Substance Use Disorder Treatment During COVID-19: *Harm Reduction Strategies*

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Learning Objectives

1. Discuss the current state of substance use disorders during the COVID-19 pandemic.
2. Describe challenges that clinicians face when treating SUDs, with a focus on opioid, alcohol, and methamphetamine use disorders.
3. Critically review how to incorporate harm reduction strategies into the clinical care of SUDs.

Substance Use During COVID-19

As of June 2020, 13% of Americans reported starting or increasing substance use as a way of coping with stress or emotions related to COVID-19 (CDC):

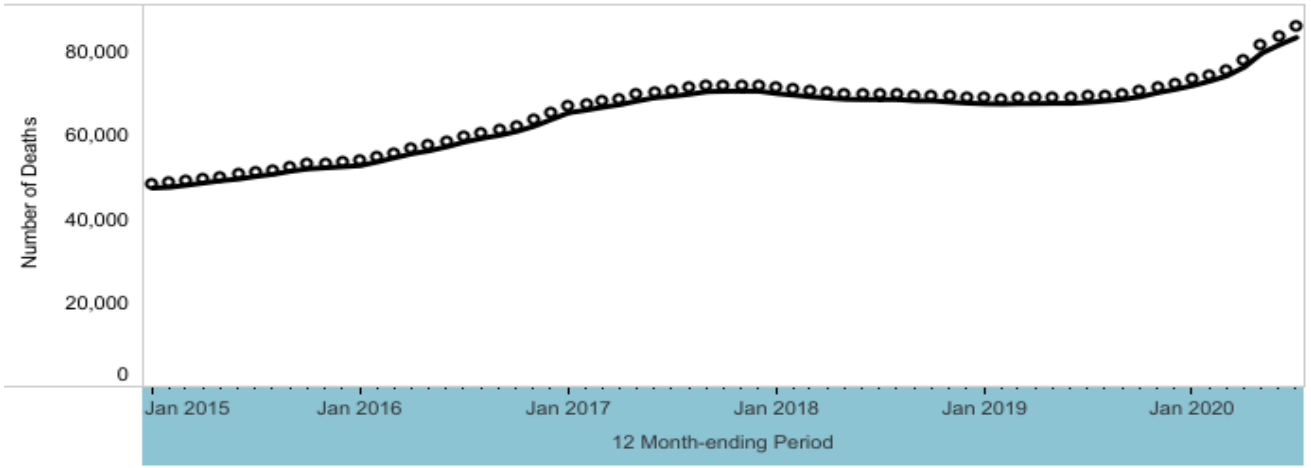
- Bereavement
- Social isolation
- Lack of access to recovery resources
- Financial hardships – stress
- Unsafe living environments
- Trauma

Substance Use During COVID-19

- COVID-19 affects the respiratory system = higher risk in patients who smoke tobacco, marijuana, or vape
- Individuals with SUDs who have unstable housing, incarceration risk, & limited access to healthcare = higher risk
- Quarantining may disrupt access to treatment & SUD community support
- Risks of COVID-19 infection transmission may be greater in group homes & sober living environments

Based on data available for analysis on: 2/7/2021

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: United States

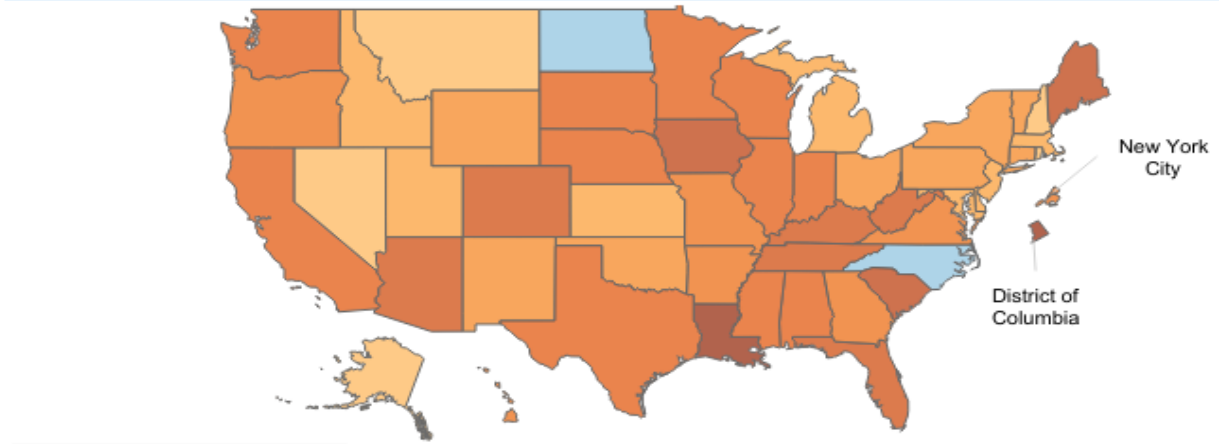


Select Jurisdiction
United States

Predicted Value

Reported Value

Figure 1b. Percent Change in Reported 12 Month-ending Count of Drug Overdose Deaths, by Jurisdiction: July 2019 to July 2020



Select predicted or reported number of deaths

Predicted

Reported

Percent Change for United States

22.8

Legend for Percent Change in Drug Overdose Deaths Between 12-Month Ending Periods

-6.3 — 56.8

NOTES: *Reported* provisional counts for 12-month ending periods are the number of deaths received and processed for the 12-month period ending in the month indicated. Drug overdose deaths are often initially reported with no cause of death (pending investigation), because they require lengthy investigation, including toxicology testing. Reported provisional counts may not include all deaths that occurred during a given time period. Therefore, they should not be considered comparable with final data and are subject to change. *Predicted* provisional counts represent estimates of the number of deaths adjusted for incomplete reporting (see **Technical notes**).
Deaths are classified by the reporting jurisdiction in which the death occurred. Percent change refers to the relative difference between the reported or predicted provisional numbers of deaths due to drug overdose occurring in the 12-month period ending in the month indicated compared with the 12-month period ending in the same month of the previous year. Drug overdose deaths are identified using ICD–10 underlying cause-of-death codes: X40–X44, X60–X64, X85, and Y10–Y14.

Regional Overdose Death Data- 2020

- Drug overdose deaths ↑ ~21% in the first three quarters of 2020 compared to 2019
  - Deaths among males ↑ 26%, compared to 11% among females
  - Deaths among Black people ↑ 37%, compared to 16% among White people
- The St. Louis Metro region accounted for ~ 55% of all drug overdose deaths in MO in 2019 & 2020
- The St. Louis Metro Region accounted for ~ 80% of all drug overdose deaths in MO among Black individuals
- Overdose deaths involving a combination of opioids & stimulants ↑ by ~ 82% statewide between 2019 & 2020
- Opioid-involved drug overdose deaths represent the majority of total drug overdose deaths in MO (75%)

Data is from the Missouri Department of Health & Senior Services, Bureau of Healthcare Analysis & Data Dissemination. Counts are preliminary

What Does Fentanyl Really Look Like?

Substance Use Disorders

Alcohol Use Disorder

Tobacco Use Disorder

Caffeine Use Disorder

Cannabis Use Disorder

Hallucinogen (PCP, LSD) Use Disorder

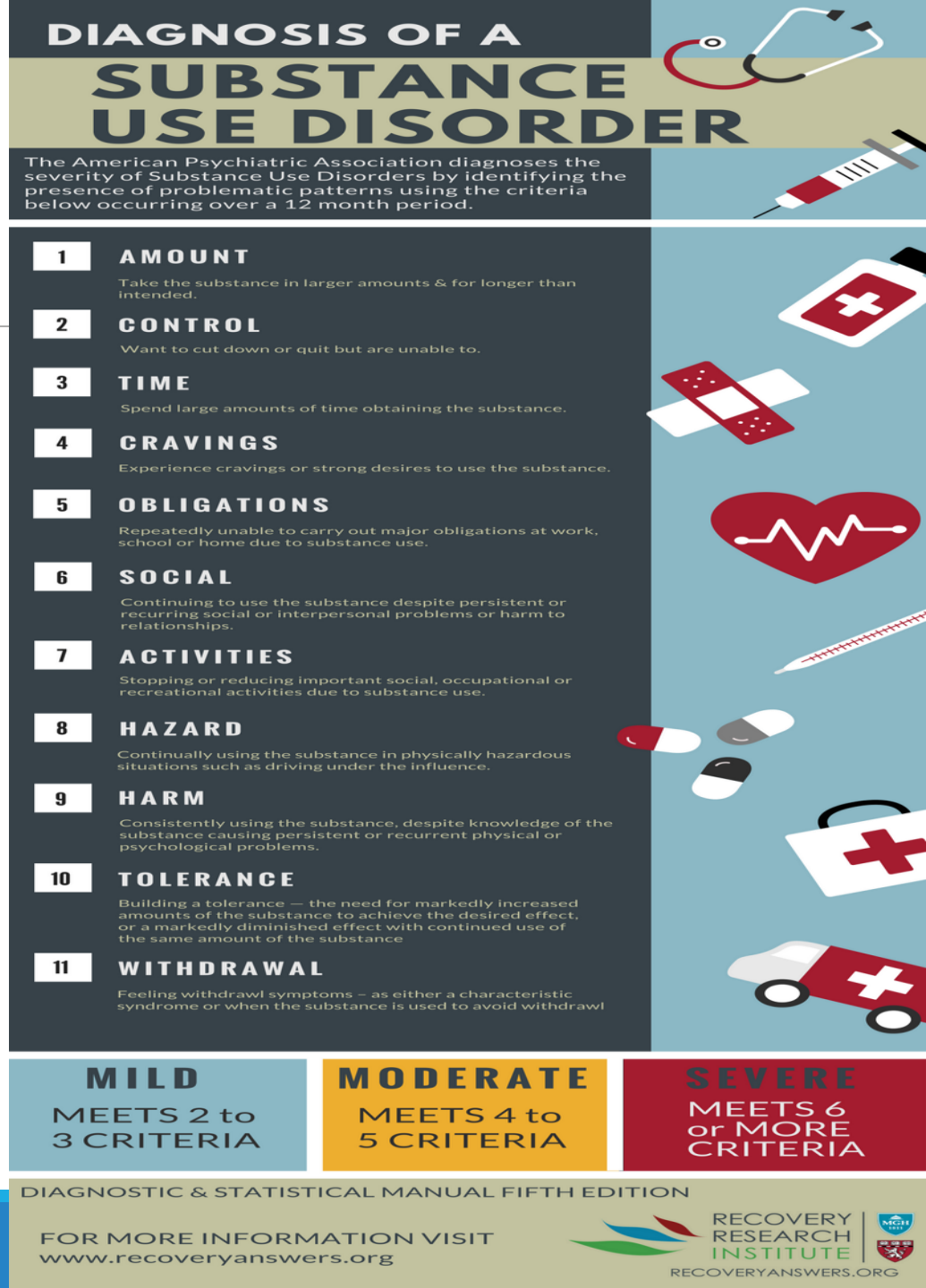
Inhalant Use Disorder

Opioid Use Disorder

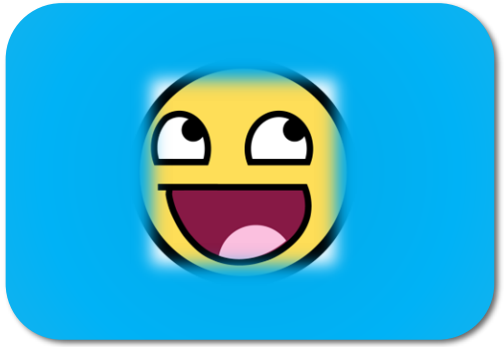
Sedative, hypnotic, or anxiolytic Use Disorder

Cocaine Use Disorder

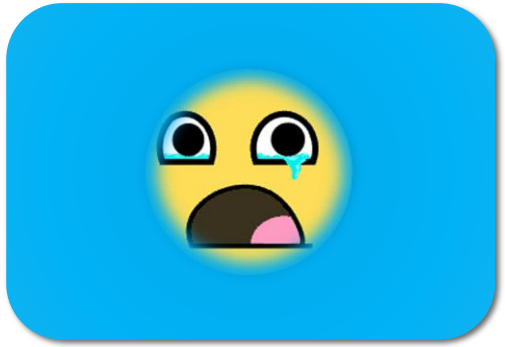
Amphetamine Use Disorder



Why Do People Use Substances?

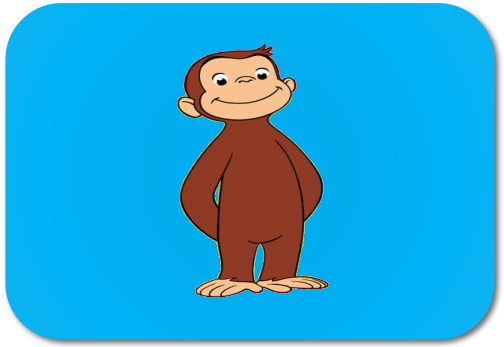


To feel good

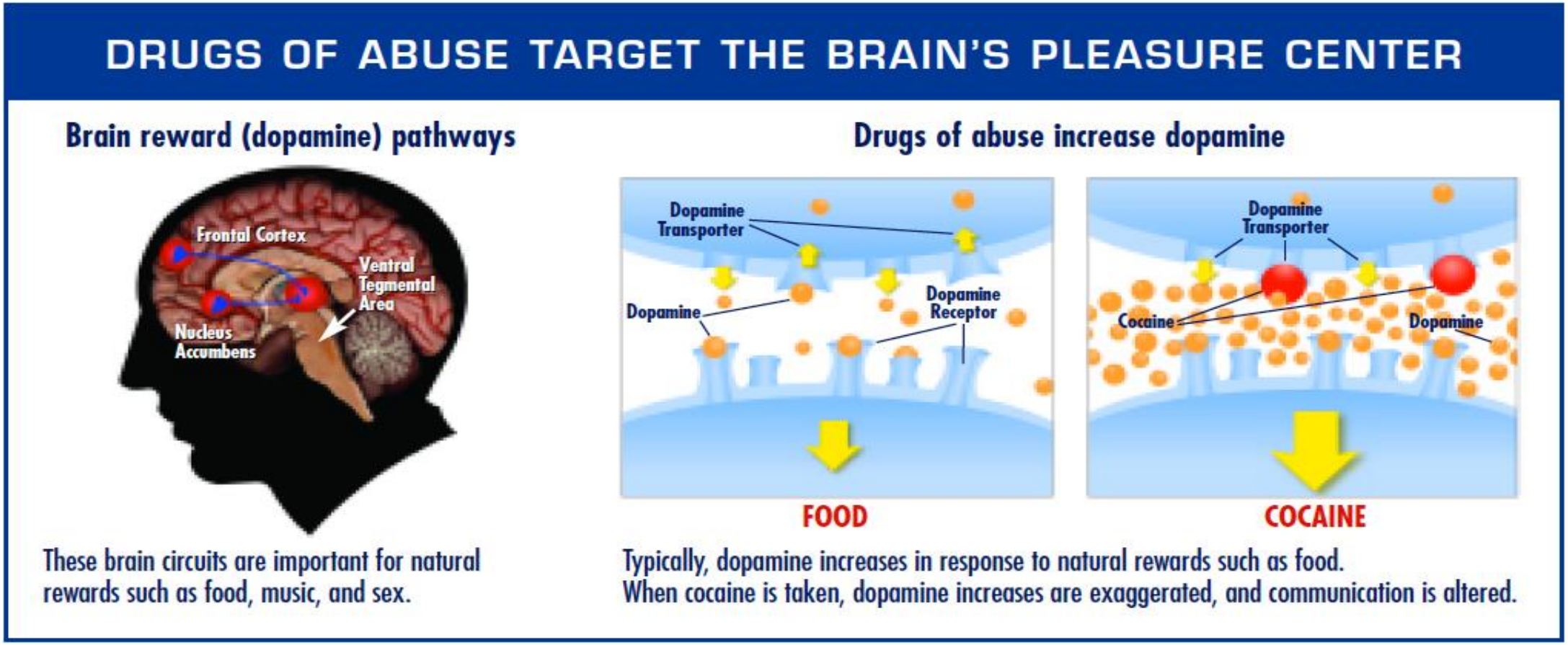


To feel better

To do better

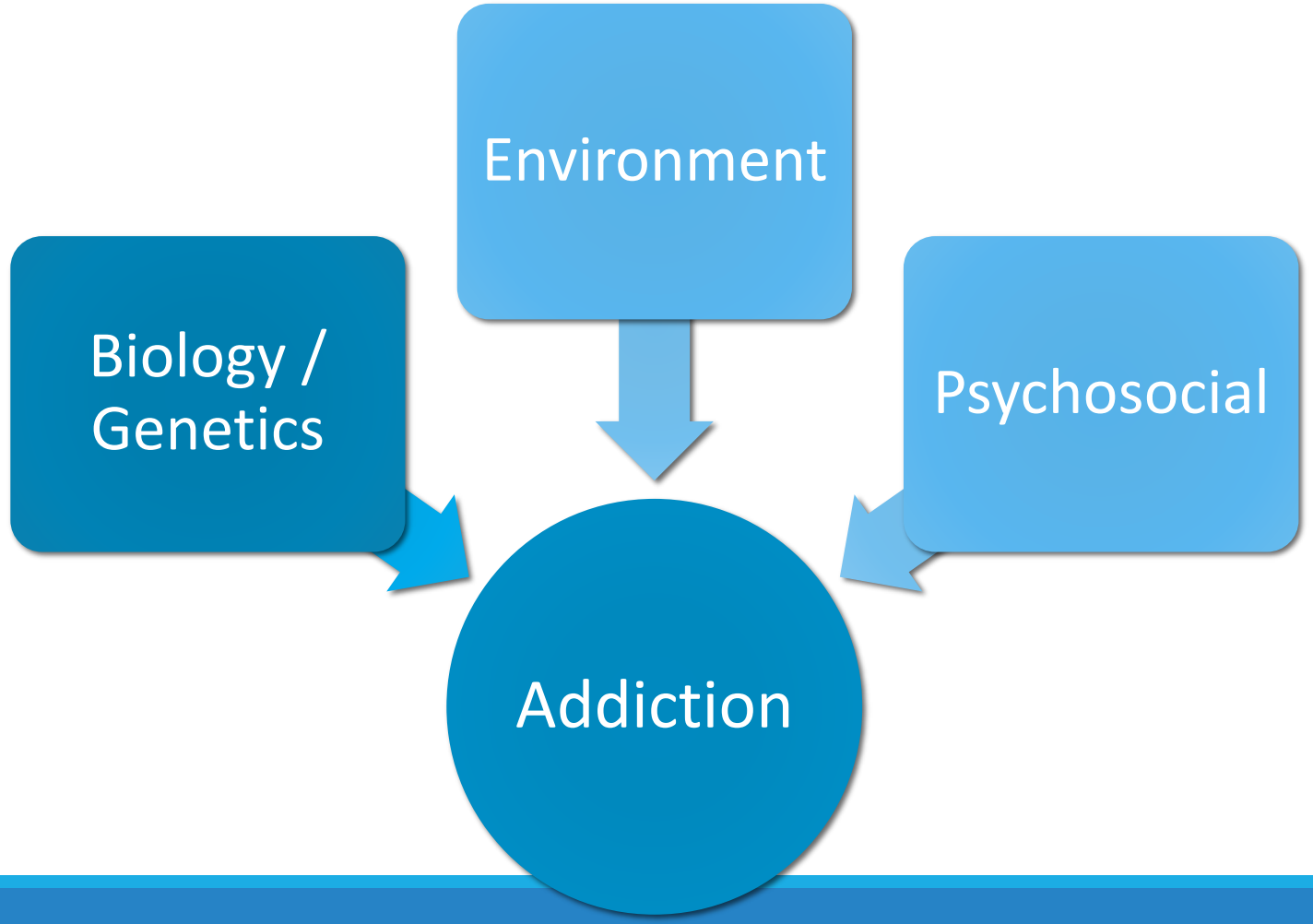


Curiosity



http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain

Substance Use Disorders



Stigma-Busting

1. What phrases, terms, concepts do you hear within your practice with regard to substance use disorders and treatment?
2. How are substance use disorders depicted in the media? News sources? Side conversations among friends?

RECOVERY DIALECTS

Language matters but can change depending on the setting we are in. Choosing when and where to use certain language and labels can help reduce stigma and discrimination towards substance use and recovery.

	Mutual Aid Meetings	In Public	With Clients	Medical Settings	Journalists
Addict	✓	✗	✗	✗	✗
Alcoholic	✓	✗	✗	✗	✗
Substance Abuser	✗	✗	✗	✗	✗
Opioid Addict	✓	✗	✗	✗	✗
Relapse	✓	✗	✗	✗	✗
Medication-Assisted Treatment	✗	✗	✗	✗	✗
Medication-Assisted Recovery	✓	✓	✓	✓	✓
Person w/ a Substance Use Disorder	✓	✓	✓	✓	✓
Person w/ an Alcohol Use Disorder	✓	✓	✓	✓	✓
Person w/ an Opioid Use Disorder	✓	✓	✓	✓	✓
Long-Term Recovery	✓	✓	✓	✓	✓
Pharmacotherapy	✓	✓	✓	✓	✓

https://www.changingthenarrative.news/

Language Matters

Use	Avoid
Risky medicines	Risky patients
Substance use disorder / opioid use disorder	Abuse / abuser / opioid abuse disorder
Person with an opioid use disorder	Addict / junkie / someone like you
Person in long-term recovery	A person who is “clean”
Sterile syringes	“Clean” / “dirty” needles
Medication-assisted recovery / substance use disorder pharmacotherapy	Opioid substitution therapy
Bad reaction / breathing emergency	Overdose / OD

APhA Academy of Pharmacy Practice & Management Pain, Palliative Care, & Addiction Special Interest Group
https://www.changingthenarrative.news/

IndyStar. HOME NEWS NORTH SPORTS THINGS TO DO 40° ARCHIVES USA TODAY JOBS MORE Subscribe

2nd Indiana county ends needle exchange, with 1 official citing moral concerns

Cincinnati.com | The Enquirer

Should 'tough love' mean we ignore those overdosing?

CDC Injury Center
@CDCInjury
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#DYK? Fentanyl is a synthetic #opioid pain reliever approved to treat severe pain, but fentanyl-related overdose deaths are rising across the US. Learn more: go.usa.gov/xUBXC

1:30 pm - 13 Feb 2019

Health

New Strain of Fentanyl Is Resistant to Our Only Overdose Antidote

The New

OPINION

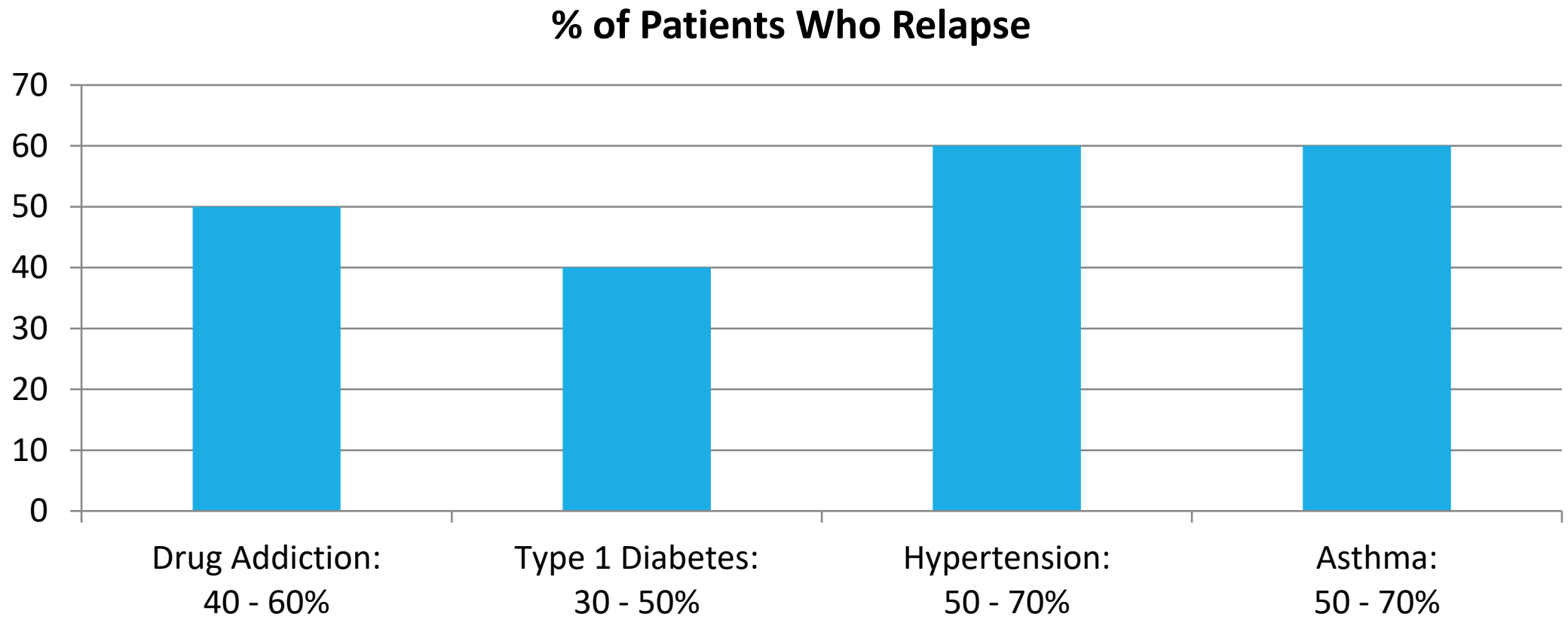
Addicted to a Treatment for Addiction

https://www.changingthenarrative.news/

Substance Use Disorders: Barriers to Treatment

- Stigmas that prevent treatment:
  - “Treatment doesn’t work”
  - People with addictions are “bad, crazy, can’t be helped, don’t want to be helped”
  - “They have an addictive personality”
- Treatment outcomes are improved if the substance use disorder is addressed collaboratively with other medical conditions

Perspective: Substance Use Disorders Recurrence and Recovery



JAMA, 284: 1689-1695, 2000

“We must help everyone see that addiction is not a character flaw —
it is a chronic illness that we must approach with the same skill and compassion with which we approach heart disease, diabetes, and cancer.”

— Former Surgeon General, Dr. Vivek Murthy

Harm Reduction

"A set of practical strategies and ideas aimed at reducing negative consequences and death associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of all people."

What Does Harm Reduction Look Like?

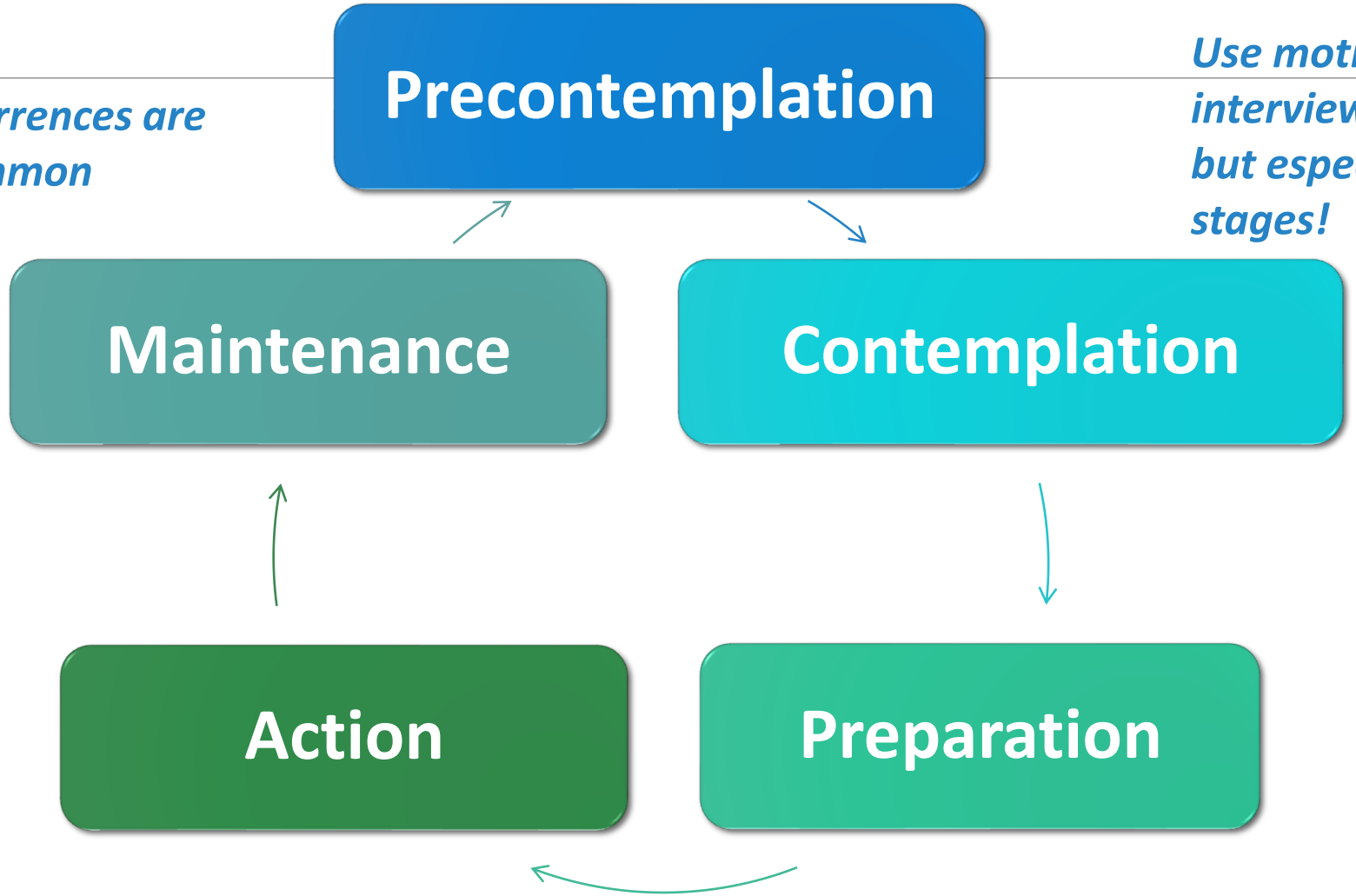
Let's talk about some examples:

- Condom use to prevent STIs
- HPV vaccine
- Influenza vaccine
- Fire extinguisher in the house/apartment
- Wearing seatbelt in vehicle
- Wearing helmet on bike/motorcycle
- Sterile syringe access
- Access to naloxone

Stages of Change & Harm Reduction

Remember: recurrences are possible and common

Use motivational interviewing in every stage, but especially the early stages!



Motivational Interviewing – PACE

A person-centered style of communication that explores a person's own internal motivations to help resolve ambivalence.

Partnership: communication is a collaborative effort among two experts.

Acceptance: to respect that another person has worth, autonomy, and self-direction.

Compassion: to value the well-being of the patient. To see the world as they see it.

Evocation: drawing out the patient's reasons for change.

MI SKILLS

Open Ended Questions
Affirmations
Reflective Statements
Summarizing Statements

The Process: *Ask-Offer-Ask*

1. **Ask** information from the individual
   - "Tell me more about your experience."
   - "Tell me what you know about how to stay safe while using."
2. **Offer** new information
   - "Would it be okay for me to tell you…"
   - More about opioid safety, harm reduction
3. **Ask** concerns about the new information
   - Address new concerns
   - "What are your thoughts now about what I've shared?"

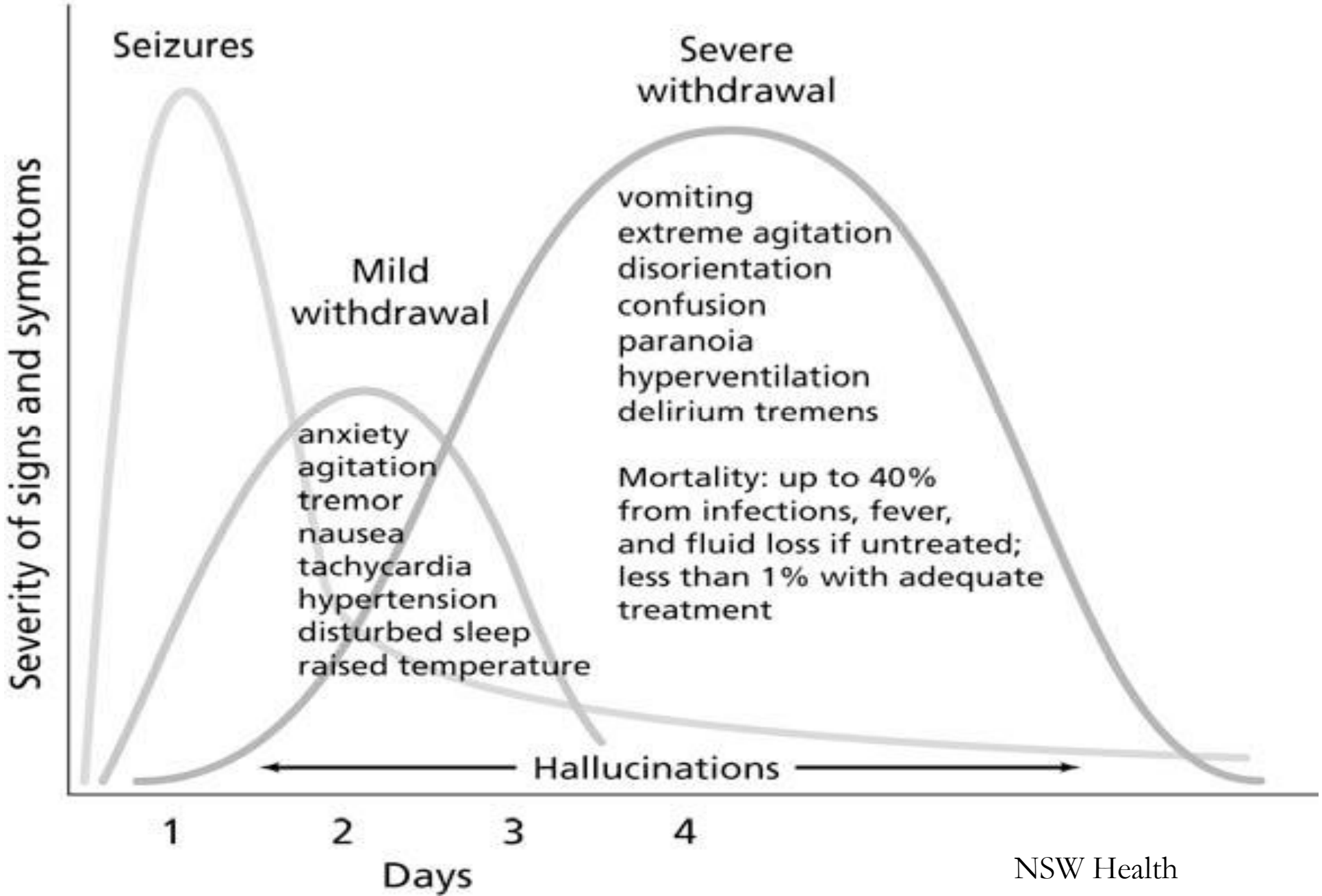
Confrontational and directive approaches are linked with more **patient resistance** and **poorer outcomes**

A patient-centered, supportive, and empathic style is associated with **better outcomes**

Alcohol Use & Risks

- Altered sleep architecture
- Depression
- Impaired judgment / risk behaviors
- Hyperlipidemia (HDL/TG elevated)
- Hypertension / cardiomyopathy
- Pancreatitis / hepatitis / jaundice / cirrhosis
- GI bleeds / Anemia
- Vitamin deficiencies / malnutrition
- GI cancer (esophageal, liver, pancreas); lung cancer (link with nicotine use)
- **Withdrawal & seizure risk

Course of alcohol withdrawal



NSW Health

Alcohol Withdrawal Treatment

- Evaluate the need for medically managed alcohol withdrawal
- Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised (CIWA-Ar)
- BZDs used: lorazepam, chlordiazepoxide, oxazepam, diazepam

Fixed-schedule treatment:

- Lorazepam 2 mg q 6 hr x 1 day
- Lorazepam 1.5 mg q 6 hr x 1 day
- Lorazepam 1 mg q 6 hr x 1 day
- Lorazepam 0.5 mg q 6 hr x 1 day

OR

- Chlordiazepoxide 50 – 100 mg q 6 hr x 1 day
- Chlordiazepoxide 25 – 50 mg q 6 hr x 2 days

Symptoms-triggered treatment:

- Give benzodiazepine only when patient has symptoms

Alcohol Use Disorder Treatments

- Disulfiram (Antabuse®)
- Naltrexone (Vivitrol®, ReVia®)
- Acamprosate (Campral®)

	Naltrexone (Depade®, ReVia®)	Extended-Release Injectable Naltrexone (Vivitrol®)	Acamprosate (Campral®)	Disulfiram (Antabuse®)
Action	Blocks opioid receptors, resulting in reduced craving and reduced reward in response to drinking.	Same as oral naltrexone; 30-day duration.	Affects glutamate and GABA neurotransmitter systems, but its alcohol-related action is unclear.	Inhibits intermediate metabolism of alcohol, causing a buildup of acetaldehyde and a reaction of flushing, sweating, nausea, and tachycardia if a patient drinks alcohol.
Contraindications	Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analgesics; acute hepatitis or liver failure.	Same as oral naltrexone, plus inadequate muscle mass for deep intramuscular injection; rash or infection at the injection site.	Severe renal impairment (CrCl ≤ 30 mL/min).	Concomitant use of alcohol or alcohol-containing preparations or metronidazole; coronary artery disease; severe myocardial disease; hypersensitivity to rubber (thiuram) derivatives.
Precautions	Other hepatic disease; renal impairment; history of suicide attempts or depression. If opioid analgesia is needed, larger doses may be required, and respiratory depression may be deeper and more prolonged. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see *www.niaaa.nih.gov/guide*.	Same as oral naltrexone, plus hemophilia or other bleeding problems.	Moderate renal impairment (dose adjustment for CrCl between 30 and 50 mL/min); depression or suicidal ideation and behavior. Pregnancy Category C.	Hepatic cirrhosis or insufficiency; cerebrovascular disease or cerebral damage; psychoses (current or history); diabetes mellitus; epilepsy; hypothyroidism; renal impairment. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see *www.niaaa.nih.gov/guide*.
Serious adverse reactions	Will precipitate severe withdrawal if the patient is dependent on opioids; hepatotoxicity (although does not appear to be a hepatotoxin at the recommended doses).	Same as oral naltrexone, plus infection at the injection site; depression; and rare events including allergic pneumonia and suicidal ideation and behavior.	Rare events include suicidal ideation and behavior.	Disulfiram-alcohol reaction, hepatotoxicity, optic neuritis, peripheral neuropathy, psychotic reactions.
Common side effects	Nausea; vomiting; decreased appetite; headache; dizziness; fatigue; somnolence; anxiety.	Same as oral naltrexone, plus a reaction at the injection site; joint pain; muscle aches or cramps.	Diarrhea; somnolence.	Metallic after-taste; dermatitis; transient mild drowsiness.
Examples of drug interactions	Opioid medications (blocks action).	Same as oral naltrexone.	No clinically relevant interactions known.	Anticoagulants such as warfarin; isoniazid; metronidazole; phenytoin; any nonprescription drug containing alcohol.
Usual adult dosage	*Oral dose:* 50 mg daily. *Before prescribing:* Patients must be opioid-free for a minimum of 7 to 10 days before starting. If you feel that there's a risk of precipitating an opioid withdrawal reaction, a naloxone challenge test should be employed. Evaluate liver function. *Laboratory followup:* Monitor liver function.	*IM dose:* 380 mg given as a deep intramuscular gluteal injection, once monthly. *Before prescribing:* Same as oral naltrexone, plus examine the injection site for adequate muscle mass and skin condition. *Laboratory followup:* Monitor liver function.	*Oral dose:* 666 mg (two 333-mg tablets) three times daily; *or* for patients with moderate renal impairment (CrCl 30 to 50 mL/min), reduce to 333 mg (one tablet) three times daily. *Before prescribing:* Evaluate renal function. Establish abstinence.	*Oral dose:* 250 mg daily (range 125 mg to 500 mg). *Before prescribing:* Evaluate liver function. Warn the patient (1) not to take disulfiram for at least 12 hours after drinking and that a disulfiram-alcohol reaction can occur up to 2 weeks after the last dose and (2) to avoid alcohol in the diet (e.g., sauces and vinegars), over-the-counter medications (e.g., cough syrups), and toiletries (e.g., cologne, mouthwash). *Laboratory followup:* Monitor liver function.

AUD & Harm Reduction During COVID-19

- Do not stop cold-turkey on your own
- Take a multivitamin, thiamine 100 mg, and folic acid 1 mg daily
- Stimulants can mask adverse effects of alcohol leading to higher than intended alcohol consumption
- Cocaine + alcohol = Cocaethylene (CE) = increased risk for cardiac arrest
- Explore online recovery resources: https://www.smartrecovery.org/

SMART Recovery®
Life beyond addiction

Alcoholics Anonymous®

Methamphetamine Use & Risks

- Administered orally, intravenously, snuffed/snorted, or inhaled
- Duration of action 8-24 hours
- Metabolized to amphetamine
- Rewarding effects lead to increasing self-administration
- Binges may last 12-18 hours & as long as 2-7 days

Methamphetamine Use & Risks

Signs and symptoms

- Paranoia
- Hallucinations marked by fearful, panic-stricken, agitation and hyperactivity
- Rages leading to violence
- Body sores from scratching
- Anxiety / depression
- Insomnia
- CVD disease / hypertension

Behaviors

- Withdrawal from social activities
- Consumed with use and acquisition of the drug
- Increased stereotyped, non-interactive behaviors
- Decreased judgment / increase in risky actions

Methamphetamine-Related Hospitalizations

- Trauma: 18-33%
- Psychosis: 8-80%
  Jones, J Clin Nursing, 2018
- Neurologic harms of MA
  - Stroke: 2-5x risk for hemorrhagic (not ischemic) stroke
  - Cognitive impairment: learning, executive function, concentration, memory
  - Parkinson's: 1.5-3x
  - Seizures: seems more cocaine-related
  - Psychosis: ~27% in dependent persons

  Lappin, Addiction, 2019; Kim, Biomol Ther, 2020

Methamphetamine Use Disorder Treatment

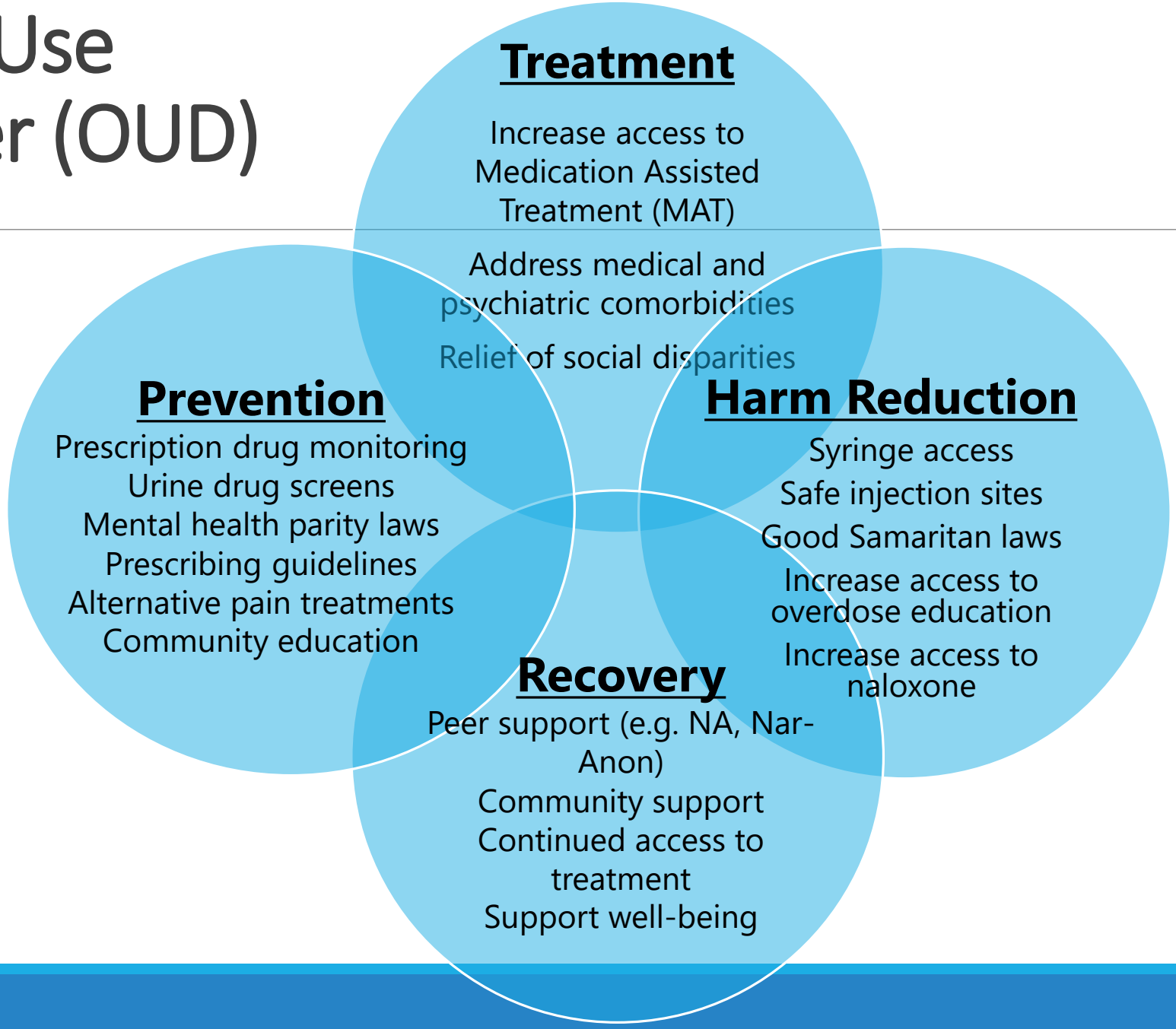
23 pharmacotherapies have been tested in RCTs, with some potential in the following products:

- Dexamphetamine, methylphenidate
- Naltrexone
- Topiramate
- Bupropion
- Mirtazapine

Methamphetamine Use & Harm Reduction During COVID-19

- Hydrate & eat. Keep sports drinks, nutritional shakes, snacks on hand
- Take a multivitamin daily
- Brush your teeth, floss every day
- Schedule time to sleep
- Rotate injection sites
- SQ injections greatly increase risk of infection
- Do not attempt to drain abscesses on your own
- Get tested for HIV every 6 months

Opioid Use Disorder (OUD)



4 Principles of the Medication First Model

1. People with OUD receive pharmacotherapy treatment as quickly as possible, prior to lengthy assessments or treatment planning sessions;
2. Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
3. Individualized psychosocial services are continually offered but not required as a condition of pharmacotherapy;
4. Pharmacotherapy is discontinued only if it is worsening the person's condition.

MissouriOpioidSTR.org/treatment

OUD Treatment

Pharmacological

- Buprenorphine/naloxone (Suboxone)
- Methadone
- Naltrexone

Nonpharmacological

- Cognitive behavioral therapy (CBT)
- Rehabilitation programs
- Support groups
  - Narcotics Anonymous (NA), SMART Recovery, Nar-Anon

OUD Treatment

	Methadone	Naltrexone	Buprenorphine
MOA	Agonist	Antagonist	Partial agonist
Administration	Oral	Oral or 380 mg IM (monthly)	Sublingual, buccal, subdermal implant, or SQ
Regulations	CII (only avail at federally certified OTPs)	Not scheduled	CIII (requires prescriber waiver)
Dosing Pearls	Receive treatment 6 to 7 days/week initially	Must be abstinent from short-acting opioids for 7 days & long-acting opioids for 10-14 days	Treatment often begins weekly in outpatient setting
	• Methadone is the most used and most studied OUD medication in the world. • The World Health Organization (WHO) considers it an essential medication.	• IM initiated prior to release from controlled environments (e.g., jails, prisons, residential rehabilitation programs) may be useful in preventing return to opioid use after release.	• Buprenorphine is a partial agonist with a ceiling effect on opioid activity. • It is less likely than methadone and other full agonists to cause respiratory depression in an accidental overdose.

OUD Treatment

	Methadone	Naltrexone	Buprenorphine
Pharmacology	Reduces opioid withdrawal and craving; blunts or blocks euphoric effects of self-administered illicit opioids through cross-tolerance and opioid receptor occupancy	Blocks euphoric effects of self-administered illicit opioids through opioid receptor occupancy. Causes no opioid effects.	Reduces opioid withdrawal and craving; blunts or blocks euphoric effects of self-administered illicit opioids through cross-tolerance and opioid receptor occupancy.
Client Education	• Dose will start low and build up slowly to avoid oversedation. • It takes several days for a given dose to have its full effect. • Methadone treatment has been associated with QTc prolongation (BBW)	• Need to be opioid free for at least 7–10 days before first dose to avoid XR-NTX-precipitated opioid withdrawal (which may require hospitalization). • Risk of overdose after stopping the medication.	• Need to be in opioid withdrawal to receive first dose to avoid buprenorphine-precipitated opioid withdrawal.

Choosing an OUD Treatment

- No strong evidence supporting use of one agent over other
- Patient specific considerations
  - Patient motivation
  - Pregnancy
    - Preferred: methadone or buprenorphine (without naloxone)
  - Access barriers
  - Co-existing alcohol abuse: naltrexone approved for treatment
  - Side effect profile of each treatment option
- Respect patient preference

SAMHSA. Medications for Opioid Use Disorder. HHS Publication No. (SMA) 18-5063FULLDOC.2018.

OUD Treatment Process

Patient Ready for OUD Treatment

Obtain methadone at DEA-approved opioid treatment program

Obtain naltrexone at clinic or substance use treatment center

Obtain buprenorphine at clinic or substance use treatment center from DEA-waivered provider

- MD/DO
- NPs, PAs, CNSs, CRNAs, CNMs

https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator

Common Approach to Buprenorphine Induction

1. Once in moderate withdrawal → 4 mg SL
2. **WAIT** 1 to 2 hours after first dose
3. No withdrawal = no more until day 2
4. Withdrawal = repeat 4 mg SL
5. Continue until withdrawal symptoms abated (8 – 16 mg/day)
6. Day 2:
   - No withdrawal upon waking = continue day 1 dose
   - Withdrawal upon waking = increase by 4 mg for AM dose, may use another 4 mg later in day if needed

FDA approved dosing:
Day 1: Max 8 mg
Day 2: Max 16 mg
*mu receptors 80-95% occupied at 16 mg/day

- *Long-term treatment outcomes up to 8 years show lower illicit opioid use in those with more time on medication.* ***Individuals should take buprenorphine as long as they benefit from it and wish to continue.***

SAMHSA. Medications for Opioid Use Disorder. HHS Publication No. (SMA) 18-5063FULLDOC.2018.

DEA Changes in Bupe Prescribing

Due to the nationwide public health emergency as a result of COVID-19, the DEA increased flexibility in the prescribing & dispensing of controlled substances in 2020:

- Authorized practitioners may admit & treat new patients with OUD & may prescribe controlled substances to patients using telemedicine without first conducting an in-person evaluation
- Practitioners can prescribe buprenorphine to new & existing patients with OUD via telephone
- X waiver requirements removed in Jan 2021; then cancelled in February 2021

Closing the Gaps in OUD Care

- Declaration of a national public health crisis in 2017.
- Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018.
- A majority of people with active OUD are still not engaged in any form of treatment.
  - ~40% of those started on buprenorphine are not retained in treatment at 6 months
  - Access to OUD treatment continues to be a struggle for rural and unserved/underinsured communities.
- Offering access to OUD treatment in primary care settings has helped to reduce stigma associated with initiating treatment.

Wu LT, Zhu H, Wartz MS. Treatment utilization among persons with opioid use disorder in the US. *Drug Alcohol Depend.* 2016;169:117-27.
Bach and Hartung *Addict Sci Clin Prac*. (2019) 14:30.

OUD & Harm Reduction During COVID-19

- Encourage access to sterile syringes
- Provide easy access to naloxone
- Educate on 911 Good Samaritan Laws
- Ensure safe opioid prescribing
- Recommend treatments that are effective

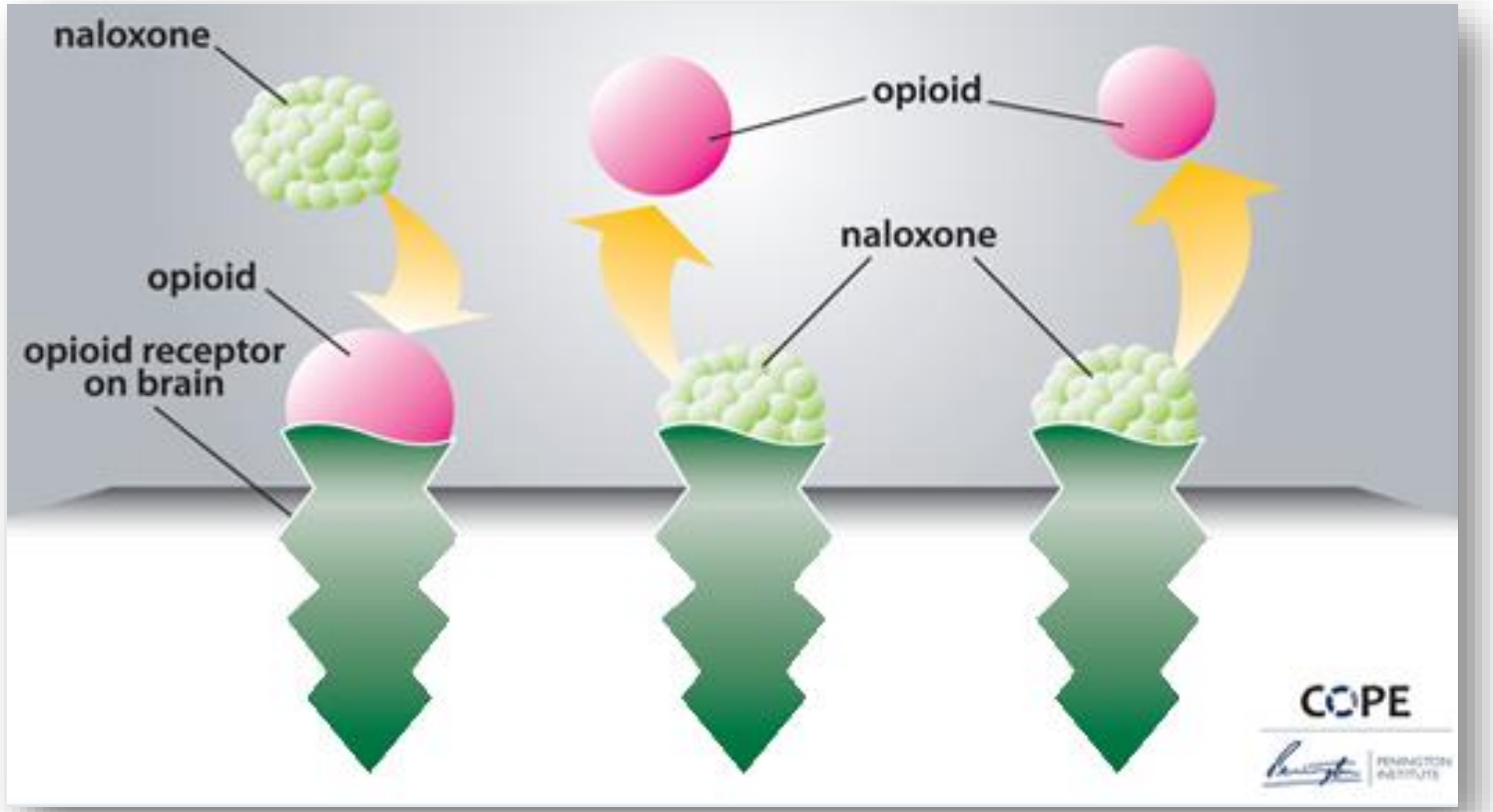
https://www.youtube.com/watch?v=QRsx45mvP_U&feature=youtu.be

https://youtu.be/PvvRJBHs8r0

Harm Reduction in Primary Care

- Provide ongoing education about the risk of opioid use & overdose
- CII prescribing electronically
- Discuss the use and access to sterile syringes / offer hepatitis C & HIV testing
- Co-prescribe naloxone along with opioid medications
- Review of Prescription Drug Monitoring Program (PDMP)
- Medication-Assisted Treatment (MAT): *imbedded Suboxone prescribers*
- Offer substance use disorder resources real time
  - *SBIRT- Screen, Brief Intervention, Referral to Treatment*
  - *Motivational interviewing incorporation into communication*
  - *Behavioral health consultants available for interventions*

Naloxone is **a competitive opiate antagonist** with no agonist activity. Antagonist at mu, delta, and kappa opioid receptors



- Naloxone has a *stronger affinity* to opioid receptors than other opioids.
- Duration of action: 30-90 minutes

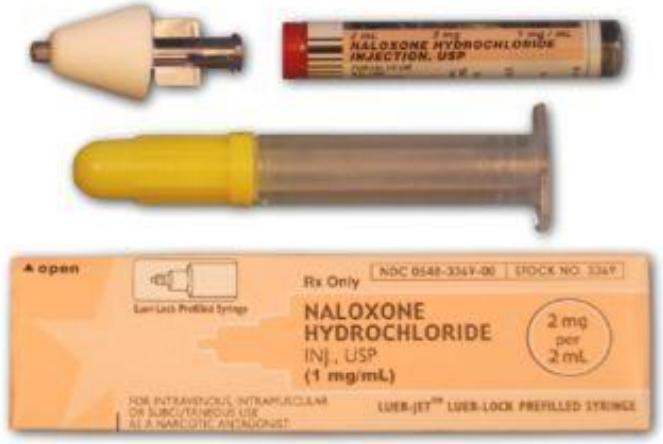
Naloxone Rescue Treatment

Naloxone (Narcan)

- Reverses analgesic, dysphoric, and other pharmacologic effects of opioids
- Naloxone is NOT effective in reversing an overdose with benzodiazepines, barbiturates, or stimulants

Is it safe to use?

- FDA-approved and used by EMS to reverse opioid overdose for > 40 years
- Has minimal interaction in the body without the presence of opioids
- Rapid opioid reversal causes: hypertension, tachycardia, sweating, recurring pain, agitation, other withdrawal symptoms



Who Should Receive Naloxone?

1. **Daily opioid doses the exceed 50mg MME**
2. **Taking an opioid with a benzodiazepine and/or alcohol**
3. History of opioid abuse, overdose, or other substance use disorder
4. Receiving opioid prescriptions from multiple doctors and pharmacies
5. **Currently using heroin**
6. Receiving methadone treatment
7. **Recent release from opioid treatment program, jail, or hospital**
8. Those with difficulty accessing emergency medical services
9. Opioid prescription plus: smoking/COPD/respiratory illness or obstruction, renal dysfunction, hepatic disease, cardiac disease, HIV

Gwira Baumblatt JA, et al. High-risk use by patients prescribed opioids for pain and its role in overdose deaths. JAMA Intern Med. 2014;174(5):796-801.

Teaching Patients, Friends, Family, Caregivers

Identify the Overdose

1. **Identify if someone is experiencing an overdose**
   - No response upon yelling their name or vigorously rubbing chest with knuckles
   - Blue lips or fingertips
   - Slow breathing (< 8 breaths/minute)
   - Limp body or choking/gurgling/snoring noise
2. **Administer naloxone** via IM or IN delivery system
   - Place the person in the recovery position:
   - On their side with their top leg and arm crossed over their body
3. **Call 911 for help**

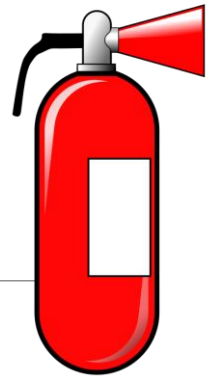
Administer Naloxone and *Stay Until Help Arrives!*

4. If breathing is shallow or non-existent, **perform mouth-to-mouth rescue breathing**

5. Stay with the person- do not leave someone alone after giving naloxone

- The effect of naloxone wears off in 30 to 90 minutes and clients can go back into overdose if a long-acting opioid was taken (methadone, Oxycontin)
- Clients may want to take more opioids upon reversal due to feeling opioid withdrawal symptoms
- Some clients may become agitated or combative during withdrawal

Addressing Naloxone Stigma



- How to address concerns of “risk compensation”
  - Current observational study data demonstrates reductions in community level opioid overdose death rates & reduced opioid-related ED visits among patients with chronic pain who were co-prescribed naloxone rescue kits.
- Studies that have looked for risk compensation from naloxone access among people who use heroin have found no clear evidence of it.
- Comparator public health interventions:
  - Seat belts to prevent motor vehicle deaths
  - Vaccination and condoms to prevent STIs

Free Naloxone

https://youtu.be/8WS-k050rE4

CLINTON, MONROE, RANDOLPH AND WASHINGTON COUNTIES

Egyptian Health Department
AHampton@Egyptian.org
(618) 273-3326 ext. 2119

MADISON, ST. CLAIR, BOND, JERSEY, MACOUPIN COUNTIES

Chestnut Health Systems
SR-Narcan@Chestnut.org
(618) 512-1781

MISSOURI

Missouri Network for Opiate Reform and Recovery
www.monetwork.org
(844) 732-3587

Prevent+Ed

https://prevented.org/
(314) 962-3456

Self-Stigma & Harm Reduction

“We all know this. Society judges us. We are seen as worthless, as bad people that deserve to be treated with contempt and disdain; that we are nothing more than "junkies."

What some may not understand is that over time we internalize these judgments. It's called self-stigmatization. We come to believe we are the things society says we are. We come to believe that we are unworthy of help. That we don't deserve it. It, thus, becomes so much harder to break our cycle of addiction.

And this is one reason Harm Reduction is so important. To be accepted for who we are. To have a connection that accepts us not as flawed and damaged but as a person; that connection gives us back our self-worth.”

Chad Sabora, BA, MS, JD, Missouri Network for Opiate Reform and Recovery
Matthews S., Dwyer R, Snoek A. Stigma and Self-Stigma in Addiction. J Bioeth Inq. 2017; 14(2): 275-286.

Additional Helpful Resources

- Centers for Disease Control and Prevention Overdose Provisional Data: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
- Miller, W.R., Rollnick, S. (2013). Motivational interviewing: helping people change, 3rd edition.
- Stigma reducing language: https://www.changingthenarrative.news/
- Prescribe to Prevent: www.prescribetoprevent.org
- Missouri SAMHSA funded programming: https://www.nomodeaths.org/
- Partnership for Drug-Free Communities: https://partnershipdrugfree.org/
- Providers Clinical Support System: www.pcssnow.org
- Substance use treatment locator: http://findtreatment.samhsa.gov or 1-800-662-HELP
- http://neverusealone.com/
- https://www.na.org/

Questions? kgable@siue.edu

SIUe School of Pharmacy