

## COVID-19 and Substance Use in New Hampshire

### Survey Report, May 2020

#### Executive Summary

##### Survey methods

In order to elucidate the impact of the COVID-19 pandemic on drug use and people who use drugs (PWUD) in New Hampshire, an online survey exploring drug use patterns and COVID safety practices among PWUD was developed using Qualtrics software. The survey included 13 fixed choice response items and 3 opportunities for narrative responses and was emailed to 383 diverse stakeholders asking them to share their observations and to forward the link to other observers. Leaders of 11 relevant NH networks agreed to circulate the survey to their constituents. Total number of recipients is unknown.

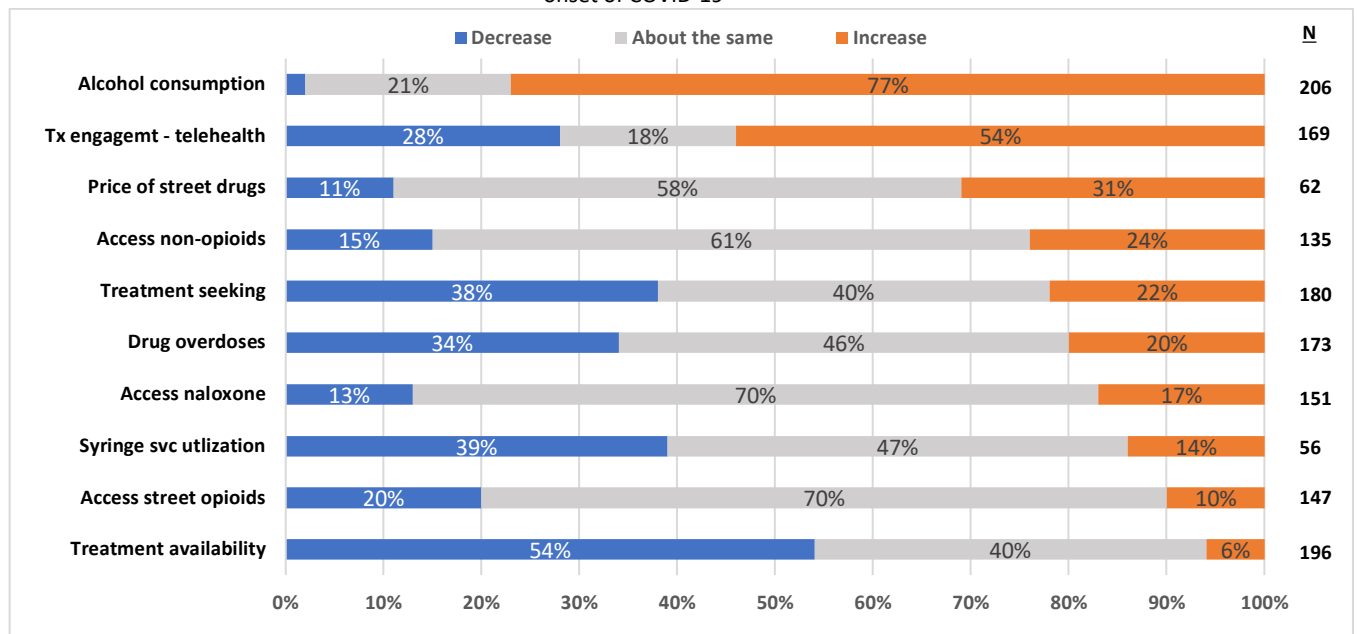
##### Findings

339 individuals responded, including 42% healthcare, 26% first responders, 24% community-based, 3% legal/justice/policy and 4% other observers, with responses from all 10 NH counties. 54% of responses were from non-metro (rural) counties and 46% from metro (more urban) areas as defined by Rural Urban Continuum Codes of the U.S. Department of Agriculture.

##### *SUD Responses*

Responses to 10 fixed choice items on substance use patterns across all observers and locations are shown in Summary Chart 1. Topics queried are listed in left margin and number of respondents providing a response other than “don’t know” to each item is indicated on the right margin. Percent of responses observing “decreased”, “about the same” and “increased” visually indicated.

Executive Summary Chart 1 – Please indicate your observations of changes in the following, if any, in your community since onset of COVID-19

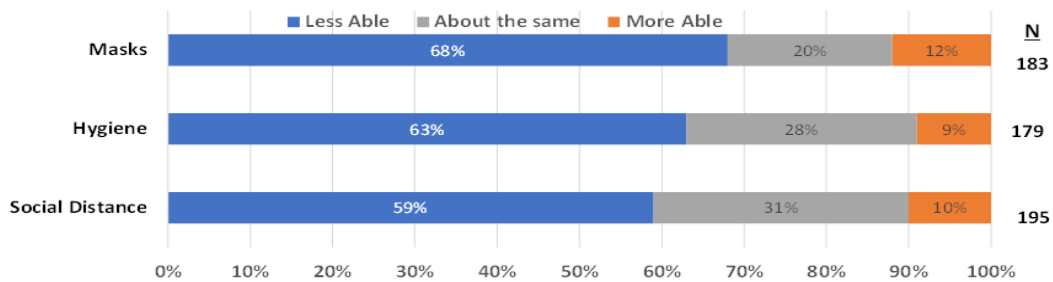


The 24% of observers who reported increased access to street drugs other than opioids were asked which drugs were increasing; they most frequently reported methamphetamine, cocaine and cannabis.

### COVID Safety Practices Responses

Responses to fixed choice items related to ability of PWUD to engage in COVID safety practices across all observers and locations is shown in Chart 2. Chart structure is similar to Chart 1.

Executive Summary Chart 2 Please share your observations about the extent to which people with substance use in NH are able to engage in recommended safety behaviors compared with people without substance use



### Variations by observer role and geographic location

Variation in observations between different observer roles and geographic perspectives were analyzed using unadjusted ordered logistical regression with the following findings (tables/charts in full report):

- First responders and healthcare observers were more likely to report decreased drug overdoses than community-based observers ( $p < .05$ )
- Community observers were more likely to report increased access to street opioids than healthcare or first responders though all groups most frequently reported no change ( $p < .05$ ).
- First responders were less likely to report increased alcohol use than community and healthcare groups ( $p < .05$ ) though over 50% of all groups reported increased use.
- Community-based observers were more likely to view PWUDs as less able to engage in hygiene practices compared with treatment providers and first responders ( $p < .05$ ).
- Observers in metro areas were more likely to report decrease in opioid overdoses than those in non-metro areas ( $p < .05$ ).
- Observers in non-metro areas more frequently reported that telehealth had increased engagement of patients in treatment than metro observers ( $p < .05$ ).

### Narratives Responses

162 narrative responses elaborated on observations related to drug use and COVID-19 safety among PWUD in NH. Key themes included telehealth, COVID -19 safety practices, drug use patterns, treatment access, naloxone use, and relapses concerns among others; illustrative comments are provided in Table 10 of the full report. An additional 68 comments focused on education needs to better support PWUD during COVID-19 and are summarized in the full report.

### Key Survey Messages

#### Observations (integrating both fixed choice and narrative responses)

- Alcohol use is increasing in NH.
- Clear and consistent changes in opioid and street drug use were not observed across the State.
  - There may be regional and rural/urban differences in patterns of use

- Persons who use drugs (PWUD) may
  - Avoid EMS and healthcare engagement due to fear of COVID-19 exposure and may try to self-manage overdoses and other drug related problems.
  - Be less able to engage in COVID safety practices for many reasons, potentially increasing their vulnerability to contracting COVID-19.
  - Be unaware or dismissive of COVID-19 risks.
- Risks for relapse among previously stable persons in recovery are significant during COVID-19.
- Treatment access and paradigms of care are changing.
  - Telehealth has improved engagement for some and reduced engagement for others.
  - Many are not aware of and/or do not have access to telehealth opportunities.

#### *Intervention Considerations*

- To reduce harm among people who use drugs (PWUD)
  - Continue aggressive naloxone distribution through diverse venues.
  - Expand SSPs and street outreach for substance and COVID harm reduction, including
    - Education related to COVID-19 and risk reduction practices
    - Mask distribution and problem solving around difficulties in use
    - Identify opportunities for hand washing and other hygiene
  - Develop shelter and housing opportunities with good social distancing options.
  - Develop quarantine options for COVID exposed or affected persons with healthcare support.
- To reduce harm from rising alcohol and other drug use in association with COVID-19
  - Enhance screening for unhealthy alcohol and drug use in relevant health settings.
  - Promote public health messaging regarding physical, psychological and social harm of unhealthy alcohol use
    - Note alcohol and other drug use as potential drivers of anxiety, depression, domestic violence and diverse medical conditions.
- Optimize telehealth opportunities including both treatment and recovery supports
  - Increase public awareness of existing telehealth opportunities.
  - Provide telehealth means (wireless access, devices, etc.) to those without it.
  - Educate providers on telehealth therapeutic approaches to improve care.
  - Enhance patient accountability in the context of reduced supervision.
  - Advocate to retain positive gains of telehealth post COVID-19.
- Optimize safety of in-person treatment with enhanced COVID safety practices.

#### *End Executive Summary*

*See full report for study details and contributors.*

*Please contact [Seddon.Savage@dartmouth.edu](mailto:Seddon.Savage@dartmouth.edu) with questions, comments, concerns..*

# Full Survey Report – COVID-19 & Substance Use in New Hampshire

## Background

When the COVID-19 pandemic arrived in New Hampshire (NH) in early March 2020, the State was in the midst of a drug overdose epidemic that had been raging for over a decade. From 2006 to 2017 drug deaths in NH more than quadrupled, and in 2018 NH had the third highest per capita rate of opioid associated deaths among U.S. states.<sup>1</sup> However, in the context of intense and multifaceted efforts to address harmful opioid use, 2019 was the second consecutive year that closed with a small decrease in drug overdose deaths in New Hampshire.<sup>2</sup> Whether the reduction in deaths was due to reduced opioid use, increased treatment capacity, enhanced access to naloxone and/or other factors is not certain.

COVID's arrival in NH and its more immediate threat to larger segments of the population overwhelmed attention to the opioid epidemic. However, the opioid epidemic has not gone away and the pandemic has the potential to alter its evolution in ways that are not yet clear. It could disrupt drug and drug precursor supply lines changing availability of different street drugs, and it could alter access to harm reduction strategies such as use of naloxone and regional syringe service programs, as well as access to opioid and other substance use treatment. Depending on the directions of change, the pandemic could result in more -or fewer- drug overdoses, and it could drive people who use drugs (PWUD) into- or away from- treatment. Anecdotal reports regarding such changes have been abundant across the state, but no clear and consistent pattern of observed changes has emerged. Our survey was launched to begin to shed light on these issues.

## Purpose

The primary objectives of the survey were to:

1. Determine what, if any, changes in drug availability, drug use patterns and practices, treatment seeking, and treatment access among PWUD have been observed by key stakeholders in the context of the COVID-19 pandemic in NH.
2. Determine how PWUD in NH have been observed to engage in COVID-19 risk reduction practices compared with people without drug use challenges.

The ultimate goal is to integrate these observations with other lines of evidence (medical examiner data, drug seizure data, EMS and public health data, etc.) to better understand the nature of drug use changes and special COVID vulnerabilities in order to help inform public health responses to support PWUD in NH during the COVID pandemic.

## Survey methods

Key stakeholders with different perspectives on drug use in NH were queried regarding their observations of changes in substance use and related activities since the onset of COVID 19 and their observations of the extent to which people who use drugs (PWUD) are able to engage in practices to reduce the risk of contracting COVID.

Survey questions were entered into Qualtrics survey software, and a link to the online survey was emailed to potential respondents. The survey questions as they appeared online are attached as Appendix 1. Respondents were asked to indicate which of 11 roles best described their perspective (or to choose "other" with an option to describe) and to indicate the county in which they were making their observations or if their perspective was statewide. They were asked to respond to two queries with respect to several items each. The first related to observed changes in drug use and treatment

related issues in their communities, and the second related to the engagement of PWUDs in COVID safety practices. Each item had four response choices indicating observations of decreased/less, about the same, increased/more or don't know.

There were three opportunities for open-ended responses to 1) expand/clarify item responses, 2) provide additional observations related to COVID impact on SUD in NH, and 3) indicate education/information/resources needed to improve care or support for PWUD during the pandemic.

A link to the survey was initially emailed on April 21<sup>st</sup> to a list of 383 people who were members of an interest group associated with Dartmouth-Hitchcock Substance Use and Mental Health Initiative or of the Healthcare or Opioid Task Forces of the NH Governor's Commission on Alcohol and other Drugs. Recipients were invited to forward the survey to others in NH in a position to observe drug use patterns in NH. The survey closed 7 days later.

Follow-up emails were sent within 24 hours of the initial mailing to leaders of 12 statewide networks with a request that they circulate the survey to their constituents. Representatives of the 11 groups listed here indicated they would forward the survey, but the actual number of recipients is not known.

- NH Police Chiefs Association
- NH EMS
- NH Drug Courts
- NH Doorways Treatment System
- NH Recovery Hub
- Northeast NIDA Node
- NH Public Health Networks Continuum of Care & Prevention Coordinators
- New Futures
- Recovery Task Force NH Governors Commission on AOD
- Treatment Task Force of the NH Governors Commission on AOD
- NH Integrated Delivery Networks

The survey study was approved by the Dartmouth College Committee for the Protection of Human Subjects on April 17, 2020 as Study 00032053 and granted an exemption from further review.

### **Data Management**

Data was transferred from Qualtrics to Stata/SE v.15.1 for analysis. Unadjusted ordered logistic regression was used to identify differences in regional and observer perspectives.

Regional differences were examined both by county and by metro/non-metro based on Rural Urban Continuum Codes.<sup>3</sup> Rural Urban Continuum Codes (RUCC) classify all U.S. counties on a urban-rural scale ranging from 1 (most urban) to 9 (most rural) with 1-3 being classified as Metro and 4-9 as non-Metro. Three NH counties are classified as Metro, including Hillsborough, Rockingham and Strafford, and 7 as non-Metro including Belknap, Carroll, Cheshire, Coos, Grafton, Merrimack and Sullivan. (Table 1)

Observer perspectives were collapsed from the 11 role/perspective codes in the survey to 4 for analysis in order to have sufficient statistical power to identify differences based on role/perspective. The 4 roles/perspectives were healthcare, first responder, community-based, and legislative/policy/justice. (Table 2) Due to the small number of respondents in the

legislative/policy/justice group, this group was not included in analysis. Twenty-five of 39 observers who coded themselves as “other” were subsequently assigned to one of the four observer groups based on their narrative description of their role and/or review of organization affiliation if shared. The remaining 14 did not easily fit a defined observer category and remained as “other”.

Data was obtained from 339 respondents of whom 242 answered all questions on the survey. All item responses other than “don’t know” were included in the analysis, whether or not the respondent completed the survey. Responses of “don’t know” were taken to indicate inadequate observation to render an opinion and so were excluded from analysis. Therefore, the number of responses differ for different items. For example, for the item on drug prices, 77% of observers indicated “don’t know” and only 23% offered observations which were included in analysis, while for alcohol consumption only 19% indicated “don’t know” and 81% offered observations which were included in the analysis.

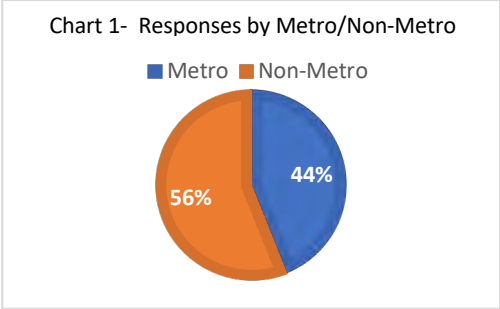
**Findings**

*Respondents*

The survey methodology did not permit calculation of a response rate since the number of actual recipients is not known.

Responses were obtained from each of the 10 NH counties (Table 1). Relatively low numbers of responses from some counties did not permit analysis for regional or geographic differences by county, therefore counties were divided into RUCC determined metro and non-metro counties to assess geographic differences. Fifty-six percent of respondents were classified as non-Metro and 44% Metro. (Chart 1). Statewide perspectives were not included in this calculation. The number of responses from each county, as well as the county designations as RUCC metro or non-metro and the specific RUCC code number are shown in Table 1.

Table 1- Location of Observation				
NH County	% of responses	# of responses	Rural Urban Continuum Codes (RUCC)	
Belknap	7.20%	19	Non-Metro	4
Carroll	2.65%	7	Non-Metro	6
Cheshire	4.92%	13	Non-Metro	4
Coos	2.27%	6	Non-Metro	7
Grafton	14.39%	38	Non-Metro	5
Hillsborough	22.35%	59	Metro	2
Merrimack	15.15%	40	Non-Metro	4
Rockingham	8.33%	22	Metro	1
Strafford	8.71%	23	Metro	1
Sullivan	4.55%	12	Non-Metro	7
Statewide	9.47%	25		
	100%	264		



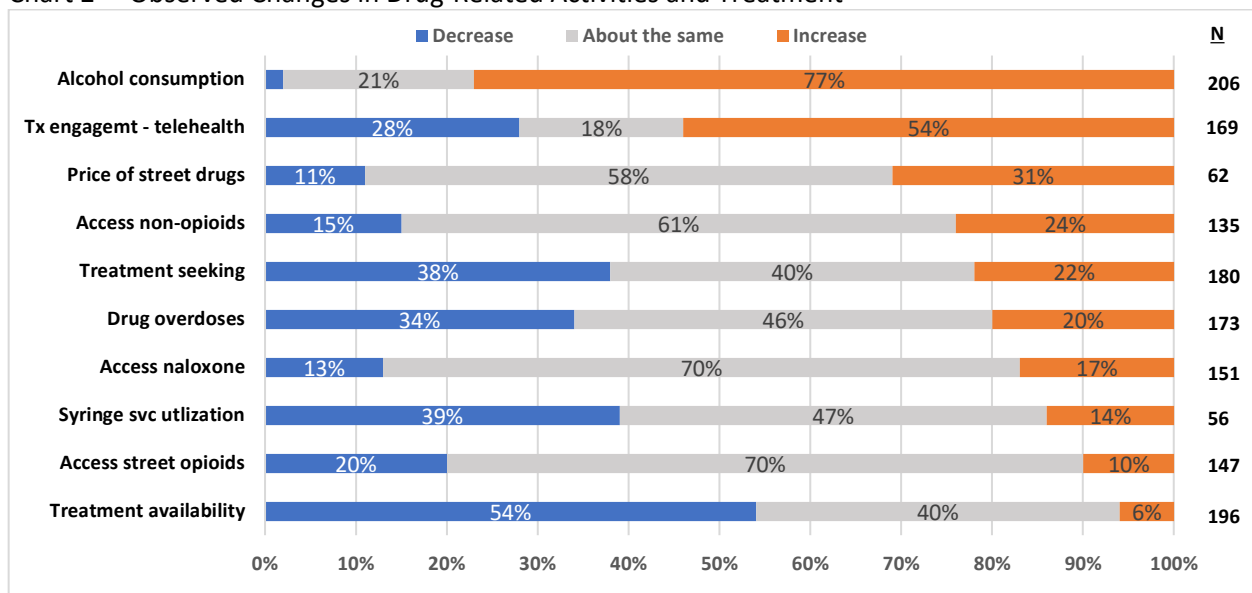
The 339 responses included observers from all observer with categories distributed as shown in Table 2. Nine respondents did not indicate a role.

Table 2 - Observer Perspective/Role		
Category	N	N
<b>Healthcare</b>		<b>139</b>
Addiction or mental health treatment	111	
Healthcare provider or staff (other than SUD-MH)	28	
<b>First Responders</b>		<b>80</b>
Emergency medical service (EMS)	58	
Law enforcement	22	
<b>Legal, policy, justice systems</b>		<b>11</b>
Legislative, policy, advocacy	2	
Corrections system	4	
Judicial system	5	
<b>Community based perspectives</b>		<b>86</b>
Harm reduction, syringe service or similar	1	
Person with drug use (PDU) or family/friend	6	
Recovery support system	46	
Community-based prevention or intervention	33	
<b>Other</b>	<b>14</b>	<b>14</b>
<b>Total Observer Role Responses:</b>	<b>330</b>	<b>330</b>

### Observed Changes in Drug- Related Activities and Treatment

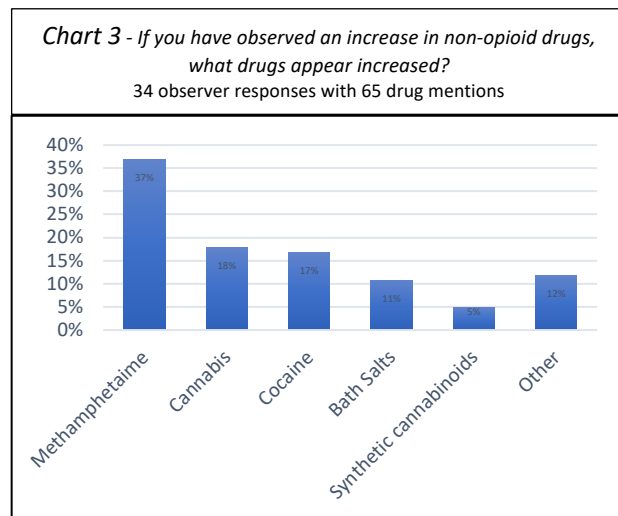
Observed changes in drug and treatment-related items for the respondent group as whole (including all NH regions and all observer perspectives) are shown in Chart 2. “Don’t know” responses are not included and were large for many items making the actual number of reported observations variable for the different items; numbers of responses (N) for each item, excluding “don’t know” or no answer, are noted in right hand column.

Chart 2 – Observed Changes in Drug-Related Activities and Treatment



The item for which there was greatest apparent consensus was observed changes in alcohol use with 77% of observers agreeing that alcohol use has increased in NH since the onset of COVID-19 and only 2% reporting a decrease.

70% of observers reported no apparent change in access to street opioid with the remainder divided, 20% noting decrease and 11% increase. Sixty-one percent reported no change in access to other street drugs with 24% reporting increased access and 15% decreased. For the 24% (N=34) who observed increased access to non-opioid street drugs, the most frequently mentioned increases were in methamphetamine (37% of mentions) , followed by cannabis (18%) and cocaine (17%), followed by bath salts (11%) and synthetic cannabinoids (5%) and other 12% (other included 4 mentions of alcohol, 3 fentanyl/heroin and 1 Suboxone). (Chart 3)



Observations regarding drug overdoses were mixed, with 34% observing them to be decreased, 46% about the same and 20% increased; however, there appeared to be some regional and observer variability (see Differences sections).

54% of respondents observed a decrease in treatment availability since onset of COVID while 40% observed it to be about the same with only 6% endorsing an increase. Observations about treatment seeking were mixed with 38% reporting it was decreased, 40% unchanged and 22% reporting an increase. While these combined observations, weighing towards decrease in treatment availability and decrease or no change in treatment-seeking, would suggest reduced overall engagement in treatment, 54% of respondents agreed that telehealth had increased engagement in treatment with 18% noting about the same and 28% decreased engagement. There were some urban-rural differences in telehealth responses (see Geographic differences section) and the narrative comments provided rich caveats regarding both the value and limitations of telehealth for SUD (see Narrative section).

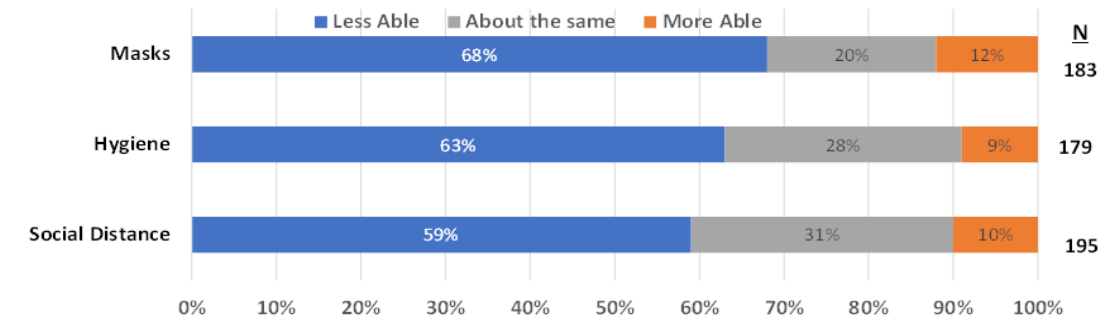
A high number of respondents endorsed “don’t know” for change in drug prices and access to syringe service programs (SSP) leaving only 62 and 56 responses respectively offering an opinion. However, of those who provided observations, observations on drug prices weighed towards increased (31%) or unchanged (58%) with 11% decreased, while SSP access weighed towards decreased (39%) or unchanged (46%) with 14% increased. Naloxone availability was largely observed to be unchanged (70%) with decreased (13%) and increased (17%).



### Observations of COVID Safety Practices

Observations regarding the extent to which people who use drugs (PWUD) are able to engage in COVID safety practices compared with people without substance use are shown in Table 4.

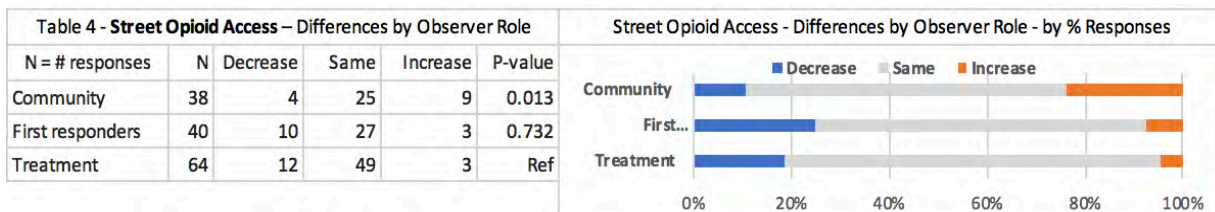
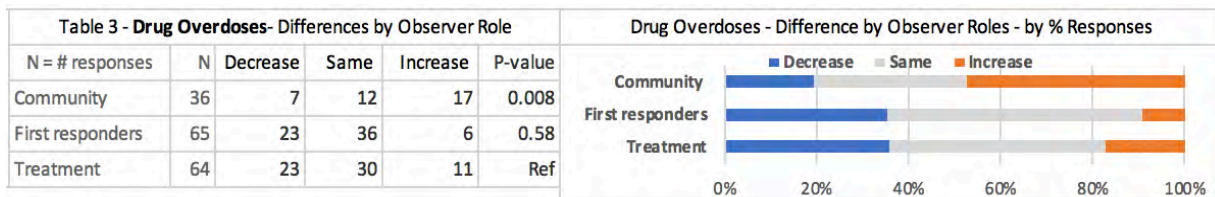
Chart 4 – Engagement of PWUD in COVID Safety Practices

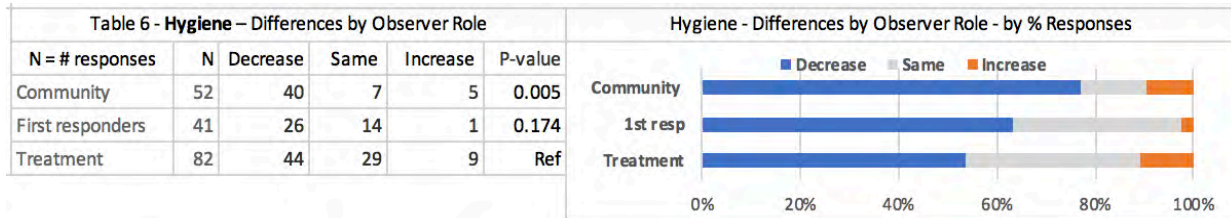
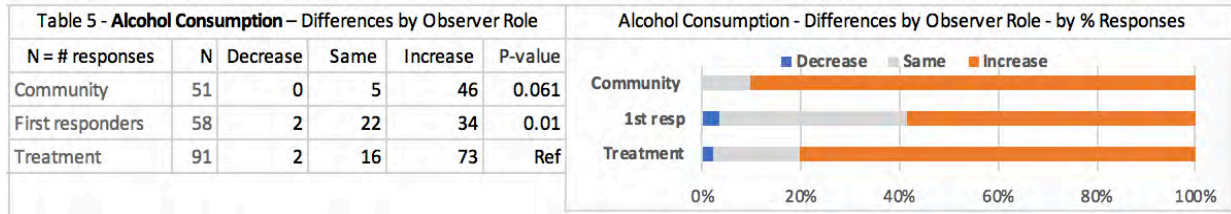


Respondents largely agreed that PWUD are less able to engage in COVID safety practices than others with 68% observing they are less able to use masks, 63% less able to optimize hygiene practices, and 59% less able to engage in social distancing. Many observers offered comments elucidating these some of their challenges. (See Narrative section).

### Perspective/role differences in observations

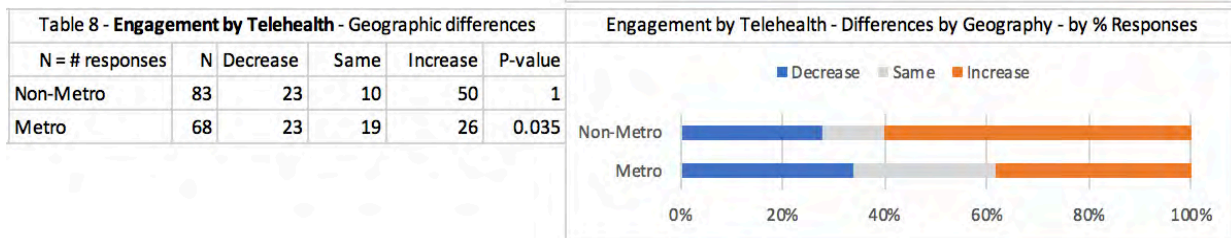
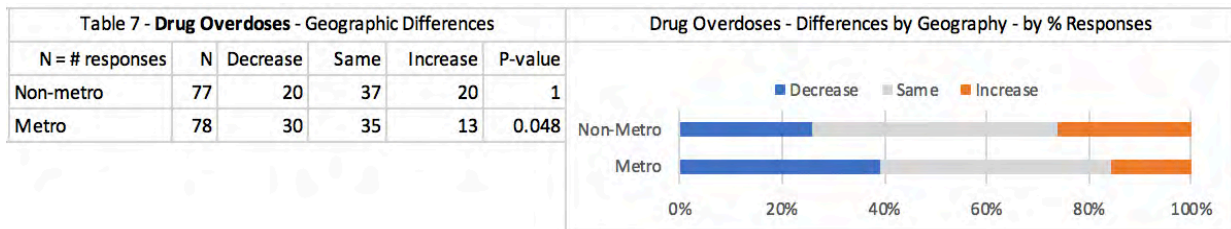
First responders and healthcare observers were more likely to report they observed decreased drug overdoses than community-based observers who more frequently reported an increase ( $p < .05$ ) (Table 3). Community observers were also more likely to report increased access to street opioids than healthcare or first responders though all groups most frequently reported no change ( $p < .05$ ) (Table 4). While over fifty percent of first responders endorsed observation of increased alcohol consumption, they were significantly less likely to do so compared to community and healthcare groups ( $p < .05$ ) (Table 5). Community-based observers were more likely to view PWUDs as less able to engage in hygiene when compared with treatment providers and first responders. ( $p < .05$ ) (Table 6)





### Geographic differences in observations

There were no significant differences in observation of substance use issues or COVID safety practices by county. However, when counties classified as metro counties using rural urban continuum codes (RUCC) were aggregated and compared with non-metro counties, observers in metro areas were more likely to report decrease in opioid overdoses than those in non-metro areas ( $p < .05$ ) (Table 7). Non-metro observers more frequently reported that telehealth had increased engagement of patients in treatment than metro observers ( $p < .05$ ) (Table 8). Other findings did not vary by rural-urban status.



### Narrative Data

Survey respondents had three opportunities to provide open-ended text comments. Table 10 provides a summary of key narrative themes with illustrative comments. Some common narrative themes are discussed below. Responses from the first two narrative opportunities are considered together as there was significant overlap in themes. The third is discussed separately.

1. *Feel free to expand or qualify any of your answers above (followed query on the 10 drug-related and treatment items)*
2. *Please feel free to share any additional observations, comments or recommendations related to the impact of COVID 19 on people with substance use abuse disorder in NH?*

There were 86 individual text responses to opportunity 1 and 76 responses to opportunity 2. Between these 47 related to telehealth and technology, 37 related to COVID safety behaviors, 23 to drug use patterns, 21 treatment access or seeking, 9 relapse or relapse risks, 8 related to trust and belief issues, 4 to naloxone use, 3 to syringe service programs, and 25 to unique issues, not thematically related. Some responses mentioned more than one theme. Key themes are discussed below.

Comments reflected divergent experiences with telehealth. There were many comments on the inherently less personal nature of telehealth and telehealth recovery services, the less “energetic quality” of telehealth services, and how these do not meet recovery needs for human contact. Despite robust online resources in the state listed at key websites, some observers felt that many people are not aware of opportunities for engagement in telehealth and tele-recovery services and it was noted that many clients with SUDs lack the technology resources to participate.

At the same time a roughly equal number commented on positive aspects of telehealth noting it had made it easier for some patients to engage in treatment, overcoming transportation, childcare and other barriers, permitting better attendance at groups and allowing greater comfort in discussing difficult issues than face to face sessions. Some voiced their hope that robust telehealth services would continue post-COVID 19.

Regarding treatment access, several respondents noted challenges getting patients into higher levels of care, such as IOPs or inpatient treatment. They noted COVID screening procedures interfered with access and perceived that staffing was reduced in some settings either due to furloughs or staff concerns about the ability to social distance in treatment settings.

A number of respondents observed that there was reticence among some drug users to call 911 or go to ERs with overdoses due to fears of COVID exposure and that many were relying on their own naloxone supplies to manage overdoses; concern was expressed that this could result in increased overdose deaths.

A number of observers reported increasing relapse and risk for relapse in people both in early recovery and in people in previously stable long term recovery due to lack of in person group support, social isolation, closing of recovery housing and less supervision of recovery, for example lack of urine drug screening and associated accountability.

Observers enumerated many reasons that engagement in safety practices may be more difficult for persons who use drugs (PWUD), potentially putting them at greater risk of contracting COVID. Among these:

- Many lack regular access to news and information, so their understanding of COVID risks and safety measure may be limited.
- Even when information is available, many lack trust in media or government and do not believe COVID concerns or that safety behaviors will make a difference. Some perceive conspiracies.
- Some drug users engage in manual labor or other jobs at which social distancing may be difficult or impossible
- Housing insecurity creates challenges for social distancing and hygiene
  - May lack consistent access to bathrooms due to lack of housing and because fast food restaurants, libraries, community centers which provide access, are closed.
  - Many couch surf and stay with different people different nights or in crowded shelters amplifying potential for COVID exposure.

- If exposed to or experiencing COVID, quarantine opportunities are few.
  - Masks are difficult to find and purchase may not be possible.
    - Even when available, many have difficulty wearing masks due to
      - Anxiety, hypersensitivity
      - Respiratory problems, some related to higher rates of tobacco use.
  - The impulse to use drugs may be stronger than fear of COVID
    - Use requires close interactions with others to procure drugs and paraphernalia.
    - Many people elect to not socially distance due to fear of over-dosing alone.
3. *Is there any information/education/training that would improve your ability to address the impact of COVID-19 on people with substance use and use disorder in NH?*

There were 68 individual responses which identified educational or information needs in the following areas.

- Education for providers on
  - How to better conduct group and individual therapy and SUD recovery supports via telehealth. (9) Especially for intensive outpatient treatment programs (IOPs) and higher levels of care (3)
  - Self-care for providers (1)
  - Information on drug trends and how to address newer drugs. (1)
- Education for PWUD on
  - Current treatment and recovery resources (10) (also share with helpers)
  - COVID Safety (5)
  - Harm reduction (4)
- Need resources per se, not education (masks, gloves, money, etc) (6)
- Other comments, not education suggestions (17)
- Don't know/unsure/non-sequitor (13)

Table 10 - Narrative themes and sample illustrative quotes	
Theme	Illustrative quote
Alcohol use is increasing	"In my region, alcohol consumption has become the primary substance of choice. "Someone posted to FB said, hmm "do you think it's bad if I have a drink during my telehealth session?" "The past few weeks, there's typically been someone with a blood alcohol level over 400 daily which we only used to see about weekly." "Seeing increased alcohol consumption, amongst those with and without a diagnosed alcohol use disorder, as a mechanism for coping with stress related to COVID-19. "Clients are reporting being able to use more alcohol undetected as they are working from home."
Telehealth- mixed clinical responses	"The expansion of telehealth capabilities in SUD treatment has been a major benefit from the otherwise devastating global pandemic. " "Some clients seem more willing to share and talk about difficult topics on this venue, and others find it hard to talk at all due to the lack of human connection." "Telehealth services do not provide the 'energetic quality' provided in person with face to face mtgs. This increases risk for the most vulnerable"
Telehealth access challenges	"Many patients do not have access to unlimited cell service. Some don't have video-capable phones and most don't have computers" "Rural living, combined with erratic connectivity, clients without computers or smart phones, along with partial closures of treatment, have made it difficult for those needing connection and treatment."
Naloxone use & opioid overdoses	"Information from the field is that narcan is being used a lot - two users covering for each other - if one uses and overdoses second person admin. narcan - which has been widely distributed They have organically begun to do this out of fear of COVIN 19 and being brought to an emergency room." "We are not sure about how many overdoses are actually happening because although the number of patients going to the hospital has decreased, we think this is because people aren't calling 9-1-1" "We have seen several overdoses who have either refused to go to the ER or who report they had to be narcened and sought no assistance."

Changing drug use patterns	<p>"Methamphetamine use has increased significantly, most often being mixed with opioids and other drugs."</p> <p>"More alcohol and methamphetamine use, decrease in fentanyl availability likely due to border closings..."</p> <p>"Use of Cannabis as well as alcohol has increased dramatically."</p> <p>"Telemedicine without face to face for the first appointment is flooding suboxone into diversion"</p>
Relapse & relapse risks	<p>"Isolation and lack of access to recovery supports and treatment has caused a great many with a life-threatening issue."</p> <p>"Recovery residences are reporting significant increase in relapses of their residents."</p> <p>"Social distancing is seriously increasing stress and anxiety on those in recovery. Recovery is based on a peer model that is social in nature"</p> <p>"From the work that I do I have seen more people relapsing during the pandemic."</p> <p>"Due to COVID, many patients have increased anxiety. As far as relapse vs those maintaining stability I would say its 50/50."</p>
Changing access to treatment	<p>"While accessing treatment has not been impossible, it has definitely been more time consuming and trickier to navigate. Every day the resource availability may change from place to place"</p> <p>We have been trying to get clients into a higher level (IOP is our highest) of care when needed and was very difficult. We have noticed a decrease in availability of treatment due to facilities closing down or just putting people on a wait list.</p>
COVID-19 Safety	<p>"Those currently in active addiction may not be aware of the severity of COVID19."</p> <p>"They do not have access to proper PPE and a lot of the time their survival relies on them sharing resources with one another. This unfortunately is not always sanitary."</p> <p>"Clients with addiction don't always have consistent places to sleep, shower, eat so they are forced to seek out options to do so on a daily basis. This sometimes leads to their having to interact with different individuals from day to day."</p> <p>"I believe that a majority of the population we serve do not have the resources for personal safety coupled with lack of fear."</p>
Social Distancing	<p>"You can't social distance in a tent or a shelter, or at least it's a lot more difficult."</p> <p>"Clients are reporting that they are not social distancing as much as recommended due to fear of overdosing while alone... continuing to venture out...and engage in substance use together for harm reduction."</p> <p>"Many of the jobs they have are manual labor and this reduces their options for social distancing"</p>
Masks	<p>"Hospitals are making back alley deals for PPE, how are people who are addicted supposed to get a mask &amp; gloves?"</p> <p>"I am struck by [patients] inability to tolerate the discomfort of a mask, difficult to use a mask if you have anxiety issues"</p> <p>"Many are also loath to wear masks given high proportion of cigarette smokers/vapers"</p>
Personal Hygiene	<p>"Regular make-shift sources of hygiene access (local homeless cafe, libraries, community centers, etc) are all closed."</p> <p>"Not being able to take care of themselves in regards to SUD or MHD, they may be unable to wash their hands or shower, maybe no money for hand sanitizer let alone food and shelter".</p> <p>"Unless already connected with a treatment team, their ability to acquire hand sanitizer and masks is greatly diminished."</p>

## Discussion

While our survey responses did not clarify the direction of change, if any, in opioid and street drug use, it is clear that a large majority of respondents observe alcohol use to be rising in the State. This is consistent with national data suggesting alcohol sales rose by 32% for spirits, 27% for wine and 15% for beer for the period of March 7<sup>th</sup> to April 25, 2020 compared to the same period one year ago.<sup>4</sup> And it is not surprising that in a time of extraordinary stress when many are seeking relief, use of our most readily available intoxicant is increasing.

Increased alcohol use has implications for the population as whole, in addition to persons with identified alcohol or other substance use disorders. Increased alcohol use across the population almost certainly means unhealthy alcohol use by many, increasing risks for alcohol-associated morbidity including serious hepatic and gastrointestinal dysfunction, cardiovascular problems, accidents, evolution of alcohol use disorder and others. In addition, there is risk of increased psychosocial problems often associated with alcohol misuse, including anxiety and depression, interpersonal distress, domestic violence, and abuse. There have been reports of rising domestic abuse in association with COVID-19<sup>5</sup> and it is quite possible that increased alcohol use, in addition to isolation and other stressors, is a contributor.

Among respondents who observed increase in street drug use, methamphetamine, cocaine and cannabis were the top three drugs observed to be rising in use. The NH Therapeutic Cannabis Program noted a 20% rise in cannabis sales at NH cannabis dispensaries in March.<sup>6</sup> Similar to increased food sales reported in March, this increase may simply reflect stocking up on a valued therapeutic product due to fear of shortages or buying more at one time in order to make fewer trips out. However, the possibility of a shift in cannabis use from the original therapeutic indication for which the individual was certified

to self-medication of stress or boredom and the possibility of sharing with non-certified persons for similar purposes must be considered. While not necessarily intrinsically harmful used in this way, cannabis use, like alcohol and other drug use should be monitored by healthcare providers and servants of the public health to assure that use intended for relief, does not end up generating harm.

It is important to consider opportunities for intervention both at individual and societal levels. Alcohol and other drug screening in all types of clinical practices with brief counseling or referral to treatment as indicated is of paramount importance at this time. Public education regarding signs and symptoms of alcohol associated physical, social and psychologic problems are critical too; all too often the secondary problems associated with alcohol are misattributed and alcohol never identified and addressed as a contributing cause.

The differing observations of first responders and healthcare workers with those of community observers regarding drug overdoses is worth noting. Narrative comments suggest greater use of naloxone in the community with fear of calling 911 or going to an ER due to perceptions of risk of COVID exposure in healthcare settings. Community observers may be observing overdoses that are increasingly managed in the community without EMS or hospital intervention, so that EMS and healthcare providers observe a decrease. While the impact of such management may become clearer as medical examiner numbers on overdose mortality data become available, the observation underscores the importance of continuing aggressive naloxone distribution to the community and a need for public education on balancing the relatively low risk of COVID exposure in association with NH health systems with the risk of fatal overdose.

Treatment access has been greatly enhanced in NH over the past two years with the development of the regional Doorway system and expansion of both private and public treatment options. Our survey findings suggest, however, that COVID 19 may have reduced use of this capacity due to fear of contagion, furloughing of staff, and emergence of other barriers to treatment. Respondents articulated concerns particularly about availability of treatment at IOP and residential levels. Telehealth has been rapidly expanded in an effort to meet treatment needs, but observer responses affirm that, while this may improve engagement for some, limitations in technology access and the less personal nature of remote interaction may limit effectiveness for others. Education to help improve the quality and effectiveness of group and individual therapy via telehealth was the most frequently mentioned educational need.

The difficulty of PWUD in engaging in COVID-19 safety practices highlights a new set of vulnerabilities of this population. Outreach education is needed to be sure PWUD are aware of the health risks of COVID-19 and of strategies to reduce the risk of acquiring the infection. Practical interventions are also needed. Public health interventions might include mask distribution- perhaps through SSPs or other outreach services-, housing/shelter opportunities that support social distancing, consistent opportunities for hand washing and showering, and better access to technology to assist PWUD in accessing critical information and in participating in treatment, recovery or other virtual community activities.

While we did not specifically ask observers to rate observations of relapse, both relapse and relapse risks were mentioned frequently in open-ended responses. It is important to promote increased public awareness of currently existing online recovery supports and treatment opportunities and to develop safe paradigms for in-person care during the COVID pandemic for people for whom in person meetings and sessions are more effective.

As the COVID 19 pandemic continues and changes, we anticipate continuing changes to drug access, use patterns and treatment engagement. We intend to repeat revised versions of this survey at intervals going forward to gather observations as the pandemic and its impact on PWUD changes.

## **Limitations**

Our data, both the item response choices that we have analyzed using quantitative methods and the narrative responses that have been arranged thematically, are fundamentally subjective and as such, are prey to observer bias, faulty recollection and other potential distortions inherent in subjective reporting. Our findings should be understood as qualitative and used in conjunction with more objective quantifiable data (drug seizure data, overdose death data, treatment episodes and others) to provide a fuller picture of the status of substance use and its risks in NH. The survey's value is likely more in elucidation, than in clear characterization of these issues.

The survey was launched quickly in the context of the rapidly changing COVID-19 epidemic, with relatively little capacity to gather input from key stakeholders regarding either content inclusions or dissemination mechanisms. This led to some oversights, most notably perhaps not including an item asking about observations of relapse in previously stable individuals. In addition, engagement of key stakeholder organizations in the development process would likely have netted more numerous responses and a more controlled and methodical sampling strategy.

While the survey garnered responses from all counties in NH and from a diversity of observer perspectives, open circulation of the survey resulted in an unknown response rate which makes it difficult to determine how representative the sample is. In addition, our relatively low number of responses did not afford the statistical power to tease out many regional or observer differences.

In setting up our survey, we inadvertently allowed individuals to skip individual item responses. While skipping items may have been a de facto proxy for the choice "don't know" we can't know this for sure, so the skipped questions remain open to interpretation. In addition, some respondents did not enter regional and observer identification data which diluted our ability to use these in analysis.

## **Conclusions**

While the direction of changes in opioid and other street drug use were not clearly elucidated by this survey, it is clear that respondents observe alcohol use to be rising in the state. Actions at clinical and societal levels to educate, recognize and intervene in unhealthy alcohol use are critical to avoid a wave of increased alcohol-related morbidity, mortality and social harm as a consequence of COVID-19 associated distress, potentially compounding the challenges of the pre-existing opioid epidemic. Optimizing technology access, increasing quality and availability of telehealth treatment and recovery services, and enhancing public awareness of these opportunities is important to reduce substance-related harm during the COVID Era, and possibly going forward. Early advocacy for retention of those elements of telehealth that have proven safe and effective will help retain positive gains when emergency orders are no longer in effect as COVID resolves. At the same time, safe strategies to provide in-person treatment and groups to support recovery during COVID for those for whom virtual care is unsatisfactory are needed. Outreach to people who use drugs that supports social distancing, mask wearing, and increased opportunities for personal hygiene is needed to reduce their risk of developing COVID. Continued aggressive distribution of naloxone is critical as some PWUD appear to



avoid calling 911 or presenting to emergency rooms with overdoses due to fear of COVID-19. In addition, education on balancing the relatively low risk of contracting COVID in the state health systems with the risk of inadequately treated overdose, infections or other substance-related problems is needed.

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*Many thanks to all who participated for sharing their observations and to all who generously circulated the survey to others.*

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Updated with Executive Summary, May 27<sup>th</sup>, 2020*

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## **COVID survey questions**

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**Start of Block: Default Question Block**

This research project is being conducted by researchers at Dartmouth College, Hanover, NH, USA. It is a study of substance use patterns in NH during COVID-19. This short survey should only take about 3 minutes. Your participation is voluntary. Dartmouth researchers will not hold any information that identifies you unless you voluntarily provide an email address to receive the results of the survey. However, any online interaction carries some risk of being accessed. Completing the survey indicates your consent.

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Q1 Please indicate your major role or predominant perspective with regard to substance use issues (choose one)

- Addiction or mental health treatment providers of staff (1)
- Healthcare provider or staff (other than behavior health specialty) (2)
- Emergency medical service (EMS) (3)
- Law enforcement (4)
- Corrections system (5)
- Judicial system (6)
- Legislative, policy, advocacy (7)
- Harm reduction, syringe service or similar (8)
- Recovery support system (9)
- Person with drug use (PDU) or family member of PDU (10)
- Community-based prevention or intervention (11)
- Other (please specify, text box will appear on next page) (12)

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*Display This Question:*

*Please indicate your major role or predominant perspective with regard to substance use issues (c... = Other (please specify, text box will appear on next page)*

Q1a Other:

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Q2 (Optional) Name of the organization, agency or other with which you work

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Q3 Please indicate in what NH county you are primarily making your observations or indicate if your role/perspective is more statewide.

- Belknap (1)
  - Carroll (2)
  - Cheshire (3)
  - Coos (4)
  - Grafton (5)
  - Hillsborough (6)
  - Merrimack (7)
  - Rockingham (8)
  - Strafford (9)
  - Sullivan (10)
  - Statewide perspective (11)
-

Q4 Please share your observations of changes in the following, if any, in your community since COVID 19 entered our communities:

	Increased (1)	Decreased (2)	About the same (3)	Don't know (4)
Access to street opioids (fentanyl, heroin, etc.) (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to other street drugs (2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Price of street drugs (10)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug overdoses (3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol consumption (4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syringe service utilization (5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to naloxone (Narcan) (6)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treatment seeking by people with SUD (7)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treatment availability for people seeking it (8)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impact of telehealth on patient engagement (9)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Q4a Feel free to expand or qualify any of your answers above.

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*Display This Question:*

*If Please share your observations of changes in the following, if any, in your community since COVID... = Access to other street drugs [ Increased ]*

Q5 Please indicate which, if any, of the following drugs appear increased in use or availability since onset of COVID 19 (Check all that apply)

- Cannabis (1)
- Methamphetamine (2)
- Bath Salts (3)
- Cocaine (4)
- Synthetic cannabinoids (5)
- Other (please specify, text box will appear) (6)

*Display This Question:*

*If Please indicate which, if any, of the following drugs appear increased in use or availability sin... = Other (please specify, text box will appear)*

Q5a Other:

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Q6 Please share your observations about the extent to which people with substance use disorders in N.H. are able to engage in recommended COVID 19 safety behaviors compared with people without substance use.

	More able (1)	Less able (2)	About the same (3)	Don't know (4)
Social distancing (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal hygiene/handwashing (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use of masks in public (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Q7 Please feel free to share any additional observations, comments, or recommendations related to the impact of COVID 19 on people with substance use and use disorders in NH

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Q8 Is there any information/education/training that would improve your ability to address the impact of COVID 19 on people with substance use and use disorders in NH?

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Q9 If you would like to receive findings from this survey, please provide an email address (results will also be posted at <https://med.dartmouth-hitchcock.org/sumhi.html>):

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Thank you for your participation. Questions about this project may be directed to [Seddon.R.Savage@Dartmouth.edu](mailto:Seddon.R.Savage@Dartmouth.edu)

End of Block: Default Question Block

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