriers to treatment.

The Data:

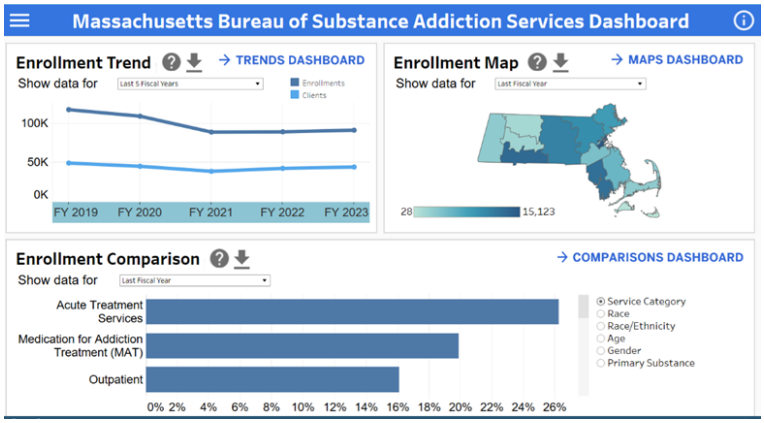
All Food and Drug Administration (FDA)-approved MOUD treatments—buprenorphine, methadone, naltrexone-- have been shown to decrease substance use and cravings, and methadone and buprenorphine treatment substantially reduce the risk of overdose and death from any cause.[69] Estimates show that broader access to MOUD could reduce opioid-related deaths by 50 percent.[70] Additionally, the use of MOUD has been shown to reduce the use of other substances, increase the ability to get and retain employment, improve birth outcomes for those who are pregnant, and increase the chances of staying in treatment.[71,72] When taken during pregnancy, MOUD decreases overdose risk, with decreased risk with each continued week of use.[73] In general, negative health outcomes including risk of overdose increase when stopping medication treatment, particularly if done abruptly. For incarcerated individuals, receiving methadone during incarceration can increase the continued use of treatment after release[74,75,76] and receipt of any MOUD reduces the risk of overdose post release.[77,78]

Changes in opioid tolerance—through disruptions such as incarceration/release from incarceration, hospitalization discharge—create fatal overdose risk if an individual returns to drug use. Another way changes in tolerance occur is an interruption in substance use disorder (SUD) treatment. Treatment interruptions can occur for diverse reasons, and these interruptions contribute to high-risk periods for those with opioid use disorder (OUD).[79,80] It is well established that leaving detoxification services without a plan to continue care in MOUD puts people with OUD at high risk of overdose, as does termination of residential treatment, compared to other forms of treatment.[81]

Although enormous variability in the quality, duration, and type of treatment (e.g., outpatient, residential, etc.) contribute to the inconsistency of the research about the effectiveness of many treatment types, data are clear and consistent about the importance of ongoing treatment with MOUD.[82] Among the impediments to broader MOUD use are insurance restrictions and cost-sharing (e.g., deductibles, co-payments, and coinsurance). Research suggests prior authorization and cost-sharing requirements are commonly applied to MOUD in Medicaid managed care plans.[83] These restrictions and financial burdens can be barriers to treatment receipt and removing them is linked to increased buprenorphine receipt.[84,85,86,87,88] Prior authorizations can restrict if and when a patient can begin buprenorphine treatment as well as at what dose they may commence. Higher doses of MOUD have been shown to best treat people whose OUD is due to fentanyl use.[89,90,91,92] Clinicians and treatment advocates have called for the removal of prior authorization and cost-sharing for buprenorphine.[93,94]

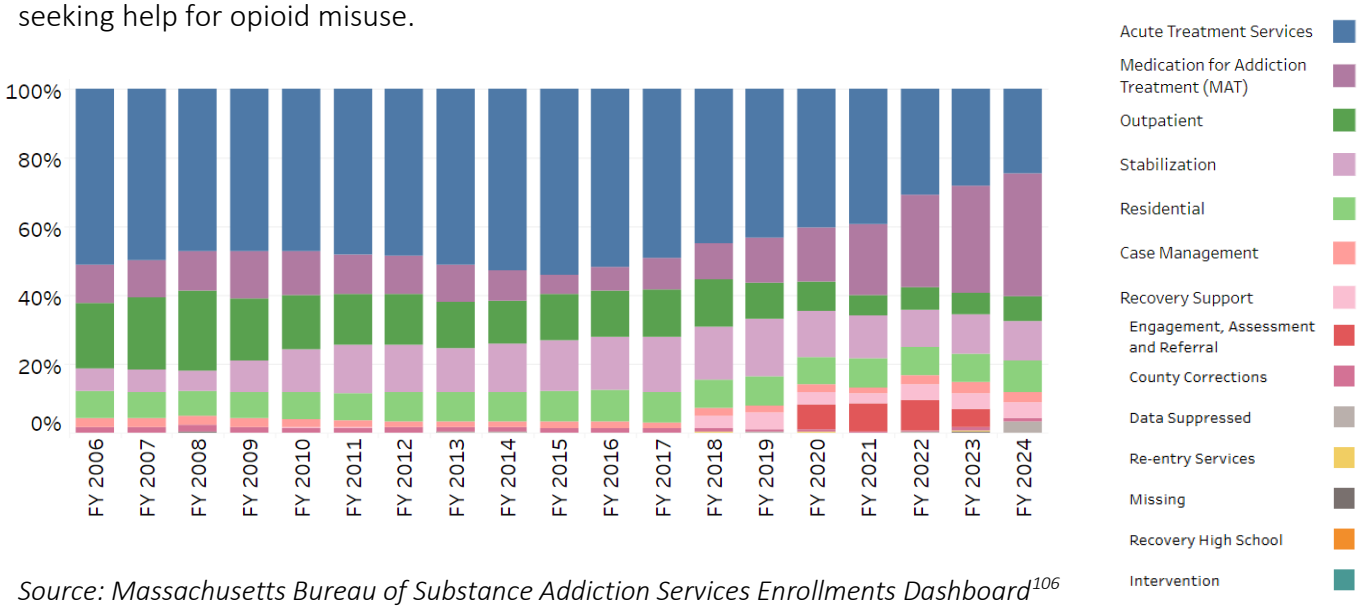
The treatment system itself poses impediments to MOUD, especially for patients of minoritized races and ethnicities. Calls for MOUD treatment delivery to change—and the necessity to drastically change them during the COVID-19 pandemic—have led to natural experiments and improvements worth adopting. Several studies demonstrate that MOUD can be offered successfully and safely outside traditional pathways, to "meet patients where they are", with greater equity. These include models of MOUD delivered via mobile health vans[95,96], via telehealth[97,98] started in hospitals under COVID-19 era permissions that allow hospitals and health centers to provide up to 72 hours of methadone care to start people on MOUD[99], via

EMS, by street outreach teams[100,101], via collaborative practice agreements allowing pharmacists to start and continue MOUD care[102], via pharmacies operating as medical unit extensions of opioid treatment programs[103], and even in public libraries leveraging telehealth permissions (see call-out box). Additionally, efforts for homeless shelter-based buprenorphine distribution have shown success in reducing overdose deaths and other health costs.[104,105]



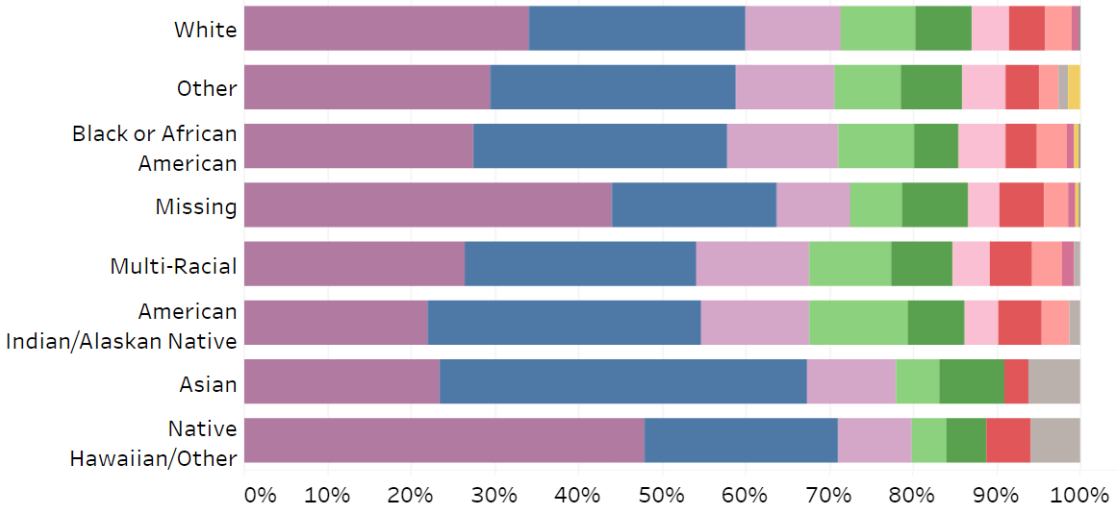
Current status:
Data displayed on the publicly accessible Bureau of Substance Addiction Services (BSAS) Data Dashboard show that treatment seeking has been on the decline over the past 5 years (prior to the COVID-19 pandemic), with reductions in enrollments and clients, and most enrollments over the last fiscal year being for acute treatment services (i.e., detoxification), followed by medications for addiction treatment.

Looking over time, acute treatment services and stabilization units have been supplanted by MOUD (labeled here as Medications for Addiction Treatment or MAT) enrollments for people seeking help for opioid misuse.



Source: Massachusetts Bureau of Substance Addiction Services Enrollments Dashboard[106]

However, by race, there are notable differences in the kind of treatment received. Statewide in FY 2023-2024*, for BSAS clients with problematic opioid use, MOUD treatment was more commonly received by White enrollees. White clients represented substantially more enrollments than Black or African American, Multi-racial, American Indian/Alaska Native and Asia clients, who all received more acute treatment services (detox).



**See legend from figure above*
Source: Massachusetts Bureau of Substance Addiction Services Enrollments Dashboard[107]

These trends suggest the need for a robust, multi-pronged approach to address disparities in treatment enrollment, stigma in the community, and structural challenges that impede staffing for response from diverse populations and backgrounds. Some programs in Massachusetts have approaches that are innovative in reaching diverse populations, including programs like Casa Esperanza[108], Entre Familia[109] or the Black Addiction Counselor Education Program (BACE).[110]

Telehealth permissions allow for patients to begin treatment on MOUD with buprenorphine, but MassHealth and other insurers require the patient to have an in-person visit to the prescriber within the first year in order to reimburse for visits. If, instead, a pharmacist was considered a designee of the prescriber and permitted to perform a confirmation or follow-up visit to fulfill the requirement, patient burden could be minimized and a pharmacist's expertise as a medication expert with greater accessibility in the community could facilitate the care episode.

Pharmacists are recognized as providers by the state of Massachusetts but cannot prescribe medications and can only be reimbursed for minimal counseling activities, using medication management billing codes. In contrast, in Maryland, pharmacists are allowed to prescribe and there is parity in reimbursement for this and related services they provide.[111]

Regarding medication coverage, the Massachusetts Medicaid program contracts with 17 entities, including managed care plans and accountable care organizations, to administer health insurance benefits for 1.2 million Medicaid beneficiaries in Massachusetts. These plans must follow medication coverage and utilization management policies determined by the state in the state-uniform preferred drug list. In 2024, the Massachusetts Medicaid preferred drug list included buprenorphine-naloxone and extended-release naltrexone (Vivitrol). The state-uniform preferred drug list instructs plans to use prior authorization only for generic buprenorphine-naloxone at doses > 32mg and any dose of generic buprenorphine-naloxone over a 90-day supply. All brand-name buprenorphine-naloxone products (e.g., Zubsolv) require prior

authorization (M Stewart, personal communication, November 2024).[112] Compared to most other states, Massachusetts coverage is superb[113]. In addition, the buprenorphine generic products do not have cost-sharing (e.g., deductibles, co-payments, and coinsurance) for Medicaid patients, which further reduces important and known barriers to MOUD access. However, not all private insurances operate similarly, and cost-sharing for buprenorphine is common among these entities[114], with few exceptions[115].

What's Needed:

- Decriminalize nonprescribed buprenorphine possession. Vermont eliminated all adult criminal penalties for possession of 224 mg or less of buprenorphine. Rhode Island passed similar legislation in 2021, which exempts buprenorphine from the list of controlled substances that result in criminal penalties. The net result of these laws is to immediately reduce unnecessary criminal justice contact and may have other benefits including treatment uptake and stigma reduction, without impacting public safety or altering prescribing practices. At the same time, many PWUD try nonprescribed buprenorphine before seeking formal treatment from a physician, so decriminalization can create a firmer and less risky pathway in that regard. Initial NIDA-funded research at Brown University shows police officers generally find this targeted decriminalization of a very low-risk addiction treatment medication acceptable, and that did not diminish their ability to provide public safety or enforce other laws. Many public health organizations therefore urge adoption of this approach.
- Consistent with Initiative #10, all substance use and drug treatment services, including opioid treatment programs (methadone clinics), should provide access to Harm Reduction supplies (e.g., naloxone, fentanyl test strips, safer use materials) and information (e.g., where to access low-barrier MOUD, mobile health vans, wound care, drug checking services).
- Align pharmacist capacities for SUD care and hormonal contraception access with newly legislated permissions pertaining to HIV prevention provision (PrEP/PEP). Specifically for the provision of SUD care and hormonal contraception, amend laws to: a) permit all community pharmacies to collaborate with prescribers and b) confer prescriptive authority to pharmacists to expand access to these essential, public health services. With respect to SUD medications, state practice of pharmacy laws/regulations should include express permission to administer any FDA-approved form of buprenorphine and methadone. Pharmacists should c) be designated by the state as providers who can receive reimbursement for these public health services at rates comparable to other providers. In Massachusetts, pharmacists cannot prescribe medications, and current statute only allows for pharmacist-prescriber collaborations within institutions like hospitals and not in community settings where health disparities could best be mitigated by these policies.
    - The Legislative Analysis and Public Policy Association (LAPPA) provide model act guidance to assist with articulation and adoption of these laws.
    - Several states have passed legislation expanding pharmacist's roles in SUD care (e.g., Nevada) or other public health services (e.g., Rhode Island—see callout box) while other states have expanded pharmacist's roles more broadly (e.g., Maryland, Idaho). Importantly, parity in reimbursement for specific procedures or services is spelled out so that proper incentives are built within the systems for sustainable care delivery.

- Expand and extend telehealth permissions and parity with in-person care and remove barriers to receiving ongoing telehealth care including requirements around in-person visits to the prescriber. If pharmacists are conferred provider status, as encouraged above, picking up one's MOUD prescription at a pharmacy coupled with a brief consultative visit with a pharmacist should be considered fulfillment of any in-person visit requirements.
- Funds should be earmarked to pilot expansion of MOUD coupled with Harm Reduction services in non-traditional treatment settings such as libraries, school health clinics, pharmacies, and additional mobile van models especially mobile methadone.
- Promote the expansion of methadone via the 72-hour rule at hospitals, clinics, and FQHCs. Expand mobile methadone programs and facilitate the application and implementation of OTP medication units in supermarket pharmacies, community retail pharmacies, hospitals, urgent care, and other healthcare settings. Pass legislation affirming the essential public health role of these services and ensure they cannot be zoned out or stalled by moratoriums by local legislative authorities, boards or health or other planning commissions. Similar legislation was passed by Washington state in 2023[116], amending their definition of "essential public health facilities" to expressly include "opioid treatment programs including both mobile and fixed-site medication units" in the list of essential public facilities.
- Finally, this legislative session, the House and the Senate passed different versions for *An Act relative to treatments and coverage for substance use disorder and recovery coach licensure*.
    - In H. 4758, language is included to address pregnant people and use of MOUD. It reforms the state's child protective service laws to ensure pregnant patients can access evidence-based treatment for OUD without fear of being reported to the Department of Children and Families.
- To benefit the lives of more people with OUD in Massachusetts, legislators could require *all public and private insurers* to remove prior authorizations on all MOUD medications, as has been done in other states, and to remove all cost-sharing for buprenorphine products. In addition, to avoid medication shortages, pharmacies could be required to stock a minimum quantity of buprenorphine products. Last session's House and Senate versions of the "Opioid Bill" contained language that would take action in this area and should be adopted.

What else can be done?

Protections from the American with Disabilities Act (ADA) should also remain front of mind when considering the access to MOUD. The ADA includes protections from discrimination for individuals in recovery from OUD.[117] This does not include individuals who are also engaging in active drug use and does include taking prescriptions of MOUD. The ADA protects against the discrimination of a SUD since an SUD is defined as a disability.[118] This includes people who may be "regarded as" having an SUD. Active enforcement of the ADA and swift responses to ADA complaints filed regarding MOUD access violations reduces stigma of these life-saving medications and reduces harm.

ADA enforcement also pertains to skilled nursing facilities (SNFs), which includes nursing homes and long-term care (LTC) facilities. SNFs assist with continued care as a piece of long-term recovery from previous hospitalizations, and MOUD has been seen to hinder admissions into the facilities.[119] However, refusal to admit an individual due to need for MOUD is discrimination and

in violation of the ADA.[120] Identified barriers can include the preparedness of the staff, the perceptions of addiction, and lack of resources.[121] Steps to remedy this and ensure equitable access to MOUD include making sure all SNFs offer all forms of MOUD, minimize obstacles for hospitals to refer patients to SNFs, filing Department of Justice complaints when patients experience discrimination, and increasing preparedness of staff through education on the legal obligations around admission criteria.[122]

For incarcerated individuals:

- Ensure community standards for MOUD dosing are the standard for individuals in the Department of Correction and Houses of Correction. Require all locations to provide induction for MOUD in addition to maintenance medication.
- Provide incarcerated individuals with increased education about MOUD and how to access medication.
- Improve referral/communication mechanisms between the correctional healthcare service provider and the correctional MOUD care provider to ensure wholistic healthcare approaches and to ensure individuals are getting access to MOUD.

Libraries Serve as a Resource for Harm Reduction

Libraries have long served as a hub for social services to their patrons. In Massachusetts, librarians work to support social determinants of health, with some going even further and hiring a social worker. The public library in Cambridge was the first in the state to make this hire in 2021, with Boston, Somerville, and Worcester then making similar hires. These social workers are able to connect patrons with resources and provide food and/or clothes. By bringing in social workers to locations that people experiencing being unhoused are often spending their days, it is meeting people where they are - a core component of harm reduction.

Another step some libraries are taking towards harm reduction can be seen through the piloted program, Buprenorphine By the Book (BBB), taking place in San Diego, California. Buprenorphine is a very effective medication for opioid use disorder (MOUD) and this program is intended to address barriers to accessing the treatment by allowing for tele-visits to library patrons. The library created a dedicated space and offered tablets for patron to meet with local clinicians that can provide buprenorphine care without accessing the clinic in-person. The study found that those receiving the telehealth care were more likely to take buprenorphine and decrease substance use. Learn more by watching this YouTube video: https://youtu.be/pNg2sMr6wrY

In addition to providing services from a social worker, or the success of BBB, libraries in Massachusetts can apply to be a fentanyl test strip distributor through DPH. By integrating harm reduction measures into a location that is already a part of communities, it increases the opportunity for access and meets local needs.

5. Support and Protect the Harm Reduction Workforce

Recommendations made by the 2018 Harm Reduction Commission to "foster a culture of harm reduction in the Commonwealth" led to important state budgetary considerations that subsequently allowed for the creation of the Harm Reduction Advisory Council (HRAC), a group of experienced Harm Reductionists that serves as paid consultants to DPH. HRAC, with support from DPH, hosted its first Statewide Harm Reduction Conference in May 2024, bringing state-funded programs conducting Harm Reduction together for peer learning, networking, workshop exchanges, workforce development, and inspiration.

The Harm Reduction workforce extends beyond state-funded programs, into varied settings like churches, hospitals, and other social services but also into living rooms and community spaces. It is radical empathy, peer-led and empowered, and centers on the motto of 'any positive change' as its metric of success. For many, it is not a job, but a way of being that is incorporated into their every act. People work in Harm Reduction, and people embody Harm Reduction. As one peer worker put it: "It's not work. For us, this is our life." This workforce welcomes people with lived and living experience, but also those with no experience using drugs. Compassion, tolerance, and dignity for PWUD center this workforce.

Background:

For people with lived and living experience using drugs, legal employment options and opportunities have historically been limited. The Harm Reduction workforce is growing and constitutes of a variety of services and roles which includes community health/peer specialists, medical workers and behavioral health staff, outreach workers, HIV care navigators, wound care staff, drug checking staff, overdose prevention specialists, among many others.[123] With roots in the HIV prevention movement focused on linking to care rather than the addiction treatment or recovery workforce, staffing and roles continue to evolve. This evolvement leads to jobs that do not always fall into a standard or more typical classification code for other employments. Much of Harm Reduction work is grassroots to its core, which can lead to less formal measures to support the workforce.

Between June – August 2022, the RIZE Massachusetts Foundation created a project to "identify, quantify, and understand the Harm Reduction workforce".[124] This project had the goals of increasing recruitment, looking at retention methods, and providing opportunities for additional training and education. They had key findings in each of these areas, with recommendations that can contribute to future efforts around the workforce.

The Challenge:

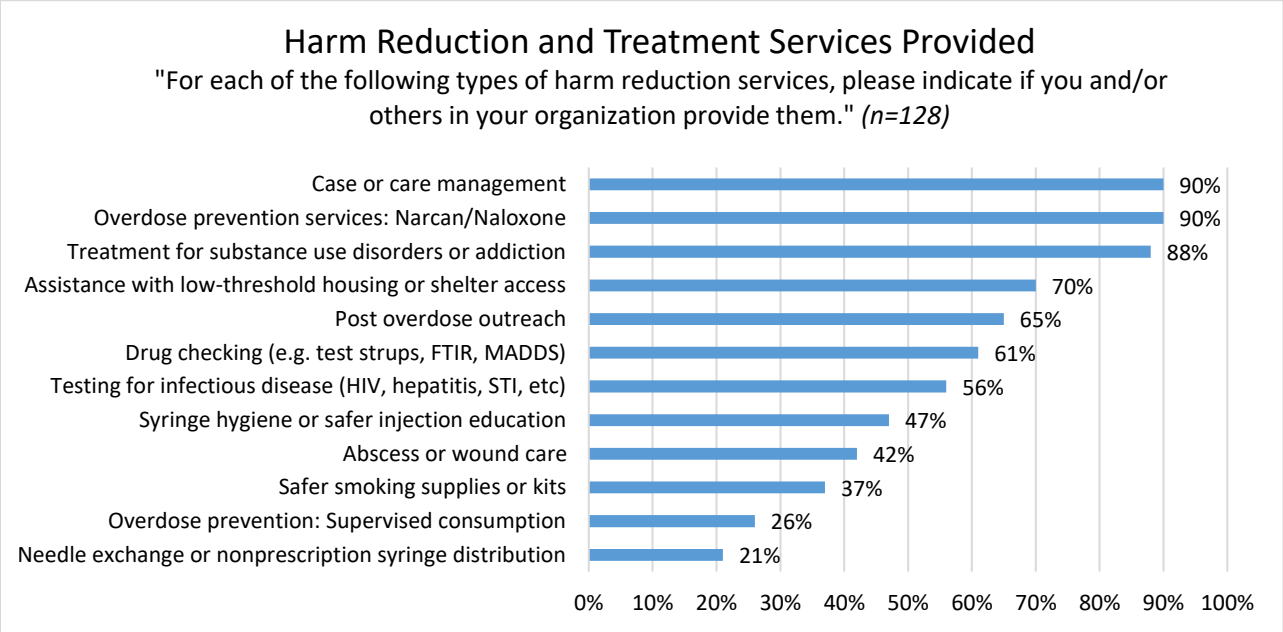
To adequately provide Harm Reduction services, the workforce needs to grow, be adequately compensated, and supported in their work. While some Harm Reduction services are provided funding through short-cycle grant funding, which can lead to decreased long-lasting sustainability, one of the main challenges is the retention of employees. Further, staff experience high levels of burnout, and lack access themselves for behavioral and mental health supports. Almost 50% of the workforce is experiencing burnout.[125] Grief and trauma supports are essential

because this workforce, like no other in behavioral health, witnesses an extraordinarily high rate of death of peers, staff, and clients. Finally, obstacles for those receiving Harm Reduction services exist already with stigma, but other employment barriers such as a criminal record or sobriety requirements can lead to fewer individuals with lived or living experience being able to join or remain in the workforce.

Racial and ethnic diversity of peer workers across the substance use and Harm Reduction workforce is too low. Contributing to this problem is the fact that much peer work is volunteer or extends outside of usual workdays and hours. These challenges may be exacerbated for BIPOC communities. Given the rise in overdose deaths in Black, Indigenous, and Latine populations across the state, a diverse and equity-centered Harm Reduction workforce is more important than ever.

Black and Latine communities also have disproportionate involvement with the state carceral system, leading to these communities having disproportionate consequences.[126] This criminalization is deeply rooted in the long-lasting impacts of the War on Drugs, which increased policing and surveillance of BIPOC communities.[127] These barriers include having criminal records, which impacts the ability to access housing, employment, and other resources. The Boston Bar Foundation and Greater Boston Legal Services have been working since 2019 on a CORI Sealing Clinic that helps low-income individuals to seal their records. While this work is critical for all individuals involved in the criminal legal system for all types of charges, expanding state-wide efforts to decrease barriers from CORIs is also a Harm Reduction effort.

In a RIZE Massachusetts Foundation-funded project, Brandeis researchers collected and analyzed data from 128 different organizations and 74 frontline workers providing Harm Reduction services. The results showed the range and variety of Harm Reduction and treatment services provided by the organizations.



Source: Understanding & Bolstering the Harm Reduction Workforce in Massachusetts | RIZE Massachusetts[128]

What's Needed:

We recommend the following approaches to support this workforce:

- Building support networks for individuals working in the Harm Reduction field through convenings such as conferences, which also include capacity building and coalition building. This includes creating an advocacy body to lead these efforts that is organized by people with lived and living experience.
- Create a coalition bringing together insurers, employers, policymakers and those currently providing services with lived and living experience to identify or create mechanisms to address the workforce challenges, and make recommendations to the state.9
- Include more Harm Reduction training to all professionals that may provide overlapping services, including behavioral and mental health providers.
- Improve resources for providing interpreter services and learning materials in multiple languages.
- Provide trauma-informed behavioral and mental health services, as well as Harm Reduction services, to the Harm Reduction service workforce themselves.
    - To retain the workforce, services should be provided to those giving Harm Reduction services to other people, as this work can often be emotionally and mentally taxing. This could take a variety of forms that could best meet the needs of the staff. One form could be in-staff clinicians providing services to their staff, for organizations that are of that size. Organizations that do not have their own clinicians could receive services from community behavioral health centers. To create this relationship and build this connection, a central hub or office could investigate locations able to provide services, and those in need of receiving them. Through partnership and collaboration, services could be shared through local options, or telehealth. Additional options for support structures could include peer support or group supervision.

What else can be done?

Ultimately, the Harm Reduction workforce will remain fluid and is evolving as new needs and services emerge. As Harm Reduction services do so, it is critical for the Commonwealth to provide the necessary services to support and retain workers in a sector that is so critical to community wellbeing and saving lives.

To support the workforce working with youth, additional education and training to inform service providers could improve harm reduction efforts in both youth and family settings. This could include naloxone and MOUD education within primary care and emergency departments as a collaborative effort for other youth service providers. More on youth and family considerations are discussed in the next section.

6. Nurture Youth & Family with Harm Reduction

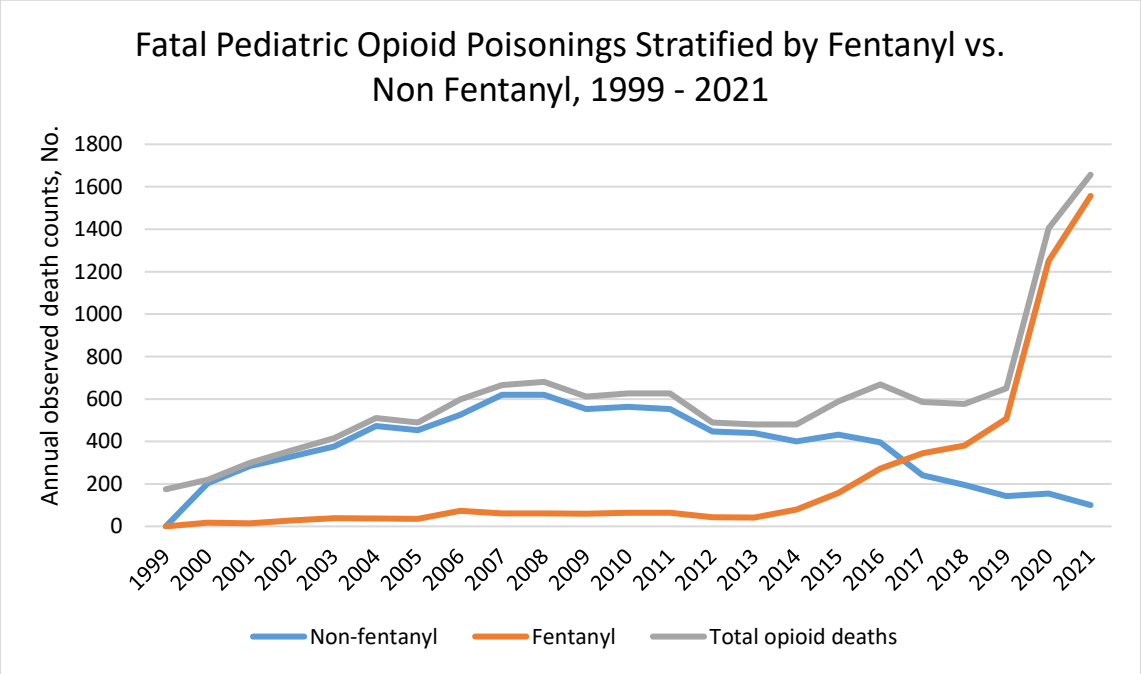
Harm Reduction needs exist across the lifespan, and institutions at every level of our community can play a role in broadening Harm Reduction efforts. Thus, schools and community youth and

family organizations should have similar protections to be able to effectively implement Harm Reduction efforts. By better aligning school policies and Harm Reduction, this can interrupt the school-to-prison pipeline that criminalizes substance use, increase education around substance use, and provide a more wholistic approach to families that center reducing harm during the formative ages of K-12.

Background:
School policy around substance use has evolved, with many zero-tolerance policies in place. Zero-tolerance policies exist in schools in response to a variety of acts, but typically include weapons, substances, and acts of violence that take place in school settings.[129] As these punitive measures have become more restrictive, alternative approaches have begun to take their place. This varies across school districts, cities, and states, but the zero-tolerance policies had already created the "school-to-prison pipeline" which funnels students, typically students of color, into the criminal legal system due to extreme punishments in school.[130] These infractions and approaches showed mixed results over time, and little evidence supports their effectiveness.[131]

Despite national survey data indicating persistent low rates of illicit drug use other than marijuana and reductions in use of prescription opioids and heroin, overdose deaths have increased dramatically among youth.[132] In 2014, when fentanyl came on the scene, rates of non-fentanyl related overdose deaths decreased, with fentanyl-related overdose deaths increasing.

Figure: Fatal Pediatric Opioid Poisonings Stratified by Fentanyl vs Non-Fentanyl, 1999-2021



Source: National Trends in Pediatric Deaths from Fentanyl – JAMA Network[133]

These data depict how the growing crisis of youth overdose coincides with evolving school policies and abstinence-based education models, which evidence is showing does not reduce harm. This impact is felt beyond youth and reverberates through families and communities.

The Challenge:

In a 2024 publication of national death statistics, overdose deaths are now the third leading cause of death for pediatrics, after gun-related injuries and car crashes.[134] The CDC shows that for adolescents (age 10-19), there was a median 109% increase in overdose death rates from 2019 to 2021.[135] This includes deaths from manufactured fentanyl, other opioids, and counterfeit pills, with the research showing that in almost two-thirds of those that died, there was one or more bystanders in the environment when the overdose occurred, with no response administered.

Figure: Confirmed Opioid-Related Overdose Deaths, All Intents, Compared to All Deaths by Age: January 2023 – December 2023

	<15	15-24	25-34	35-44	45-54	55-64	65+	Unknown	Total
All Deaths	325	377	992	1,708	2,737	6,442	48,581	25	**61,187**
Confirmed Opioid-Related Overdose Deaths, All Intents	2	64	388	605	483	425	135	2	**2,104**

Source: Massachusetts Department of Public Health[136]

In Massachusetts, overdose deaths represent 17% of all deaths occurring among those age 15-24 years, and a 2020 survey showed that Massachusetts ranked in the top five states with the highest percentage of adolescents using illicit substances other than marijuana. [137] Taken together, these data show the critical need to address illicit drug use, specifically fentanyl, in school settings, and to equip young people with the tools to stay safe from overdose.

Most of the focus to address overdose-related deaths has been on adults. While these can decrease negative outcomes across the board as they improve community wellbeing, it is important to consider the specific needs of youth and families. Early intervention is a critical component to protect against negative outcomes from adverse childhood experiences. This applies to the growing mental health problems that youth are facing. Untreated mental health concerns may result in coping behaviors that could lead to harmful substance use or other harmful behaviors. While much research shows the importance of proper support, many school environments may lack the funds, staff, or infrastructure to adequately address the needs.

Robust research shows the connection between experiences with school discipline and future incarceration, highlighting connections between the social determinants of health with mass incarceration.[138] These findings describe the school-to-prison pipeline, which refers to policies and practices that show both direct and indirect connections between schools to interactions with the criminal legal system. Beyond this, research shows that the students who have higher levels of substance use and depressed feelings often have lower support in their community, feel less safe, and have higher instances of school discipline and contact with the police.[139] Efforts to disrupt this cycle can be seen in alternative responses to school-based use of substance. By responding to these instances in a way that strives to prioritize the reduction of harm rather than punishment, overall harm can be reduced.

Primary prevention school-based programs that focus on abstinence-only and seek to instill fear of substance use are unsuccessful and increase stigma of PWUD. Nationwide evaluations of school-based education programs that employ these approaches, such as D.A.R.E., show that students still continue consumption with substances, while also having lower self-esteem than other students who did not receive the educational programming.[140,141]

Students that have family members using substances at home may experience disruptions that could impact their education experience. These impacts can include things such as neglect and maltreatment, having to change homes or schools, mental health risks, and the potential loss of a parent or family member due to overdose.[142] The impacts of overdoses in the community can clearly be seen in schools, which provide an opportunity for programs and interventions to support the school's sphere of people impacted by overdose.

For family members that want to stay connected to each other while on probation or parole, these are often punitive in nature and take place in a courthouse of detention facility. This perpetuates the underlying sentiment in the school-to-prison pipeline and exacerbates stress that could come from familial separation.

The Data:

For decades, educational curriculum and related youth programming have been exclusively abstinence-only based. However, data indicate that abstinence-only curriculum and services often show increases in substance use, stigma, and fatal overdoses.[143] Consequently, new and more comprehensive educational curriculum that build from lessons learned from other substance use, adolescent behavior change, and Harm Reduction have been developed, effectively piloted, and implemented in schools in several states including California and Illinois.[144]

In Massachusetts, there is no age requirement for obtaining Harm Reduction supplies, including naloxone, fentanyl test strips, community drug checking, or sterile syringes, similar to emergency contraception. Providing Harm Reduction supplies such as naloxone in schools could decrease the overdoses and be a source of education through school-based activities. However, Massachusetts law states that school-owned medications may only be administered by school registered delegates. The U.S. National Association of School Nurses supports schools having naloxone as a part of emergency response and preparedness in schools.[145] Additionally, some states are taking initiative to include fentanyl test strips in school environments in addition to naloxone. Colorado's House Bill 24-1003 is an example of this policy, with some high school students encouraging other students to use fentanyl test strips through school newspaper editorials.[146] Becky Pringle, the president of the National Education Association, encourages a more collaborative approach beyond just schools but for communities and government agencies to come together to provide the necessary resources to address the problem at hand.[147] While the large age span of K-12 presents different challenges, research shows the willingness of young adults (aged 18-35) to accept and use fentanyl test strips.[148] Importantly, research is consistent that provision of evidence-based harm reduction tools like naloxone does not increase risk-taking behaviors.[149,150]

Research reflects positive outcomes of school-based mental health services and universal interventions. It includes the improved social, emotional, behavioral and academic outcomes, along with improved self-esteem, better self-regulation, and fewer mental health problems.[151, 152, 153] School-based services are also shown to overcome barriers to services that may exist outside of school, such as coordinating parent schedules or transportation.[154] Further, research shows that providing screenings, intervention and treatment of SUD are ideal to perform in a school-based setting.[155]

Successful youth-oriented recovery strategies provide access to FDA-approved MOUD and youth-oriented support for young people with OUD. Medications provided via mail-based delivery as well as mobile health van show promise and leverage existing Massachusetts capacities.[156]

A number of schools in Massachusetts are piloting an alternative response to when students consume substances. This alternative curriculum is one policy strategy that is rooted in Harm Reduction at a school-based level. Schools pose a unique location of intervention as overdose deaths in adolescents and teens continue to rise, often due to fentanyl and fentanyl analogs.[157]

The Opportunity:

Expanding access to naloxone and fentanyl test strips is an affordable way to be prepared for and avoid overdoses. By providing this as one component of a multi-tiered approach to Harm Reduction, efforts can expand across the lifespan throughout the Commonwealth. This could include putting naloxone in first aid kits, making naloxone and fentanyl test strips available, accessible, and permitting students to carry them on campus, raising awareness about 911 help-seeking and protections under the Good Samaritan Law (GSL), and teaching about the signs of an overdose when learning about the signs of needing to perform cardiopulmonary resuscitation (CPR) or the Heimlich maneuver.[158]

Additionally, by providing increased behavioral support for youth, risk factors for substance use and/or the secondary impacts can be reduced. School-based mental health services have also been shown to increase access to providers and overcome cost, insurance coverage, and provider availability barriers.[159] For the successful implementation, proper funding sources are needed. Depending on the locality and school, considerations for the investment in counselors, psychologists, and social workers are critical. Students and schools need to be better equipped o meet the changing health risks in their settings by facilitating quicker response to overdose instances and providing education and services in Harm Reduction, as well as other broader behavioral health services.[160]

What's Needed:

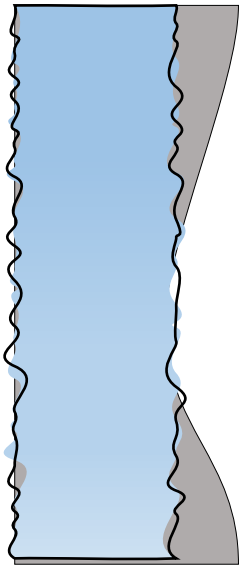
- Naloxone and Fentanyl Test Strips in Schools: State legislation has the opportunity to require schools to have naloxone on their campus, extend this access to other harm reduction supplies and information, such as fentanyl test strips, and permit students to carry and administer naloxone in a suspected overdose emergency on campus. This

legislation does not have to mandate the state to provide the naloxone, but rather the schools can partner with DPH to get naloxone and other Harm Reduction tools, including fentanyl test strips. The National Association of School Nurses also provides a Naloxone Education for School Nurses Toolkit that can support these efforts. This approach is consistent with the International Guidance on Human Rights and Drug Policy and Initiative #1, securing a right to Harm Reduction services across the lifespan.

- Increased Mental Health Supports: State level incentives for schools to allocate funding to school-based mental health services. This includes an increase in investment from state budgets for all schools to equitably get access to these services, and not only those with excess budgetary means.
- Non-Punitive Responses to Substance Use in Schools: Creating systems and infrastructure in the schools to respond to substance use that is grounded in reducing harm, and not punishment. This includes adopting primary prevention educational curriculum that is evidence-based and incorporates Harm Reduction as part of health courses, and adoption, as school standard, non-punitive supports and educational opportunities like iDecide.
- Adopt universal comprehensive health education standards on substance use. Educational curriculum and related youth programming that is not exclusively abstinence-based is crucial. Data indicate that abstinence-only curriculum and services often show increases in stigma and fatal overdoses.[161] Illinois recently passed an exemplary law (see call-out box). Additionally, this curriculum should include specific content around substances that teens use in growing popularity, included but not limited to vaping, cannabis, and alcohol.
- New Family-Friendly Resources and Visitation Spaces: Community recovery spaces exist in 39 communities across Massachusetts. Increased programming for families seeking peer support as well as for families new to substance use concerns is needed. Monitored community spaces should be available for children with a parent on probation or parole, to foster connection and support, and to avoid punitive or overly clinical environments. Such spaces could also connect youth and family members to available support in the community. Online opportunities to provide this connection could also be made available. This could include platforms to communicate, social media, or external support to aid in these efforts such as family coaches.

Illinois Passes Legislation for New Substance Use Education in K-12

On July 28, 2023, The Illinois Legislature passed SB2223, now Public Act 103-0399, pertaining to the curriculum for substance use education in public schools across the state. This legislation states that "the improved K-12 health education standards shall be comprehensive, reality-based, safety-focused, and evidence-based standards that reduce substance use risk factors and promote protective factors". This curriculum includes learning about the history of drug policy in the United States, how trauma and loss may contribute to substance use, and the safe way to use resources like naloxone and fentanyl test strips.



A New Approach to School-Based Substance Use Events

Massachusetts is working to limit punitive approaches to substance use in the school setting. The Center for Addiction Medicine at Massachusetts General Hospital, the Office of Youth and Youth and Young Adult Services at DPH, and the Institute for Health and Recovery have collaborated to create a new, more equitable alternative to the current punishments. iDECIDE (Drug Education Curriculum: Intervention, Diversion, and Empowerment) is a "drug education curriculum developed to provide behavioral support and psychoeducation for middle and high school students". iDECIDE is intended to be an alternative to traditional punitive responses for school-based substance use events. There are currently 400 schools in Massachusetts using the iDECIDE method, and evaluation of the impacts are underway.

What else can be done?

Additional considerations to the proposed efforts can make for more robust approaches that focus on providing services across the lifespan. This includes catered approaches that consider programs before kindergarten, after high school, and on college campuses.

7. Rethink Criminal Legal System and Police Response to Overdose

Background:

Many debates are underway about the best way to respond to substance use in public spaces and people who are unhoused that consume substances. The question often at the center of these debates is whether substance use and related issues should be addressed through public safety or public health approaches. Over the past decade Massachusetts sought a fair and effective balance between these approaches. However, while public health efforts have expanded, they have not overcome the deeply rooted focus on criminalization both the criminal legal system and our broader society are accustomed to. This tension has serious implications, especially for people leaving incarceration who are at extremely high risk of fatal overdose—up to 50 times the risk of death by overdose compared to the general population in Massachusetts.[162] Revisiting the criminal legal system's responses to overdose and opioid use can reduce harm and improve health outcomes.

A brief history of Massachusetts' response to substance use through criminal legal systems can be found on **Appendix G.**

The Challenge:

Arrest and incarceration negatively impact health outcomes, especially for individuals with SUD. Overdose has become the leading cause of death for people recently released from incarceration, with those leaving incarceration at particularly high risk of fatal overdose.[163, 164,165,166] Responding to substance use by increasing interactions with law enforcement increases the likelihood of arrest and incarceration, which in turn exacerbates the health risks for PWUD.

While Massachusetts' Good Samaritan Laws (GSL) offers protection against arrest and prosecution when seeking medical help for an overdose, the GSL does not protect against arrests for all drug-related charges. For example, people can still be charged with intent to distribute, or arrested on existing warrants, or if illegal weapons are present. Moreover, there are misconceptions about the GSL in general, whom it applies to, and in what situations it affords its protections. These uncertainties can deter people from seeking help in an overdose emergency. Additionally, systemic distrust of law enforcement, especially in communities of color that experience over-policing and harms caused by law enforcement, can discourage people from trying to do the right thing and call for help.[167]

This hesitancy is compounded by Section 35 involuntary civil commitment.[168] While intended to protect individuals at risk of harming themselves or others, it is among the most coercive paths to treatment, and there is limited evidence of its efficacy and increasing evidence of harm.[169] This, as well, may deter individuals from seeking help in overdose emergencies.

Access to naloxone in criminal-legal settings is changing. The expansion of MOUD in criminal-legal settings across Massachusetts has been substantial, but interviews conducted for this report indicated that there has not been a commensurate increase in naloxone provision in these locations. Evolution of the current overdose crisis means that the risk of fatal overdose expands to include 1) people who have been on MOUD but did not link to care post release, 2) people with OUD who never received MOUD while incarcerated and now have no opioid tolerance, and 3) people who use stimulants who may not be expecting fentanyl in their stimulant , have no tolerance for opioids, and may not perceive a need to have naloxone. Expanded MOUD will reduce risk in the former two groups, but not the third.

Finally, the housing crisis in Massachusetts heavily intersects with substance use, as many PWUD lose their housing as their dependency progresses. Ten percent of Massachusetts overdose decedents were experiencing homelessness at the time of their death and 8% were recently released from incarceration.[170] Encampments are subjected to police executed sweeps, where displaced individuals experience additional barriers when their access to services is disrupted. This could include naloxone distribution, syringe access, other safe use supplies, HIV treatment and other medical and mental health care, or access to MOUD. These sweeps can therefore worsen health outcomes by undermining efforts intended to protect and improve them.

Together, these issues highlight the tension between law enforcement and Harm Reduction. It is important to consider policies that address substance use that improve health outcomes, and do not unnecessarily criminalize, perpetuate fear, and create barriers, while also acknowledging the shared goals of safety and public order in our communities.

The Data:

Good Samaritan Laws are used to provide protection from liability for individuals who intervene in emergency situations to provide assistance and/or care.[171] These laws vary from state to state in their scope and level of protection. Research shows that GSLs can address barriers to receiving

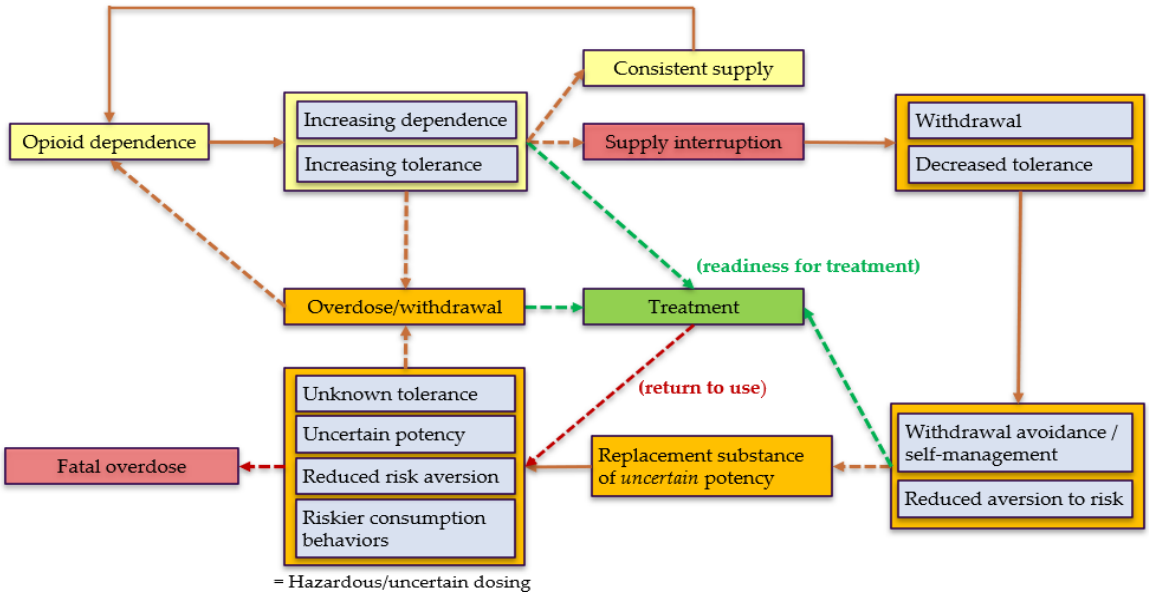
care when an individual is experiencing an overdose.[172] However, even when a GSL is passed, many individuals may fear involving it because of distrust that paramedics or police will protect them in accordance with the law. [173,174,175] Protections need to be clear and upheld.[176]

Section 35 involuntary civil commitment (ICC) may undermine effective therapeutic approaches, and much research shows that that ICC is viewed similarly to incarceration, especially by individuals who have previously experienced incarceration.[177,178]

Provision of naloxone to people at risk of overdose is a fundamental prevention tool. Studies of naloxone provision at release find it acceptable and effective[179,180,181], and several states, such as Rhode Island and North Carolina, facilitate access to naloxone in criminal justice settings by leveraging vending machines so naloxone and other public health materials are available on-demand at release. One large trial in the United Kingdom demonstrated that a high percentage of the justice-involved persons receiving naloxone upon release administered it to someone experiencing overdose in their community. This suggests that release from incarceration is an important time to equip people with the tools to save themselves and others in their networks.

Research shows that disruptions in drug consumption among people with opioid dependence--something that can happen from a housing sweep and forced relocation--can increase the risky behaviors that lead to overdose.[182] Likewise, police seizures of illicit drugs create a supply interruption that subsequently increases fatal overdose risk in a community.[183] The mechanisms by which this occurs warrants further research, and a causal model is found below.[184] By extension, encampment sweeps and forced relocation by police are similar massive disruptions experienced by PWUD that also create a supply interruption. These models suggest we can anticipate and therefore mitigate the risks of overdose at specific known points.

Figure: A causal pathway from police drug seizures to increased risk of fatal opioid-related overdose (from del Pozo et al., 2024)



The Opportunity:

Research shows the existing GSL in Massachusetts can be strengthened. Changes to law can also de-emphasize punitive measures and coercive approaches to treatment, which may happen under Section 35, and instead focus on effective approaches encourage voluntary enrollment and offer extensive supports. Additionally, interactions between police and the unhoused can decrease the utilization of harm reduction and treatment services. Statewide naloxone distribution would center the provision of this lifesaving medication across a wide range of community settings. Technologies such as public health vending machines and naloxone distribution boxes can help facilitate access to naloxone across the criminal-legal systems, including in drug courts, jails, prisons, and community corrections.

What's Needed:

Overdose prevention planning and education as well as provision of naloxone and fentanyl test strips to all justice-involved persons at points of release and in all drug court settings will save lives and provide lifesaving tools at a critically important, risky time. Implementation of naloxone and other Harm Reduction supply access via public health vending machines, installation of naloxone distribution boxes, or via discharge planning is needed in all jails, prisons and courthouses.

The Good Samaritan Law in Maine

Maine updated their GSL in 2022, which set the protections from arrest as the default, rather than the exception in overdose situations. This protection applies to someone "who in good faith calls for assistance for another person experiencing a suspected drug-related overdose, any person rendering aid at the location at the suspected drug-related overdose, and any person who is experiencing a suspected drug-related overdose". A list of exceptions to this protection enumerates 23 serious crimes that are unlikely to be relevant to overdose situations. Maine aims to signal to their state that the priority is in providing care to the people of the state and reducing deaths, rather than arrests and punitive responses for other actions around the same time. This effort can help build trust and confidence to encourage people to seek help when needed.

For Massachusetts, strengthening the GSL would include:

- Protecting from arrest, which is shown to be more effective than only protecting from prosecution or charges, as Massachusetts' current law is written.[185]
- Expanding protections beyond specific drug related crimes, with exceptions that are data-driven, following the example and language of Maine's GSL.[186]
- Protection from arrest on existing bench and nonviolent felony arrest warrants, including protections from providing names and sharing personal information with law enforcement.[187,188, 189, 190, 191]
- Increase education and training around GSL so the public in Massachusetts understand the protections it provides, and the law can be implemented correctly by police.[192]

Amend Section 35 to:

- Forbid the use of Massachusetts correctional facilities for involuntary civil commitment;[193]
- Require greater oversight of initial petitions, including review by an independent licensed clinician and include in this process a Harm Reduction impact assessment by a trained Harm Reduction provider, community health worker, or certified peer support recovery specialist who will both assess the need for a civil commitment, and be instrumental in planning for it if it is indicated.
- Forbid the loss of housing or employment for individuals civilly committed via Section 35
- Require a "Post Commitment Plan of Safe Care" for the individual prior to leaving Section 35 civil commitment, to equip them with resources, information, offer Harm Reduction supplies, and, if receiving MOUD during Section 35 placement, linkage to a community-based clinician, clinic, or telehealth provider to preserve continuity of care.

Additionally, the potential harm of housing sweeps and drug seizures should be considered *prior* to acting, as they often do not create the desired outcomes. A confidential, expert consultation with groups such as the Harm Reduction Advisory Council or similar Harm Reduction-oriented community advisory board should be encouraged—if not required--for municipalities and police departments employing such tactics.

What else can be done?

- To ensure existing GSL and any of its changes are implemented equitably, BIPOC and other vulnerable or minoritized populations should be included in community education efforts and implementation as the populations most likely to distrust law enforcement when seeking care.[194, 195, 196]
- The role of prosecutors is also critical and influential. The discretion around whether to charge and what types of charges to bring, diverting low-level incidents, and/or dismissing charges as appropriate are opportunities to apply Harm Reduction principles.[197]
- An analysis of Providence, Rhode Island overdose events found that few required police involvement.[198] These findings led to a policy shift in the city: police no longer co-respond with the fire department to suspected overdose events. These actions have had no major impact on overdose fatalities or safety concerns (personal communication, Providence Fire Chief Kenyon). Massachusetts jurisdictions should review local data and consider amending local response plans to encourage 911 help-seeking in an overdose emergency.

8. Apply Harm Reduction in Housing Settings

Background:

- Demographers categorized homelessness into three temporal groups: transient (roughly 80% of those using a shelter), episodic (10% of all shelter users), and chronic (10% of all shelter users).[199] Transient homelessness may be brief and only once (i.e., loss of employment, weather emergency); episodic homelessness presents as repeated, often brief shelter stays; and chronic homelessness, often the hardest to house because of significant medical issues, disabilities, or other unique service needs. While individuals experiencing chronic

homelessness represent a minority of all individuals experiencing homelessness, they are the most visible and frequently targeted by media, political rhetoric, police, businesses, and NIMBY protests.

- Traditional approaches to transitional housing take a "treatment first" approach, where people experiencing homelessness who use substances need to meet certain criteria like treatment attendance or sobriety to earn access to housing. The Housing First (HF) model is an evidence-based one that does not require sobriety or have treatment requirements to secure housing and provides access to services while working toward permanent housing placement. Harm Reduction Housing (HRH) is an approach that brings Harm Reduction actively into the shelter, low-barrier/transitional, or permanent supportive housing setting. HRH integrates supportive services like HF with a focus on minimizing the negative consequences of substance use through the active provision of Harm Reduction supplies, services and policies.
- In Massachusetts, while some housing programs are encouraged to adopt a HF approach, there is no statewide mandate requiring all programs to do so. However, various state initiatives and funding sources increasingly emphasize the importance of HF principles[200], particularly for programs aimed at serving homeless populations.

Source: Coalition on Homelessness and Housing in Ohio[201]

A brief history on Harm Reduction in housing settings can be found in **Appendix H.**

The Challenge:

- **Stigma and Misunderstanding**: There is often stigma associated with substance use, which can lead to community resistance to HF and HRH initiatives. Misunderstandings about Harm Reduction can create fear and opposition among residents and local leaders.
- **Lack of Funding**: Harm Reduction programs often require dedicated funding for both housing and supportive services, which may not be sufficiently prioritized in state or local budgets. Many funding streams may be tied to more traditional models that prioritize treatment requirements, abstinence or sobriety before access to housing.
- **Regulatory Barriers**: Existing zoning and regulatory frameworks may not accommodate HF or HRH models, creating challenges in developing or implementing these programs in certain communities.

- Limited Awareness and Training: Service providers and community organizations may lack adequate training in Harm Reduction principles, limiting their ability to effectively implement these strategies in housing programs. More broadly, training for providers and community organizations on housing resources and shelter alternatives is a fundamental missing element.
- Fragmented Services: People may face challenges accessing comprehensive healthcare, mental health services, and substance use treatment in traditional housing models, leading to gaps in support. Supportive housing in a HF model integrates case management and care access onsite. In addition, with advances in telehealth, expansion of pharmacy delivery, and the opportunity to provide mobile or, in some places, onsite health care, complex healthcare can be better coordinated and fragmentation can be minimized.
- We aren't connecting the dots and chances to problem solve on housing within systems of care are missed. For instance, while progress is being made with MassHealth's leadership to encourage hospital staff to be trained in routing people to housing resources and holding hospitals accountable for not discharging to homelessness, other systems of care need to align as well. Housing supports are often overlooked and compromised in the SUD treatment, mental health, court, and carceral systems, as well as places where these systems overlap such as involuntary civil commitment (Section 35).
- Overburdening: According to Boston HMIS data from 2016 to 2018 and a 2019 community of origin custom assessment, more than 50% of the people in Boston's shelters come from ZIP Codes outside of the city limits. More low-barrier/transitional and shelter services are needed in more locations in Massachusetts.

The Data:

- Housing First programs increase housing stability and decrease rates of homelessness.[202] They have been demonstrated to house families and individuals with intersecting vulnerabilities, such as veterans, individuals experiencing substance use or mental health issues, survivors of domestic violence, and individuals with chronic medical conditions such as HIV/AIDS. Although cost effectiveness study's have been mixed , HF programs appear to reduce the use of illicit drugs, improve the health status of people living with HIV/AIDS, and reduce the use of costly emergency services, all of which are indicators of improved health.[203]
- Each of the Harm Reduction services incorporated into HRH principles (i.e., naloxone provision, syringe access, safer smoking materials, test strips, HIV testing/counseling, MOUD) are evidence based, which justified their immediate application in MA during two events in recent history: the COVID-19 pandemic and actions addressing the Mass and Cass encampments in Boston.
    - Evidence from a Brandeis-led evaluation of the Isolation and Recovery Housing (aka the state-run COVID-19 hotels) experience was similar to those found in other initiatives in California, Scotland, and Portugal, all of which extended Harm Reduction supplies, with some further providing monitored alcohol and drug consumption spaces onsite. Outcomes reported included a reduction in alcohol and drug consumption, increases in social functioning, sleep, and medical care uptake, and

intentions to reconnect with family and friends post discharge. No guests died while isolating in Massachusetts.

- While almost $40 million in federal funds were recently invested to help implement HF models of housing supports in Boston, an unprecedented additional almost $19 million more in Coronavirus State and Local Fiscal Recovery Funds (SLFRF) was directed toward low-barrier transitional housing and supportive services, specifically to address the Mass and Cass encampment and housing crisis. Following a series of rapid tent encampment removals in 2021-2022 around "Mass and Cass", an area known for concentrated public drug use and homelessness, city and state jurisdictions collaborated with police to relocate 612 unhoused people into 7 low-threshold HRH sites. The 7 low-threshold shelters and housing locations were staffed and operated on HF and HRH principles, involving trained staff and onsite resources. This large-scale natural experiment, tracked via a public dashboard, resulted in enormous improvements in the health and welfare of people experiencing chronic homelessness[204,205] and decreased violence in the immediate affected area.
    - Early evaluation data from a Brandeis-led study of the sites found reductions in methamphetamine use, shifts to more marijuana use, less syringe reuse, and improvements in sleep, MOUD and primary care needs uptake as well as overall improvement in quality of life.
    - Ongoing data collection from a National Institutes of Health-funded study of the sites indicates that 99% of residents access Harm Reduction services or supplies there. 44.6% of residents continuing to inject drugs named their housing site as the main source of sterile syringes and 34.1% residents smoking drugs primarily obtained safer smoking supplies from the housing sites. Many used HIV testing and counseling services (39.7%) and 17.0% of residents reported starting pre-exposure prophylaxis for HIV prevention at or facilitated by their HRH site. None of the HIV+ residents in this study experienced HIV medication or treatment disruption during the relocation and placement into the HRH sites.
        - Compared to their behaviors before moving to the HRH sites, residents reported reductions in crack/cocaine (69.9%), methamphetamine (71.4%), and opioid (71.2%) use, obtaining drugs from fewer dealers (an overdose risk; 35.8%), and less drug use in public (55.7%).
        - Additionally, 26.4% of residents initiated or centralized primary healthcare at their housing site or began care proximal to the housing site since coming to the HRH location.

The Opportunity:

Addressing these impediments will require a concerted effort to promote education, secure funding, foster collaboration, and create policies that support Harm Reduction strategies in housing. This includes investing in an adequate supply of housing with abstinence- and non-abstinence-based options.

In 2016, California became the first state to mandate inclusion of HF principles in state-funded housing initiatives.[206] While many Massachusetts and some city-based initiatives and programs adopt HF principles or HRH, it is not consistent. On the one hand, the patchwork approach allows for local programming to match local community capacity. On the other hand, for the large and growing populations experiencing chronic homelessness across the Commonwealth, the inability of HR programs to "do it all" and persistent stigma leaves public safety, emergency departments, and institutional approaches like involuntary civil commitment (Section 35) as the only universally available local solutions. Housing needs are a top priority of this and future administrations and more options are necessary to address this broader crisis. To align state and local policies with Harm Reduction principles, supportive, harm-reducing strategies need to replace traditional punitive approaches to substance use and housing receipt.

What's Needed:

- Low-barrier, supportive housing in more cities around Massachusetts. This includes setting individuals up for success as housing becomes available. Without proper supports, individuals may face unsafe or unhealthy conditions, or predatory landlords or owners. Without proper supports in this housing, individuals may remain at high risk of an overdose-related death.[207]
- Protect housing and employment for those placed in involuntary civil commitment (Section 35, see Initiative #7).
- Require HF principles in every shelter, transitional, and permanent supportive housing program throughout the state.
- Require HR services and supplies (i.e., adopt HRH principles) be available and accessible in every low-barrier/transitional, shelter, and permanent supportive housing program and other places, such as sections of skilled nursing facilities, that have been adapted to provide affordable housing.
- Conduct housing and social support staff training and community education on HF and Harm Reduction to support these policy and practice changes.
- Provide training and supports to substance use treatment, mental health, court, and carceral systems to link people to housing resources and create system-specific mechanisms of accountability for not doing so.
- Create a council to coordinate policy review, alignment, and metrics for overseeing the implementation of HF principles and HR services (HRH) across the respective programs. This council could also oversee the evaluation of the programs on HF and HRH adoption to measure their effectiveness in reducing chronic homelessness, improving health and safety for residents, and reducing mortality. Inclusion of PWUD in this council is necessary as these policies and programs impact their lives.
- Local jurisdictions can review and update their zoning laws and policies to include more land for multiple units (like multifamily housing), offer density bonuses to developers, ease height and density restrictions, create land banks and streamline the permitting and approval process for missing-middle housing types, such as Accessory Dwelling Units.

What else can be done?

We can act today—without any legal restrictions—to provide broader access in shelters, low-barrier/transitional, and permanent supportive housing settings to naloxone, test strips, syringes (where permitted by local approval) and non-syringe safer use tools and education, such as safer smoking, snorting, and boofing (anal) materials and supplies. Provision of safe materials is an opportunity to co-promote safe monitoring via Safespot, the anonymous virtual spotting hotline. Isolation and stigma are the underlying mechanisms causing overdose deaths and drug-related harm. Finally, promoting the use of tools like the Eviction Prevention: A Toolkit for Tenants and Service Providers can support long-term housing goals for people once housing is obtained.

9. Addressing Health-Related Social Needs and Social Determinants of Health is Harm Reduction

Background:

A growing body of research highlights the intersections between the criminal-legal system and a variety of social needs, including both health-related social needs (HRSN) and social determinants of health (SDOH). Social determinants of health (SDOH) are the conditions in which people are born, grow, learn, work, play, live, and age, and the wider set of structural factors shaping the conditions of daily life. These structural factors include social, economic, and legal forces, systems, and policies that determine opportunities and access to high quality jobs, education, housing, transportation, built environment, information and communication infrastructure, food, and health care; the social environment; and other conditions of daily life.[208] HRSNs focus more on individual factors that impact the ability to maintain health and well-being. These are factors that increase risk for poor health outcomes, and include things such as financial instability, lack of affordable housing, or lack of access to healthcare.[209]

The harmful policies of the "War on Drugs" have had a devastating effect on community health and well-being, disproportionately impacting communities of color.[210] These communities, already experiencing structural barriers, have faced additional harm from drug-related policies such as drug testing, mandatory reporting, zero-tolerance policies, over-policing, and forced treatment. These mechanisms have only served to deepen existing health inequities and worsen both HRSN and SDOH that contribute to poor outcomes.[211]

The Challenge:

Drug use is commonly viewed as a reason for poor access to resources or poor health – however, poor access to social services and health providers are commonly a driver of substance use. Lacking social supports and undermining the role of HRSNs can contribute to harmful substance use. Difficulties meeting income needs has been known to increase the risk of overdose, in addition to contributing to risk of developing an SUD.[212] Additionally, an increased risk of overdose is associated with being disabled, being unemployed, renting a home instead of owning, and those living below the federal poverty line.[213]

In broader context, across the nation, wealth has become more and more concentrated in fewer households.[214] The wealth gap between racial groups continues to widen, which can concentrate

the risk of negative health outcomes in lower income groups. Moreover, while education is often seen as a route for improving economic outcomes, it does not benefit Black and Latine individuals to the same extent as White individuals.[215]

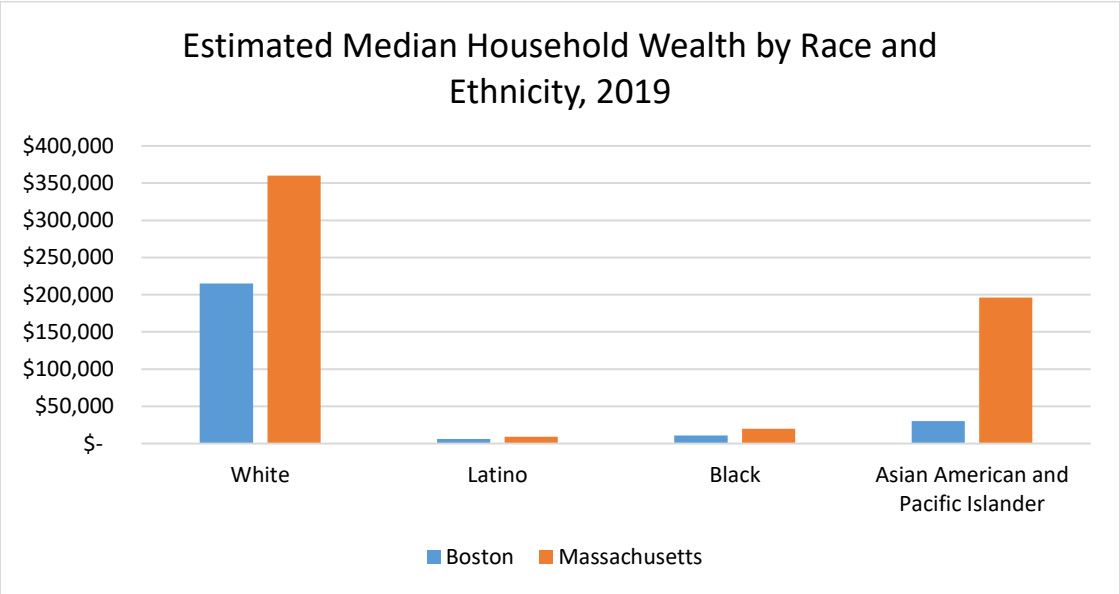
The Data:

Robust research shows the need for the HRSNs to be a part of the discussion when looking at Harm Reduction.[216,217] A variety of factors put people at risk of overdose, and those risks are exacerbated for people who are unhoused, poor, or facing barriers to employment based on a criminal record. Also, protective factors against SUD and overdose like education may be compromised or inaccessible.

Higher rates of overdose are associated with lower income and more economically disadvantaged ZIP codes.[218] Research shows that higher unemployment benefits play an important role in reducing substance use harms, including fatal drug overdose, showing the importance of having social safety net programs.[219] These types of programs are critical to meeting basic needs, are shown to reduce poverty and increase economic stability, while also reducing stressors that can increase overdose risk.[220]

For concrete evidence of the income gap in Massachusetts, in October 2022, The Urban Institute provided data gathered in 2019, on the differences in wealth by race in Massachusetts and Boston.[221]

Figure: Local estimates from Urban Institute's "Financial Health and Wealth Dashboard"



Source: Urban Institute – Financial Health and Wealth Dashboard[222]

The Opportunity:

The Commonwealth can address underlying causes of SUD and the overdose crisis by taking actions to reduce poverty. By expanding measures to improve overall economic wellbeing, the positive outcomes can translate to promoting community health. To increase income support,

Massachusetts can increase low-barrier forms of assistance. While Massachusetts doesn't have any bans on receiving federal SNAP or TANF benefits for those with felony drug convictions, there is opportunity to expand access to income support.[223] This includes making the process of applying for these benefits more accessible, with fewer eligibility requirements (to the allowable extent) that can increase equity in their implementation. Further, economic supports like an earned income tax credit (EITC) are shown to decrease binge drinking[224], reduce entrance to foster care, and decrease psychological distress, child neglect and suicide, all of which act on adverse childhood events (ACEs) that give rise to problematic substance use.[225] Additionally, guaranteed basic income (GBI) programs are an innovative approach to provide economic supports and are being implemented across the nation through many pilot programs.[226]

What's Needed:

- Support flexible work requirements for programs like TANF. Raise awareness about and adopt wider use of the second-level CORI review by DPH for hiring prospective employees who have criminal records.
- Include people with lived and living experience of drug use in the conversations around existing assistance programs and when designing new assistance programs to ensure they incorporate Harm Reduction, are low-barrier, accessible, and culturally relevant.
- Consider supporting GBI pilots for families with low income. Cambridge Recurring Income for Success + Empowerment (RISE)[227] is an example of such an effort in Massachusetts. Outcomes from GBI pilots specific to overdose or SUD are limited, but positive outcomes documented from across numerous pilots provide information on the impacts to HRSN, financial health, family and community wellbeing, all of which influence the context of drug use and drug-related harm.
- Increase support for culturally relevant Harm Reduction and treatment services. A social determinant of health is the availability of culturally relevant care. Centering culture and providing tailored supports to the diverse populations in Massachusetts will improve outcomes and engagement across communities.
- Apply and enforce the Americans with Disabilities Act (ADA) to protect

Just Income GVN: A Harm Reduction Approach for Individuals Recently Released from Incarceration

The *Just Income GVN* program offers a guaranteed basic income of $800 per month for one year to individuals recently released from incarceration in Alachua County, Florida, with no strings attached. The pilot year (2022-2023) highlighted the essential role of stable income in addressing immediate needs such as housing, groceries, and transportation—critical for individuals re-entering society after incarceration. Managed by formerly incarcerated individuals, the program aligns with harm reduction strategies by alleviating some of the financial stressors that often lead to recidivism and overdose risk. By offering unconditional financial support, *Just Income GVN* acknowledges the broader social determinants of health, promoting stability and reducing barriers to successful reintegration into the community, which in turn lowers the risk of overdose and other negative outcomes.

people with OUD from discrimination in the workplace, housing, education, healthcare and other services. While the ADA does not protect people who actively use drugs from discrimination, its protections benefit many Harm Reduction workers. Active inquiry into ADA violations is critical. Discrimination is a social determinant of health and can be a factor in HRSN.

Chelsea Eats Program: Addressing Food Insecurity and Health-Related Social Needs

Launched in 2020, *Chelsea Eats* was designed to support families excluded from federal assistance programs in Chelsea, MA. With unrestricted funds distributed via Visa debit cards, it enabled recipients to spend on essential needs. Notably, 1 in 6 families in the community participated, with over 73% of funds directed toward food-related purchases. Post-research revealed that the majority of recipients were women and Latine individuals, highlighting the program's role in addressing food insecurity—a key social determinant of health that impacts broader community well-being. This initiative, targeting food pantry clients, emphasizes the connection between economic support and improved health outcomes in underserved populations.

What else can be done?

While income support is a critical piece of the HRSNs, broader community initiatives should consider the systemic nature of inequities and work towards integrated and community-centered approaches. This includes affirmative policy like access to economic supports, but also should include removing the harmful policies that perpetuate poverty, racial disparities, and other threats to both HRSNs and SDOHs. Actions should include increased data and evaluation on the impact of social determinants of health and HRSN initiatives on Harm Reduction and overdose outcomes, and additional education opportunities about the intersectional nature of the social determinants of health, HRSN, substance use, and overdose.

10. Act to Expand Protections for Overdose Safety and Reduce Disease Transmission: Establishing a Right to Harm Reduction

Background:

The International Guidance on Human Rights and Drug Policy[228], developed in collaboration with researchers, PWUD, UN agencies, and community organizations, provides a helpful framework for our report and this first suggested initiative. The guidance highlights the measures countries should undertake or refrain from undertaking to comply with their human rights obligations, while considering their obligations under international drug control conventions. In this way, the guidance articulates a human rights standard that embraces a universal right to health. While Massachusetts is not a nation-state, the guidance provides organizing principles and articulates rights we may find meaningful and applicable at this moment in history.

Although 140 WHO Member states include a right to health in their constitutions, the U.S. is not one of them.[229] It is therefore important that states adopt this role, and several have acted to include constitutional commitments to health and healthcare, either as a universal view or specific to certain populations. These commitments range from a programmatic statement or one of public concern, to a more actively stated individual right or government duty.

See **Appendix I** for a brief history of additional relevant efforts.

The Challenge:

Too many medical care providers such as hospitals, primary care offices and substance use treatment programs do not provide Harm Reduction services, supplies, and information. This severely strains access and availability to Harm Reduction services and supplies statewide and limits state-support for Harm Reduction services to only locally approved jurisdictions (see initiative #1).

The Data:

State constitutional commitment to health and healthcare is associated with reduced infant mortality and reduced health inequality.[230] Harm Reduction efforts can reduce persistently high rates of fatal opioid overdoses — which have claimed more than 2,000 lives every year since 2016 in Massachusetts — and prevent the spread of diseases like Hepatitis C and HIV.

Ensuring access to Harm Reduction for all Massachusetts includes provision of sterile syringes distribution and disposal services, naloxone, safer smoking supplies, fentanyl test strips and drug checking services, and pre-/post-exposure prophylaxis (PrEP, PEP) for HIV infection.

What's Needed:

In the past legislative session, the House and Senate passed different versions of Harm Reduction legislation forward. This demonstrated a strong commitment to providing a range of Harm Reduction services, supplies, facilities and information that save lives, mitigating harm, and reducing the risk of infectious disease transmission. We hope that building on the latest evidence on the effectiveness of particular interventions will help generate a consensus to secure and protect access to Harm Reduction for all in the state and amplify the success of the Commonwealth to date. Such an approach is consistent and synergistic with recent undertakings that secured the *right to reproductive and gender-affirming care in the Commonwealth*[231] and *encouragement and protections for health care providers engaging in Harm Reduction service and supply provision* (see **Appendix I**).

Suggested Actions:

To protect the health and dignity of PWUD and provide safeguards for broader public health, a right to Harm Reduction services, supplies, and information is urgently needed.

From the International Guidance on Human Rights and Drug Policy

1.1 Harm Reduction

The right to health as applied to drug policy includes access, on a voluntary basis, to harm reduction services, goods, facilities, and information.

In accordance with their right to health obligations, States should:

i. Ensure the availability and accessibility of harm reduction services as recommended by UN technical agencies such as the World Health Organization, UNAIDS, and the UN Office on Drugs and Crime, meaning that such services should be adequately funded, appropriate for the needs of particular vulnerable or marginalized groups, compliant with fundamental rights (such as privacy, bodily integrity, due process, and freedom from arbitrary detention), and respectful of human dignity.

ii. Consider the development of other evidence-based interventions aimed at minimizing the adverse health risks and harms associated with drug use.

iii. Remove age restrictions on access to harm reduction services where they exist, and instead ensure that in every instance in which a young person seeks access to services, access is determined based on the best interests and evolving capacity of the individual in question.

iv. Exclude from the scope of criminal offences, or other punitive laws, policies, or practices, the carrying and distribution of equipment, goods, and information intended for preventing or reducing the harms associated with drug use, ensuring also that criminal conspiracy laws do not capture people using drugs together for this purpose.

v. Ensure that any law prohibiting the 'incitement' or 'encouragement' of drug use contains safeguards protecting harm reduction services, excluding from liability those who provide information, facilities, goods, or services aimed at reducing harms associated with drug use.

vi. Ensure that victims of, or witnesses to, an overdose or other injury occurring as a result of drug use are legally protected against criminal prosecution and other punishment in situations in which they have sought medical assistance for the overdose or injury.

The Challenge and Opportunity of Harm Reduction Commonwealth

Nothing About Us Without Us: Advancing with Community Engagement

The motto of "Nothing About Us Without Us" harkens from the disability rights movement and was adopted by Harm Reduction because of the embodiment of its shared foundational principles. A Harm Reduction Commonwealth centers people with lived and living experience with drugs in conversations of policies, services, and actions about them. Engaging communities in discussions about Harm Reduction can be challenging, particularly in areas where misconceptions prevail. Successful implementation requires establishing trust and understanding among local residents and stakeholders. Building on the investments in trust and equity that have been established recently and that have actively involved people with lived and living experience, now is the time to shift perceptions and address misunderstandings. The Harm Reduction Advisory Council (HRAC) embodies such an approach at the state-level and demonstrates the promise of investing in Harm Reduction leadership and the wisdom of the Harm Reduction community. We highlight other notable community engagement efforts with statewide reach:

- Our state joined 3 others in the recently concluded, large HEALing Communities Study, led locally by Boston Medical Center. As part of the National Institutes of Health-funded project, 14 Massachusetts communities received multi-year supports, access to world-class researchers, community investments in a set of standardized opioid-reducing interventions, and technical assistance to implement them during the study. Across the sites and within communities involved, the trial's goal of reducing overdose deaths by 40% was not achieved, though many other positive effects resulted from the study. In Massachusetts, layered on top of opioid task forces and other local initiatives over the years formed by brute force, love, desperation, and sometimes grant funding, some of the many legacies of the HEALing Communities Study are the actualization of being part of something larger than any one individual, the networking and new collaborations sewn, and the ability to call upon multi-sectoral partners to accomplish local initiatives. Communities that were not involved in the HEALing Communities Study also benefited from observation of the study, "spillover" of ideas to these other areas, and the study as inspiration for focused efforts to reduce overdoses.
- The recently created Office of Community Health and Equity within the Bureau of Substance Addiction Services at DPH exemplifies the institutional commitment to community engagement needed to propel changes in conversation and structure. The Office is a team whose goal is to better serve communities by listening to their substance use needs and helping the Bureau respond. In addition to proactively developing relationships with communities, they assist in formation of community advisory boards, establishing training for culturally responsive services, and centering the Black, Indigenous, and Transgender and Gender Expansive voices in the grantmaking process. This entity is a key resource for a Harm Reduction Commonwealth.
- The statewide opioid recovery and remediation fund (ORFF) combined will bring over $900 million into Massachusetts for substance use prevention, Harm Reduction, treatment, and

recovery support. At this point, taking up the ORFF funds that have been extended to cities and towns across the Commonwealth presents an opportunity to leverage these legacies, learnings, and infrastructures that have invested so heavily in community engagement and activation. Specific requirements for community feedback as part of the spending plans at the municipal level encourages community engagement.

These community conversations are platforms for dispelling myths about Harm Reduction, reducing stigma, engaging in dialogue about local Harm Reduction needs, and streamlining the provision of high-quality standardized Harm Reduction services in places that need or want them.

Policy makers and community partners should continue and expand their commitment to equity, justice, stigma reduction, and democratic, free and fair exchange of ideas through active involvement and support of community engagement. Where engagement is not yet occurring, community conversations about Harm Reduction should be initiated and nurtured.

Conclusion

Harm Reduction has a long history in Massachusetts, where leading voices and programs have helped shape the modern Harm Reduction movement and secure access to the services recognized today as essential to maintaining public health, preventing HIV and Hepatitis C, and reversing preventable and otherwise fatal overdoses. The pace of the opioid crisis continues to claim too many lives in our communities, and too many more would have been lost if not for concerted efforts by the state to invest in Harm Reduction alongside prevention, treatment, and recovery. For the benefits of Harm Reduction to extend to all in Massachusetts, there are actions we can take today and areas we can invest in—legislatively and financially. Doing so will secure a more equitable and sustainable Harm Reduction Commonwealth, inspire health and Harm Reduction innovations, and set a national standard.

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Appendices

Appendix A: A Harm Reduction-Centered Approach

Centering Harm Reduction creates a more wholistic approach to health and healthcare that can further the wellbeing of all people in Massachusetts. Research shows the benefits that can come from Harm Reduction, which includes reducing health and safety issues, providing broader public health benefits due to decrease in disease transmission, reducing visits to the emergency room which can otherwise incur expensive costs, and reducing stigma.[232] By reducing the harm that comes from substance use and the criminalization of drug use, Harm Reduction approaches improve health on individual and communal levels. A testament to the advocacy and evolution of Harm Reduction was recent actions by the U.S. Department of Health and Human Services (HHS), which has incorporated many Harm Reduction components within its Overdose Prevention Strategy.[233] One effort from HHS includes increasing the amount of research on Harm Reduction strategies and promoting evidence-based approaches that can be easily integrated into our existing health system infrastructure. Further, HHS is working to expand sustainable funding strategies that can increase the capacity for Harm Reduction services to be available, which can include Harm Reduction grants and planning grants for mobile crisis intervention services.[234] Finally, HHS Harm Reduction efforts include a component to increase education on Harm Reduction, overdose, and substance use that can educate the public to reduce stigma, but also educate those using substances around the effects and potential harms.

Centering Harm Reduction also allows for addressing health-related social needs and the social determinants of health. Many standard approaches to reducing deaths from overdose focus on responding to the acute event. They do not address basic needs and other environmental or social factors that increase the risk of subsequent overdoses and also play roles in an individual's overall wellbeing. Focusing more broadly on Harm Reduction can help increase the opportunities for intervention that encompass multiple levels of societal structures for improved health.[235]

The roots of Harm Reduction trace to activism around the HIV/AIDS epidemic and the injustices experienced by the LGBTQ and PWUD communities, both of whom were at acute risk of contracting the virus, but this vulnerability was ignored by the larger community. Challenging medical, legal, housing, and social structure systems to recognize the needs and lives of PWUD, Harm Reduction encompasses a philosophical and political movement rooted in love, dignity, and respect for bodily autonomy. Harm Reduction embraces positive changes that "reduce the risks of injury and death" rather than only counting abstinence as a measure of success. It rejects criminalization as the solution to drug-related harm. Services that embody Harm Reduction include SSPs, naloxone distribution, low-barrier medication for opioid use disorder (MOUD), and community drug checking. In everyday life, people employ concepts of harm reduction all the time: wearing a helmet when bicycling, a seatbelt when driving, and reducing salt intake to lower your blood pressure are all examples of people acting to mitigate risk to self and others while living their lives.

Appendix B: General Principles of Harm Reduction

To better understand Harm Reduction, and what it means for the Commonwealth, understanding the general principles is critical. The National Harm Reduction Coalition uses the following eight principles to explain and guide their work.[236]

1. Accepts, for better or worse, that licit and illicit drug use is a part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
2. Understands drug use as a complex multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence and acknowledges that some ways of using drugs are clearly safer than others.
3. Establishes quality of individual and community life and well-being – not necessarily cessation of all drug use – as the criteria for successful interventions and policies.
4. Calls for non-judgement, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
5. Ensures that people who use drugs and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
6. Affirms people who use drugs themselves as the primary agents of reducing the harms of their drug use and seeks to empower PWUD to share information and support each other in strategies which meet their actual conditions of use.
7. Recognizes that the realities of poverty, class, racism, social isolation, past-trauma, sex-based discrimination, and other social inequities affect both people's vulnerability to and capacity for effectively dealing with drug related harm.
8. Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use.

Appendix C: History of Harm Reduction: Nationally and in Massachusetts

National Overview

The movement of Harm Reduction emerged in the U.S. during the mid-1980s, primarily in response to the HIV/AIDS epidemic, which was significantly affecting people who inject drugs (PWIDs). Recognizing the need to reduce harm among this population, the first SSP was established in Tacoma, Washington, in 1988. This marked a critical step towards acknowledging and addressing the public health needs of PWIDs.

In 1991, the Harm Reduction Coalition (HRC) was founded to advocate for Harm Reduction policies and practices on a national level. By 1994, the Centers for Disease Control and Prevention (CDC) began funding demonstration projects to evaluate the effectiveness of SSPs. These efforts helped to formalize and expand Harm Reduction strategies across the country. Hundreds of advocates and organizations throughout the country formed core Harm Reduction supports through mutual aid and community organizing. Many state laws have changed to permit the operation of SSPs.

The 2000s saw broader acceptance and policy changes regarding Harm Reduction. In 2000, the Office of National Drug Control Policy recognized Harm Reduction's role in reducing the spread of infectious diseases among PWIDs. Despite a federal funding ban for needle exchange programs in 1988, state and local initiatives continued to develop.

Significant progress was made in the 2010s, highlighted by the passing of the Comprehensive Addiction and Recovery Act (CARA) in 2015, which provided funding for Harm Reduction programs, including SSPs and overdose prevention efforts. In 2016, the CDC reported a significant reduction in HIV transmission among people who inject drugs, attributing much of this success to Harm Reduction strategies.

Massachusetts Overview

Massachusetts has been at the forefront of Harm Reduction efforts since the early 1990s. In 1994, the state established its first state-sanctioned SSPs in Cambridge and Boston, led by local activists and health officials. These programs demonstrated the effectiveness of SSPs in reducing HIV transmission and set the stage for further initiatives.

Despite facing political and public resistance, SSPs opened in other cities in the years that followed. Demonstrating critical leadership, DPH recognized the effectiveness of SSPs and supported them. Legislation altering the classification of syringes as paraphernalia and allowing their distribution was passed in 2006 but creation of SSPs required authorization for state-funded programs by local officials. A revision of the law in 2016 amended the required authorization to local boards of health in order for state funded SSPs to open in a locality. Further clarification of permissions for syringe provision occurred when a landmark court case ruled, in *AIDS Support Group of Cape Cod v. Town of Barnstable,* that any organization or individual can distribute syringes in the state, and that programs are not limited to those operated by DPH.[237]

Since July 1, 2016, many local boards of health have approved syringe services, with 86 approvals documented by an official letter submitted to DPH as of 8/19/24.

The 2000s brought further institutional support and innovation to Massachusetts. In 2007, the DPH launched pilot programs for overdose education and naloxone distribution (OEND) following a model pilot launched the year prior by the Boston Public Health Commission, thereby addressing the rising opioid crisis. The passage of the Massachusetts overdose GSL in 2012 provided legal protections for those seeking medical help during an overdose, marking an important legal milestone for Harm Reduction.

In the 2010s, Massachusetts continued to expand programming and supports for Harm Reduction. As new SSPs opened, investments in OEND followed. The state established a statewide naloxone distribution program in 2022, significantly increasing access to this life-saving medication. The state convened a Harm Reduction Commission in 2018[238] which provided a number of ground-breaking recommendations and articulated supports for Harm Reduction initiatives, such as fentanyl test strips and drug checking, safer smoking materials, and broad

naloxone access. Among the many impacts of this Commission was legislative language which allocated state funds for key investments in Harm Reduction.

Key Figures in the Harm Reduction Movement

Many individuals have made significant contributions to the Harm Reduction movement and continue to do so, both nationally and in Massachusetts. Below we include a small selection (arranged alphabetically by last name) and encourage readers to explore the linked ongoing oral history and artistic projects to meet other notable leaders:

- Chris Alba: Chris Alba worked with the Harm Reduction Coalition, Healthy Streets/Health Innovations, the City of Revere and other organizations to expand services and support for people who use drugs, shaping Harm Reduction policies in Massachusetts and beyond.
- Dan Bigg: Known as the "Godfather of Naloxone," Dan Bigg co-founded the Chicago Recovery Alliance in 1992 and pioneered the distribution of naloxone, which has saved countless lives by reversing opioid overdoses.
- Rhoda Creamer: Rhoda Creamer played a critical role in developing Harm Reduction services in Massachusetts, particularly in establishing SSPs and advocating for policy changes.
- Mark Kinzly: Co-founder of the Texas Overdose Naloxone Initiative (TONI) and a driving force in New England, Mark Kinzly advocated for Harm Reduction for over two decades, focusing on overdose prevention and the integration of Harm Reduction into public health frameworks.
- Gary Langis: Gary Langis has been a leading figure in Massachusetts, particularly in syringe access and overdose prevention, training and distributing naloxone across the state.
- Harry Leno: An advocate and harm reductionist, Harry Leno was influential in peer-led Harm Reduction efforts, providing outreach and education to people who use drugs and building the legal pathway for syringe access in Massachusetts.
- Joy Rucker: Joy Rucker has worked tirelessly to ensure that Harm Reduction services are accessible to marginalized communities, emphasizing the intersection of racial justice and Harm Reduction.
- Edith Springer: As a social worker and Harm Reduction educator, Edith Springer was instrumental in introducing Harm Reduction principles to social work and drug treatment, training numerous health professionals and activists.
- Imani Woods: A founding member of the national Harm Reduction Coalition and advocate for syringe access known for her work in advancing racial justice, public health, and access to services for PWUD.

For more on Harm Reduction history in Massachusetts, visit the Voices of Harm Reduction in Massachusetts oral history project and read the compiled zine entitled, Harm Reduction Historia – A Collection of New England Harm Reduction Legacies.

Appendix D: A Closer Look at Changes in Overdose Deaths in Massachusetts

There are numerous hypotheses about what might be driving the changes in the number of overdose deaths. To explore answers to this question, we drew upon the interviews conducted

for this report, the wealth of expertise of thought leaders in Massachusetts, and available data to generate possible hypotheses. Two commonalities rose to the top of the hypothesis list: Hypothesis 1) the change is due to progress in SSPs access, as programs integrate Harm Reduction efforts like naloxone, fentanyl test strips and drug checking, safer smoking, and low-barrier access to care and MOUD,

Hypothesis 2) there are changes in the drug supply occurring that are reducing the purity and therefore lethality of fentanyl specifically.

While there were further theories as to the forces driving the supply changes—ranging from increased law enforcement interdiction to international drug control treaties to demographic changes in PWUD to infighting among drug cartels to environmental crisis effects—we selected these two because we can test them and contribute to the broader knowledge of effects of the drug supply on overdose deaths.

To explore these hypotheses, we conducted two analyses: one considering geography and Harm Reduction services and one considering drug supply data from the statewide drug checking program, Massachusetts Drug Supply Data Stream (MADDS).

1. Geography and Harm Reduction Services

We first compiled the counts of overdose deaths in cities or towns with 10 or more deaths in 2022 or that increased the number of deaths to 10 or more in 2023. We then tabulated whether these locations had active Harm Reduction programming (defined as a brick-and-mortar or regularly scheduled mobile SSP, whether DPH-funded or not) during the periods of 2022 to 2023 and statistically compared the counts in overdose deaths in the cities or towns by SSP status. We also conducted follow-up outreach to sites and DPH to verify dates of known operational and other major challenges during 2022 and 2023. These data are available upon request from the report authors.

Among the subset of 35 locations that had a reduction in overdose, this represented a median 27% reduction or 267 fewer deaths of their denizens. The 18 cities and towns that had increased or sustained high overdose deaths had a median 14% increase or 100 more deaths of their denizens.

There were no statistically significant differences between communities experiencing a change (reduction or not) and their SSP presence (p value=NS), although the drop in deaths was higher (13%) in places with SSPs than in places without SSPs (7%).

Stratifying by change in overdose statistics:

Harm Reduction Services Differentiated Places that Improved

Of the 35 locations with a decrease in overdose deaths, 20 were in locations with SSPs and 15 were in locations without SSPs. What mattered most, as hypothesized, bore out: communities

with SSPs saw 10.1 fewer overdose deaths per year and communities without SSPs saw 4.3 fewer deaths per year (p=.005). This suggests that SSPs helped save lives in their communities.

Harm Reduction Undermined in Places that Did Not Change

Of the 18 locations with a persistently high rate or an increase in overdose deaths, 8 were communities with SSPs and 10 were locations without SSPs. Paradoxically, there was a statistically significant difference by SSP presence in the number of overdose deaths: the 8 communities with SSPs saw +9.2 overdose deaths and the 10 communities without SSPs saw +2.6 deaths. Why?

We took a closer look. Notably, half of the 8 SSPs located in places with sustained increases in overdose deaths experienced tremendous social strain and major disruptions to services due to political and police actions (Boston, Framingham) or were newly launched locations (Haverhill, Greenfield*) that were not fully operational during the 2022 to 2023 period. With sufficient public and political support, reduced police interference, and time to establish and grow their programs, the data suggest that these communities would benefit, as have the other 20 programs in the state, and experience reductions in overdose deaths.

> *Take-home point 1:*
> Recent larger reductions in overdose deaths in Massachusetts occurred in communities with active SSP and Harm Reduction service presence, suggesting their actions, local support, and advocacy in communities are part of the story of reduced overdose mortality.

2. Drug Supply Changes

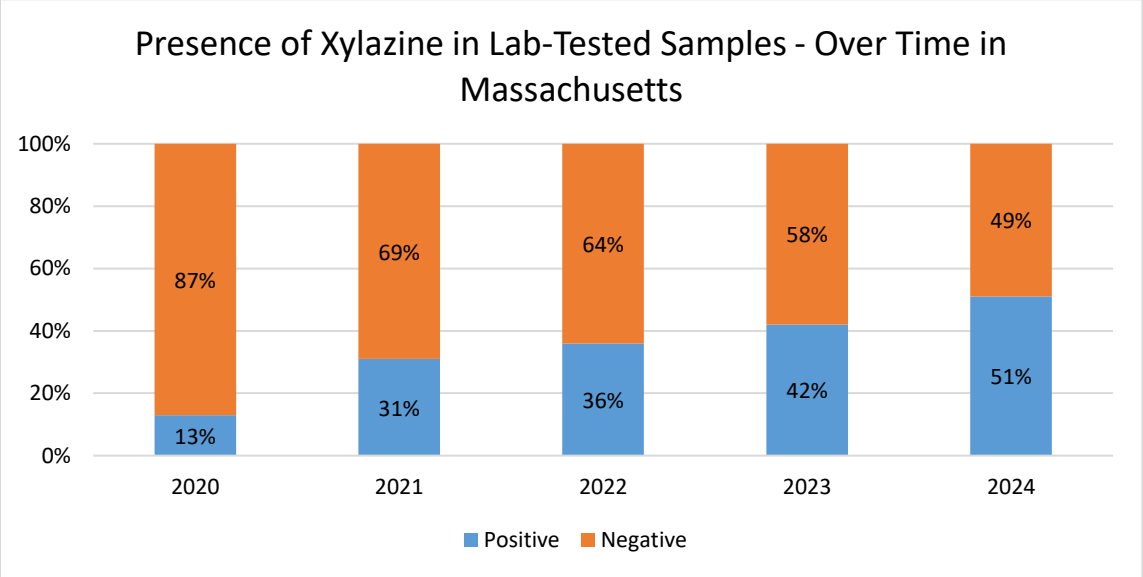
The illicit drug supply is toxic and unregulated. Substances are quickly evolving and data to detect these changes are critical to mount the appropriate response at the individual and institutional levels.

During 2022 and 2023, the Massachusetts Drug Supply Datastream (MADDS), the statewide drug checking program that operates in 19 locations and Harm Reduction programs, detected several shifts to the drug supply locally, and we highlight three here with potential impact on overdose deaths.

First, the largest and most compelling shift came with an influx in the opioid drug supply of the veterinary sedative xylazine. This alpha 2 adrenergic medication appears to cause many health problems such heavy sedation, painful hard-to-heal wounds, and complex withdrawal in humans. Overdose deaths involving xylazine increased from 9 and 11 in 2020 and 2021, respectively, to 115 in 2022. However, the mechanism of xylazine in causing overdose death isn't entirely clear. Nevertheless, the large increase in the presence of xylazine in Massachusetts death data confirmed the earlier drug supply changes detected by MADDS. The role of xylazine is important because two studies suggest that xylazine may not increase overdose risk, and may instead serve to reduce overdose mortality by: a) replacing a short-acting fentanyl effect with a longer,

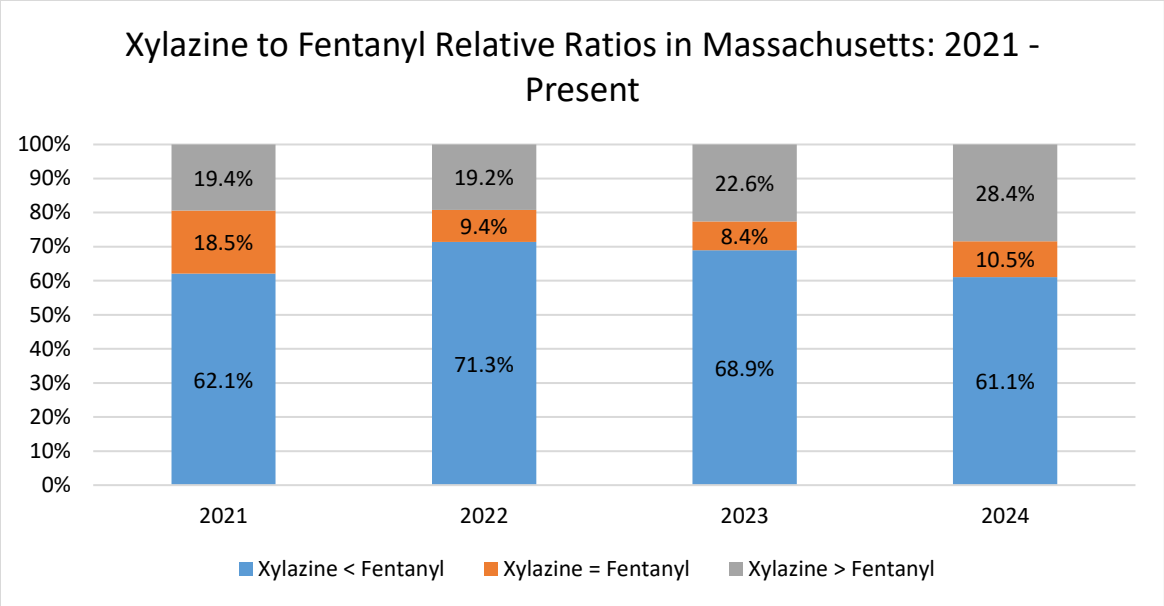
*Note: Greenfield has had an SSP since 2017. In this 2022 to 2023 period, however, operations were halted for a substantial part of the year

sedating effect of a non-opioid which may result in less overall drug use, b) serving as a "cut" of fentanyl which reduces the amount of fentanyl in any given drug, and c) changing the symptoms of what an overdose presents as--to include lowered blood pressure, slowed breathing and unresponsiveness--wherein naloxone is more likely to be administered.



**Updated November 8, 2024*
***Source: StreetCheck: Community Drug Checking*[239]

Xylazine persists in the drug supply in 2024, and does not appear to be leaving anytime soon. While xylazine has been detected in 51% of the opioid supply tested by MADDS in 2024, the quantity or amount of xylazine (i.e., concentration) in a given drug sample hovers around 8% and the quantity of fentanyl present in this case averages 8.7% (i.e., a ratio of 1:1 or less of xylazine to fentanyl). In contrast, >90% of the Philadelphia area drug supply contains xylazine where it comprises 25-40% of a given drug sample.[240] So, the potential "dose" of xylazine in a Massachusetts drug sample is lower than in Philadelphia, but higher than in years prior to 2022.



**Updated November 8, 2024*
***Source: StreetCheck: Community Drug Checking*[241]

In places around Massachusetts where xylazine is endemic in the drug supply, the amount of xylazine approximates the amount of fentanyl in the drug. Xylazine's rapid emergence and establishment in the opioid supply of many areas of the state suggests it may have impacted the reductions in overdose mortality, alone or in combination with SSP capacity there. In communities where xylazine is entrenched (e.g., counties of Worcester, Berkshire, Norfolk, Hampden, Hampshire, Franklin: Worcester, Springfield, Chicopee, Pittsfield, Northampton) we see reductions in overdose deaths. The converse is also observed: where xylazine does not appear in the opioid supply or is found in lower quantities, its potential death-preventive effects were not observed and deaths increased 2022-2023, most notably in the counties of Suffolk, Barnstable, Bristol and Essex (e.g., Boston, Taunton, Barnstable, Peabody, Methuen, Haverhill). We also note that Suffolk and Essex counties are home to the highest proportions of people of color in the state: Suffolk County residents are 55.4% Black/African American and Essex County residents are 33.1% Latine.[242] Supply differences may also help explain some of the racial and ethnic disparities observed in overdose mortality.

Take-home point 2: Changes in the drug supply appear to have influenced the recent reductions in overdose deaths in Massachusetts. In particular, the veterinary sedative xylazine may be contributing to a reduction in fentanyl overdose deaths. Places experiencing increases in overdose deaths had less xylazine in their drug supply, and therefore less exposure and use of xylazine. The SSP and Harm Reduction service findings (Take-home Point #1) are synergistic with the supply changes.

A second trend discovered when examining the drug supply hypothesis gave a different clue. Comparing 2023 to 2022, there was an increase in the amount of para-fluorofentanyl, a fentanyl analogue used in synthesis of the drug that is also potent and active in its own right, in fentanyl

samples. Commonly, "fentanyl" is actually comprised of many different substances. As one individual interviewed for this report put it: "Fentanyl isn't in everything, but everything is in fentanyl." The illicit manufacturing process of fentanyl means that drugs are commonly not "cooked" completely or correctly, and remnants of precursors or the synthesis process are found—sometimes in large amounts—in fentanyl drug samples tested by MADDS. In most of the poor synthesis processes, the result is many precursors of no effect left inside an incompletely synthesized drug, and thus the expected net effect on the use experience is a weaker sensation. One notable exception in these synthesis processes is the substance and precursor para-fluorofentanyl, which produces similar effects to fentanyl and can cause overdose.[243] In this way, the manufactured fentanyl with para-fluorofentanyl may be more erratic and of higher and unpredictable potency. In 2023, the amount of para-fluorofentanyl was significantly higher ($p<.01$) in fentanyl samples compared to 2022 and 2024, especially in the communities in Hamden County (Holyoke, Springfield), Franklin County (Greenfield), and Suffolk County (Boston). It is thus possible that these Massachusetts communities experienced a higher "dose" of fentanyl than other communities which may have contributed to higher death rates, alone or in combination with the SSP constraints noted above.

The changes discussed here were only gleaned through drug checking and drug supply monitoring. Unlike a contaminant in the food or water supply, the drug risk environment lacks legal regulation. Harm Reduction efforts like drug checking need to be available statewide to fill the knowledge gaps and save lives.

Take-home point 3: Changes in the drug supply also appear to have influenced places experiencing ongoing or increased overdose deaths. Some specific communities had higher percentages of para-fluorofentanyl, a potent fentanyl analog, in addition to the fentanyl drug supply which may have compounded risk and contributed to the rise in overdoses there. Combining these take-home findings, communities with SSP and Harm Reduction services have tools, supplies, and a knowledgeable workforce able to respond and adapt quickly to drug supply changes to support risk reduction and prevent overdose deaths in their local areas. Communities lacking such capacity, or that hinder existing SSP and Harm Reduction service operations, are less efficient and able to respond to rapid drug supply changes with timely provision of prevention and intervention tools.

The final trend we examined was changes in fentanyl presence and amount (i.e., concentration or percent per weight of a given drug). Using the MADDS dataset, we conducted statistical "hurdle" models looking at changes in fentanyl from 2022 to 2024. We found that the presence of fentanyl in any of the samples submitted (whether opioid, stimulant, etc.) increased over time and that, when present, the amount of fentanyl detected in a given drug initially rose over time but has in recent years been falling, in a trend that looks like an "upside-down U" shaped curve. This is important because it suggests that the potency of fentanyl may be declining in the drug supply, as other additives, like xylazine or other sedating drugs, rise, and this may contribute to reduced deaths in our communities. As a parallel, the reduced levels are akin to consuming

lower alcohol proof beverages. Risk persists, but harmful outcomes are reduced compared to widespread consumption of higher proof substances.

Take-home point 4: Overall, fentanyl continues to contaminate the drug supply but the *concentration* of fentanyl present in the opioid supply appears to be declining. Reduced fentanyl concentrations in a given opioid drug may explain the observed reductions in overdose deaths in some communities.

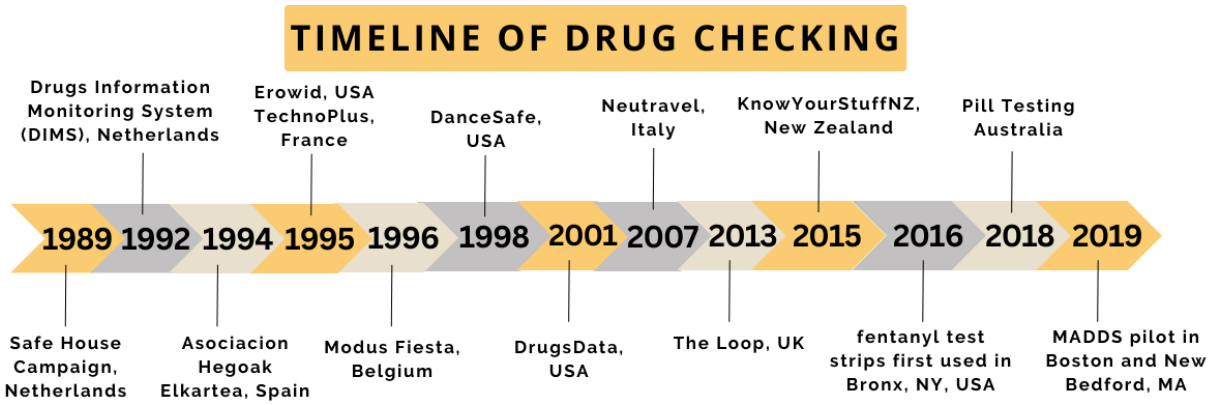
Synthesizing across the findings, it appears that the combination of supply changes and Harm Reduction programming at the local level matter. Harm Reduction programs are equipped to see and respond to changes in the drug supply, allowing for more efficient actions like awareness campaigns, tailored response programming, and activation of treatment resources, that ultimately save lives. In communities with Harm Reduction services, PWUD are better informed, equipped and empowered to adopt changes in behavior that reduce their risk and further improve the quality of their lives.

KEY TAKE-HOME POINT: This preliminary analysis of recent overdose trends points to the importance of drug supply monitoring and of Harm Reduction programs—especially SSPs— as informational tools and interventions that protect local communities and save lives. We carry these findings into the next section, a collection of comprehensive action steps for a strong **Harm Reduction Commonwealth**.

Appendix E: Brief History – Syringe Service Programs in the Commonwealth

- Please see Appendix C for a detailed history of SSPs in Massachusetts
- Possession and free distribution of syringes by individuals and programs is not illegal in Massachusetts. The distribution of syringes through DPH-funded programs is required to obtain approval from the local board of health. Free provision of safe consumption materials such as supplies for safer smoking, snorting, or boofing (anal route of administration) by individuals and through programs is legal and does not require local board of health or other approvals.

Appendix F: Brief History – Drug Checking in the Commonwealth



In 2019, DPH funded a pilot project to assess the feasibility of conducting drug supply monitoring of remnant drug samples donated by community members to a community organization and police department remnant samples from non-criminal cases otherwise set for destruction. The successful pilot birthed a community drug checking service and drug monitoring program called MADDS (Massachusetts Drug Supply DataStream). MADDS sites use field-based tools long used by law enforcement to instead be used by trained public health and Harm Reduction workers. Training and equipping community organizations to collect, test, and analyze remnant drug materials accurately reflects the contents of the drug supply. There are now 19 MADDS sites around Massachusetts that conduct community drug checking, and they have collected and analyzed over 7000 drug samples to date.

Massachusetts law includes in its definition of "drug paraphernalia" items used for "testing [or] analyzing" a controlled substance, including "testing equipment used, primarily intended for use or designed for use in identifying or in analyzing the strength, effectiveness or purity of controlled substances." Although all drug checking equipment (test strips, advanced devices) falls under the definition of drug paraphernalia, there is no criminal penalty in Massachusetts for using or possessing drug paraphernalia without the intent to sell it. However, there is no exception from illegal drug possession penalties for users of drug checking services, or program staff providing such services, to possess drug samples for the purpose of testing.

Because of this, permissions to operate drug checking programs are formalized in signed local agreements. Each of the MADDS sites operates within a jurisdiction under the written approval of a local law enforcement agency (District Attorney, police chief), conducting community drug checking within that jurisdiction at locations such as Harm Reduction organizations, healthcare centers, and mobile health vans. The agreement acknowledges the existence of the programs and permits organizations in the local jurisdiction to operate the services with the understanding that this pertains solely to the possession, transport, and testing of remnant drug samples for the purposes of drug checking, public health and Harm Reduction.

Appendix G: Brief History – Rethinking Criminal Legal System and Police Response to Overdose

Massachusetts' response to substance use through the criminal legal system and law enforcement has evolved over the last decade, shaped by a complex history of punitive policies and changing public health perspectives. A few key developments that have been central to this evolution: the GSL, Section 35 involuntary civil commitment for SUD, access to naloxone in criminal legal settings, and police-led housing sweeps. While the state has therefore made strides in incorporating harm reduction strategies, the overall response continues to reflect a strong history of criminalization and stigmatization of PWUD.

One significant shift occurred in 2016 when Massachusetts expanded the GSL, which provides legal protections for individuals seeking medical care for an individual experiencing a drug-related overdose.[244] Under the current GSL, individuals who seek help for themselves or others during a drug-related overdose are protected from charges, prosecution, or related parole or probation violations.[245] While this law encourages 911 help-seeking in a suspected overdose emergency, it also highlights the existing tension between Harm Reduction and punitive frameworks that are still shaping Massachusetts' response to substance use.[246]

Another key component of response is the state's use of statutory requirement, Section 35, which allows for individuals to be involuntary committed due to a problematic SUD, typically at a treatment facility but may also at facilities under the supervision of the Department of Correction.[247] While this policy was created with the intention of providing treatment, critics highlight the focus on forced treatment rather than voluntary care, which evidence suggests leaves people more prone to leaving treatment prematurely and a return to substance use.[248]

Additionally, Massachusetts has made efforts to increase naloxone access, including to individuals formerly incarcerated, as discussed in previous sections. Since 2015, The Massachusetts Department of Correction and Houses of Correction have worked to provide naloxone in jails and prisons. However, disparities in access remain and an assessment of the naloxone distribution strategies throughout the system is needed.

Finally, housing sweeps, which are police-led dispersals of the unhoused, disproportionately impact people with an SUD, especially when they are displaced from areas where they were

receiving services.[249] These sweeps can exacerbate existing barriers to healthcare and stable housing[250], as well as increase the overdose risk and negative health outcomes (such as sharing or reusing needles), which can continue the cycle of instability and risk. Further, while court decisions leave the criminalization of housing encampments up to local governments, the ruling's ambiguity has led to confusion over implementation.[251]

These four key areas show the variety in the nature of Massachusetts' response to substance use: there have been important steps toward evidence-based protective and rehabilitative practices, but much of the framework still relies on punitive responses. Massachusetts must continue to move the policies towards health-centered approaches that do not prioritize punishment.

Appendix H: Brief History – Harm Reduction in Housing Settings

- Housing First (HF) is an evidence-based model that uses housing as a tool and a right, rather than a reward, for health and recovery and that centers on providing or connecting people experiencing homelessness to permanent housing as quickly as possible. HF providers offer services as needed and requested on a voluntary basis and do not make housing contingent on participation in services. The components of HF are well documented and researched, with best practices showing effectiveness compared to usual model approaches.[252,253, 254,255] HF does not require abstinence or treatment to access or maintain housing.
- The HF model is contrasted with a model known as "treatment first" or "housing readiness," which is exhibited in some transitional housing models. This model requires unhoused people to earn their way into transitional housing and make progress on certain goals; when they are deemed well enough, they earn their spot in permanent housing. In these "treatment first"/"housing readiness" models, abstinence or treatment participation are typically a requirement of graduation to readiness and necessary for housing receipt.
- Harm Reduction Housing (HRH) within the shelter, outside of a shelter, low-barrier/transitional, and permanent supportive housing settings is critical. HRH integrates supportive services like HF with a focus on minimizing the negative consequences of substance use through the active provision of Harm Reduction supplies, services and policies. For example, programs adopting HRH provide access to safe use supplies, naloxone, syringe disposal, HIV testing and counseling, and MOUD care onsite. HRH were applied during COVID-19 pandemic in locations across the state and in Boston around the intersection of Massachusetts Avenue and Melnea Cass Boulevard, known as "Mass and Cass", encampment disruptions in 2021 and continue in 2024.

Appendix I: Brief History – Establishing a Right to Harm Reduction

Massachusetts law does not contain a right to public health or Harm Reduction services. However, Massachusetts has taken some steps to increase access to these services and supplies. In 2019, the Massachusetts Medical Society adopted a universal right to health framework to guide the association's work, broadening their vision to include social determinants of health and

the circumstances in which patients, families, and communities are treated.[256] As the first state to establish near universal healthcare coverage in 2006, Massachusetts is better aligned than any other US state to adopt key aspects of the right to public health, and especially as it relates to Harm Reduction.

In September 2024, Department of Public Health Commissioner Robbie Goldstein issued a memo instructing all boards they may not discipline a healthcare professional solely for the provision of Harm Reduction supplies to a patient. The memo follows a similar document from July 2024, wherein the Massachusetts Board of Registration in Nursing published an Advisory Ruling on Nursing Practice clarifying that the provision of Harm Reduction supplies and/or services is within the role of the nursing profession, does not violate Standards of Conduct, and is consistent with expected duties of the nursing profession. Further, it stated that licensed nurses would not be subject to disciplinary action solely for provision of Harm Reduction services or supplies to a patient. These declarations set the stage for further action.

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