[Dodi Swope]: Good afternoon and welcome to The Role of Prevention in Addressing Opioid Overdose Webinar. We're so thrilled you can be with us today. As we wait for participants to join us, there's a couple things on your screen that we'd like to invite you to participate in. One is our poll. We'd like you to rate your experience, and others that are working with you, on your Preventing Drug Overdose grants. We'd like you to rate your experience in terms of how comfortable you are in addressing opioid overdose, from “we're just getting started,” to “we've got this!” And we've got a solid three, right in the middle. Thanks for getting us started there. The other thing I wanted to draw your -- oh, we've got a solid four. Sorry about that. Now we have a three and a four; that's wonderful.

We also wanted to draw your attention to the PowerPoint download right under the poll slide. Those are the slides for today, and you're welcome to click on that, and you can download the slides so you have them with you today as we go through the presentation and so you have them for the future. The webinar is being recorded today, and we will be posting it onto our CAPT Connect site, so all of the materials will also be available there.

So, welcome to the webinar. We're seeing lots more people join us every second here. We'd like to welcome you to this afternoon's webinar, The Role of Prevention in Addressing Opioid Overdose. We're thrilled you can be with us today. We're asking you to take part in our poll, which asks how much experience do you, and thinking about those that you're working with on your Preventing Drug Overdose grant, how much experience do you have in addressing opioid overdose, from one, “just getting started on the topic,” to “we've got this!”
And I think, even for the most experienced folks on the call—I don't know if anybody's going to click number five, because I don't think any of us feel that we've totally got this, but we do appreciate those who have been at this a little while longer than others and really invite you to share your expertise as we go through today's content. We're going to keep the room open for about three minutes more before we get started on the webinar today. So the other thing that you can do, as you're waiting, is download the slides. That's available right under the slide that says 'poll,' and the slides are there for you to upload to your computer at this point, if you'd like.

So we welcome you today, and we're just waiting for folks to come on in and get settled in our room. Please do take part in the poll if you haven't done that yet, and please feel free to download the slides. We hope most of you are staying warm out there. It's pretty cold in parts of the country today. I will encourage folks, throughout the webinar, to write in the chat box if you have any questions throughout the presentation. We have a lot of people on the call today, so we will not be opening the phone lines for folks to chime in verbally, just because it would make it more difficult for us to get back to the slides and the content that we want to share, but we do encourage you to use that chat. So, if you've filled in our poll, we thank you very much for that, and you can download the slides in the PowerPoint download. And, this will also be available on the CAPT Connect site post the webinar. It might take a little while for us to get it posted, but it will be there in very short order.

So welcome today. We're going to get started in just a few seconds with our webinar, *The Role of Prevention in Addressing Opioid Overdose,* and we're thrilled that you can be with us today. There are still several folks joining from across the country, and we're just giving them a few more minutes to get in the room before we get going for today. We're thrilled you could join us. Welcome everyone to today's webinar. I'm seeing lots of folks joining here right as we come into the 3:00 mark. We will ask if you could please answer our poll question, which is how much experience do you have in addressing opioid overdose, from your perspective and those you're working with on this issue. And we invite you to download the slides in the download Power Point pod right under the slides. Welcome today, and I think we're going to move right into our content for the day as folks continue to join us.

As I look at the poll, I see that we're pretty evenly spaced between folks who are very new to this topic and just getting started—and this webinar is meant to really help prepare you, so have no fear, you're going to get a lot of very good information today that will help you get going—to folks who are feeling a little closer to, “I feel like I know the content, and I'm ready to get started with the work.” So, we appreciate very much that you've taken part in that slide, and I'm going to ask my folks there to turn us to the next layout, and we'll get started with the presentation for today.

So, thanks so much, everybody for joining us. My name is Dodi Swope, and I am welcoming you to *The Role of Prevention in Addressing Opioid Overdose,* and we have a wonderful panel for you today, and we hope that you will share any questions or thoughts you have in the chat with us. We see that there's a broad range of experience on the webinar today, so we really hope those with more experience in the topic will share your experiences, your
lessons learned and also the challenges that you're facing. This is a great opportunity for that. So, welcome. Our webinar is being funded under the Substance Abuse and Mental Health Services Administration’s Center for the Application of Prevention Technologies, and we are recording and archiving this webinar for future use. So, just wanted to alert everyone that we are recording today. Thanks so much for participating.

Today's objectives: what we hope to accomplish with you today is that we want you to understand the scope of the opioid overdose problem, nationally. We're going to talk a lot about that at the beginning. We're going to, throughout today's webinar, discuss the role of prevention in addressing opioid overdose. We're going to talk about the current evidence for overdose prevention, and we're going to talk about opportunities for collaboration with the treatment sector and other stakeholders. So, we're thrilled that you're with us today, and we're going to dive right in with introductions to the panel.

So, I'm going to ask the panelists just to pop in and say a quick hello. We're joined today by Josh Esrick. Josh, can you say a quick hi?

[Josh Esrick]: Hi, everyone. Yeah, my name is Josh Esrick. I'm a policy analyst with Carnevale Associates. We're a small policy consulting firm that does a variety of different work related to behavioral health. And, for the past couple of years we've been working with the CAPT on a number of different initiatives, including helping develop a number of products related to the non-medical use of prescription drugs and its consequences, such as overdoses. So, looking forward to talking with all of you today.

[Dodi Swope]: Thanks so much, Josh. And, we're also joined by Maria Valenti. Maria, do you want to jump in and say a quick hi?

[Maria Valenti]: Sure, Jodi. Hi, everyone. My name is Maria Valenti, and I am the epidemiologist TA provider for SAMHSA's CAPT, predominantly in the Northeast.

[Dodi Swope]: Thanks so much. And, my name is Dodi Swope, and I am a T/TA specialist with the CAPT as well. We're primarily out of the Northeast, but I know many of you from my work across the country. So we're thrilled that you can join us today.

So, I want to get us going with this image. I don't know if those of you who are listening have ever heard the story of the blind men and the elephant. It's a fable that comes out of the East; India, I think, but don't quote me on that—I don't have the actual reference for where it comes from. But, the story basically tells of men who were blind from birth, brought in front of an elephant and asked to experience a part of the elephant in sequence. And so, each person goes up to the elephant and has a limited experience with it, and from that limited experience with the elephant, they determine what they think the elephant is.

So for example, the first person comes up and feels the elephant's trunk and says, “Hum, okay. An elephant is like a hose. I get that.” The next one comes up and feels the elephant's leg and says, “Hum, feels like a tree trunk. I guess an elephant is like a tree,” and so on and so on this goes with different parts of the elephant. Then, later the five gentlemen are asked
to sit together in a circle and discuss elephants, and as you might imagine there's a lot of misunderstanding and potential conflict, because each person only experienced a limited part of that issue, and their perception was shaped by that limited experience that they had, and none of them had the ability to see the totality of the elephant and fully understand what an elephant is.

This is something I think we've run into in prevention since we started doing prevention work, that substance misuse and substance use disorder is a complex issue, and there are many, many different lenses by which people experience it—some more limited than others. And so it's very important that we sit together and share those lenses that we have, so that we can get to the totality of understanding the problem and work towards impacting it positively. I think what I really want to say on this slide is that this is what we, as prevention, bring to this epidemic. We know how to build collaborations. We've been doing it for a long time. Even though the elephant we've been dealing with is a little different, might have been underage drinking, might have been binge drinking, but we're very good at bringing people together to share perceptions so that we understand the totality of the problem—and we do that through that SPF process that we all use.

And, so I just wanted to start this webinar by saying, you know, we bring a very important skill set to the party. What we need to do now is understand that elephant a little bit better, and that's our purpose for today. So with that I'm going to hand it over to Maria Valenti, who is going to help us look at the scope of the problem and help us start to build some of that common language. Welcome, Maria.

[Maria Valenti]: Thanks, Dodi, and hi everyone. So, part of the shared understanding that Dodi was talking about, kind of understanding the elephant, is, to begin, just to get a grasp of the scope of the problem, and I'm going to talk to you a little bit about that. So let's get down to it.

So first, it's really important to have a concrete definition of opioids and what we're preventing. This slide has the definition listed, and I'm just going to read it off for you: So, opioids are a class of drugs that include the illegal drug heroin, as well as powerful pain relievers that are available legally by prescription, such as oxycodone (OxyContin), hydrocodone (Vicodin), codeine, morphine, fentanyl, and there are others. But, these drugs are chemically related and interact with opioid receptors on nerve cells in the brain and body.

Now let's see. So here are three maps of the United States, and they're color coded by estimated age-adjusted death rate per 100,000 for drug poisoning. And as you can see in the key in the upper right, that purplish color is the lowest rate, and that's 0 through 2, and the colors vary until you get to red at the highest level, which is greater or equal to 20. And as you look across the maps from left to right, there's 2004, 2008, 2014. You can really see changes in the colors, meaning the rates of poisoning mortality are changing. In the 2004 map there's a moderate amount of purple—and I'll just get my pointer, see if I can get my pointer here—and a little amount of red...there are some areas of red. And as you look...
across the years to 2008, that purple gets smaller and smaller, while the red is growing. And, this really indicates that overdose rates are on the rise.

And so let's see here. There's this graph, and it looks at trends over time related to overdose deaths from opioid pain relievers and heroin, and it's from 1999 to 2014. The blue line is the opioids, and the red is the heroin. And as you can see, since—let's see, I'll take my little arrow here—2000, the number of opioid-related overdose deaths has substantially increased over time, and you can follow that arrow. And, it really more than tripled or quadrupled from 2000 to 2014, and it increased by 13.5% in the last 5 years. Now let's take a look at the heroin line over here, the red line, and you can see that it remains fairly stable over the years, 1990 to about maybe 2008-ish, and then from there really escalates. And it's dramatically increased in the last 5 years, by 248%, and that's a pretty drastic leap, there.

Okay, and now let's see this one. And this to me is a really interesting graph, because it shows drug use patterns among patients entering substance abuse treatment programs across the country who are heroin dependent, looking at the kinds of opioids they used when they first started. So when you look at the 1960s, you can see that most people used heroin as their first opioid, and much less used prescriptions as their first opioid, and that stays the case from the '70s, the '80s, the '90s. Well, the distance between the two lines decreased until, really, the 1990s, and that's—I'm circling that here—and there's a change here. So, people entering treatment for heroin dependence begin to report prescriptions as their first introduction to opioids, rather than heroin. And, they were introduced to opioids through prescription drugs, not heroin, in that transition that's happening, and we're still seeing today. And that is my introduction to the scope of the problem, and I'm going to hand it off to our friend, Josh.

[Josh Esrick]: Thanks, Maria. Hi, everyone. So yeah, we're going to first take a couple of minutes now to talk about some of the risk factors for opioid overdoses, because it's important to understand, you know, what's really driving this epidemic before we can start talking about how we can begin to address the epidemic.

Now, something to note as we move forward, throughout this presentation and for this section, is that because, as Maria showed, a lot of the problem of the opioid epidemic, the overdose epidemic, is being driven by prescription opioids, which are a legal substance with valid medical uses that individuals have a legitimate right to access when it's medically appropriate. Because of that, sometimes the issues that we're dealing with when it comes to opioid overdose are a bit different than in other prevention issues, because of that legal status, which will be seen as we begin talking about risk factors.

So, on this slide we have a number of different risk factors that have been identified in the research as being associated with opioid overdoses. As you'll note, we only have risk factors listed here. We don't have any protective factors, and that's because the research surrounding the opioid epidemic and prescription opioids overall is still relatively new, and there hasn't yet been any clearly identified protective factors associated with preventing opioid overdoses.
There are a number of protective factors associated with the non-medical use of prescription drugs, and because of the connection between non-medical use of prescription drugs and opioid overdoses, information on those factors may be interesting and relevant to you, and that information is available on the CAPT website. But, because today we’re focusing specifically on opioid overdoses, which is a similar topic to the nonmedical use of prescription drugs, but not the exact same topic, we'll only be talking about factors specifically found in the research to be associated with overdoses.

I’m going to go a bit in depth on these first two risk factors that we have listed here: history of substance use and misuse and access to prescription drugs, and then we're going to come back to this slide to talk a bit more about the rest of these factors. So, we're going to move right along here.

So, our first big risk factor is that individuals who have a history of substance use or misuse are at a greater risk of experiencing an opioid overdose, and then we have some examples of what that history can look like that have been found in the research. So for instance, individuals who have misused prescription drugs in the past 90 days are at a greater risk of experiencing an overdose, which I think makes sense pretty much on the face of it. Individuals who have misused prescription drugs in the past are at a greater risk to misuse them in the future, and if you're misusing prescription drugs, you're at a risk for overdosing on those prescriptions, particularly the opioids.

Secondly, individuals who misuse particularly potent opioids are at a much greater risk for experiencing an overdose. An example of that is fentanyl. In the past year or so, you've probably actually seen some various anecdotal police reports of diverted fentanyl being seized that's been 50 to 100 times stronger than heroin or morphine, and a lot of times the individuals who are misusing those opioids aren't aware of how much more potent they are than the opioids they might be more familiar with, and therefore don't have the tolerance for them and experience an overdose.

Our third example is a pretty interesting one here, and really, I think, starts to speak to how prescription opioids can be a bit different than other substances, which is that individuals who use prescription opioids and benzodiazepines at the same time are at a greater risk for experiencing an overdose. And, benzodiazepines are an example—well, a category, rather—of prescription drugs that includes sedatives, anticonvulsants and muscle relaxers; and a common benzodiazepine is Xanax.

And notice the wording here. It doesn't say 'misused,' it says 'used.' Individuals who are using prescription opioids and benzodiazepines exactly as prescribed are actually at pretty significant risk for experiencing an overdose, because of the way that prescription opioids

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1 For more information on risk and protective factors related to the non-medical use of prescription drugs, refer to the CAPT’s revised decision-support tool Preventing Prescription Drug Misuse: Understanding Who Is at Risk, available on the CAPT area of SAMHSA’s website: [https://www.samhsa.gov/capt/tools-learning-resources/preventing-prescription-drug-misuse-understanding-who-risk](https://www.samhsa.gov/capt/tools-learning-resources/preventing-prescription-drug-misuse-understanding-who-risk)
and benzodiazepines can sort of interact in an individual's body, and that's why, without jumping too far ahead, strategies for preventing this particular risk factor from taking effect really focus more on prescribers than individuals. You know, encouraging prescribers not to prescribe these substances at the same time, because of that risk that they can cause an overdose.

And then we have—our last three bullets here are all pretty straightforward, so I'll go through them pretty quickly in the interest of time. You know, individuals who have any lifetime heroin use are at a risk to continue to use heroin, and therefore at a pretty significant risk of experiencing a heroin-related overdose. Likewise, individuals who used any sort of injection drugs in the past 90 days, and individuals who have heavy alcohol use are at risk for experiencing any form of opioid overdose.

And so moving right along, the other risk factor that I really wanted to go in depth into a bit is access to prescription drugs, which, again, is a risk factor that really speaks to how this topic can be a bit different than other types of substance use prevention, because individuals have that legitimate access to prescription drugs when it's medically appropriate—when you're dealing with this risk factor, it's going to be important for you to balance individuals maintaining that legitimate access while, you know, preventing the illegitimate access that can be a risk, which we will be talking about on this slide. And again, without jumping too far ahead, when you are beginning to deal with different stakeholders to address this issue, you will find some stakeholders more interested in maintaining that legitimate access than they are interested in blocking illegitimate access, and other stakeholders where the opposite holds true.

So, our first example here of how access to prescription drugs can be a risk factor for overdoses is really just what we already talked about, how individuals who have that access and exposure to prescription opioids and benzodiazepines are at a risk for overdoses because of how they interact with each other. Also, individuals who have a maximum-prescribed daily opioid dosage greater than 100 mg are at a greater risk for an overdose. And actually, what that means is greater than 100 mg of morphine equivalence, because opioids—the strength of opioids is judged on a scale of morphine, on how powerful they are related to morphine, and research has found that individuals who are prescribed an amount greater than 100 mg per day are at a significantly greater risk for experiencing overdose. That's why best-prescribing practices generally say that individuals shouldn't get a greater prescribed amount than that, but of course there will always be legitimate exceptions to that. And so again, if it's a risk factor you're interested in dealing with by working with prescribers, you need to still balance that legitimate access, where individuals should be getting that greater daily amount, versus, you know, when it's becoming too great a risk.

Also, individuals with any sort of prescription for opioids are at a risk for experiencing overdose. That bullet says 'tranquilizers,' because that particular study was focused more broadly on the topic of prescription drug overdoses, and tranquilizer overdoses are also something that individuals can experience, but, you know, today obviously we're focused on opioid overdoses.
And then our last two bullets are pretty connected to each other: Individuals who have filled prescriptions for two or more types of controlled substances and individuals who have four or more filled prescriptions of any type are both at a greater risk for experiencing an overdose, both because there is that greater potential for them to be in-taking more than 100mg per day of opioids, but also because both of these risk factors are potential warning signs that an individual is engaged in doctor shopping, which we'll be talking about at a moment, and doctor shopping is also a risk factor for experiencing an overdose. In fact, moving right along, doctor shopping is what we're going to talk about right now.

In case you're not familiar with the term, doctor shopping is when individuals sort of attempt to obtain illegitimate access to prescription drugs by going to multiple different providers without communicating that fact to obtain prescriptions, generally prescription opioids that they can misuse, and related to that is pharmacy hopping, where individuals either try to fill the same prescription at multiple different pharmacies, or multiple prescriptions at different pharmacies to, again, avoid any sort of tracking or monitoring strategy. And individuals who engage in that behavior, you know, because they're doing so to misuse prescription opioids, are at a greater risk to then experience an overdose.

Likewise, individuals who have witnessed a family member overdose are at greater risk for experiencing overdose themselves, not so much because the act of witnessing the overdose is a risk factor, but because if an individual does witness a family member overdose, it likely means there are a number of other environmental and potential behavioral factors at play in their life that are causing them to be at risk.

Also, individuals who have been incarcerated or had a change in their tolerance related to incarceration are at a greater risk for experiencing overdose. You know, if an individual was misusing opioids but has been incarcerated for a period of time and didn't have access to the opioids while they're incarcerated, their tolerance to opioids will go down. And if they're not aware of that and then they get released from incarceration and begin taking opioids again at the same rate that they had been prior to incarceration, they might not have the tolerance to do so anymore and then experience an overdose.

Individuals who have been admitted to a psychiatric hospital are also at greater risk for an overdose, which, you know, speaks to how substance use disorders are often co-occurring with mental health disorders and, oftentimes, with substance misuse that causes individuals to be at risk for experiencing overdose.

Individuals who have experienced homelessness in the past 90 days are vulnerable to experiencing an overdose, and, of course, individuals who have experienced a nonfatal overdose are at a very high risk for experiencing another overdose, because all of the factors are already in place for that to happen to them. So that really just talks a bit about, you know, what's been driving this problem of the opioid epidemic. We will move on to strategies to address that epidemic, but before we get to that, I'm going to turn things over to Dodi.
[Dodi Swope]: Thank you so much, Josh. That was wonderful, and I really appreciate the depth that you went into on those risk factors. I want to ask participants on the webinar now to join us in this discussion box underneath the slide, and we want to ask you to really think about what Josh just presented, and what resonated as seeming similar or different to risk factors that you've addressed as a prevention person in the past. I think it's a little intense when you see the risk factors all in one slide, as Josh just showed us. Oftentimes they seem very different, but I challenge us to think about where are the places that the work we've done in prevention prior to addressing opioid overdose, where are the similarities? Where are the risk factors similar?

The one that comes up for me, as I'm waiting for people to type into the discussion box, is the whole issue of access. It's something that we've worked on forever in terms of prevention in general, is that access is a risk factor. The ways that folks get access to prescription drugs and other opioids may be different, but oftentimes the simple issue of access is a similar factor.

So, Brandon is saying, “In Missouri we’re working on addressing access from doctor shopping and pharmacy hopping by joining the rest of the country in implementing a PDMP.” PDMP, just in case anybody out there doesn't know—I know we speak in alphabet soup in public health—that's prescription drug monitoring program. Some people call them PMPs, or prescription monitoring programs, but that’s what Brandon's talking about. That's great to hear that that work is moving forward in Missouri, Brandon.

Ellen says, “In Kentucky we've been working on prescription drugs for quite a while.” Yes, we know, Ellen, you were one of those red areas from the very beginning. The risk factors are very familiar to you. And so, Ellen, we invite you to participate as we go into really sharing strategies and dealing with challenges to participate in that conversation for the newer folks, because I think we really have to learn from each other as we embrace this work.

Thomas says, “We’re noticing a rise in opioid use with our homeless populations,” and that is one of those risk factors that Josh just spoke to, and it's a population that's challenging to reach, and so it's a very important one for us to keep our sights on.

Kelly says, “In Wyoming, prescription lock boxes and working with doctors on prescribing.” I'm guessing that those are ways that you are thinking about reducing access, Kelly, and that's great. We're going to talk a lot more about strategies in the next section with Josh.

Iris contributes that, “Family use and attitude toward drug use,” yes, “have long been a focus of prevention.” That's a great point, Iris. And I think those are the kinds of places where we can bridge our experiences with underage drinking, with binge drinking, with other kinds of substance misuse and substance use disorders. This is a new elephant, but it's not an entirely new field, and it's important to think about that.

Kathy, yes, absolutely, “Past use is also a predictor. Addiction is a disease.” It doesn't go away by itself, and so that past use is an important indicator and risk factor, absolutely. And,
Kimmy says, “Doctor shopping with benzos from one doctor and with an opioid from another seems to be prevalent.” That's important, and, as we say, that's a very frightening risk factor, because oftentimes people don't understand the dangerous-ness of simply using those drugs, even as directed, together, as Josh just pointed out.

I wanted to invite folks out there, too. If there was anything that wasn't clear, or that you had a question about, or that you wanted to push a little further on with Josh around the risk and protective factors, now would be the time to ask that question or make that comment, before we move on to the next section of the webinar. So I'm just going to give folks a minute if there's a question that's brewing out there, we'd love to hear it now.

We can—we'll be taking pauses throughout today's webinar to check in with you and see if there are any questions out there in the room, but we really appreciate those who have joined in the discussion. And, I think it's important to say that there are places where there's a lot of similarities in our prevention work. Thinking about access, thinking about family use and family attitudes and perceptions, as well as past use, are all things that we are familiar with from our other prevention efforts.

So I see someone is typing out there, and I don't want to rush them. So take your time, and we'll see if there's a comment or a question we want to address before we move on. Yes, Bonnie, we will make sure that the presentation is available on your CAPT Connect account after the webinar has been recorded, and we'll make sure that you have it available, so no worries. Wonderful! All right, so with that I am going to hand—-we do have a pod, Bonnie that we can add in a little bit. Maybe we'll add it during the next poll, where you can download the slides right from today's webinar, so that you can get them right away, if you'd like. Okay, I'm going to hand it back to Josh who's going to take us through some of the strategies, what the evidence says about how to prevent opioid overdose.

**[Josh Esrick]:** Thanks, Dodi. Hi again, everyone. So yeah, we're now going to begin talking about some of the strategies for preventing opioid overdoses and what the evidence says about those strategies. Now before we get started on this, it's important to note, again, as I mentioned when we were talking about the risk factors, that the evidence base on various issues surrounding opioid overdoses is still relatively new and still being developed. And, there is still a fairly limited number of strategies where evidence of effectiveness for preventing overdoses has already been found, and it's known that this strategy can be effective.

There are a number of other strategies that we aren't talking about today that have been found effective for preventing the non-medical use of prescription drugs, and again, because of the close relationship between non-medical use of prescription drugs and opioid overdoses, you might be interested in learning more information about those strategies, and information on those strategies is available on the CAPT website. And, it is possible that in the future there will be found evidence of effectiveness that those strategies, or that other prevention strategies from, you know, other fields will be found effective for preventing...
overdoses. But today we’re only going to be talking about those strategies where that evidence of effectiveness has already been found.

So, actually, before we get started though, I just want to note another potential resource that you might find interesting, which is SAMHSA’s Opioid Overdose Prevention Toolkit, which is available on SAMHSA’s website at that link. You'll note it says 'store', but the toolkit is completely free to any individual who wants to access it, and the toolkit has a variety of information that you might find interesting on it. It provides information to equip healthcare providers, communities and local governments with materials to develop practices and policies to help prevent opioid-related overdoses and deaths. It provides information on some other strategies that might be related to opioid overdoses; potential guidelines to follow when implementing strategies; important facts about the opioid epidemic that you might find interesting, either for yourselves or to share with other potential stakeholders; advice for preventionists as they're moving forward with addressing opioids. It addresses a variety of different issues, and including those for healthcare providers, first responders, treatment providers and those recovering from opioid overdoses. And it has a pretty wide audience that it can support: law enforcement, family advocates, individuals in recovery, professional care providers and prevention specialists, community coalitions and other stakeholders interested in addressing this topic.

So, today we’re going to be talking about strategies for addressing opioid overdoses that have been sort of divided into four different categories here: education, tracking and monitoring, supply reduction and harm reduction. And as we move forward with this discussion, you will note that there’s a fair amount of overlap between these categories. You know, an education strategy can include providing information on a strategy from one of the other categories, or a supply-reduction strategy could include tracking-and-monitoring elements. This categorization is really just to try to make it easier for the purposes of this discussion, not really to, you know, point out any important differences between the different strategies.

Also note what we don’t have up on that screen. We don't have treatment strategies. There are a number of treatment strategies that can be effective at helping to prevent opioid overdoses and overdose deaths, such as medication-assisted treatment and, you know, obviously prevention and treatment are on the same continuum, and therefore, you know, it's important to collaborate with treatment providers when the opportunities arise to help address this issue. However, specifically talking about treatment strategies would be outside the scope of this webinar. We’re really just focusing on prevention strategies today, but do bear in mind the important role that treatment can play in preventing overdoses.

So, our first category here is education strategies. And, education strategies are strategies to raise awareness and understanding of overdoses, and the steps that the audience

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2 For more information and to download SAMHSA's Opioid Overdose Prevention Toolkit, visit https://www.samhsa.gov/capt/tools-learning-resources/opioid-overdose-prevention-toolkit
engaging with the strategy can take to help address overdoses. An educational strategy can take a lot of different forms. It can target a lot of different potential individuals. Prescribers, which could mean physicians, but it could also mean any individuals that can prescribe opioids, including dentists, physician assistants, depending on the state, even veterinarians. You know, they all have access to prescribing opioids and could potentially be a source of opioids that get misused by individuals and therefore, you know, can cause overdose deaths, and therefore can be a potential target for an educational strategy to prevent that.

An educational strategy can also target pharmacists or patients, first responders, the community as a whole, or specific groups within the community such as individuals at risk for experiencing an overdose, or individuals likely to encounter another individual who is experiencing an overdose. And, educational strategies can include a lot of different information, depending on what the needs of your community are, including: the dangers of overdoses, how to recognize an overdose that's in progress, how to recognize an individual who is at risk for an overdose, how to respond to an overdose that's in progress, relevant laws related to responding to an overdose, information on other strategies to prevent overdoses.

So, a lot of different forms that it can take, and we have a few examples here on the screen. Prescriber education is one of the most important examples of an educational strategy because of that role that prescribers can so often take in providing access to prescription drugs and prescription opioids, specifically. So, prescriber education will generally cover a number of different topics, including the benefits and risks of prescribing opioids, strategies to prevent individuals’ abuse of opioids while maintaining legitimate access for individuals. It could include information on best prescribing practices developed by national or state agencies, and how to recognize individuals who are at risk for experiencing overdose. It can also include how to talk with their patients about overdoses, and potentially referring individuals to substance use treatment, if it seems that that would be appropriate, and that could be a potential avenue to explore for collaborating with treatment. And also it could include information on other strategies that are relevant to prescribers, such as a PDMP.

Now, prescribers get education on opioids, prescription drugs, just general medical information from a number of different sources, including continuing medical education, pharmaceutical companies, universities, state agencies and so forth. And if you're interested in implementing prescriber education, you could seek out one of these sources and try to work with them to make sure there's information on opioid overdoses in another educational course they're already developing. You could also potentially develop educational materials yourself, which you might, you know, deliver one-on-one to prescribers or, you know, try to hold events and inviting prescribers in your area to attend and things of that nature.

There have been a few different prescriber education initiatives that have been evaluated. The State of Utah implemented a form of prescriber education that they called ‘Provider Detailing.’ It was found that that prescriber education, when combined with a social marketing campaign, reduced opioid overdose rates by 14% in that state. Also, the State of Washington implemented some opioid prescriber education, specifically for physicians who
were treating individuals on worker's disability compensation, and it was found that that
prescriber education reduced the overdose rate among that specific population by 50%, 50,
5-0, so that was certainly a very successful implementation of a strategy. So, it can be
effective.

Our next example of a strategy is patient education, which is generally something that
patients receive directly from their prescribers and includes information on how to safely use
their opioids and, you know, the risks of an overdose and the dangers of that. And also
information on how to safeguard their opioids so that other individuals don't—potentially that
children don't misuse them and then experience an overdose themselves and things of that
nature. And generally, because it comes from their prescribers, if they're interested in
providing patient education, it would usually be a preventionist would usually be involved,
you know, by working through the prescriber, rather than directly interacting with patients;
but you could also potentially develop a social marketing campaign, you know, that targets
providing this kind of information to people.

An educational strategy can also target first responders. This is actually a topic I'm going to
come back to in a moment, so I'm not going to go too in depth now, but basically that's
training on how to respond to an overdose that's already in progress and, you know,
preventing it from becoming fatal, and the various facets of what that can involve.

And then, we also have social marketing campaigns, which I think everyone should be
pretty familiar with. You know, it's the traditional multimedia prevention campaign that, you
know, can be focus tested, developed, you know, specific message, specific audience, and
can be—you know, I think we're all familiar with social marketing campaigns from other
forms of prevention. So, I'm not going to go in depth on that. And then, finally, like I already
noted, educational strategies can target specific groups in the community or be community-
wide.

So, coming to that issue of first responders. This is kind of a complicated thing, because
there are actually two different kinds of first responders. And so, the main takeaway that you
should get from this slide and the next slide is both the information that I'm going to say, but
also that this is a specific example of the importance of using clear and common language,
and making sure that you're on the same page as, you know, the other stakeholders you
might be talking with, so that when you say 'first responder', you know, you make sure that
you're clear, and you know that whoever you're talking with is also thinking of first
responders in the same way that you are.

Because first—when you say 'first responder,' it can mean professional first responders,
which could be emergency medical personnel, but also police or firefighters. You know, the
individuals who respond to an overdose scene upon someone contacting 911 or another
emergency service hot line, and what professional first responders can do varies by the
state. You know, in some states any of these individuals could administer naloxone, and
naloxone is something that we'll be talking about in more depth later in this presentation, but
I'll just say for now, naloxone is a specific type of medication that can reverse overdoses.
But, in other states only medical personnel can administer naloxone, and police and firefighters can't. And therefore, if you are working with police and firefighters, and how to respond to an overdose in a state where they're not allowed to administer naloxone, what that education would look like would be different than in a state where they could administer naloxone. And in all cases, you know, it would -- you really just—I mean, you know, working with first responders, making sure they understand, you know, what is an overdose, and, if it's occurring, how they should be responding to it. And, you know, a lot of states, state agencies are involved in this topic already, but there is—there can certainly be—a role for prevention if, you know, depending on what the needs of the community are.

But then we have our other type of first responder, laypersons. Because, when you say the word ‘first responder,’ you could literally mean the first individual to respond to an overdose, and that is generally going to be a layperson, and therefore you can provide educational strategies to laypersons on how to recognize an overdose is occurring and how to respond to an overdose. Now again, in some states laypersons are allowed to administer naloxone, which we'll be talking about in a bit more—in the future of this presentation, and SAMHSA and other federal agencies explicitly support training and equipping layperson first responders to administer naloxone, and in states that allow laypersons to administer naloxone, state agencies do so as well.

Now, it's important to note PDO grant funds should not be used to support naloxone administration. However, because of how closely related naloxone administration is to preventing overdoses, you know, it's important to be aware of this information. You might be engaged with naloxone administration through other funding sources, or you might be involved with other stakeholders that are involved with naloxone administration, and therefore it's important to know about this stuff.

And there is information also to provide individuals beyond just naloxone. For instance, it's important that individuals know that they should be contacting emergency medical services, and if they are in a state that has some form of Good Samaritan law, which we'll also be talking about more later in this presentation, that they should be aware of that fact and not be afraid to contact emergency medical services if they're with someone who experiences an overdose. So, that sort of summarizes how, the first responder issue there.

Our next category of strategy is tracking and monitoring strategies. Now, this could mean a few different things. We're just specifically going to be talking about PDMP-related tracking and monitoring, but, you know, prescribers could be doing their own form of tracking and monitoring that would sort of fall under best-prescribing practices, just requiring their patients to have a face-to-face follow-up before getting a refill of a Schedule II controlled substance or something of that nature. So again, we see that overlap potentially between education and other strategies. But, so we're just going to be talking about PDMPs right now.

Now, it's important to note that there are 49 states and The District of Columbia that have PDMPs, and all 50 of those PDMPs are all different from each other, so it's hard to, you
know, give any blanket statements. But in general, if a state is interested in improving their PDMP—and before going on, it's actually important to note that both of these strategies, expanding and improving PDMPs and the mandatory use of PDMPs, are state-level strategies, rather than strategies that, you know, a community prevention organization would be directly implementing. However, as we move forward, we will see there is a role that community preventionists can play in supporting the strategy.

So with that aside, one of the common best practices for expanding and improving a PDMP is to implement some sort of proactive reporting system. So, rather than the PDMP just collecting data and having it sit there until someone who has access to it goes and takes a look, having the PDMP develop reports to potentially law enforcement agencies or regulatory agencies, or even developing some form of prescriber report card, which I know some states are doing, where they send out to each prescriber information on their prescribing habits and how they compare to other prescribers in their medical specialty. And so all these different proactive reporting strategies, ways of making sure the information is useful as quickly as possible to try to prevent doctor shopping and pharmacy hopping, they're also preventing pill mill behavior, where prescribers are acting unethically to issue large quantities of prescription opioids.

And then our other strategy here is mandatory use of PDMPs. I believe there are only 13 states that actually mandate that their prescribers and pharmacists check their PDMPs prior to issuing and dispensing their prescriptions, and the other—in all states, you know, prescribers and pharmacists input information, but in general they're not required to check information. And even in the states that do mandate that prescribers and pharmacists check their PDMP, there's usually all sorts of exemptions. So if a prevention organization wanted to support the use of the PDMP, it would really be about, you know, educating prescribers and pharmacists on the importance of using the PDMP and potentially figuring out criteria for when they should be using it versus when, maybe, it's not as necessary and things of that nature.

And then with expanding and improving PDMPs, prevention organizations can really work with prescribers to, you know, maybe understand what the prescriber report card is really saying, and then working with prescribers to maybe implement best practices to lower their prescribing rates if it seems that they're way out of line with their colleagues and things of that nature. So a few different types of opportunities there.

A third category is supply-reduction strategies, which generally means either statutory and regulatory sales limitation policies on prescription opioids, and then law enforcement actions against diverted prescription opioids, and against heroin. Now it's important to note SAMHSA grant funds may not be used to advocate for specific policies, but it is important to know what policies are in place in a state so that you can provide education about what those policies are, and potentially support law enforcement in their implementation—rather, in enforcement of the various statutes.
For instance, I was giving a presentation similar to this one a few months ago, and one of the participants, a county-level participant on that call, shared that in their county they had developed a very close relationship with law enforcement through—well, actually through implementing take-back programs, and also through helping implement a tip-and-reward program, so that individuals could report pharmaceutical-related cons, and also there were some former law enforcement officers that were part of their prevention coalition. And as a result of all this work that they've done to develop this close relationship, the prevention organization started sending clinicians on ride-alongs with the police officers when they were going into areas with vulnerable populations. That was specifically for non-medical use of prescription drugs, as well as for individuals who were vulnerable to that misuse. But, it's just an example of how there really are ways of getting close with law enforcement and collaborating with them and supporting their efforts and then taking advantage of the opportunities that they offer to, you know, maybe reach out to populations that you otherwise might have difficulty reaching.

And then as far as statutory and regulatory sales limitations policies go, an important role that preventionists can play in that, is that a lot of times these kinds of policies can have pretty large exemptions that might not be totally clear to prescribers or pharmacists what they mean. For instance, a state might have a policy that requires individuals to have a face-to-face checkup before receiving a refill of a Schedule II prescription opioid; however, the statute also says that in cases of emergencies, individuals can receive an automatic refill for up to 7 days, but then the statute doesn't, you know, define what an emergency is and leaves that up to the pharmacist to determine if this is an emergency and I should just give them a 7-day supply. Preventionists could work with prescribers and pharmacists to try to, you know, figure out what that means and when it seems like it's a legitimate emergency versus someone trying to just obtain opioids that they might misuse and things of that nature. So again, there really can be a role for prevention organizations. If they're proactive, they can really get involved in these kinds of supply-reduction strategies.

Finally, we come to harm-reduction strategies. And, harm reduction generally means preventing an overdose from becoming a fatal overdose. And that generally means these strategies revolve around expanding access to naloxone, which, again, as we noted, PDO grant funds should not be used for naloxone administration, and also grant funds should not be used to advocate for specific policies, in case you're in a state that kind of restricts naloxone access. But, it's important to just be aware of this information that surrounds these topics. We will be going more in depth, actually, on naloxone a bit later in this presentation, but for now it's just important to note that, as I said, naloxone is an opioid antagonist, which means it bonds with the opioid receptors in individuals' nervous systems, and it blocks opioids from having an effect and sort of renders them inert, because they can't reach the receptors. It's pretty fast acting, too. It generally takes effect within 5 to 10 minutes.

And when a state does allow laypersons to have access to naloxone, it often is in the form of overdose education and naloxone distribution programs, whereby laypersons receive a variety of information about overdoses and how to administer naloxone and a supply of
naloxone. And, those are potentially—you might find that there is a OEND program in your community, and you could potentially collaborate with them, you know, even though your funds can't directly support naloxone administration, because this naloxone administration is ongoing in the community, it might provide a collaboration opportunity.

But, it's also important to note that states might allow laypersons to obtain naloxone just through a standing order whereby pharmacists can just dispense it basically at their discretion, when they feel it's appropriate. Or, a state could allow third-party prescription, whereby prescribers may issue naloxone to individuals who don't, themselves, need it, but might encounter individuals who are vulnerable to an overdose. And then there's the whole topic of states providing naloxone to various professional first responders, which we'll be talking about a bit more in a moment.

One last note is on the topic of Good Samaritan laws, which again actually comes back to that point about using clear language and making sure everyone knows what you're talking about when you're talking about a topic. Because, when we say 'Good Samaritan laws', we can actually mean one of two different things. There's one type of Good Samaritan law which means providing [protection from], you know, criminal and civil liability against individuals, or rather for individuals, so that if a professional administers naloxone and something goes wrong, they don't receive a wrongful death suit because they had Good Samaritan protections, things of that nature.

But, a Good Samaritan law can also mean protecting an individual against drug-related crimes related to an overdose if they report that overdose to emergency medical services. You know, the goal there being to prevent situations where if two friends are in an apartment, one overdoses and the other doesn't contact 911 because there's drug-related paraphernalia in the apartment. So there are good Samaritan laws to protect against that, and states determine which kinds of good Samaritan laws they want to implement, and every state has different laws.

They might only have the liability protection laws and not the reporting overdoses laws or vice versa. And if they have good Samaritan laws protecting against liability, there might be different kinds of liability or for only certain types of professionals. It really depends on what's going on in the state. So it's kind of a potentially confusing topic, and it's just important to know what is going on in your specific state. And so now I'm actually going to turn things back over to Dodi for a bit, and then I will be back to go a bit more in depth on naloxone.

[Dodi Swope]: Thanks so much, Josh. Wow, that was a lot of information. Now you understand why we make sure that we record these webinars, because there was a rich wealth of information that was in what Josh said and not necessarily on the screen. Josh, just to put a bug in your ear as we're doing this next poll, one of the comments in the chat box was an interesting example about how prescriber education programs have been coordinated with social marketing campaigns to increase their outcomes. So, I'm just giving you that for a minute to think about, if that's something you might have an example of. I'm
also inviting anyone out there in the webinar world today, who might have combined those two strategies and found that to be a successful piece of work, we'd love to hear an example of that if you have one.

So, we also are interested in having you share with us, out of the strategies that Josh just outlined—of which there are many, and they're complicated, each single one of them—which were the most familiar? Are there any there that you feel like oh, yeah, I know exactly how I would go about doing that in my community, because I've done something similar? Or, what are the ones that feel potentially very new and maybe pretty challenging, pretty much a stretch for you as a preventionist in your local community?

And I think we probably have folks across the entire continuum on that question that there are some folks who are very familiar with what Josh was just describing, and then there are those who are like, wow, this feels like a real stretch for me. These are not the typical partners I've worked with before. We'd like you to share about that in the discussion pod, and also, if you've had any experience with prescriber education and social marketing campaigns that have been combined, we'd love to hear about that as well.

So, I see there are people typing into the discussion pod, and we welcome your discussion now. Just to say again, the other piece that we've talked about in the chat is that the slides—we'll bring that pod back up at the end of the slide show so you'll be able to download those slides right after this webinar. We'd love to give you time to kind of think this part through. What are the strategies that are most familiar, and where does it feel new and potentially challenging? I know for myself, in some of my work over the past decade in the State of Massachusetts where I live, I think for me it was very familiar to work with law enforcement, but the ways in which I worked with law enforcement were very, very different, depending on the issue I was working on. And so, I sometimes could use the same relationships, but other times I needed to leverage the relationships that I had to get an introduction to another part of the law enforcement system that might be more relevant to this topic of opioid overdose prevention.

So we welcome you to share that in the chat box. People are very quiet out there in webinar world. We have time for you to chime in here. What strategies are most familiar, and what feels new and potentially challenging? Great, Brandon. Thanks so much. We appreciate your participation. Brandon says, “We're attempting a fairly holistic approach. We provide education to the general public, training for social workers and other groups, and coordinating with law enforcement.” So, real specific strategies to different segments of the population, but in a coordinated way. That's terrific. “Recently we've been giving OEND—” that one does not roll off my tongue, so I apologize. “...trainings to professional first responders.” So, really working sector by sector in terms of thinking about which strategies come together for that holistic approach at the community level.

And, Brandon, I just have to underline that idea that that's the way—that's what we bring. Again, as preventionists, we bring that holistic approach. I have a very dear friend I've worked with for years, and every time he sees me, he shakes my hand, and he says, “Oh,
Dodi, multiple strategies and multiple domains,” and I think I taught him that 15 years ago, but he just has that branded on my forehead. And now we're talking about that same approach, but in, sort of, a little bit different sectors, potentially making different relationships. You're also working with implementing PDMP, as you mentioned earlier, in Missouri, right? And the Good Samaritan strategies as well. It sounds like there's a lot going on in Missouri. That's terrific, Brandon. Thanks so much for sharing that.

I see some other folks are chiming in. Please do feel free. You know, the reality is for some folks in some parts of the country this is very new work, and there's nothing wrong with that. And so if this is new to you, please do. This is a learning community to share what's new and, you know, the challenges of getting something started. That can be a very hard time to sort of bring this up in a community and really get people to start talking about it. You don't want to wait until the crisis is that deep red that Maria pointed to in the map. You want to get started on this as early as you can, even though it's sometimes hard to get it going.

Brandon would like to hear other people's thoughts on how to get prescribers to engage. That's a huge challenge, Brandon. I appreciate that, because they're very busy, generally, and they don't operate on our schedule. We're going to talk about that in a little bit. “It can be difficult to get them as an audience if you don't have an MD after your name." Absolutely. There's a—it reminds me of the old days, and I've been around prevention for a long time. But, when we used to go into schools and colleges, and we'd say, “Okay, we're entering somebody else's fiefdom here. We need to really understand what's the hierarchy, who do we talk to, where's the gatekeeper?” That's very true in healthcare environments as well. And, there is a tremendous emphasis on what those medical degrees are. And so, we're going to talk about that a little bit later, I think, as well, Brandon and hopefully address that.

Rick has said that he has data from the PDMP. That's great. “…that shows what appears to be large numbers of prescriptions in small communities. How do we know if this is over prescribing?” So, Josh, I'm going to ask you to stew on that one a little bit, and that's—Rick, can you tell us what part of the country you're in? You don't have to tell us what state, but if you could tell us sort of where you are, it might help us answer that. Oh, you're in Wyoming, too? Great. Thanks so much, Rick.

And, Mark from Wyoming says, “It's new for Wyoming, accessibility to naloxone as of June, this year. Wyoming is one of the only three states that have not passed legislation to increase access to naloxone. However, there will be a bill introduced in the new year regarding this. Do you have any suggestions for effective ways to educate legislators on this topic?” So there's another question for us to be stewing on.

“In Tennessee, local-level coalitions spearhead medical forums, and they've been very successful in training prescribers on guidelines.” That's a great strategy, Susan, or Sarah. I'm sorry, Sarah in Tennessee. Thanks so much. “Medical forums?” Allen, I think, wants to hear a little bit more about that, Sarah, if you could type more in the chat box.
We’re really starting to get a conversation going here. This is terrific. I think, if I were to take a quick answer on the suggestions for effective ways to educate legislators on the topic, I think if you look back in this webinar, there’s some great information that you could help provide people, just information about what works. Not necessarily advocating for policy, because as Josh has underlined over and over again, that’s not what our SAMHSA dollars can be used for, but educating people about what works, that is something preventionists can do.

Michelle asks, “Are people driving in from remote locations to this county as a hub for medical servicers, Rick?” That's a great perspective from the West, Michelle. Thank you. So it could be that there’s easier access in some of those small communities and people are traveling to them. Okay, I am going to move us along. So, I’m going to hand it back to Josh at this point. Sorry, we just started to get into a wonderful conversation there. We’ll come back to it in just a few slides.

[Josh Esrick]: Thanks, Dodi. Yeah, so now I’m going to talk about naloxone. And actually, before I do that, I want to—a question came up about prescriber education potentially interacting with social marketing, so I just want to really briefly do an aside on that. The example that I was talking about was from the State of Utah. They implemented a—and it was done by the state itself, so they potentially had more resources than, you know, a prevention organization might—but they implemented sort of a multi-pronged approach addressing prescription opioid use, as that study found, had an effect on overdoses as well.

So they implemented a form of prescriber education they called Provider Detailing, which was a series of events they held at the county level where they invited all the different physicians—actually the folks, not physicians—in the county to come to the event, and they provided information on the dangers of non-medical use of prescription drugs, and they provided county-level statistics on misuse rates and overdose rates and things of that nature. And they—I think there was a one-month follow-up where they tried to get more information on that. I'm actually not positive on that, but that was the provider detailing part, and at the same time the state also implemented a social marketing campaign they called Use Only as Directed, which I believe that is still ongoing, while the provider detailing was only a short-term thing. Use Only as Directed was a multimedia social marketing campaign. It has a Facebook site. There's still a site online for it where they, you know, sort of provided information that sort of reinforced the prescriber education, but the Use Only as Directed was focused on the community as a whole. I don't know all the details on exactly how the two were coordinated, but I do know that they were implemented at the same time, and, you know, were complementary to each other, and the research found that to be the case. So that helps provide just a little information on that topic.

So, naloxone. We've talked about it a bit, and I want to just talk about it a bit more, because, again, it's important to know information about this topic, even if the grant funds specifically from PDO can't support administering naloxone. We're going to start with just some basic terms, just to clear up any confusion that individuals might have. First of all, naloxone is a
generic term, and naloxone is a medication that can—it's an opioid antagonist, and it can reverse overdoses, as I mentioned, by binding with opioid receptors. Naloxone can come in a lot of different forms, but the only two forms that it can come in where it can reverse overdoses are if it's an injection or if it's a nasal spray.

Naloxone that's in tablet form or in the patch form or any other form cannot reverse an overdose, because it's too slow acting. Only the nasal spray or an injection is fast-acting enough, and it generally takes effect within 5 to 10 minutes, and it is generally recommended that if someone administers naloxone and doesn't see any effect within 5 to 10 minutes, just administer another dose of naloxone, because it's not possible to overdose on naloxone.

Now, Narcan is a brand name for naloxone. Narcan can come as an injection, but it most commonly comes as a nasal spray, because Narcan is the only FDA-approved nasal spray for naloxone. And any nasal spray you see—or you might have seen some, because Narcan has only been recently approved, past couple of years. Any nasal spray that you see that is not branded as Narcan is the result of someone converting injection naloxone into a nasal spray, which was an off-brand use of that naloxone, and it was not FDA-approved to do so, and therefore if you—that is something you should be aware of, especially if you do have funding from another source to support naloxone administration, that any nasal spray naloxone you see that is not branded Narcan has not been approved by the FDA.

Also, there is another brand name known as Evzio, and they create an auto-injector to administer naloxone, which is much simpler to train individuals with than a regular injector. The downside is it is significantly more expensive than an injector. Although, Evzio has been known to donate supplies of their auto-injector to communities at times.

Suboxone is a brand name for a medication that combines buprenorphine and naloxone; however, it cannot be used to reverse overdoses. It is generally a tablet, and because it combines buprenorphine and naloxone, it doesn't have a sufficient dosage of naloxone. And, Suboxone is generally used for the treatment of opioid use disorders.

Also, naloxone is not the same thing as naltrexone, despite sounding the same and actually being pretty chemically similar. Naltrexone is also an opioid antagonist; however, it is significantly longer and slower acting than naloxone, and it's used for relapse prevention in opioid use disorders, and used for alcohol use disorder treatment. So, naltrexone and Suboxone are not the same as naloxone, although they are—they sound the same, and they're often talked about at the same time, because they have other uses that relate to dealing with opioids, but not specifically for preventing overdoses.

Also, I think I've tried to emphasize this in a few places, that the role of the state is paramount when it comes to naloxone distribution, because it would be state laws and policies that determine how and who can distribute naloxone, and who can receive naloxone. And so, preventionists that are interested in expanding access to naloxone are
really going to be governed by what is allowed by their state. You know, whether they can expand access to naloxone to laypersons, or whether they can only do so to professionals. And if it's only to professionals, maybe to only certain kinds of professionals. And, maybe there are certain educational requirements that have to be met prior to administering naloxone. These are all topics that preventionists need to be aware of if this is a topic that they're interested in getting involved with.

State laws and policies also can potentially dictate how many naloxone doses individuals can have a supply of at one time, and how large those naloxone doses are. And that's important because, as I mentioned, there are cases where individuals might not see any effect after administering naloxone and therefore need to administer a second dose of it. This can particularly be an issue for individuals who have overdosed on very potent opioids such as fentanyl. There have been quite a few reported cases where one dose of naloxone is not sufficient to reverse that overdose, because it just couldn't get between the opioid and the opioid receptor, and therefore additional dosages were necessary.

Also, it can potentially be the case that because of how long, or rather how short, the time naloxone is active in an individual's body, it could be that the effect of naloxone wears off before the effect of the opioid that caused the overdose wears off, and therefore individuals could overdose, receive naloxone, have the overdose reversed, have the naloxone wash out of their system and start overdosing again. And, that is why it can be important to ensure that individuals are referred immediately to treatment services where they can be monitored to make sure that that doesn't take effect. That is not a particularly common issue, but it is potentially one. So, just something to keep in mind.

Finally, I just want to note something about the growth of naloxone access laws, which I think really, really enforces the point that Maria was making at the start of this presentation about how recent a phenomenon all this is. Back in 2001, there was only one state, New Mexico, that had any form of a naloxone access law, which—and when we say 'naloxone access law', we could mean a law that expands access to laypersons, or as professionals, or any law that expands naloxone beyond just medical personnel. In 2001, New Mexico was the only state. In 2005, it was only New Mexico and Connecticut, and in 2010, which was not that long ago, there were only 6 states that had naloxone access laws. And then, all of a sudden, by 2015 it was 37 states, and now, this year, it is well over 40 states. It's really become a particularly relevant topic recently, and a lot of states have seen expanding access to naloxone as a way to help address opioid overdoses.

So that about does it for me. I'll be in the chat for the rest of this time in case you have any more questions. And, I am going to turn things over to Dodi.

[Dodi Swope]: Thank you so much, Josh. Josh is probably like, whew, that was a lot of talking. We appreciate all the depth of your expertise, Josh. It's just terrific. And one of the things I want to say to the group out there is we have access to Josh as one of our core experts. And so if you have follow-up questions or things that you'd like to ask, go to your resource team and ask them, and we'll see that we can connect you up. Josh is really a
wealth of information on this topic, and we're so appreciative of all of his work. Thanks so much.

So, we wanted to ask you to share and to continue the great conversation that's been going on in this discussion pod. And, we wanted to ask you, as you develop naloxone distribution and education plans as part of your PDO grant requirements, what are you starting to see as early successes, or what are some of the biggest implementation challenges, either that you're currently facing or that you anticipate facing? I imagine, just looking at some of the comments that we've had to date, it's really about bringing along some of the communities where this hasn't been as big an issue and trying to share the lessons learned from other states that have maybe been at it a little while longer. That's why we have these national webinars. So we'd love to hear from you. Additionally, any final questions for Josh, we can get him back on the line if we need to. So, please feel free to type any questions like that in the chat box as well.

The next section of the webinar, just so that you know, is going to be exploring collaborations and how we can start to work in exploring our role as prevention providers in this work. So, but for now we're asking you, any early successes out there in thinking about naloxone distribution and education? Or, any challenges in implementing your plans or implementing what you're trying to do? I see that multiple attendees are typing. I think—I'm just going to do a little riffing here while I'm waiting for the chat box to fill.

I think that one slide where all the different terminology was that Josh shared with naloxone and Narcan and Suboxone and naltrexone, this is why we need to have a common language, right? That's why we all need to sort of work on understanding the talk of this work, and it is quite challenging. So, you know, we're here to help you with that. We're here to provide you information sheets and things like this webinar so you can go back and do a review of what all those words mean, and making sure that you're clear about the differentials between them.

But for right now we're hoping to hear from you about your challenges in naloxone distribution and education. So, Michelle says, “Some of the communities in Tennessee that have had successful implementations of harm reduction strategies like naloxone distribution have went out into other communities in our state to help show them how they implemented those strategies.” That's wonderful, Michelle, and I think that's very true from the lessons we've learned here in Massachusetts as well, is that once a community sort of grasps this and started to do it, they become huge champions in the work, and they really can help you think about how to expand that to other communities.

I didn't want to miss Brandon, too. “A success that they had in Missouri was that they granted law enforcement the ability to carry naloxone.” That is huge, Brandon. “The St Louis region had over 60 documented saves by police officers in the past year.” And, that really changes the game in the community. Police officers feel there's something they can do to really help people, and it does make that shift from seeing people as sort of breaking the law to people that are sick and I need to help them, and I think that's absolutely what you're
saying. It really changes the prejudice, and it really does also help to kind of back that with education. There are a lot of states that have done wonderful work around stigma reduction and educating about addiction as a disease. I also want to say that the Surgeon General's Report is a great place to get a lot of information about this.

Rick, Josh responded here to your question about over-prescribing and how it's tricky to know. I'm going to let you read that one. And we'd love to be able to do more networking from what we can share from our experience here in Massachusetts, Rick, so we'll be in touch about that. Any other final thoughts on naloxone distribution challenges or successes before we move on? Looks like we're ready with that. And, you know, as we said, this is just the very beginning of this work. We're going to have a lot more time to digest what Josh has shared with us and what Maria has shared with us, and a lot more time to work more individually with the different regions and the challenges that you're facing in your particular state, as well.

We're going to change the discussion a little bit now to go back to that blind men and the elephant idea, that, really, the part that I feel is our strongest part as prevention providers is that we understand the efficacy of collaboration. We understand how to build effective collaborative relationships, and we know how to bring sort of nontraditional partners to a table, and that's something that I think in this particular issue is a very, very important thing. As you've seen from what Josh has shared, there's a lot of different sectors that are doing their own strategies, but they're not necessarily talking to each other, and I think that's a place where we can really make a difference. So, we wanted to explore, for the next few minutes, just a little bit about collaboration.

So, as we think about our process for getting the discussion of the elephant going in our communities, we use the SPF process, and one of the things that we always do at the very beginning is assess the readiness of our communities, and assess the readiness of who we have at the table to address those issues, and think about, do we have the right people at the table? As I said earlier, sometimes it's about we have law enforcement at the table, but we don't have the right law enforcement person at the table to be able to make the change that we're hoping to make. But we can use the law enforcement person that we have built that trusted relationship with potentially to make a relationship with another person who would be helpful to us as we address opioid overdose. So, thinking about who's at your table, who's missing from your table, and really thinking deeply.

The other strategy I wanted to share here was, for me, I have a brother who works in the healthcare system, and he can tell me a lot about how that system works. And so that's really, really helpful, and that a sort of insider's view, and he can help me find a gatekeeper. So, that's the first step. I do just want to, as I go to the next slide, point that the slides are available right down here. If you can -- let me see if I can find my -- oh, Maria, I can't find my arrow. Here it is. I think I have it now. Let's see. Oh, there's my arrow. Okay, I'm going to pull it all the way here. Here's the slides, right down here. Oh, on the other side of the arrow. If I could get it to point the other way, you'd see it. Feel free to download those right now if you want, so that you can have that information right at your fingertips. Thanks so much.
Okay, so one of the things we wanted to think about, and I think if you go back and kind of think about the context that both Maria and Josh shared previously in the webinar, you start to think about where do I need to collaborate on the state sector level? Josh talked about some of the risk factors that would lead us to think about, boy, it would be really important to have a conversation with folks in the Department of Mental Health. Obviously, we've talked a lot about the importance of connecting to treatment and other kinds of authorities that may be managing methadone or Suboxone treatment programs. Those are important people to start to think about getting meetings with and start talking about how we can collaborate together.

One of the things that I found, and this is a part of my background in public health, is that this opioid epidemic shares a lot in common with the HIV epidemic of the past several decades. And, there's a lot that the folks who worked in the front lines of HIV learned about how to address that epidemic that can be applied to this one. And, it can be very, very helpful to find some of those lessons learned, particularly when it comes to doing outreach to folks who may not trust the systems that are meant to help them quite as much as we hope they would. And so I think there's a lot to be learned from HIV and other infectious disease prevention programs.

Injury prevention also—while we might not ever think of them as being on our collaboration list, although some of you may have if you were working with alcohol poisoning, very clearly they have lots of connections to emergency preparedness and first responders, and they can be great gatekeepers in helping us understand how those systems work in our communities and in our states. And then medical examiners have a lot of data that can be very, very helpful in terms of helping us understand what's going on in our state. So those are some of the state collaborators.

If you guys have other thoughts out there in the world, we'd love to hear them. You can add them into the chat box. If you've had different departments that you've worked on at your state and engaged in collaboration with, we'd love to hear from you in the chat box. Again, each state is structured a little bit differently, so the departments you might work with might have different names, might have different titles, might be organized a little bit differently. So, it's very important for you to sort of understand the map that works in your state.

So, one of the really important collaborations is thinking about what's going on with treatment across that continuum of care, as Josh mentioned. And so, I do want to say that MAT, or Medication Assisted Treatment, providers are key in the effort to reduce opioid overdose deaths. And, what that means basically is that folks are given medication to help them manage their addiction so that they are less at risk for opioid overdose. And so, sometimes those MAT providers are staff at methadone clinics, sometimes they are Suboxone providers through primary care centers or other kind of buprenorphine providers. Sometimes they are detox or other inpatient providers. Sometimes those treatment professionals are outpatient treatment providers, clinicians that are working in mental health clinics and behavioral health clinics, and sometimes they're folks that are doing those brief interventions, the screening and brief intervention program or the SBIRT programs that
we're familiar with that are right up on that line between prevention and treatment on the continuum of care.

So really thinking about what's the lay of the land in treatment where you are trying to do your work, and who's out there, and think outside the box of just one type of treatment provider, but think about all of the aspects that might be in existence. Before I go on, I just wanted to note that Ellen is making a request in the chat box that if there's more information about medical forums, she'd love to hear about that. And, she shared her email address. So, thanks so much for that, Ellen. That's great.

It is important to say that the reason that we focus so much on collaborating with treatment is that there's real evidence that shows that increased access to treatment leads to a reduction in the incidence of people who are dying from overdose. So, and that's our core strategy here, is that we want to reduce the number of people that are dying from overdose. So, access to treatment is an important thing in working in collaboration there. It's very, very critical.

So the other piece that's very, very critical is law enforcement. And as I said before, law enforcement, it might be a different part of law enforcement than you've worked with before in your communities if you were addressing alcohol misuse. But, so oftentimes it might be the folks that are looking at interdiction for street heroin. It might be folks that are doing release from incarceration. There's a lot of different places where you might want to be looking. There's this terrific toolkit that we are sharing through this link. And again, you can grab the slides down there in that pod, and you can click on this link, and you can get this law enforcement naloxone toolkit, which can be a really helpful resource for getting your law enforcement folks on board.

Great, and then this is one I really wanted to spend a little time talking about: collaborating with healthcare providers. And I think it was Brandon who said, “Boy, sometimes it's really hard to get these folks to talk to us if we don't have a MD after our name,” and I think that's absolutely right. That it is important to respect that healthcare has its own way of working. As I said, I have a family member who works in healthcare, and one of the things that they're always saying is, “It's billable hours, it's billable hours, it's billable hours. I don't have time to come to a coalition meeting. I don't have time for you to come and meet with me for an hour. I need you to access me in a way that works for me, because I am on the clock all the time as I'm working.”

So really figuring out where are those access points, really, really important to think about. But we do want to think about how can we increase the awareness of healthcare providers about how this epidemic has rolled across the country and where those risk factors are so that they're coming on board with us and starting to pay attention to those risk factors and

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3 The Law Enforcement Naloxone Toolkit referred to here can be accessed at the following link: [https://www.bjatraining.org/tools/naloxone/Law-Enforcement-Training](https://www.bjatraining.org/tools/naloxone/Law-Enforcement-Training)
collaborating with us to address that. We think there’s a role for them in prescriber education, thinking about what they're currently doing and how can we support and help their efforts to be really successful.

I love the question that someone had earlier about, “Can you share some examples of prescriber education that we could then share with our providers?” That's something we're working on, making sure that there are plenty of resources at the CAPT for you to do that. They have a role, obviously, in naloxone distribution, and you want to find out what they're doing currently and how you can take them the next step. We've talked a lot about the prescription monitoring issues and the role of prescribers in that. And then, also thinking about distribution of naloxone rescue kits, that oftentimes healthcare providers are the ideal setting for where those things can take place. So, we encourage you to think carefully about that.

We'd like to ask you, what are some of the other examples of potential collaborators or influencers that you're finding out there in your communities that are helpful? So if any of you have had any success, we'd love to ask you to share that in the discussion pod. We've talked about law enforcement, we've talked about treatment providers, and we've talked about healthcare providers, but we believe there are many, many others. So, if you have ideas about who else we might collaborate with in this work, we'd love to hear that in the chat box. I see lots of people typing. We’re hoping that you’ll be thinking about lots of different collaborators that might be brought into this work.

Someone mentioned earlier in the chat, “How do I inform my legislators so that they're simply well educated about the issues so that they make the right policy decisions?” Again, we can't advocate for policy, but we can make sure that people are well educated in understanding what's effective and what the situation is, what the scope of the problem is out there. So that's one particular piece. I also think Departments of Public Health are another area that might be very, very helpful. Other behavioral health entities, health boards, things like that. Your federally-funded community health centers can be a huge help, because they often have a very broad definition of health and are often engaged in other kinds of prevention activities as well.

So let's see, Brandon says, “Depending on the state laws, educators are options.” Absolutely. “Adapt Pharma is offering free Narcan to every high school in the country.” Wow. But again, I love what you said, Brandon. You've got to check your state laws. That's a really, really key piece. “Colleges and universities are also good options.” Thinking about those health centers that are on college campuses, and the residential advisers. That’s great. “Or other housing staff.” That's a great suggestion, Brandon. Thank you. Those are great. And I think oftentimes we have those relationships, because we've been working on those binge drinking issues for years with college campuses. So we may already have an idea there.

Michelle is typing. I'm going to ask for one more idea here, and then I'm going to move us along, because we're running out of time. Boy, this was a really rich webinar. We really
appreciate everybody's time. I'm actually going to keep moving. Sorry, Michelle, we're going to -- if you could go into the other chat and capture your thought there, we'd love to still hear from you about what you were suggesting. But, I'm going to move us along so that we don't run out of time.

Here are some examples. Thanks so much, Michelle. I just noticed you popped over there. That's great. Some other examples of new partners. One of the things that was a huge challenge in Massachusetts when we embarked on this work was figuring out how to hear from the people that were actually the target of our efforts, which were people who were actively using drugs. That felt like a huge stretch for us around the kind of prevention we'd been doing prior to that. But what we did was we looked for what I like to call those low-threshold programs. So those harm reduction programs, sometimes they're needle exchange programs. Sometimes they are folks that work with homeless populations. But, where is it that I can hear about what's really going on at the ground level in my community? Friends and families of drug users can be incredibly instructive in what's going on. Really thinking about the folks who are coming out of jail and prison is really important, because they're very, very high risk.

We've talked about some of these other ones. We have a lot of peer support groups out here in the Northeast, and they've been immensely helpful to us in our prevention efforts, particularly around education. So, Michelle says, as far as campuses being used, "Tennessee has coalitions on state campuses," and she wonders if other states have college coalitions that could spearhead strategies. That's a great idea, Michelle, and I do think those exist in many, many states. Thanks so much for that.

So in closing for today, just collaboration is key. We have to continue to do the work that we've always done, which is to bring people to the table, keep expanding relationships, keep bringing people together, because we're stronger together to address this work than we are if we each try to do it on our own. It is very, very critical that we be honest about what the lay of the land is in our own particular states or local communities so that we respect that and work within those limitations. There are strategies that can be done at many different levels of readiness, so we encourage you to really think about that. And it's really important to think about not just the folks who get paid to do this work, but all the folks who are involved in this work. And it's important to value all of those, as parents or other folks who might volunteer. We want to make sure that we value that work as well.

Boy, this was such a rich webinar, and we really appreciate your work today. There's our contact person for this webinar; Amanda's information is on the slide. Don't hesitate to call us if there's any additional information that we can provide you. And finally, we really do value your feedback. We use that to make every webinar that we do a little bit better than the last one. So, we ask you to click on this slide, right now, before you forget, before you go off and do something else, to give us your quick feedback on how this went. It's pretty quick and easy, so we're going to ask you to do that. As I did say at the beginning, there's a very long list of resources at the end of these slides, so we encourage you to take a look at those and dig deeper. We'll be back with you soon. Thank you so much for your work today.
REFERENCES


