Rapid Assessment of Consumer Knowledge (RACK) Lowell

What is RACK?

Rapid Assessment of Consumer Knowledge (RACK) is a brief, mixed methods research approach to gain insight into local challenges and responses to the opioid crisis as shared by the people who use drugs there. RACK reaches beyond clinical and administrative data to learn about fentanyl and other drug use, treatment experiences and access, and the lived effects of recent policies, like prescribing limits and the Good Samaritan Law.

How did RACK Lowell work?

The BMC research team conducted extensive community outreach prior to data collection, identifying and meeting with community stakeholders and tailoring survey items. Surveys (n=50) and interviews (n=14) were conducted over an 8-day period in August 2017 by a team of 7 researchers. Participants were recruited through community organizations, treatment programs, street outreach, and chain referral.

Who participated in RACK Lowell?

- The sample was young, with 36% under the age of 30, a majority of whom were homeless or unstably housed (44%), and most participants were white (80%).
- The drugs used by the majority of the 50 people who participated in RACK were opioids by injection or by inhalation, and participants had a hard time distinguishing heroin from fentanyl locally. 64% also used cocaine—primarily by injection—and half used crack.
- Almost all participants had been exposed to fentanyl in the past year (94%) with both negative and extremely positive feelings expressed:

Drug	Participants, n (%)	Route of Administration	n (%)
Cocaine	32 (64)	Snort: Inject: Smoke:	9 (25) 26 (72) 1 (3)
Crack	25 (50)	Inject: Smoke:	1 (4) 24 (96)
Opioids (such as heroin, oxycodone, fentanyl etc.)	47 (94)	Snort: Inject: Oral:	16 (34) 31 (66) 6 (13)
Heroin Prescription pain medication Fentanyl	43(92) 15 (32) 41 (87)	---	

When I first started using, I remember like I could spend $100 in a day and do heroin all day long and then not have to touch it for the rest of the week and you have like… I'd get diarrhea, I'd get a little nauseous and stuff, but it wasn't that bad. I could still go to work, I could still function. Now [with fentanyl], like the withdrawals are so much worse. You can't function. I feel like I can't get away from it, like I think about it more. It's more painful, it is more psychological. I feel like it's actually like messing my head up really bad. It's messing with my emotions more definitely because I'm very, very emotional lately.

I was scared of fentanyl when it first came out. Now it's like, 'give me more', you know?

Interviewer: Okay. Do you feel like the fentanyl gives a better high?
Participant: No. I hate fentanyl personally.
Interviewer: How come?
Participant: Fentanyl is what's making everybody die.
Interviewer: Why do you think they're dying?
Participant: Because they're not realizing the fentanyl is in it—I've saved four different people from overdosing, one person being my girlfriend.

It [fentanyl] makes you want to do more dumb stuff. It makes you feel invincible…Injecting more heavily, bigger shots

What was learned about overdose risks and policies to address them in Lowell?

- Despite reports of personally experiencing (67%) or witnessing (100%) overdoses, naloxone access in Lowell was strained: 37% indicated that naloxone was not easy to get or they did not know how to access it. 2 of 5 RACK participants were unfamiliar with the Good Samaritan Law, and there was considerable confusion about the law, its limits, and its impact. Confusion about the law was greater among people who were younger, of non-white race, who were Hispanic/Latinx, and/or individuals

with a lower educational attainment. An emergent theme from the interviews was concern about local application of civil commitment for substance use (Section 35) and its effects on help-seeking as well as increased overdose risk due to decreased opioid tolerance upon release from a civil commitment episode.

- Lacking good access to naloxone, people navigated overdose risk by changing behaviors: using less, doing a test shot, using together, using in public places, and going to dealers who "product test" their supply.

> *I always end up doing a little shot first, like a little tester shot, because you can always do more. You can't do less. You can't take back what you've already done.*

- The availability of new sterile syringes was inconsistent with the high rate of drug use by injection and the frequency of injection reported by participants. Among people who inject, 71% (n=24/34) used the volunteer-run mobile syringe unit. This unit operated for only two hours/week; otherwise access was limited to pharmacies.

> *A lot of these dealers, they have people they call their little guinea pigs. They have them come over and try the drugs to make sure how good it is or if it's bad, how much to do, how much to sell, should the price change….Like, I've been a product tester for a couple people*

- While prior experience with medications for opioid use disorders (MOUD) was 84%, and several were still taking prescribed buprenorphine or methadone, negative opinions about MOUD were common. Some spoke about difficulties accessing buprenorphine locally, and many shared stories of difficulties getting to the methadone clinic located on the edge of town.
- Some participants voiced concern about new cases of HIV in the area, and some shared that they were among those recently diagnosed with HIV. While participants were not asked their HIV or HCV status, many of them expressed concern over transmission due to shared materials and sex work. Interview and observational data suggested high overlap between transactional sex and drug use in Lowell.

What are recommendations for Lowell, following the RACK findings?

- **Improve** access to new sterile syringes, safer use materials, and safer sex promotion materials through the establishment of syringe service programs, both mobile and brick-and-mortar sites.
- **Establish** mechanisms and opportunities for safe syringe disposal
- **Expand** peer-delivered services, engaging people who use drugs and in recovery in outreach and service delivery efforts. Train and equip peers to distribute naloxone and consistently educate on the Good Samaritan Law.
- **Develop** and disseminate materials for lower English literacy levels as well Spanish language awareness campaigns on the Good Samaritan law and naloxone access
- **Provide** trainings to law enforcement, hospital staff, area service providers, and the courts on the potential unintended consequences and risks of civil commitment.
- **Support** MOUD engagement, especially facilitated transportation to opioid treatment programs and more ready access to buprenorphine
- **Increase** awareness of and reduce stigma of MOUD among people who use drugs, and among people providing healthcare, recovery and support services. Efforts may include training and outreach to service providers and first responders who are routinely in contact with people who use drugs. A public awareness campaign may also contribute to improving attitudes within the community.