Welcome to:

Harm Reduction in Oregon

Note: You should hear music playing right now!

If not, please adjust your audio settings. **Our program will begin at 8:00 am!**

Agenda (approximate timing)

8:00-8:30 – The Current State – Dr. Todd Korthuis MD, MPH

8:30-9:30 – Best Practices; Safer Use; Continuum of Care – Justine Pope MPH, Haven Wheelock MPH

9:-30-10:30 – Community Implementation – Kelsi Junge MPH
– Peer Support – Trista Boudon CADC 1, CGAC-R, CRM; Regina Halverson CRM, PSS; Lisa Meere QMHA, CRM, PSS; Bradley Balcuns CRM, PSS

10:30-10:55 – Naloxone Co-Prescribing – Oyinda Osibanjo PhD, MPH, RPh

10:55-11:20 – Naloxone Rescue: Responding to Overdose – Melissa Brewster PharmD

11:20-12:00 – Panel Q&A

Survey Completion for 3.5 Hours CME Credit:

Survey will be emailed to all participants –
Link will be provided at end of the session

American Academy of Family Physicians – Prescribed credit, American Medical Association (AMA) Physician's Recognition Award (PRA) Category 1 Credits **3.5 hours**	**Oregon Board of Pharmacy –** Recognizes credits to toward CE hours requirements for license renewal! **3.5 hours**	**NEW: National Association of Social Workers –** LCSW CEU credits **3.5 hours**

Learning Objectives

- Define harm reduction, share core principles and best practices of harm reduction, review history
- Understand the effect harm reduction access in Oregon has on reducing infections, disease, overdose
- Identify elements of organization support needed for implementation of harm reduction
- Recognize importance of patient centered language when engaging people who use drugs
- Describe and evaluate harm reduction modalities, efficacy of techniques
- Engage in OD reversal training

Panel Questions & Answers

Submit questions via Chat feature:

For Haven: *“How do you…”*

Harm Reduction in Oregon Healthcare Settings

Todd Korthuis, MD, MPH
Professor of Medicine & Public Health
Oregon Health & Science University

careoregon.org
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facebook.com/careoregon

OHSU

CareOregon

Harm Reduction

Practical strategies and ideas aimed at reducing negative consequences associated with drug use

- **H**arm **R**eduction: Policies that advance social justice for people who use drugs [Community]

- **h**arm **r**eduction: Clinical practice that supports person to reduce substance use related harm and improve quality of life [Individual]

Healthcare Providers

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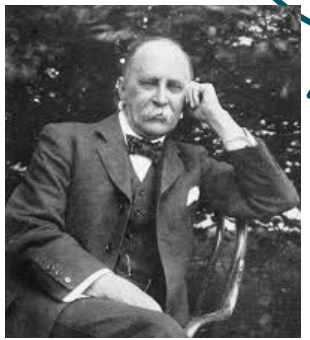
Harm Reduction – An Old Approach



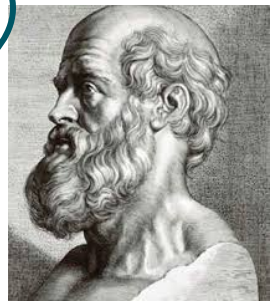
Care more particularly for the individual patient than for the especial features of the disease

-William Osler

First do no harm.

Cure sometimes, treat often, and comfort always.

-Hippocrates

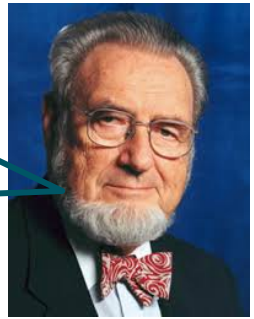


Wise and humane management of the patient is the best safeguard against infection

-Florence Nightingale

The best treatment is the one the patient will take.

-C. Everett Koop



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Use Reduction vs. Harm Reduction

Use reduction is one way to reduce harm.

HOWEVER

There are **many pathways to reduce harm.**

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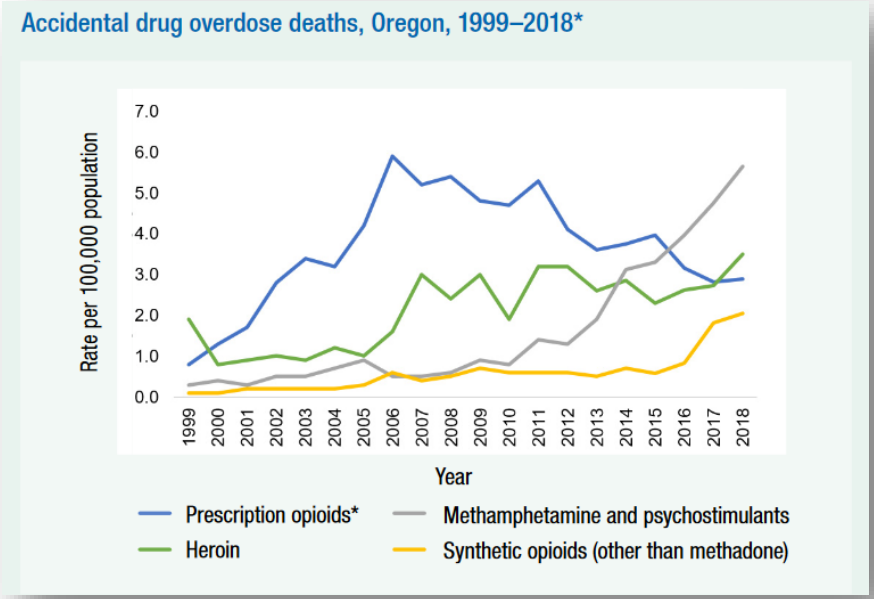
Overdose Deaths in Oregon



Source: Opioid Overdose in Oregon, 2020

Pandemic Exacerbates Oregon's Addiction Crisis: Overdose Deaths Rise 70%

By: Ben Botkin

Overdose deaths spiked nearly 70% in April and May in Oregon, which already has the fourth-highest addiction rate in the country.

The dramatic rise confirmed the fears of advocates and providers that COVID-19 would worsen the addiction crisis in the state.

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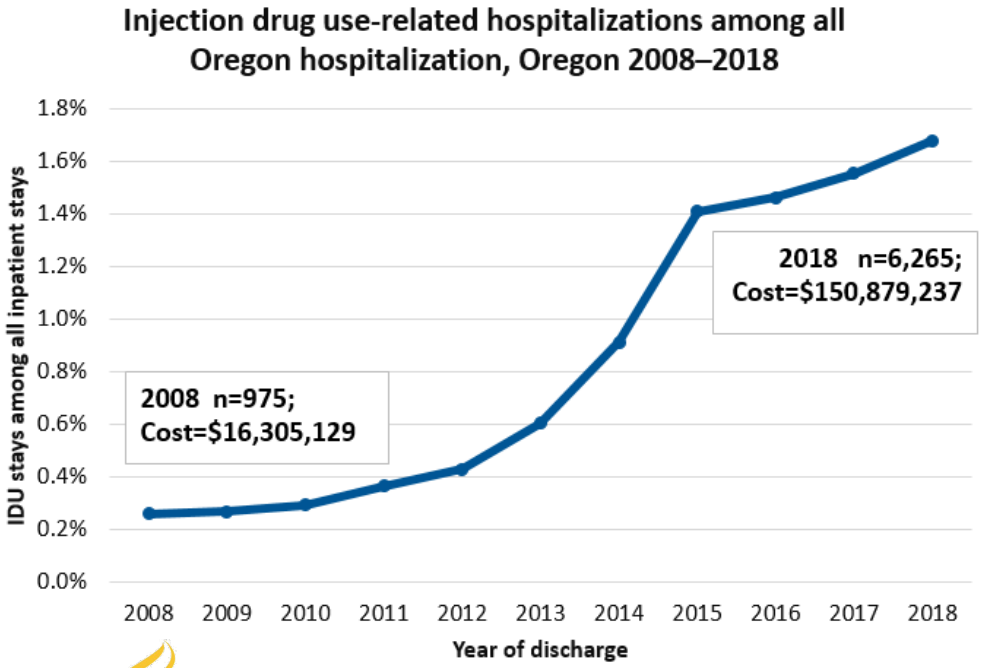
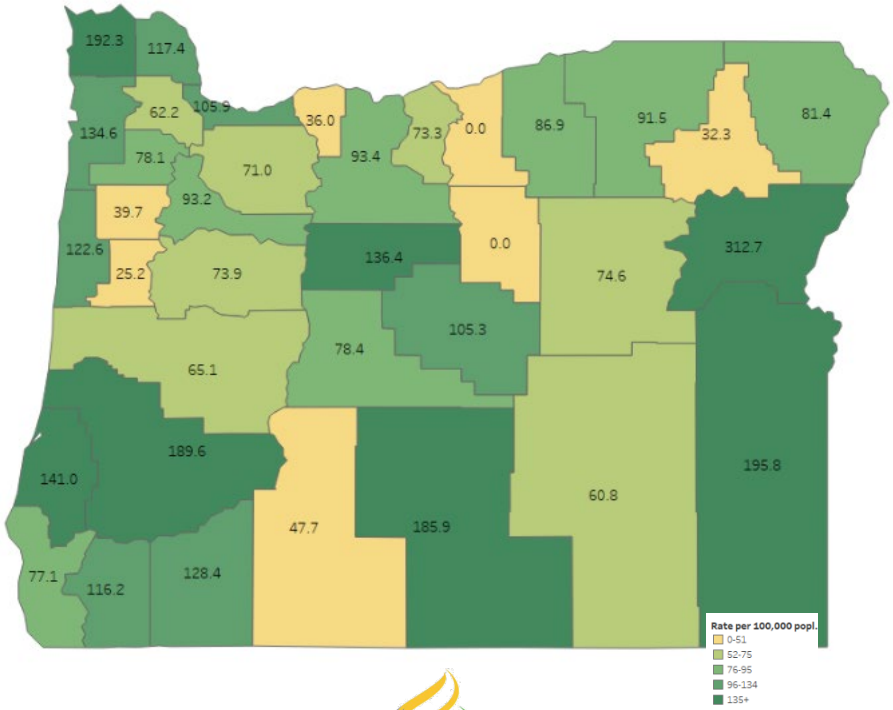
Trends in Injection Drug Use-Related Hospitalizations

- 6-fold increase in the number IDU-related hospitalizations and as a proportion of all hospitalizations, 2008—2018
- Increase began in 2011 prior to the Affordable Care Act
- 65% of patients were never re-admitted with an IDU-related hospitalization, 2008–2018
  (22,353 unique people/34,340 stays)
- Proxy measure for the increase in the number of unique persons who inject drugs

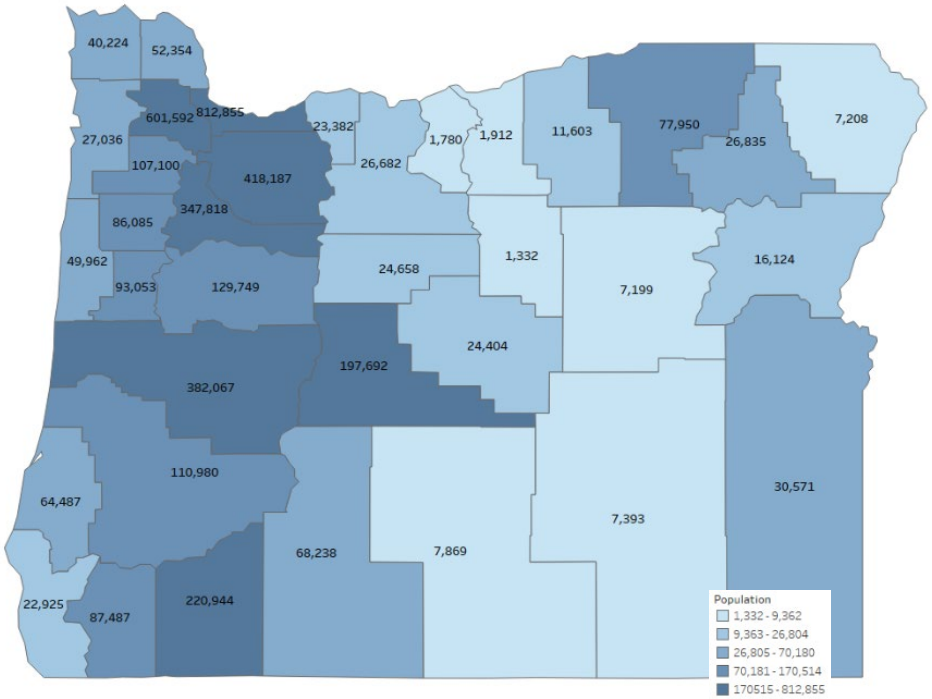


Source: Population-based trends in hospitalizations due to injection drug use-related serious bacterial infections, Oregon, 2008 to 2018

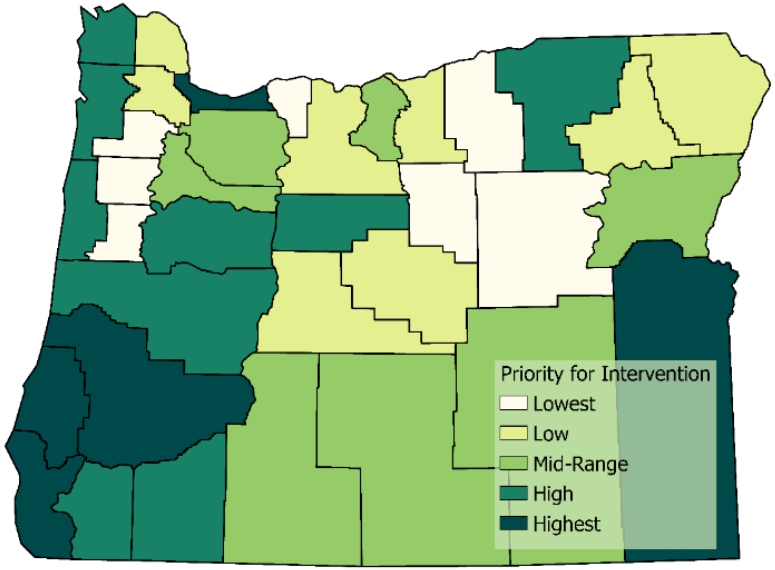
Chronic Hepatitis C Report Rate Per 100,000 Among Persons Ages 13-29 Years, 2015-2019 (mean of annual rates)



Oregon 2019 Population (NCHS)



Vulnerability To IDU-Related Disease Outbreaks By County



Vulnerability				
Highest	High	Mid-Range	Lower	Lowest
Douglas	Jackson	Lake	Wasco	Yamhill
Coos	Lane	Klamath	Crook	Polk
Multnomah	Lincoln	Baker	Union	Morrow
Malheur	Clatsop	Marion	Columbia	Grant
Curry	Linn	Sherman	Gilliam	Wheeler
	Jefferson	Clackamas	Deschutes	Hood
	Tillamook	Harney	Washington	River
	Josephine		Wallowa	Benton
	Umatilla			

Source: Risk for Injection Drug Related Outbreaks: Oregon's County-Level Vulnerability Assessment. Oregon Health Authority, Public Health Division. November 2019

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Harm Reduction, Syringe Access & Syringe Service Programs

Late 1980s

1987: Oregon's drug paraphernalia law excludes syringes (deregulation)

1988: The US Congress enacted a prohibition on the use of federal funds for SSPs through section 300ee-5 of the Public Health and Welfare Act.

Public Health and Welfare Act permitted lift of federal prohibition in the future if the Surgeon General determined SSPs were effective.

1989: Outside In opens its Syringe Exchange

Early 1990's

Emerging scientific evidence that syringes distributed could prevent HIV transmission among persons who injected drugs.

Disability Activism in US "Nothing About Us Without Us"

1993: Harm Reduction Working Group meets in San Francisco. This starts the Harm Reduction Coalition

1995: Institute of Medicine (IOM) panel reviewed HIV Prevention evidence and recommended that the US Government lift syringe funding restriction.

1995: CDC review of SSPs scientific evidence

Late 1990's

1997: Congress passed Public Law 105-78, allowing federal funding for SSPs if the Secretary of HHS endorsed the scientific evidence.

1997: Secretary of HHS Dr. Donna Shalala endorsed SSP evidence.

However, the funding restriction was not repealed.

1998: National Community Health Advisor Study identifies CHW core roles, competencies

2000's

2001-2009: Federal syringe prohibition in place.

Multnomah County establishes Community Capacitation Center to provide training for CHWs

CDC funds Poder de Salud/Power for Health

Bureau of Labor Statistics assigns CHW's an occupation code

Early 2010's

2010: The FY2010 Consolidated Appropriations Act prohibition of the use of federal funds to purchase syringes.

2010: CDC and states developed guidance documents for SSPs

2011 OCHWA founded

2012: Syringe funding ban reinstated in the Labor-HHS spending bill for US programs Consolidated Appropriations Act of 2012

Late 2010's

2015- CDC Community Health Worker Brief

2016-2018: Federal appropriations language allows DHHS to fund, under certain circumstances, SSPs, except for syringes or needles.

CDC consultation required to determine if a jurisdiction is experiencing or at-risk of significant Increases in hepatitis or HIV infections.

2017: Oregon successfully completes CDC consultation process.

2017-2018 Oregon CHW needs assessment

2019: Oregon HB 2257 Provides affirmative defense to unlawful possession of controlled substance for employee or volunteer of syringe services program.

2020's

Center for Health Care Strategies Policy Brief on how CHW workforce contributes to the health care system

2020: ORS 475.757 Syringe service program as affirmative defense to unlawful possession of controlled substance

2020: Oregon voters pass Measure 110

CHW/Peer Support are important role in the COVID-19 Response

Judith.m.leahy@dhsoha.state.or.us

Harm Reduction and Syringe Service Programs

Region	Harm Reduction or Syringe Service Programs in Oregon
Benton	Benton County Public Health
Clackamas	Outside In
Clatsop	Clatsop County Public Health
Curry	HIV Alliance
Deschutes	Deschutes County Needle Exchange Program
Douglas	HIV Alliance
Harney	Harney County Syringe Exchange Program
Jackson	Jackson County Syringe Exchange Program
Josephine	HIV Alliance
Lane	HIV Alliance
Linn	Linn County Public Health
Lincoln	Lincoln County Harm Reduction Program
Malheur	Malheur County Health Department
Marion	HIV Alliance
Multnomah	Outside In
Multnomah	Multnomah County Syringe Exchange
Multnomah	Portland People's Outreach Project
Confederated Tribe of Siletz Indians	Tribal Healthcare Services
Washington	HIV Alliance
Yamhill	Provoking Hope
Umatilla	Eastern Oregon Center for Independent Living

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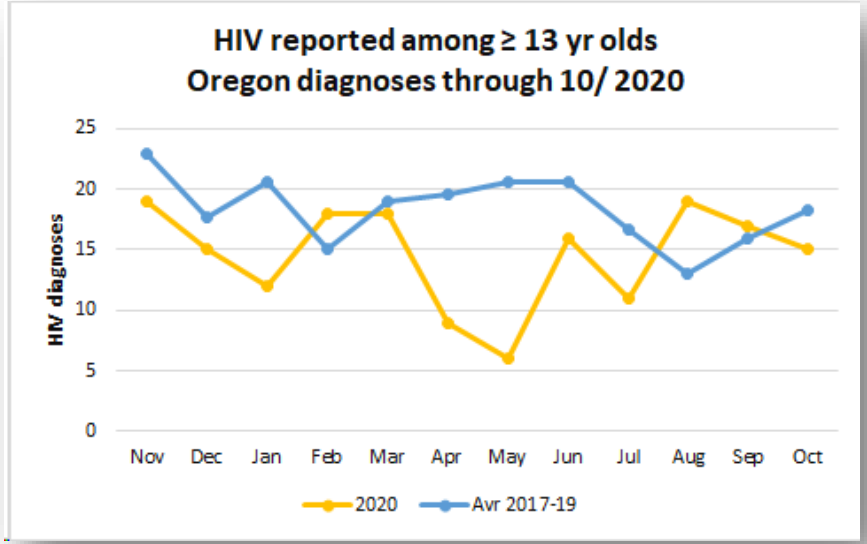
Naloxone for Overdose Prevention

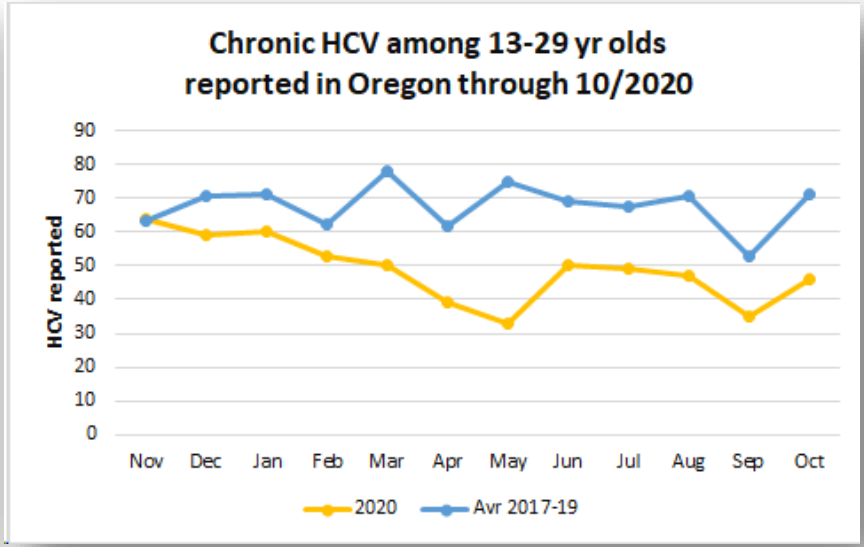
- 46% reduction in community overdose rate in Massachusetts
- Prescribe for high dose prescription opioids, too

Walley BMJ 2013

OHSU

COVID-19: Decreased HIV and HCV Screening





Source: OHA and AETC Training COVID-19 and Engaging PWID

Harm Reduction Tips for Healthcare Settings

- Tailor treatment to *patient goals*
  -Avoid Overdose/Infection? Reduce use? Treatment? Quit?
- Naloxone overdose prevention kits
- Clean needles/works
- Hep C, HIV screening
- Tips on safer use practice

- Be kind, no matter what

Links and Citations

- Oregon Health Authority, Public Health Division. Opioid overdose in Oregon: Report to the Legislature. Portland, OR. September 2020.
- Risk for Injection Drug Related Outbreaks: Oregon's County-Level Vulnerability Assessment. Oregon Health Authority, Public Health Division. November 2019
- Population-based trends in hospitalizations due to injection drug use-related serious bacterial infections, Oregon, 2008 to 2018 Capizzi J, Leahy J, Wheelock H, Garcia J, Strnad L, et al. (2020) Population-based trends in hospitalizations due to injection drug use-related serious bacterial infections, Oregon, 2008 to 2018. PLOS ONE 15(11): e0242165.

https://doi.org/10.1371/journal.pone.0242165

Thank You

Harm Reduction

Justine Pope, MPH and **Haven Wheelock, MPH**

careoregon.org
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CareOregon

Welcome! Who Are We?

Haven

Harm Reductionist, Public Health nerd, drug policy wonk and believer that we have the power to change the world and create more just systems.

Justine

Emancipatory activist researcher, daughter, harm reductionist, bookworm, volunteer, aunt, and bicyclist with an abiding commitment to social change. Serving neighbors, slinging needles, and causing trouble at neighborhood association meetings since 2017.

What Are We Going To Talk About Today?

Topic	What We'd Like You To Get Out Of It
Harm Reduction (HR) Overview	Understand *basically* what HR is – history, context, background
Basic principles of Harm Reduction	Review the philosophy and practice of HR
How Harm Reduction is an essential component of any/every continuum of care	Reflect on how HR principles and strategies fit into the health care system
Harm Reduction Strategies	Types of safer use
Relationship, language, and self care	How to decrease stigma around SUD and substance use; loving drug users; tending to yourself

Disclosures

- We love **p**eople **w**ho **u**se **d**rugs (PWUD).
- We are committed to systems and services that better honor the wisdom and needs of PWUD.
- Nothing else to disclose.

Harm Reduction Overview

History: coined during the height of the HIV pandemic; rooted in radical belief that we have to take care of each other, because no one else would

Political Context

Grounded in Public Health and Social Justice:

- HIV > HCV > Overdose Crisis
- Equity has to be at the forefront of the work, as our systems have been created to harm.

Basic Principles of Harm Reduction

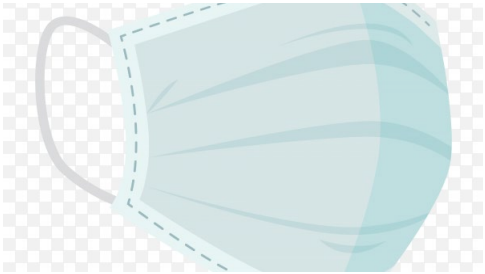
What Is Harm Reduction?

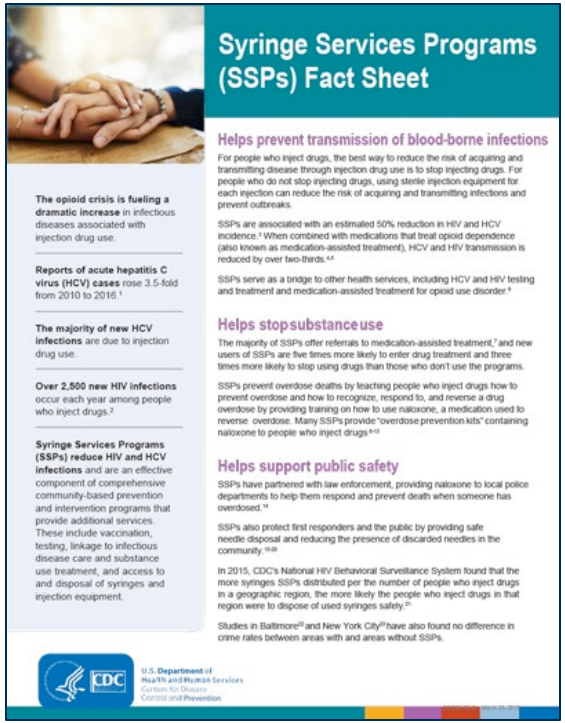
Harm reduction is a set of **practical strategies and ideas aimed at reducing negative consequences associated with drug use**. Harm Reduction is also a movement for social justice built on a **belief in, and respect for, the rights of people who use drugs**.

Harm reduction incorporates **a spectrum of strategies from safer use, to managed use to abstinence to meet drug users "where they're at,"** addressing conditions of use along with the use itself.

Source: Harm Reduction Coalition

Examples of Harm Reduction





Syringe Services Programs (SSPs) Fact Sheet

The opioid crisis is fueling a dramatic increase in infectious diseases associated with injection drug use.

Reports of acute hepatitis C virus (HCV) cases rose 3.5-fold from 2010 to 2016.[1]

The majority of new HCV infections are due to injection drug use.

Over 2,500 new HIV infections occur each year among people who inject drugs.[2]

Syringe Services Programs (SSPs) reduce HIV and HCV infections and are an effective component of comprehensive community-based prevention and intervention programs that provide additional services. These include vaccination, testing, linkage to infectious disease care and substance use treatment, and access to and disposal of syringes and injection equipment.

Helps prevent transmission of blood-borne infections

For people who inject drugs, the best way to reduce the risk of acquiring and transmitting disease through injection drug use is to stop injecting drugs. For people who do not stop injecting drugs, using sterile injection equipment for each injection can reduce the risk of acquiring and transmitting infections and prevent outbreaks.

SSPs are associated with an estimated 50% reduction in HIV and HCV incidence.[3] When combined with medications that treat opioid dependence (also known as medication-assisted treatment), HCV and HIV transmission is reduced by over two-thirds.[4,5]

SSPs serve as a bridge to other health services, including HCV and HIV testing and treatment and medication-assisted treatment for opioid use disorder.[6]

Helps stop substance use

The majority of SSPs offer referrals to medication-assisted treatment,[7] and new users of SSPs are five times more likely to enter drug treatment and three times more likely to stop using drugs than those who don't use the programs.

SSPs prevent overdose deaths by teaching people who inject drugs how to prevent overdose and how to recognize, respond to, and reverse a drug overdose by providing training on how to use naloxone, a medication used to reverse overdose. Many SSPs provide "overdose prevention kits" containing naloxone to people who inject drugs.[8-10]

Helps support public safety

SSPs have partnered with law enforcement, providing naloxone to local police departments to help them respond and prevent death when someone has overdosed.[11]

SSPs also protect first responders and the public by providing safe needle disposal and reducing the presence of discarded needles in the community.[12-20]

In 2015, CDC's National HIV Behavioral Surveillance System found that the more syringes SSPs distributed per the number of people who inject drugs in a geographic region, the more likely the people who inject drugs in that region were to dispose of used syringes safely.[21]

Studies in Baltimore[22] and New York City[23] have also found no difference in crime rates between areas with and areas without SSPs.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Syringe Service Programs (SSPs) are **proven to reduce the spread of disease and to improve the health of people who inject drugs**. Years of evidence confirm the benefits, including cost savings for health care systems. Additionally, by facilitating the safe disposal of used syringes, SSPs help preserve community and public safety.

Evidence shows that **the presence of SSPs also improves community and public safety:** they do not increase illegal drug use or crime, and often are shown to decrease improperly discarded syringes.

Needs-based access to syringes is now considered **best public health practice.**

Harm Reduction In Practice

What Might Be Offered?

- Clean needles
- Sterile injection equipment (cookers, cottons, tourniquets, alcohol wipes, clean water)
- Naloxone (narcan), the overdose-reversing drug
- Wound care (gauze bandages, antiseptic wipes, surgical tape, bandaids, antibiotic ointment)
- Safer sex supplies (condoms, lube)
- Smoking pipes/foil
- Snort kits
- Fentanyl test strips
- Sharps containers and access to safe disposal for used syringes (direct collection)

What Else?

- Harm reduction and naloxone training/overdose education
- Hot food, clothing, tarps/tents
- Support for housing/shelter, medical care and/or substance use disorder treatment
- On-site testing for infectious diseases (HIV, HCV)
- OHP enrollment, expungement services
- Access to income: can return, stimulus payment
- Love and support to individuals who wish to stop using drugs, as well as individuals who wish to continue using drugs

Building Community, Building Power

Harm Reduction and the ~~Continuum~~ Galaxy of Care

Reflection

How Do You See Yourself As Practicing Harm Reduction In Your Work?

In Your Life?

Naloxone

WE ARE AT RISK FOR OVERDOSE WHEN WE:

USE FENTANYL
MIX OPIATES WITH ALCOHOL & BENZOS
USE OPIATES WHEN WE GET OUT OF DETOX OR JAIL
USE ALONE

- How do you talk with your patient/client/clients about naloxone?
- How do you ensure your patient/client/clients have naloxone?
- Have you ever tried to get naloxone at a pharmacy?
- Do you know other community resources/ways for patient/client/clients to get naloxone?

Safer Use

- How do you talk with PWUD about safer injecting and use practices?
- How do you educate yourself about safer injecting practices, including “works”?
- How do you support or ensure safe disposal of used syringes?
- Do you know where patient/client/clients can dispose of larger amounts of used syringes?

This guide is aimed at people who inject drugs to help reduce some of the problems caused by injecting.

It includes information on safer injecting practices and types of injecting.

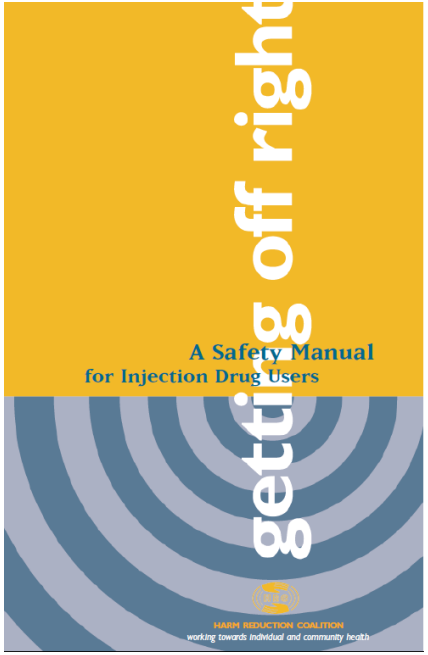
Advice on how to find a vein and the equipment that should be used.

Recommendations on how to best care for your veins, avoiding vein damage and when you may need to seek help.

Strategies for coping with overdose and information on HIV and hepatitis (Hep) B & C.

Suggestions of alternatives to injecting and advice in relation to poly drug use.

Finally, there are details of where you can get further information.



Syringe Services

- How do you talk with patient/client/clients about syringe services?

- Are you aware of syringe services and harm reduction clinics that operate in the tri-county area, and what they offer?

Safer Use: Deeper Dive

4 TAPER, DON'T QUIT ABRUPTLY!

If you've noticed yourself develop a tolerance and want to quit, it's best to taper down off of benzos. Quitting abruptly with too much of a dependency can be deadly at worst and unpleasant at best.

5 MIXING DOWNERS = BAD NEWS.

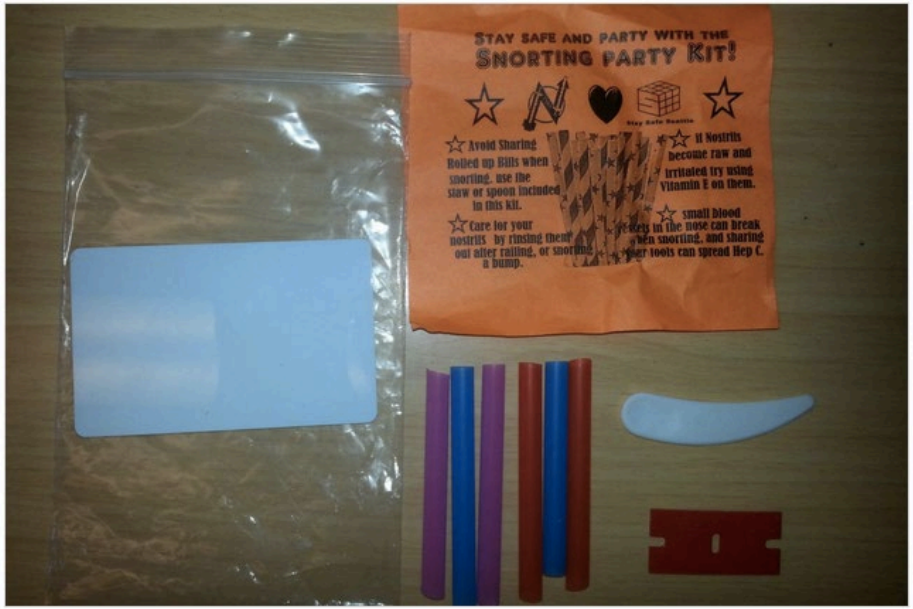
We know this point was already made, but we're here for your safety, and one of the biggest risks with benzos is mixing them with other downers. Mixing alcohol or opiates with benzos is risky business. Benzos alone are pretty safe, but with something else in the mix they can go south fast!

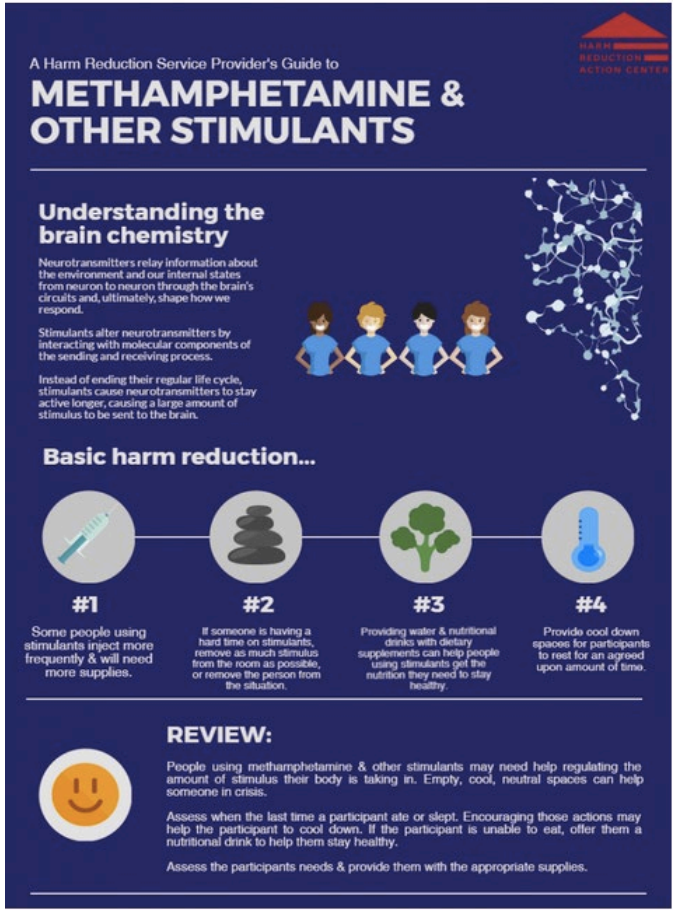
Always use in moderation, and always use your opiates first if you're mixing.

6 FENTANYL!!!

Everyone is talking about fentanyl, and yes, it **IS** in our heroin and **sometimes** in our benzos. Fentanyl is a powerful opioid, and it causes someone to overdose (stop breathing) really quickly. You can buy test strips to check your drugs for fentanyl, but your best bet if you use drugs or your friends use drugs (especially opiates like heroin or oxy pills) is to carry naloxone!

Naloxone (narcan) reverses opioid overdoses and you can save a life just by having it. It can't hurt someone, and it can keep them alive long enough to get them medical attention. If you're using opiates and benzos, tell someone where your naloxone is, so they can use it if they need to!





Safer Use: Continued

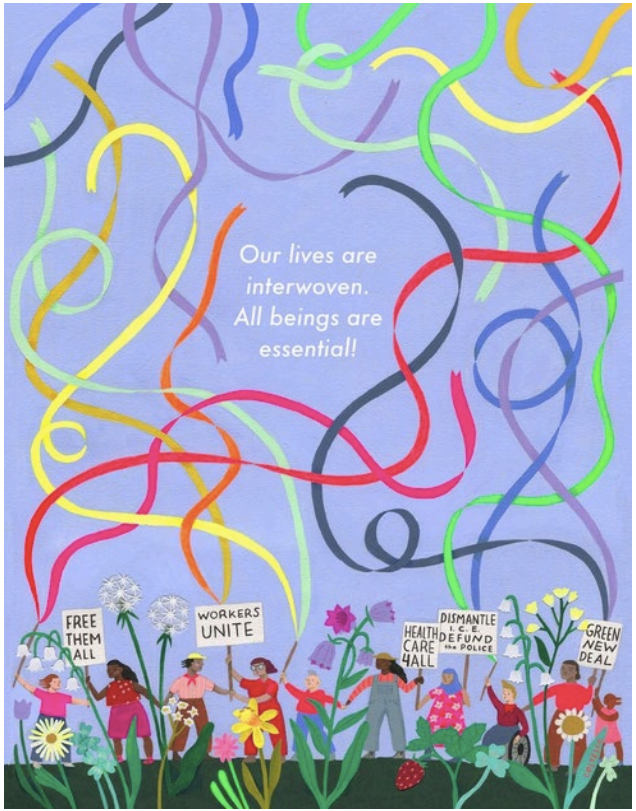
Language. Matters.

Reflection:

What has resonated with you today?

What will you take with you after this training?

Closing Thoughts



Artist: Molly Costello

Thank you!

justinepope@gmail.com
HavenW@outsidein.org

Multnomah County Health Department Harm Reduction Program

Kelsi Junge, MPH
Program Supervisor
Multnomah County Health Department

Presentation Goals:

- Understand the role of Harm Reduction services within Public Health Departments
- Learn about our Harm Reduction services and funding sources
- Consider common barriers to implementing services and learn strategies to address community concerns and build community connection

Public Health Role

- Reduce adverse health outcomes associated with injection drug use.
- Build trusting relationships with hard-to-reach populations.
- Prevent the transmission of HIV, Hepatitis C, and other infections and provide overdose education and naloxone distribution to people who use drugs.
- Collect and monitor data on overdose reversal events, client overdose risk, drug use, and service utilization.
- Coordinate with health care and public health system stakeholders to guide policy, practice, and disease intervention strategies.

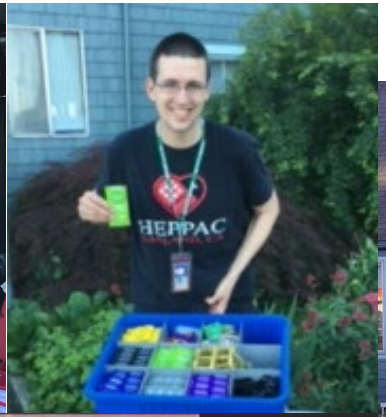
Presentation on HIV Syndemic to MC Board of County Commissioners, 2019

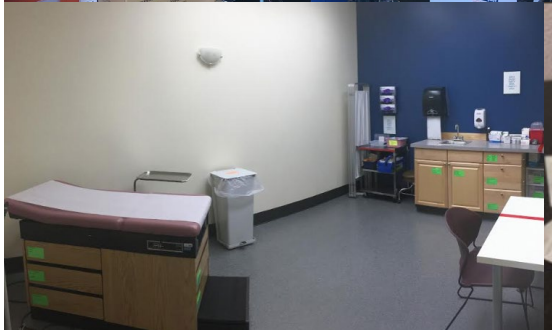
Program Overview

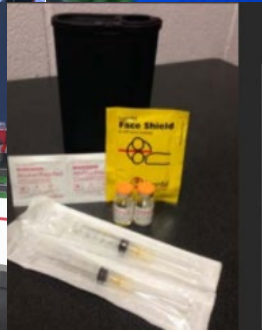
- Outside In opened the first syringe exchange in Multnomah County in 1989. MCHD began operating a site in 1992.
- MCHD operates 5 days/week at three locations and contracts to or supports other community programs.
- Since March 2020 (Covid-19) need for supplies has increased at our sites:

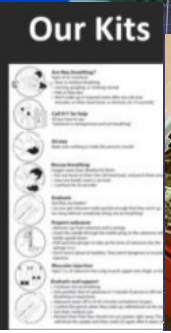
  Syringe distribution ↑178%; Naloxone kits ↑200%

MCHD Program Services









MEDICAL Supplies - 1 Month Order Harm Reduction Clinic					
Item Name	#	Ships	Order Amount	Price Per	TOTAL
Alcohol Pads (20 bx/case)	191089B	box	24 cases/480 boxes	$1.60	$768.00
Benza Towelettes100/bx 10bx/cs	865276B	box	24 cases/240 boxes	$1.74	$417.60
Bandaids--1x3"--(100/box) 24bx/cs	466878	box	4 cases/96 boxes	$2.00	$192.00
Blue Tourniquets- (1000/case)	464713B	case	5 cases	$18.65	$93.25
Cotton balls (2000 per sack)	980221B	sack	1 Sack	$33.35	$33.35
Gauze Pads--4x4" •(50/bx) 24 bx/case	16-4242	case	5 cases	$1.78	$8.90
Gauze Pads--2x2" • (100/bx) 30 bx/case	16-4228	case	1 case	$1.86	$1.86
Gloves PF Nitrile (100/bx/10bx-cs)	54976	box	S, M, L, XL	$7.50	$30.00
Med Tape 1" (12 rolls/box12bx/cs)	16-4731(	box	5 cases/60 boxes/720 ro	$4.05	$300.00
Sharps Container-- HK Container (100/cs)		case	3 cases	$25.00	$75.00
Sharps Container--1 qt. (60/cs)	305635	each	5 cases/300 containers	$171.00	$855.00
Sharps Container--1 Gal (32/cs)	3114369(	each	8 cases/256 containers	$81.25	$650.00
Sharps Container--2 Gal. (20/cs)	855063	each	24 cases/480 containers	$3.04	$1,459.20
Sharp Container 18 Gal. (5/case)	236329c(	case	8 cases/40 containers	$112.50	$900.00
Syringe 28g 1cc Master ET (100/bx)	701995	box	620 cases/3,100 boxes	$8.66	$26,839.80
Syringe 28g .5cc Master ET (100/bx)	701996	box	4 cases/20 boxes	$8.66	$173.20
Syringe 25g 3cc McKesson (100/box/100(	1031812	boxes	7 cases/70 boxes	$64.40	$450.80
Syringe 22g 3cc McKesson (100/box/100(	1031810	case	6 cases/60 boxes	$64.40	$386.40
				TOTAL	$28,863.81

Harm Reduction Clinic

Hours: Mon. and Thur.
11:00 am – 7:00 pm

FY21 Averages:

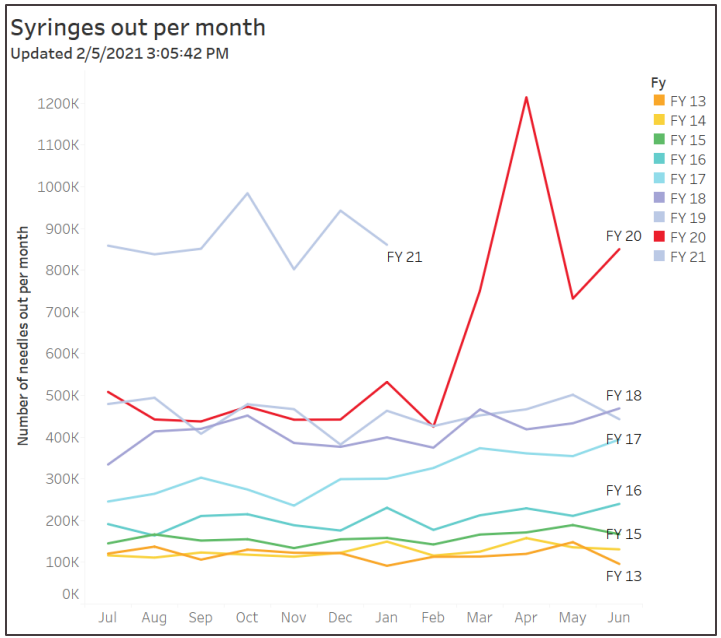
362 visits/month

352,430 Syringes

FY20 Averages:

530 visits/month

220,942 Syringes


Syringes out per month
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Fy
FY 13
FY 14
FY 15
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FY 17
FY 18
FY 19
FY 20
FY 21
Number of needles out per month
1200K
1100K
1000K
900K
800K
700K
600K
500K
400K
300K
200K
100K
0K
Jul
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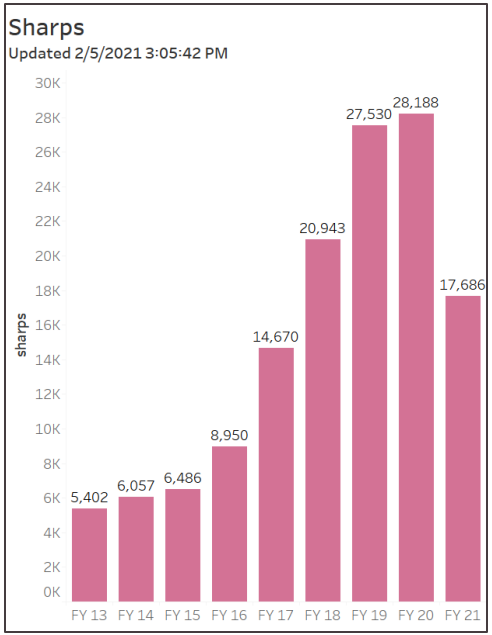
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8,950
14,670
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FY 13
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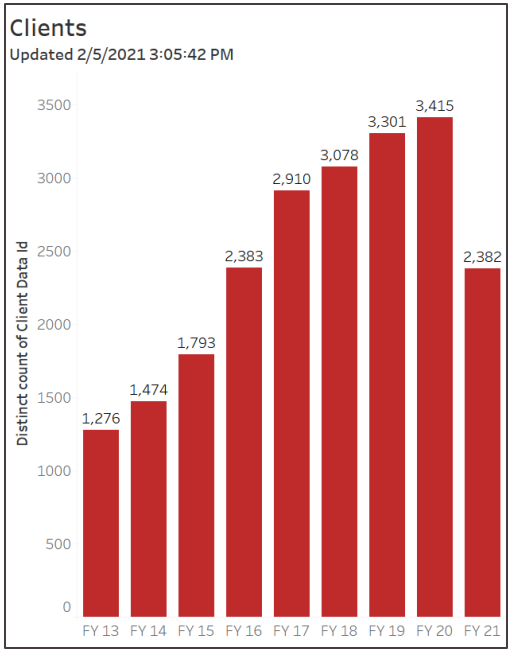
Clients
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2500
2000
1500
1000
500
0
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1,474
1,793
2,383
2,910
3,078
3,301
3,415
2,382
FY 13
FY 14
FY 15
FY 16
FY 17
FY 18
FY 19
FY 20
FY 21

Sharps Containers distributed through syringe exchange

Funding

FY21 Adopted Budget https://multco.us/budget/fy-2021-adopted-budget

Other Funds
$1,053,443

General Fund
$1,630,173

COVID-19
Support
~ $300,000

- HIV Prevention Block Grant
- SAMHSA Opioid SOR
- HIV Early Intervention Services and Outreach

Funding

FY21 Projected Costs (July 1, 2020 – June 30, 2021)

Contracts to CBOs
$465,740

SSP Supplies & Naloxone
~$1,039,054

Biohazard Disposal
~ $62,374

- County General Fund Pass-Through
- HIV Prevention Block Grant
- SAMHSA Opioid SOR

Barriers & Strategies

- Determining scope of services and generating buy-in
- Finding funding
- Developing policy and procedure
- Generating community buy-in and addressing opposition
    - Meet with stakeholders and offer information
    - Provide trainings like Naloxone Train-the-Trainer

What You Can Do Today!

Build trust and engagement with people who use drugs.

- Get comfortable talking about drug use without judgment or stigmatizing language.
- Respect bodily autonomy and practice meeting people where they are at in their life. Ask what their health needs or goals are and support them in meeting those goals.
- Learn about the resources that already exist in your community and how to connect people to culturally appropriate services.
- Advocate within your system for the health and wellness of people who use drugs.
- Where you can, break down barriers! Ensure your patients have access to the supplies they need to keep themselves safe.
- Find where you can integrate services or supply access into your existing systems.

Peer Mentor Programs

Trista Boudon CADC 1, CGAC-R, CRM
SUD Counselor; Recovery Mentor Team Lead
Clatsop Behavioral Healthcare – Cell: 971-606-0041
Email: **tristab@clatsopbh.org** Referrals for Clatsop County: **rara@clatsopbh.org**

What are “Peer Mentors?”

- Certified though MHACBO (Mental Health and Addiction Certification Board of Oregon), Individuals with lived experience with Addiction/Recovery
- Ongoing education through experiences, trainings and structured supervision
- Strong personal Program of Recovery
- Compassionate, caring, warm, kind, patient, understanding, non-judgmental, motivating, open, honest, transparent, trust-worthy, consistent individuals

What are “Peer Mentors?”

- Trauma-informed approach/person-centered language
- Some knowledge of Recovery Programs in the Community (can be trained)
- Some knowledge of Resources in the area (can be trained)
- May have additional lived experience with the Criminal Justice System, Jail/Prison, DHS Child Welfare, Domestic/Sexual Violence, Mental Health, Homelessness, 12 Step Recovery Programs, Overdose, MAT Clinics etc.

What Can Peer Mentors Do?

- Meet the client where they are in that moment
- Listen to the clients needs (support client's autonomy in their decisions)
- Assist Client in obtaining basic needs (food/shelter/clothes etc.)
- Assist in obtaining Health Insurance (when applicable)
- Connect Clients with Harm Reduction Supplies and provide Education
- Connect Clients to Detox/Inpatient/Outpatient services
- Connect Clients to all Healthcare services

Making Connections

- Connect Clients to Community Recovery programs
- Connect Client to Community Resources/Partners
- Support Clients through transitions (unsheltered to sheltered, discharge from hospital, detox etc.)
- Identify and make plans to overcome barriers (transportation, childcare etc.)
- Promotes self-efficacy / walk along side the Client / Motivation
- Advocacy

Common Community Partners

- Hospitals
- Primary Care
- Jail/Probation/Patrol Officers
- Justice System Specialty Courts (MH TX Court/Drug Court)
- Transitional Housing Agencies/Warming Centers
- Community Action Teams

Common Community Partners

- Crisis Teams
- Affected Friends and Family members
- DHS Child Welfare – Addiction Recovery Teams (ART Liaison)
- Other MH and A/D Agencies/Services/Clinicians
- DV/Sexual Violence Survivor Advocate Agencies

What Makes Peers Different?

- Relentlessly compassionate support with no expectations
- Peers can be a non-structured, non-authoritative support
- Peers can “roll with resistance” to those who aren’t “treatment ready” – (what does this mean)
- Peers will sometimes work harder than the clients
- There are no pre-requisites to Peer Support aside from having struggles with substances
- Clients/community members don’t have to fill out paperwork, sit through an assessment or get a diagnosis to meet with a Peer
- Connection to someone who’s had shared experiences

Peers Instill Hope

- Connection to someone who can help bridge the gap in between existing infrastructure to client (example)
- Promote self-efficacy
- Help build and validate Client's self-esteem, self-worth, self-love
- Guidance, support, and direct help with setting small, achievable goals
- One-on-One navigation around barriers
- Support with maintaining motivation
- Instilling hope in those who feel they are in a hopeless situation

Peer Outreach: Connecting The Dots For Those Who Are Struggling

Bradley Balcuns CRM, PSS; Regina Halverson CRM, PSS
Lisa Meere QMHA, CRM, PSS – Peer Support Specialists
Columbia Community Mental Health

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twitter.com/careoregon
facebook.com/careoregon

CareOregon

Who We Are

- Individuals who have lived experience with mental health, trauma, and substance abuse
- We have all achieved recovery, and use our lived experience to connect with others who are struggling
- We offer connection in a different way, and help some clients engage when other methods have failed

Who We Are

- We are certified through the Mental Health and Addictions Certification Board of Oregon (MHACBO) and receive ongoing continuing education and supervision
- We are held to the same ethical standards as all behavioral health professionals

Who We Are

Team HOW (Honesty, Openness, and Willingness) is Columbia County's peer outreach team: **peeroutreach@ccmh1.com**

Who We Serve

- Any individual in Columbia County who is struggling with substance abuse, mental health symptoms, or both
- We focus on individuals who are not already engaged in or well connected with a treatment provider
- Services provided regardless of insurance
- Enrollment in services at our agency is not required

What We Do

We meet clients where they are at…literally.

Options include:

- Connection to treatment
- Immediate access to detox
- Immediate access to basic needs (food, clothing, warmth) and community resources
- Connection with harm reduction resources (naloxone, MAT, syringe exchange)

What We Do

- Help with obtaining insurance benefits
- Help with accessing primary medical care
- Support after hospital discharge
- Peer support and assistance with basic needs, even if client is not ready for treatment
- Patience and recognition that everyone is worth our time and attention
- Offer and instill HOPE!

Organizations We Partner With

- Housing agencies/shelters
- Local churches
- Primary Care
- Parole and Probation
- Specialty Courts
- Jail
- Public Health
- Hospitals
- Detox/Treatment facilities

Naloxone Co-Prescribing

Oyinda Osibanjo, PhD, MPH, RPh
Senior Pharmacy Clinical Coordinator – CareOregon

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CareOregon

Learning Objectives

- Identify patients who are candidates for naloxone co-prescribing based on their risk factors for opioid overdose
- Understand the role of pharmacists in expanding naloxone co-prescribing
- Discuss concerns and/or issues related naloxone co-prescribing

Candidates for Naloxone Co-Prescribing

- Are receiving opioids at a dosage of 50 morphine milligram equivalents (MME) per day or greater
- Patients with a history of overdose
- Patients with a history of substance use disorder
- Regardless of opioid dose
    - Have respiratory conditions such as chronic obstructive pulmonary disease (COPD) or obstructive sleep apnea
    - Have been prescribed benzodiazepines
    - Have a non-opioid substance use disorder
    - Report excessive alcohol use
    - Have a mental health disorder

Source: Haegerich et al., MMWR, 2016 CDC Guideline for Prescribing Opioids for Chronic Pain ; HHS, 2019 https://www.hhs.gov/opioids/sites/default/files/2018-12/naloxone-coprescribing-guidance.pdf

Candidates for Naloxone Co-Prescribing

- Using heroin, illicit synthetic opioids or misusing prescription opioids
- Using other illicit drugs such as stimulants, including methamphetamine and cocaine, which could potentially be contaminated with illicit synthetic opioids like fentanyl
- Receiving treatment for opioid use disorder, including medication such as methadone, buprenorphine, or naltrexone
- With a history of opioid misuse that were recently released from incarceration or other controlled settings where tolerance to opioids has been lost

Source: Haegerich et al., MMWR, 2016 CDC Guideline for Prescribing Opioids for Chronic Pain ; HHS, 2019 https://www.hhs.gov/opioids/sites/default/files/2018-12/naloxone-coprescribing-guidance.pdf

Morphine Milliequivalents and Commonly Prescribed Opioids

50 MME/DAY		90 MME/DAY	
50 mg of hydrocodone	10 tablets of hydrocodone/acetaminophen 5/325 mg	**90 mg of hydrocodone**	9 tablets of hydrocodone/acetaminophen 10/325 mg
33 mg of oxycodone	Approximately 2 tablets of oxycodone sustained release 15 mg	**60 mg of oxycodone**	Approximately 2 tablets of oxycodone sustained release 30 mg

https://www.oregonpainguidance.org/opioidmedcalculator/

Source: https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

FDA Warning on Gabapentinoids

- Gabapentinoids
  - Gabapentin and Pregabalin

- FDA-approved use
  - Seizures, nerve pain, and restless leg syndrome

- Warning
  - Serious breathing difficulties may occur in patients on gabapentinoids and opioid pain medicines.[1]
    - **Note:** As of January 1, 2020, gabapentin was included as covered substance for the OR Prescription Drug Monitoring Program (PDMP).[2]

Source: https://www.fda.gov/news-events/fda-brief/fda-brief-fda-requires-new-warnings-gabapentinoids-about-risk-respiratory-depression

Opioids and Benzodiazepines

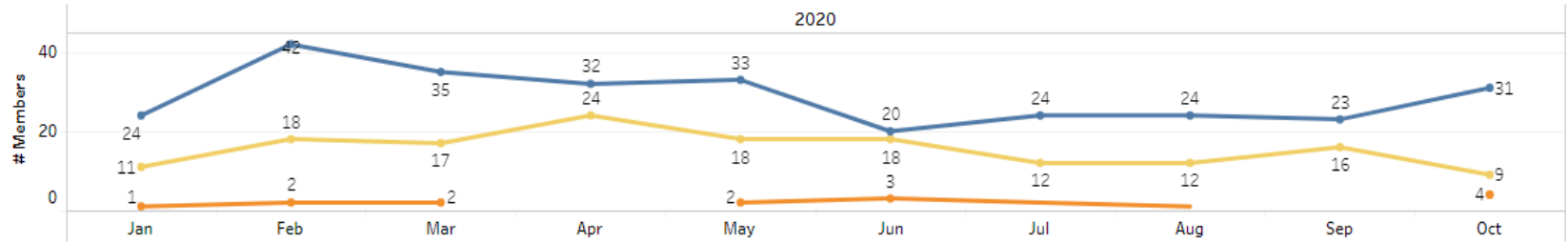
- Concurrent use of opioids and benzodiazepines is associated with the risk of respiratory depression and death.
- Case-cohort study found concurrent use of benzodiazepine prescription with opioid prescription to be associated with a near quadrupling of risk for overdose death compared with opioid prescription alone.[3,4]

Opioids and Antipsychotics

- Second to benzodiazepines, antipsychotics were the most frequently detected drugs found post-mortem of opioid use disorder. [5,6]
- Patients on opioids have reported use of antipsychotic medications to enhance the effects of opioids. [5]
- Concurrent use of opioids and antipsychotics may cause or aggravate respiratory insufficiency. [5]

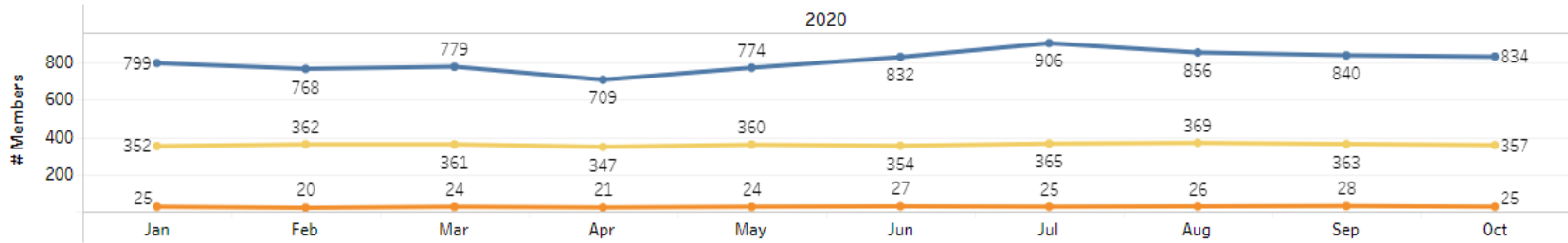
Patients on opioids ≥ 50 MED **with** naloxone for all CCOs

Shift over Time in Patient Counts per MED Group



Patients on opioids ≥ 50 MED **without** naloxone for all CCOs

Shift over Time in Patient Counts per MED Group



As Part of Prescribing Opioid Medications:

- Healthcare professionals should discuss the availability of naloxone with patients and caregivers, both when beginning and renewing treatment.
- Consider prescribing naloxone based on a patient's risk factors for overdose
- Pharmacists offer naloxone to patients when filling an opioid prescription for greater than 50 MME per day.

Naloxone – Delivery of Care and Prescribing in Oregon Pharmacies

Having determined that there is an identified medical need, a pharmacist can prescribe naloxone and the necessary medical supplies to administer naloxone for opiate overdose:

(a) When dispensing any opiate or opioid prescription in excess of 50 MME

(b) To an individual seeking naloxone

(c) To an entity seeking naloxone

Workflow Strategies

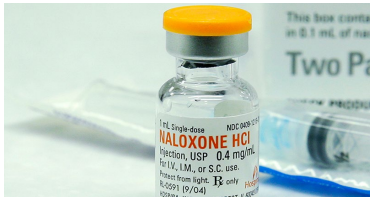
- **Medication for Opioid Use Disorder (MOUD) Clinics**
  - Prescribe naloxone to all patients on initial visit.
  - Consider developing groups that include family and friend on how to use naloxone and respond to overdose
- **Primary Care Clinics**
  - Medical Assistants review records of patients on opioids dose 50 MME or greater to ensure access to naloxone
- **Pharmacy**
  - Training technicians to identify patients who are candidates for naloxone co-prescribing will help improve uptake of naloxone

Barriers and Concerns

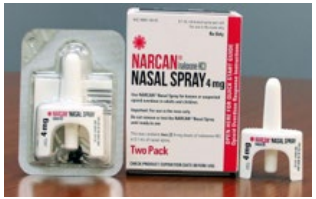
Patient-level Barrier

- Social Stigma [7]
  - Several Patients have reported being labelled as addicts when they request for Naloxone from providers or fill their Naloxone at a pharmacy
- Cost/Coverage of Naloxone [8]
  - Medicaid – Cost of Naloxone is covered with no co-pay.
  - Medicare – Based on government subsidy copay for generic naloxone -$1 to $3 or $4 - $9 copay for brand Narcan.
  - Uninsured – Harm Reduction Programs/ Syringe Service Programs provide naloxone at no cost

Naloxone Formulations Available



- 0.4mg/ml injectable naloxone vial
- Total volume is 1ml per vial
- To be used for IM injection with a syringe and needle
- Benefit allows: 2 vials per prescription fill
- When writing prescriptions:
  - Product is 0.4mg/1ml naloxone injection
  - Include directions " for I.M. injection in the event of an overdose"
- Patient will need syringe/needle



- 0.4mg/0.1ml Narcan nasal spray (brand name)
- Package contains 2 spray devices
- To be sprayed into the nostrils
- Benefit allows: 1 package (2 devices) per prescription fill
- When writing prescriptions:
  - Product is Narcan Nasal Spray Include directions "for nasal administration in the event of an overdose"
- No auxiliary items

Barriers and Concerns

Provider-level Barrier

- Logistical barriers (e.g. training and education for pharmacists and physicians) [9]
  - Naloxone is a lifesaver, like having a fire extinguisher. Hopefully, you will not need it, but it is important to have it on hand just in case you do—for yourself or someone else."
  - "Naloxone is like a seat belt. You probably won't need it, but if you do, it can save your life."
  - "Naloxone is for opioid medications like an epinephrine pen is for someone with an allergic reaction."
- Concerns about increased Opioid use [10 - 13]
  - Several studies have shown that drug use either stays the same or decreases opioid use
  - Studies have shown decreased opioid overdose related deaths due to increased naloxone access

Resources

Recovery Oriented Language Guide

https://static1.squarespace.com/static/58739f64e6f2e14a3527a002/t/5bb4f39124a6940b1fd2f909/1538585490002/Recovery+Oriented+Language+Glossary+2017.pdf

Words Matter - Terms to Use and Avoid When Talking About Addiction

https://www.drugabuse.gov/sites/default/files/nidamed_words_matter_508.pdf

Communication

https://www.pharmacist.com/sites/default/files/audience/LetsTalkAboutNaloxone.pdf

Calculating MME

https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

References

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Naloxone Rescue: Responding to Overdose

Melissa Brewster, PharmD
Senior Pharmacist, CareOregon

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CareOregon

Learning Objectives

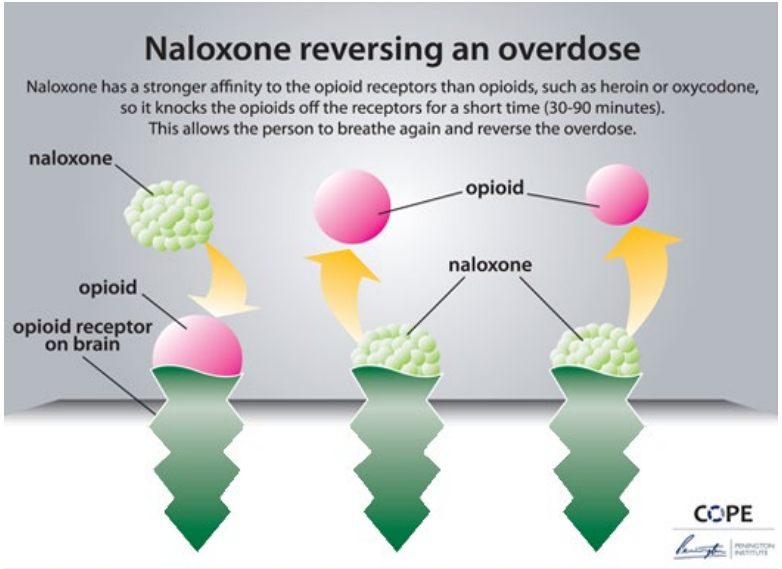
- Describe how an overdose affects the body
- Understand what naloxone is and how it works
- Understand how to recognize an opioid overdose
- List what to do in the event of an overdose

Opioid Overdose Basics

- Overdose happens when a toxic amount of drug overwhelms the body
- Opioid overdose reduces the drive to breathe
  - Minutes to hours after opioid dose
  - In 3-5 minutes, brain damage begins
- Oxygen and returning to breathing is the number one most important factor in reversing an opioid overdose

Naloxone

- Naloxone (also called Narcan®) is an opioid antagonist that kicks opioids off the receptor
  - Counteracts respiratory depression in central nervous system
  - Allows overdose victim to breathe normally
  - No effects if there are no opioids in the system
- Historically administered by EMS, now can be given by any layperson
- No potential for abuse
- Injected IM or IV (0.4 mg/mL) **or** intranasal (4 mg/spray)



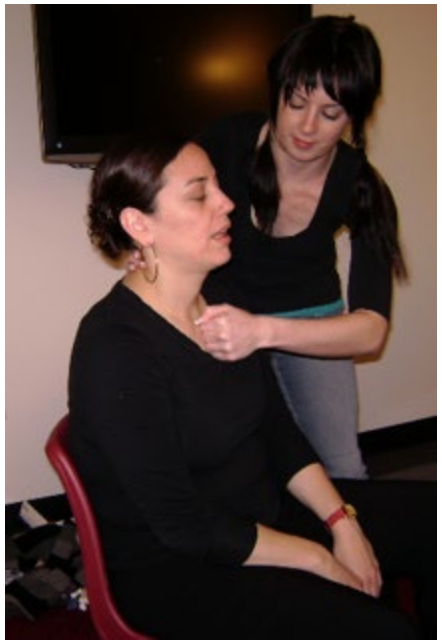
Recognizing Overdose

- Loss of consciousness
- Unresponsive to outside stimulus
- Awake, but unable to talk
- Breathing is very slow and shallow, erratic, or has stopped
- For lighter skinned people, the skin tone turns bluish purple, for darker skinned people, it turns grayish or ashen
- Choking sounds, or a snore-like gurgling noise (sometimes called the “death rattle”)
- Vomiting
- Body is very limp
- Face is very pale or clammy
- Fingernails and lips turn blue or purplish black
- Pulse (heartbeat) is slow, erratic, or not there at all

Overdose Response

Step 1: Assessment and Stimulation

- Assessment
  - Is the person breathing?
  - Is the person responsive?
  - Do they answer when you 'shake and shout' their name?
  - How is their skin color (especially lips and fingertips)?
- Verbal Stimulation
  - Call his or her name and/or say something that they might not want to hear, like *"I'm going to call 911"* or *"I'm going to give you naloxone."*
- Physical Stimulation
  - **If this does not work,** try to stimulate them with pain to wake them up.
  - Rub your knuckles into the sternum (the place in the middle of your chest where your ribs meet)
  - Rub your knuckles on their upper lip.
  - Pinch the back of their arm



Overdose Response

Step 2: Administer Naloxone

- Administer 1-2 quick rescue breaths
- Injectable:
  - Draw up entire vial into syringe
  - Inject into shoulder or thigh, stick needle in straight to get into muscle
  - Repeat after 1-2 minutes
- Nasal:
  - Stick device all the way into one nostril, press hard to click
  - Repeat after 1-2 minutes if breathing has not returned
- If breathing does not return:
  - Likelihood of a cardiac arrest
  - In more rare cases, a high dose of a high potency opioid like fentanyl may require more naloxone
  - START CPR and CALL 911!
- Naloxone only lasts 30-90 minutes, emergency response is critical

Overdose Response

Step 3: Call for Help! 911

- What to say to dispatcher:
  - Tell the dispatcher exactly where you and the overdosing person are. Give them as much information as possible so that they can find you (i.e., 3rd floor, or in the bathroom).
  - Avoid using words like drugs or overdose—stick to what you see: "Not breathing, turning blue, unconscious, non-responsive, etc." This makes the call a priority.
  - When the paramedics arrive, tell them what you know about what drugs the person may have been using—as much information as possible. If the paramedics suspect opioids, they will give the victim an injection or intranasal dose of naloxone.
  - If naloxone did not work, tell the dispatcher this

- Oregon Good Samaritan Overdose Law:
  - If someone is overdosing and you call for medical help, you cannot be arrested or prosecuted for:
    - Possessing drugs or drug paraphernalia
    - Being in a place where drugs are used
    - Violating probation or parole because of drug use or possession
    - Outstanding warrant because of drug use or possession

Overdose Response

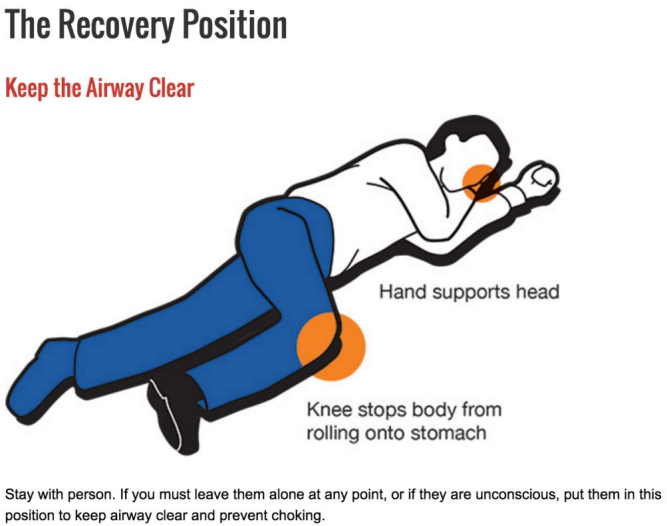
Step 4: Perform Rescue Breathing (Consider full CPR)

- Provide rescue breathing as soon as possible:
  - Place the person on their back.
  - Tilt their chin up to open the airway.
  - Check to see if there is anything in their mouth blocking their airway
  - Plug their nose with one hand, and give 2 even, regular-sized breaths. Blow enough air into their lungs to make their chest rise.
  - Breathe again. Give one breath every 5 seconds.
- You may have heard that recent CPR guidelines recommend “hands-only CPR,” or only chest compressions instead of rescue breathing and chest compressions
  - These guidelines are for layperson response to *cardiac arrest*, and NOT overdose
  - It is still recommended that you perform rescue breathing for an overdose, where the primary issue is respiratory depression, and not cardiac arrest
- Start full CPR if the person does not start breathing after two doses of naloxone

Overdose Response

Step 5: Place in Recovery Position

- If you must leave the person at all, even for a minute to phone 911, make sure you put them in the **Recovery Position**
  - Lay the person slightly on their side
  - Bend their knee
  - Turn their face to the side
  - This will help to keep their airway clear and prevent them from choking on their own vomit if they begin to throw-up
- After the person returns to breathing, place in this position until EMS arrives



Overdose Response

Step 6: Aftercare

- It is very possible naloxone will cause withdrawal symptoms in someone that uses opioids regularly
  - After giving someone naloxone he or she may feel sick and want to use again right away.
  - **It is very important that one does not use drugs again until the naloxone wears off so that a re-overdose does not occur.**
- Naloxone may take **up to 8 minutes** to have an effect and lasts for about 30 to 90 minutes in the body
  - Because most opioids last longer than that, the naloxone *may* wear off before the effects of the opioids wear off and the person *might* go into an overdose again
- **The likelihood of overdosing again depends on several things including:**
  - How much drug was used in the first place and the half-life of the drug(s) taken
  - How well the liver works to process things; and
  - If the person uses again.
- **Be gentle to yourself and the person after responding to an overdose!**

Overdose Response

Recap

- **Step 1:** Stimulate them by yelling at them and giving a hard sternal rub
- **Step 2:** Administer naloxone, one dose every two minutes until breathing is restored and person is alert
    - *Injectable:* Draw up entire vial and inject into thigh muscle
    - *Nasal:* Stick device all the way into one nostril, push hard until it clicks to administer
- **Step 3:** Call 911, explain someone is non-responsive and not breathing
- **Step 4:** Start rescue breathing
    - Get the person on their back, tip their head back to straighten the airway, pinch their nose, put your mouth over theirs and form a seal, one breath every five seconds
- **Step 5:** When the person starts to breathe regularly on their own, roll them into a recovery position on their side
- **Step 6:** Be gentle with them and yourself afterwards!

Overdose FAQs

- Isn’t this the stuff that they injected into the heart in *Pulp Fiction?*
- Isn’t there naloxone in Suboxone?
- Can Suboxone reverse an overdose?
- How does the liver affect an overdose?
- What if I give naloxone but it wasn’t an overdose?
- What if my naloxone is expired?

Preventing Overdose

Patient Counseling Tips

- Mixing Drugs
  - Most overdoses are caused by mixing multiple substances – any sedating drug can increase the risk, including alcohol
  - Use one substance at a time! If using heroin, use it first before using anything else
- Tolerance
  - Use less when you are sick, or you haven't used – even a few days of abstinence or decreased use can lower your tolerance.
  - If you are using after a period of abstinence, be careful and go slow
- Quality
  - Test the strength of the drug before you do the whole amount
  - Know the pills you're taking
  - Be careful when switching from one type of opioid pill to another
- Using Alone
  - Use with a friend!
  - Develop an overdose plan with your friends or partners.
  - Leave the door unlocked or slightly ajar.
  - Call someone you trust and have them check on you

Preventing Overdose

Patient Counseling Tips

- Age & Physical Health
  - **Anyone who uses opioids – *including people who take opioids for pain* – should be aware of increased overdose risk if they have any of the following health characteristics:**
    - Smoke or have COPD, emphysema, asthma, sleep apnea, respiratory infection, or other respiratory illness
    - Have kidney or liver disease or dysfunction, cardiac illness or HIV/AIDS
    - Drink alcohol heavily
    - Currently taking benzodiazepines or other sedative prescription or antidepressant medication
  - Drink lots of water or other fluids, try to eat
  - If you have liver damage, stay away from pharmaceuticals with a lot of acetaminophen in them, like Vicodin and Percocet
  - Carry your inhaler if you have asthma, tell your friends where it is, and that you have trouble breathing
  - Go slow if you've been sick, lost weight, or have been feeling under the weather or weak—this can affect your tolerance.
- Mode of Administration
  - Be mindful that injecting and smoking can mean increased risk
  - Consider snorting, especially in cases when you're using alone or may have decreased tolerance
  - Be careful when changing modes of administration since you may not be able to handle the same amount

Thank you!

Panel Questions & Answers

Questions submitted via Chat feature

Survey Completion for CME Credit:

- Survey will be emailed to all participants
- **LCSWs: email me for your specific survey:**

carsonp@careoregon.org

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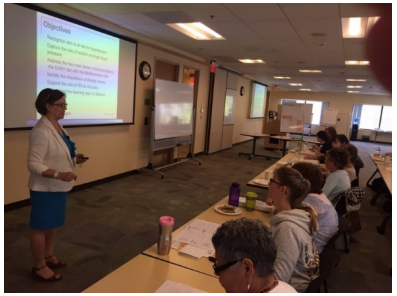

Medication education seminars

Our ongoing education series for healthcare professionals involved in direct patient care at community clinics.

These sessions examine disease states that highly impact patient quality of life, require complex management, and may lead to increased emergency department visits and inpatient stays.

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Thank You!
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