Comprehensive opioid safety initiatives and programming

Elizabeth Salisbury-Afshar
Haven Wheelock
Maya Doe-Simkins
National Health Care for the Homeless Conference
Portland, OR June, 2016

Please get permission before disseminating or reusing slides. Thanks!
Disclosures

• May include discussion of “off-label” use:
  – Naloxone is FDA approved as an opioid antagonist
  – Narcan Nasal Spray is FDA approved
  – Naloxone delivered as an intranasal spray with a mucosal atomizer device has not been FDA approved and is off label use

• If we accidentally use brand names, we don’t mean to endorse any one product and we definitely aren’t paid by those folx...

• Sometimes we get excited and use curse words
Overview

• Promising & evidence based practices to increase safety
• Overdose response and naloxone utilization
• Storage, naloxone assembly, administration & choosing products
• Overdose risk and prevention tips
• Opioid for pain guidelines & practicalities and guidelines
• Treatment for opioid use disorders
• Medication Assisted Treatment- clinical considerations for working with people experiencing homelessness
• Incorporating overdose prevention into policy & milieu
• State-specific legislative or regulatory issues
• Developing a policy & choosing materials
Adult Development and Aging
Kennedy
Geriatric Mental Health Care
24 years old
Youthful, innocent and gentle
A shy smile and polite demeanor that drew others to want to get to know him
He loved electronics, computers and the internet and was proud of the boogie board displayed on his wall
Patrick
Linehan
Cognitive-Behavioral Therapy
Borderline Personality Disorder
Social Interaction
Theory and Practice of Counseling and Psychotherapy
Drug poisoning mortality in the United States
Source: CDC/NCHS National Vital Statistics System
Especially...

- Experiencing incarceration (Binswanger, 2013)
- Entering & exiting treatment for OUD (Strang, 2003)
- Experiencing homelessness (Baggett, 2012)
- Living with HIV/ AIDS (Green, 2012)
Strategies to address overdose

- Prescription monitoring programs
  - Paulozzi et al. Pain Medicine 2011

- Prescription drug take back events

- Safe opioid prescribing education

- Opioid agonist treatment
  - Clausen et al. Addiction 2009:104;1356-62

- Supervised injection facilities
Strategies to address overdose

- **Prescription monitoring programs**
  - Paulozzi et al. Pain Medicine 2011

- **Prescription drug take back events**

- **Safe opioid prescribing education**

- **Opioid agonist treatment**
  - Clausen et al. Addiction 2009:104;1356-62

- **Supervised injection facilities**
Strategies to address overdose

- Prescription monitoring programs
  - Paulozzi et al. Pain Medicine 2011

- Prescription drug take back events

- Safe opioid prescribing education

- Opioid agonist treatment
  - Clausen et al. Addiction 2009:104;1356-62

- Supervised injection facilities
Strategies to address overdose

- Prescription monitoring programs
  - Paulozzi et al. Pain Medicine 2011

- Prescription drug take back events
  - Gray and Hagemeier. JAMA Intern Med 2012

- Safe opioid prescribing education

- Opioid agonist treatment
  - Clausen et al. Addiction 2009:104;1356-62
  - Schwartz et al. AJPH 2013; e1-6.

- Supervised injection facilities

Methadone in Norway:
Clausen et al. Addiction 2009
Strategies to address overdose

- Prescription monitoring programs
  - Paulozzi et al. Pain Medicine 2011
- Prescription drug take back events
  - Gray and Hagemeier. JAMA Intern Med 2012
- Safe opioid prescribing education
- Opioid agonist treatment
  - Clausen et al. Addiction 2009:104;1356-62
  - Schwartz et al. AJPH 2013; e1-6.
- Supervised injection facilities
Strategies to address overdose

• Prescription monitoring programs

• Prescription drug take back events

• Safe opioid prescribing education

• Opioid agonist treatment
  – Clausen et al. Addiction 2009:104;1356-62

• Supervised injection facilities
Strategies to address overdose: Overdose education & naloxone distribution

Naloxone coverage per 100K

- 0
- 50
- 100
- 150
- 200
- 250

Opioid overdose death rate

- 0%
- 10%
- 20%
- 30%
- 40%
- 50%
- 60%
- 70%
- 80%
- 90%
- 100%

Bar chart showing:
- No coverage
- 1-100 ppl
- 100+ ppl

27% reduction
46% reduction

Evaluations of overdose education and naloxone distribution (OEND) to laypersons

Feasibility
- Piper et al. Subst Use Misuse 2008: 43; 858-70.
- Walley et al. JSAT 2013; 44:241-7. (Methadone and detox programs)

Increased knowledge and skills

No increase in use, increase in drug treatment

Reduction in overdose in communities

Cost-effective
- $438 (best)
- $14,000 (worst ) per quality-adjusted life year gained

Should focus on people who use drugs
- Rowe et al. Addiction 2015; 1360-0443
Opiates, Overdose and Naloxone
Opium, opiates, opioids
What is an Overdose?
Person takes a drug

Breathing slows or stops

No oxygen to brain

Brain damage
<table>
<thead>
<tr>
<th>Deep nod</th>
<th>Overdose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nodding, but responsive</td>
<td>Unresponsive to sternum rub</td>
</tr>
<tr>
<td>Slurred speech</td>
<td>Not speaking</td>
</tr>
<tr>
<td>Sleepy &amp; intoxicated, but breathing</td>
<td>Not breathing or is very slow (&lt; 8+ breaths/minute)</td>
</tr>
<tr>
<td></td>
<td>• May make choking, gurgling, snoring sounds</td>
</tr>
<tr>
<td></td>
<td>• Blue lips or nails</td>
</tr>
<tr>
<td></td>
<td>• Gray, cold, clammy skin</td>
</tr>
</tbody>
</table>

Monitor; keep them talking.  

Call 911, breaths & naloxone
Opiate administered

COMING BACK FROM THE DEAD
An antidote for the prescription drug epidemic?
Opiate bound to receptors
Naloxone administered
Naloxone begins to displace opiates
Naloxone binds and displaces opiates
How do you know it’s an overdose?
Signs and symptoms

1. Not breathing, or breathing is very slow
2. Turning pale, blue or gray (esp. lips & nails)
3. Snoring, gurgling, or choking sounds
4. Body is limp
5. Throwing up
6. Unresponsive
Check for responsiveness
Check for breathing
Call 911 immediately
OD response, in a nutshell

1. Call 911
2. Breathe for them
3. Give naloxone
Rescue breathing

1. Clear their mouth
2. Place shield or mask on their face
3. Tilt forehead and hold chin
4. Pinch nose
5. Give normal breaths for 30 seconds
Rescue breathing
Variations

• Order of events
• Rescue breathing, chest compressions, both, neither?
Naloxone Products
Naloxone products
(PrescribeToPrevent.org)

<table>
<thead>
<tr>
<th></th>
<th>Injectable (and intranasal- IN) generic</th>
<th>Intranasal branded²</th>
<th>Injectable generic³</th>
<th>Injectable generic</th>
<th>Auto-injector branded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brand name</strong></td>
<td>Narcan Nasal Spray</td>
<td></td>
<td></td>
<td></td>
<td>Ezyio Auto-Injector</td>
</tr>
<tr>
<td><strong>Product comparison</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FDA approved</td>
<td>X (for IV, IM, SC)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Labeling includes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>instructions for</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>layperson use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Layperson experience</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assembly required</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
LET’S PRACTICE
Assemble your naloxone

1. Take the caps off and screw the white top to the tube in the middle.
2. Gently twist the open end of the naloxone into the applicator.

Stop when you feel it catch.
Stop twisting if naloxone leaks out of the white top.
Spray half up one nostril

The halfway point is when the bottom of the gray stopper is at the 1 ml mark.
Switch nostrils and spray the rest.

Half in one side (1ml)

then

Rest in the other side
Resume rescue breathing

1. Brain damage can occur after 3-5 minutes without oxygen.

2. Naloxone may take several minutes to kick in.

3. Continue breathing for them for 3 minutes.
When to give a second dose

1. After 3 minutes of rescue breathing, give a second dose if they are not breathing on their own.

2. Give second dose the same way as first dose (switch sides after 1ml).
Follow-up

1. Naloxone wears off in 30-45 minutes.

2. Person could go back into OD, since opioids last longer than 30-45 minutes.

3. Monitor for at least an hour or until EMS arrives.
Withdrawal
When in doubt:

Do more rescue breathing!
When they wake up

1. Keep them calm

2. Tell them naloxone wears off in 30-45 minutes and they will feel better.

3. Do not let them use more opioids.
Recovery position
Overdose prevention counseling

• Let’s practice with this worksheet:

Prescribing naloxone

• Writing
• Patient education
• PrescribeToPrevent.org
Oregon’s Naloxone Video

https://www.youtube.com/watch?v=wsN0ijLnK2k&feature=youtu.be
OPIOIDS IN THE CONTEXT OF CHRONIC PAIN
Pain and Rx Opioid Tx

- Estimated 30% have some form of acute or chronic pain and 40% among older adults
- 2012- 259 million prescriptions for opioids; enough for each adult in the US to have a bottle of pills
- About 50% of opioid prescriptions are from primary care providers
- Primary care providers report:
  - Concern about prescribing these medications
  - Insufficient training

CDC Guidelines for Prescribing Opioids for Chronic Pain- US 2016

• Published March 2016
• Target audience: primary care providers treating adults (>18 yo) with chronic pain (> 3 months or past time of normal tissue healing) in outpatient settings outside of active cancer treatment, palliative care, and end-of-life care
• Process:
  – Systematic literature review (AHRQ process)
  – Core Expert Consultation
  – Stakeholder/ Federal/ Peer Review Period
  – Public Comment Period
  – Finalized Guidelines

MMWR. March 2016. 65(1); 1-49
GRADE Evidence Types

- Evidence Types:
  - Type 1: Randomized controlled trials (RCTs); overwhelming observational studies
  - Type 2: RCTs (limitations); strong observational
  - Type 3: RCTs (notable limitations); observational
  - Type 4: RCTs (major limitations); observational (notable limitations) clinical experience

Slide from and used with permission of CDC Division of Unintentional Injury Prevention
GRADE Recommendation Categories

Recommendation categories:

- Category A: applies to all patients; most patients should receive recommended course of action
- Category B: individual decision making required; providers help patients arrive at decision consistent with values/preferences and clinical situation
Clinical Evidence Summary

- No long-term (>1 year) outcomes in pain/function; most placebo-controlled trials ≤ 6 weeks
- Opioid dependence in primary care: 3%-26%
- Dose-dependent association with risk of overdose/harms
- Inconsistent results for different dosing protocols; initiation with LA/ER increased risk of overdose
- Methadone associated with higher mortality risk
- No differences in pain/function with dose escalation
- Risk prediction instruments have insufficient accuracy for classification of patients
- Increased likelihood of long-term use when opioids used for acute pain

Slide from and used with permission of CDC Division of Unintentional Injury Prevention
Effective nonpharmacologic therapies: exercise, cognitive behavioral therapy (CBT), interventional procedures

Effective nonopioid medications: acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), anticonvulsants, antidepressants

Opioid-related overdose risk is dose-dependent

Factors that increase risk for harm: pregnancy, older age, mental health disorder, substance use disorder, sleep-disordered breathing

Providers lack confidence in ability to prescribe safely and are concerned about opioid use disorder

Patients are ambivalent about risks/benefits and associate opioids with addiction
Organization of Recommendations

- The 12 recommendations are grouped into three conceptual areas:
  - Determining when to initiate or continue opioids for chronic pain
  - Opioid selection, dosage, duration, follow-up, and discontinuation
  - Assessing risk and addressing harms of opioid use
DETERMINE WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN
Recommendation #1- Opioids not first-line or routine therapy for chronic pain

- Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.
- Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.
- If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

(Recommendation category A: Evidence type: 3)
Recommendation #2- Establish treatment goals

- Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks.

- Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

(Recommendation category A: Evidence type: 4)
Recommendation #3- Discuss risks and benefits

- Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

(Recommendation category A: Evidence type: 3)
Ensure patients are aware of potential benefits, harms, and alternatives to opioids

- Be explicit and realistic about expected benefits.
- Emphasize goal of improvement in pain and function.
- Discuss
  - serious and common adverse effects
  - increased risks of overdose
    - at higher dosages
    - when opioids are taken with other drugs or alcohol
  - periodic reassessment, PDMP and urine checks; and
OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION
Recommendation #4- Formulation

- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

(Recommendation category A: Evidence type: 4)
Choose predictable pharmacokinetics and pharmacodynamics to minimize overdose risk

- In general, avoid the use of immediate-release opioids combined with ER/LA opioids.

- Methadone should not be the first choice for an ER/LA opioid.
  - Only providers familiar with methadone’s unique risk and who are prepared to educate and closely monitor their patients should consider prescribing it for pain.

- Only consider prescribing transdermal fentanyl if familiar with the dosing and absorption properties and prepared to educate patients about its use.
Recommendation #5- Start Low and Go Slow

- When opioids are started, clinicians should prescribe the lowest effective dosage.
- Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to >90 MME/day.

(Recommendation category A: Evidence type: 3)
Start low and go slow

- Start with lowest effective dosage and increase by the smallest practical amount.
- If total opioid dosage $\geq 50$ MME/day
  - reassess pain, function, and treatment
  - increase frequency of follow-up; and
  - consider offering naloxone.
- Avoid increasing opioid dosages to $\geq 90$ MME/day.
- If escalating dosage requirements
  - discuss other pain therapies with the patient
  - consider working with the patient to taper opioids down or off
  - consider consulting a pain specialist.

Slide from and used with permission of CDC Division of Unintentional Injury Prevention
If patient is already receiving a high dosage

- Offer established patients already taking ≥90 MME/day the opportunity to re-evaluate their continued use of high opioid dosages in light of recent evidence regarding the association of opioid dosage and overdose risk.

- For patients who agree to taper opioids to lower dosages, collaborate with the patient on a tapering plan.
Recommendation #6- Acute pain

- Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.

- 3 days or less will often be sufficient; more than 7 days will rarely be needed.

(Recommendation category A: Evidence type: 4)
Recommendation #7- Follow up

- Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.
- Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.
- If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

(Recommendation category A: Evidence type: 4)
Tapering Opioids

- Work with patients to taper opioids down or off when
  - no sustained clinically meaningful improvement in pain and function
  - opioid dosages ≥50 MME/day without evidence of benefit
  - concurrent benzodiazepines that can’t be tapered off
  - patients request dosage reduction or discontinuation
  - patients experience overdose, other serious adverse events, warning signs.

- Taper slowly enough to minimize opioid withdrawal
  - A decrease of 10% per week is a reasonable starting point

- Access appropriate expertise for tapering during pregnancy

- Optimize nonopioid pain management and psychosocial support

Slide from and used with permission of CDC Division of Unintentional Injury Prevention
ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE
Recommendation #8- Evaluate risk factors

- Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.
- Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

(Recommendation category A: Evidence type: 4)
Certain factors increase risks for opioid-associated harms

- Avoid prescribing opioids to patients with moderate or severe sleep-disordered breathing when possible.
- During pregnancy, carefully weigh risks and benefits with patients.
- Use additional caution with renal or hepatic insufficiency, aged ≥65 years.
- Ensure treatment for depression is optimized.
- Consider offering naloxone when patients
  - have a history of overdose
  - have a history of substance use disorder
  - are taking central nervous system depressants with opioids
  - are on higher dosages of opioids (≥ 50 MME/day).
Recommendation #9- PDMP

- Clinicians should review the patient’s history of controlled substance prescriptions using state PDMP data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him/her at high risk for overdose.
- Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

(Recommendation category A: Evidence type: 4)
If prescriptions from multiple sources, high dosages, or dangerous combinations

- Discuss safety concerns with patient (and any other prescribers they may have), including increased risk for overdose.
- For patients receiving high total opioid dosages, consider tapering to a safer dosage, consider offering naloxone.
- Consider opioid use disorder and discuss concerns with your patient.
- If you suspect your patient might be sharing or selling opioids and not taking them, consider urine drug testing to assist in determining whether opioids can be discontinued without causing withdrawal.
- Do not dismiss patients from care—use the opportunity to provide potentially lifesaving information and interventions.

Slide from and used with permission of CDC Division of Unintentional Injury Prevention
Recommendation #10- Urine Drug Testing

- When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

(Recommendation category B: Evidence type: 4)
Use UDT to assess for prescribed opioids and other drugs that increase risk

- Be familiar with urine drug testing panels and how to interpret results.
- Don’t test for substances that wouldn’t affect patient management.
- Before ordering urine drug testing
  - explain to patients that testing is intended to improve their safety
  - explain expected results; and
  - ask patients whether there might be unexpected results.
- Discuss unexpected results with local lab and patients.
- Verify unexpected, unexplained results using specific test.
- Do not dismiss patients from care based on a urine drug test result.

Slide from and used with permission of CDC Division of Unintentional Injury Prevention
Recommendation #11- Opioid/benzo combo

- Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

(Recommendation category A: Evidence type: 3)
Avoid concurrent opioids and benzodiazepines whenever possible

- Taper benzodiazepines gradually.
- Offer evidence-based psychotherapies for anxiety.
  - cognitive behavioral therapy
  - specific anti-depressants approved for anxiety
  - other non-benzodiazepine medications approved for anxiety
- Coordinate care with mental health professionals.
Recommendation #12- OUD treatment

- Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

(Recommendation category A: Evidence type: 2)
Recommended Resources

• “Adapting your practice: Chronic Pain Management” (HCH Clinicians Network)
• CDC Guidelines and associated documents
• PCSS-O webinars (Providers’ Clinical Support System for Opioid Therapies)
OPIOID USE DISORDER TREATMENT AS OVERDOSE PREVENTION
# Substance Use Disorder Treatment

## From Acute Care Model
- Enters Treatment
- Completes Assessment
- Receives Treatment
- Discharged

## To Chronic Care Model
- Prevention
- Early Intervention
- Treatment
- Recovery Support Services

OUD Treatment

• Counseling (could be through formal treatment program or NA type 12 step meetings)

• Medication Assisted Treatment (Counseling + medication)
  – Methadone
  – Buprenorphine (Suboxone)
  – Naltrexone (Vivitrol)

• Detox is NOT treatment and actually increases risk of overdose
Medication Assisted Treatment (MAT) for OUD

• Methadone
  – Full opioid agonist
  – Available since 1970s
  – In US only available in certified MMT programs with strict regulations around administration
  – Strong evidence (in combination with behavioral therapy)

• Buprenorphine (Suboxone, Subutex)
  – Partial opioid agonist (has ceiling effect- safer for overdose risk)
  – FDA approved for OUD since 2002 and able to be prescribed in outpatient settings with DATA waiver (Primary care, etc)
  – Strong evidence (in combination with behavioral therapy)

• Naltrexone (Vivitrol)
  – Opioid antagonist
  – FDA approved in 2010
  – Evidence not as good for OUD (as compared to methadone or buprenorphine)- more for overdose risk
Agonist Activity Levels

- Full Agonist (e.g. methadone)
- Partial Agonist
Indications for Medications

• All patients with opioid use disorder should be offered medication as a component of treatment
  – Only 10% of patients with OUD in addiction treatment programs were actually receiving medication\(^a\)

• Factors to keep in mind:
  – Methadone heavily structured and regulated
  – Buprenorphine can be provided in a primary care setting
  – Naltrexone contra-indicated if prescription opioids are part of chronic pain treatment

Treatment Effectiveness

- Goal of treatment is to return to productive functioning

- Reduces drug use by 40-60%

- Drug treatment is as successful as treatment of diabetes, asthma, and hypertension

- Strongest predictor of recovery is retention in treatment
Benefits Of Treatment

- Reduces risk of HIV infection
- Reduces risk of overdose
- Reduces risk of infection with hepatitis C and B
- Increases rates of employment
- Decreases crime
- Increases length of life (partial/agonist Tx = strongest OD prev intervention)
How long is treatment needed?

• Individualized

• Less than 90 days in any treatment setting is of limited to no effectiveness

• Studies demonstrate that MAT (medication plus therapy) results in superior outcomes as compared to therapy alone
Treatment & unintended risk

• Medically supervised withdrawal
• Short-term care
• Induction period
• Entry in to & exit out of

Should informed consent address overdose risk?
POLICIES AND TECHNICALITIES RE: NALOXONE & SPACE SAFETY
Naloxone access laws 2001-2015

States that have expanded naloxone access laws - clockwise from top left:
2001 = 1 state
2005 = 2 states
2010 = 6 states
2015 = 37 states

Source: LawAtlas.org
LET’S TAKE A CLOSER LOOK AT POLICIES

HTTPS://WWW.DROPBOX.COM/S/TGW6OGW51RCTQYJ/FNRC_SAMPLE%20POLICY.PDF?DL=0
HTTPS://WWW.DROPBOX.COM/S/HAF20B1U9XR4CU/HOSPITAL%20OD%20PREV%20PGMS%20PROTOCOL%200709%20TEMPLATE.DOC?DL=0
HTTPS://WWW.DROPBOX.COM/S/6B08JYKZ59QH3G/STANDING-ORDER-IM.PDF?DL=0
Sharps boxes
Good lighting
Mirrors
Call button/intercom system
Monitor with timer

Doors open out
No slide bolts
Safer injection equipment
Visible naloxone rescue kit
Providing naloxone to opioid users is harm reduction on a really intimate, yet grand scale because every OD death that is prevented is hundreds if not thousands of people prevented from grieving. With each OD death prevented, it’s all that sorry, grief, and loss prevented.
INTERNATIONAL OVERDOSE AWARENESS DAY: AUGUST 31
International Overdose Awareness Day, Schaumburg
Public displays; collective grief; tangible activism
Terri preparing for vigil
displays; collective
grief; tangible
activism
OD vigil, Yarmouth
Public displays; collective grief; tangible activism
NARCANIA VS DEATH
THE HEROINE WHO FIGHTS HEROIN OVERDOSES (AND OTHER OPIATE OBLIGE FROM PILLS)

DEATH APPROACHES HIS NEXT VICTIM, SALLY SHAGGY, WHO IS OVERDOSED ON OPIATES (HERION MILLS).

BUT WAIT! BEFORE DEATH CAN TAKE SALLY AWAY, NARCANIA COMES TO SAVE THE DAY WITH HER AMAZING OPIATE BLOCKING POWERS!

POW!

NARCANIA GIVES SALLY BACK TO LIFE! HURRAY!

FIND OUT HOW YOU CAN BE A REAL LIFE SUPERHERO...

CONTACT THE DOPE PROJECT
1-800-444-6969

www.theadoption.org
Contact & appreciation

• Elizabeth: Elizabeth.Salisbury@gmail.com
• Haven: HavenW@outsidein.org
• Maya: Mdoe-Simkins@heartlandalliance.org

• Appreciation & acknowledgement
  – Lindsey Jenkins
  – Alex Walley
  – Traci Green
  – Jef Bratburg
  – Dan Bigg
  – Sarz Maxwell
  – Eliza Wheeler
  – Alice Bell
Recommended Resources:

• “Adapting your practice: Opioid Use Disorder” (HCH Clinicians Network)
• SAMHSA TIP 40
• PCSS-O webinars (Providers’ Clinical Support System for Opioid Therapies)
• Getting technical assistance from other clinics who have already implemented programs
• ASAM website (American Society for Addiction Medicine)
• Waiver to prescribe buprenorphine for OUD
Factors Associated with Risk of Opioid Overdose

- Daily dose >100 mme
- Long-acting or extended release formulations
- Combination with benzodiazepines or any other drug that depresses respiratory rate
- Long-term opioid use (>3 months)
- Period shortly after initiating long-acting or ER formulation (2 weeks afterwards)
- Age >65 years old
- Sleep-disordered breathing
- Renal or hepatic impairment
- Depression
- Substance Use Disorder (any kind)
- History of overdose

Volkow et al. Opioid Abuse in Chronic Pain- misconceptions and mitigation strategies. NEJM. 2016; 374:1253-63
Sources of Prescription Painkillers Among Past-Year Non-Medical Users

- Given by a friend or relative for free
- Prescribed by ≥1 physicians
- Stolen from a friend or relative
- Bought from a friend or relative
- Bought from a drug dealer or other stranger
- Other

<table>
<thead>
<tr>
<th>Number of Days of Past-Year Non-Medical Use</th>
<th>Percent of Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any</td>
<td>50</td>
</tr>
<tr>
<td>1-29</td>
<td>60</td>
</tr>
<tr>
<td>30-99</td>
<td>55</td>
</tr>
<tr>
<td>100-199</td>
<td>45</td>
</tr>
<tr>
<td>200-365</td>
<td>35</td>
</tr>
</tbody>
</table>

a Obtained from the US National Survey on Drug Use and Health, 2008 through 2011.5
b Estimate is statistically significantly different from that for highest-frequency users (200-365 days) (P<.05).
c Includes written fake prescriptions and those opioids stolen from a physician’s office, clinic, hospital, or pharmacy; purchases on the Internet; and obtained some other way.