Opioid Overdose
Prevention and Response
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Outline

• Basic overdose training
  – Video
  – Presentation
  – Discussion/Q&A
  – Questionnaire- Quiz, Optional training evaluation
• Opiate drug trends in WA
• Overdose education nationally and locally
  – Epidemiology
  – History of OD education
  – Support for adding a medical model
  – Pharmacy based models
• Case study of CPA- Kelley Ross Pharmacy- naloxone

Video
1. Rub to wake.

- Rub your knuckles on the bony part of the chest (sternum) to try to get them to wake up and breathe.

2. Call 911.

All you need to say is:
- The address and where to find the person
- A person is not breathing
- When medics come, tell them what drugs the person took if you know
- Tell them if you gave naloxone

3. If the person stops breathing, give breaths mouth-to-mouth or use a disposable breathing mask.

- Put them on their back.
- Pull the chin forward to keep the airway open; put one hand on the chin, tilt the head back, and pinch the nose closed.
- Make a seal over their mouth with yours and breathe in two breaths. The chest, not the stomach, should rise.
- Give one breath every 5 seconds.
4. Give naloxone.

- **For injectable naloxone**: Inject into the arm or upper outer top of thigh muscle, 1 cc at a time. Always start from a new vial.
- **For intranasal naloxone**: Squirt half the vial into each nostril, pushing the applicator fast to make a fine mist.
- Discard any opened vials of naloxone within 6 hours.

5. Stay with the person and keep them breathing.

- Continue giving mouth-to-mouth breathing if the person is not breathing on their own.
- Give a second dose of naloxone after 2-5 minutes if they do not wake up and breathe more than about 10-12 breaths a minute.
- Naloxone can spoil their high and they may want to use again. Remind them naloxone wears off soon and they could overdose again.

6. Place the person on their side.

- People can breathe in their own vomit and die. If the person is breathing, put them on their side. Pull the chin forward so they can breathe more easily. Some people may vomit once they get Naloxone; this position will help protect them from inhaling that vomit.
7. Convince the person to follow the paramedics’ advice.

- If the paramedics advise them to go to the Emergency Room, health care staff will help:
- Relieve symptoms of withdrawal
- Prevent them from overdosing again today
- By having an observer who can give more naloxone when the first dose wears off
- Assess and treat the person for other drug overdoses. Naloxone only helps for opioids.

8. What if police show up?

- The Washington State 911 Good Samaritan Drug Overdose Law (RCW 69.50.315) lets bystanders give naloxone if they suspect an overdose.
- The law protects the victim and the helpers from prosecution for drug possession. The police can confiscate drugs and prosecute persons who have outstanding warrants from other crimes.

Questions?
Evaluation

- Anonymous and voluntary
- See the information statement
- If you are willing-
  1. Take the quiz/evaluation, place in envelope when done
  2. Write down email for follow up survey on separate page

Opiate Overdoses in the U.S.
Epidemiology, Prevention, Intervention and Policy
Rx Opioids

• Prescribing appears to be leveling off for potent, long acting opioids in some states (ARCOS 2010)
• Mortality increasing nationally, declining in WA
• NSDUH indicate Rx non-medical “pain reliever” opioid use declined in 2011

Heroin

• 18 to 24-year-olds admitted to treatment for heroin increased from 42,637 in 2000 to 67,059 in 2009 (TEDS cited in [A])
• Epidemiologists in 15/21 US cities report increases in heroin, notably among young adults and outside of urban areas (NIDA CEWG June 2012)
• NSDUH data indicate the number of persons who were past year heroin users in 2011 (620,000) was higher than the number in 2007 (373,000).

Rx to Heroin

• A relationship between misuse of prescription-type opiates and subsequent heroin use is indicated by NSDUH data* and published research** particularly adolescents and young adults
• King County 39% reported being “hooked on rx-type opiates” before they began using heroin (2009)

*C. Jones 2013 article
** Peavy et al, 2012 and Lankenau et al, 2012
Drug Use Trends 2012
King County & WA State

Data sources

- Police evidence- tested by WSP crime lab
- Healthy Youth Survey data- High School
- Helpline calls
- Treatment data- publicly funded
- Drug caused deaths

[Graph showing police evidence WA State tested by state crime lab]
WA State, 12th Graders, 2012 Healthy Youth Survey

<table>
<thead>
<tr>
<th>Use Estimate</th>
<th>Estimate</th>
<th>95% C.I.</th>
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<tbody>
<tr>
<td>Alcohol, past month</td>
<td>36.1% ± 2.3%</td>
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<tr>
<td>Marijuana, past month</td>
<td>26.7% ± 1.5%</td>
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<tr>
<td>Heroin, ever used</td>
<td>5.1% ± 1.3%</td>
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23% of recent users of Rx opiates to "get high" report ever using heroin, compared to 3% for those not recent using pain killers to get high.

Helpline Calls- WA State 2012

“Mother calling about son with SUD. Reports that she’s experienced with SUD and he’s been using heroin for about 1 year and is now injecting. In the past year, the son has lost 2 heroin-addicted friends to suicide with guns to the head because they couldn’t get treatment and were afraid of detoxing.” RURAL WA

Treatment Admissions WA State
All Ages 1999-2012

- Publicly funded admissions to Inpatient, Outpatient and MMT
- Treatment admits strongly influenced by funding and capacity, as well as demand
- Overall impact of capacity expansion in mid-2000s can be seen
- Heroin increased substantially
- Rx Opioids down a bit in 2012 from peak
• As every other substance declined, – 512% Statewide among 18-29 year olds

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<th></th>
<th>Northeast Spokane</th>
<th>North Central</th>
<th>North Central Washington</th>
<th>King</th>
<th>Pierce</th>
<th>Clark</th>
<th>Overall</th>
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<tr>
<td>Rate 2012 per 100,000</td>
<td>7.6</td>
<td>8.7</td>
<td>12.0</td>
<td>10.0</td>
<td>10.6</td>
<td>13.6</td>
<td>11.8</td>
</tr>
<tr>
<td>% change 2003-2012</td>
<td>75%</td>
<td>177%</td>
<td>228%</td>
<td>35%</td>
<td>33%</td>
<td>164%</td>
<td>92%</td>
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Conclusions

- Nationally young adult heroin treatment admits are up 57%
- Treatment data indicate a dramatic increase in heroin use among young adults 18-29 across Washington State.
  - These data are a substantial, but unknown, understatement of heroin treatment utilization (and need) given the exclusion of private/self pay treatment including buprenorphine maintenance treatment
- These findings raise questions about the ability of local communities to meet the treatment needs of new heroin users, let alone the public health needs including overdose and infectious disease risks.

Background - Opiate overdoses

- Overdoses can be prevented
  - Most opiate (heroin and/or Rx) overdoses can be intervened upon before death ensues
- Low overdose knowledge
  - Risk factors; Signs of overdose; How to intervene
  - Audiences include users and family/friends as well as general population
- Bystander fear of police response may inhibit calling 911
  - Perceptions are powerful
- An antidote for opiate overdoses is available
  - Supply and access points are limited

• All of these deaths were preventable
• Many of these overdoses could have been reversed before they became fatal
O.D. Knowledge
How to increase

- General awareness needed that opiate overdoses can be prevented and if they occur they can be reversed with naloxone
  - National problem, need broad awareness
  - Supply and demand need to be built
- Regular user of opiates could receive overdose education and take-home naloxone
- Family/friends of regular opiate users should also receive overdose education including how to use take-home naloxone (and get THN if not already in household)
- SAMHSA OD Toolkit

Antidote/Naloxone
Increasing access

- Medical providers could prescribe to potential overdose
  - and to potential witnesses
  - Settings- Primary care, Emergency Dept, Pharmacy, drug treatment, jail
- Insurance (public and private) could cover Rx costs
- Pharmacists could directly prescribe and dispense
  - lowers $ and increases access tremendously in terms of time burden and geography
  - Collaborative practice agreement
- Overdose education and prescribing time could be reimbursed
  - SBIRT codes should allow reimbursement for education
  - Pharmacists’ time educating could be reimbursed
Antidote/Naloxone
Increasing access
Maintain, support and expand community, syringe exchange, social service agency based education and delivery models
Non-licensed persons e.g. PH educators, could dispense depending on local rules and with prescriber oversight

OD Education & Naloxone distribution
• Historically focused on heroin users
• Recent interest in Rx Opioids e.g. Project Lazarus
  – Medicalizing and normalizing
• Key OD educational elements:
  – Prevention, Recognition, Intervention, Follow up
  – In person, some with video, online in development
    • NYC Dept of Health- short, broad population [link]
    • Project Lazarus- pain patient oriented, longer

Naloxone for Overdose Prevention

[Image of Naloxone for Overdose Prevention]
Naloxone access

• Q. Who can be prescribed naloxone?
  • A. A prescriber can prescribe take-home naloxone to anyone who is at risk for opioid overdose.
    - WA state explicitly allows for the prescription of take-home naloxone to persons at risk for witnessing an overdose.

• Q. Where can naloxone be obtained?
  • A. Naloxone availability varies by city/town. Generally very limited.
    - To locate overdose education & prevention and naloxone programs http://hopeandrecovery.org/locations/
    - Current efforts to get in community based pharmacies

Q. What has research shown to be the impacts of distributing Naloxone to potential overdose bystanders?

• Naloxone administration has not resulted in dangerous health outcomes;[9]
• Drug users are willing to administer naloxone to each other;[9]
• Naloxone availability does not increase drug use;[9]
• Evaluation data suggests that many who receive overdose education and take-home naloxone decrease their own risk for overdose by reducing drug use and/or entering drug treatment;[9,10]

Cont.
• More than 10,000 opioid overdoses have been reversed with naloxone given by bystanders in the U.S.
  - Naloxone distribution programs generally provide overdose prevention and recognition training combined with the dispensing of take-home Naloxone (THN).
  - More than 100 programs that distribute naloxone to opioid users are operating in at least 15 states. [11]
• As of 2012, two studies in the United States have recently received funding to conduct studies of overdose education and take-home naloxone distribution to populations at high risk for overdose.[12]
Opioid overdose prevention with intranasal naloxone among people who take methadone.

Overdose education and naloxone distribution (OEND) is an intervention that addresses overdose, but has not been studied among people who take methadone, a drug involved in increasing numbers of overdoses. This study describes the implementation of OEND among people taking methadone in the previous 30 days in various settings in Massachusetts. From 2008 to 2010, 1553 participants received OEND who had taken methadone in the past 30 days. Settings included inpatient detoxification (47%), HIV prevention programs (20%), methadone maintenance treatment programs (MMTP) (17%), and other settings (11%). Previous overdose, recent inpatient detoxification and incarceration, and polysubstance use were overdose risk factors common among all groups. Participants reported 92 overdose rescues. OEND programs are public health interventions that address overdose risk among people who take methadone and their social networks. OEND programs can be implemented in MMTPs, detoxification programs, and HIV prevention programs.
Evidence base

• We know naloxone works physiologically
  – Used by EMS and in OR’s and ED’s for decades
• Community based OD education and take-home naloxone shown to impact death rates at population level
• Evaluations of existing programs not had $ for rigorous research...

Fear of police/law
How to minimize

• Good Samaritan laws at State level can change practice OR perception
• Prosecutorial/Police policy at municipal level can be changed or made explicit [Blessing by others may catalyze]
• Police could be trained and allowed to administer naloxone e.g. Quincy Mass
  i. believe we have spread the word that no one should fear calling the police for assistance and that the option of life is just a 911 call away. We have also re-infressed with the community that the monster is not in the cruiser but indeed the officer represents a chance at life. Lt. Glynn

• PH/LE communication and coordination
• To discuss overdose as public safety issue to change practice and in turn perceptions

• Training police and public essential
  – Transparency will help build trust

Naloxone- medical access