The Community: Pain Opioid Checklist

https://www.integration.samhsa.gov/clinical-practice/mat/mat-overview

Medication Assisted Treatment Implementation Checklist

This checklist provides policymakers, state and local officials, and other community stakeholders key questions to consider before engaging in efforts to increase access to medication assisted treatment (MAT) for addictions in their communities.

Approaches to the Opioid Crisis

- **Coordination & Collaboration**
- **Humanizing the Crises**
- **Prevention**
- **Early recognition**
- **Harm Reduction**
  - **Overdose**
    - overdose prevention
    - recognition
    - response
- **Treatment**
- **Social & Spiritual Determinants**

Link to:

- **Ecosystem & Stakeholders**
- **Vision of optimal care**
- **Take Action**
- **Best Practice**
- **Tools**
- **Resources (Data)**
- **Strategies**

Community Approaches to the Opioid Crisis

- **Coordination & Collaboration**
  - Multiple organizations
  - Frequency of meeting
  - Communication Infrastructure
- **Humanizing the Crises**
  - Stigma reduction strategy

- **Prevention**
  - Educational campaigns
    - Elementary School
    - High schools
    - Colleges
    - Public Campaigns

Community- Based Prevention Strategies

- Invest in surveillance to ascertain how patients in treatment for opioid abuse and those who have overdosed obtain their supply.
- Convene a stakeholder meeting with broad representation to create guidance that will help communities undertake comprehensive approaches that address the supply of, and demand for, prescription opioids in their locales; implement and evaluate demonstration projects that model these approaches.
- Convene an inter-agency task force to ensure that current and future national public education campaigns about prescription opioids are informed by the available evidence and that best practices are shared.
- Provide clear and consistent guidance on safe storage of prescription drugs.
- Develop clear and consistent guidance on safe disposal of prescription drugs; expand access to take-back programs.
- Require that federal support for prescription drug misuse, abuse and overdose interventions include outcome data

Hey Politicians, Here Are 10 Proposals That Would Actually Address the Opioid Crisis

Campaigning for the imminent primary in New Hampshire, a state greatly affected by the opioid addiction and overdose crisis, presidential candidates have been falling over each other to express their sensitivity, empathy and proposed solutions.

It seems everyone—from Clinton and Sanders to Cruz to Trump—has a bold-but-vague, or utterly unimaginative plan that limply "prioritizes treatment" yet conveniently leaves out an array

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of vitally important additional components. The White House recently added to that conversation by announcing that they are seeking over $1 billion in federal funds over the next couple of years to beef up drug treatment for people struggling with opioids.

It's great that the country is talking about opioids and overdose. But—just once—I would love to hear any of these politicians mention some concrete steps that we can all take today. Things that are free. Things that are simple, easy and quick. Things at least we can all get started on while we wait for the flow of federal funding and the next round of sensitive musings from presidential candidates.

Things like this:

1. Let's encourage all **high schools and colleges** to include an **overdose prevention** and **naloxone education** component in their **"drug awareness" programs**. We can require that, but it may take passing legislation, which is time-consuming. So let's start by simply asking our high schools and colleges to educate our young people about overdose prevention, recognition and response in the context of their existing drug education programs.

2. Let's encourage more **physicians** to become **licensed to prescribe buprenorphine**, an effective treatment for people with opioid use disorder. Smart states could subsidize the cost of that training for one year by offering a rebate to participating physicians. States can either pay through the nose to incarcerate heroin-dependent people or they can pay far less to get a doctor to start providing treatment to them. Check in with those physicians periodically to assess their comfort and success in treating opioid-dependent people. Is your healthcare provider licensed to prescribe it? Ask them, and explain why it's so important in your community.

3. **Check this list.** All areas hardest hit by fatal opioid-related overdose need to first be made aware of the scope of the problem. Counties that don't know that they're disproportionately impacted by overdose deaths can't be expected to work quickly to address it. Share the information with your community and your local public health department. Once they're aware, they can start drilling down in the data to determine which zip codes are seeing the highest rates of opioid-related arrests and deaths. Then we can start targeting solutions in those communities—like providing naloxone directly to people who use drugs and increasing overdose prevention education in local schools.

4. Which brings me to methadone. **Methadone clinics** are routinely protested and refused by the same communities which need them the most. Yet they unequivocally save lives, and are more effective at doing so than abstinence-based treatment for opioid addiction. If we're serious about tackling these problems, we must start loudly supporting expanded methadone access in our own backyards.

5. Start drafting comprehensive **911 Good Samaritan and naloxone access laws**. Yes, this is legislative and will take some time. But start now, or seek out those engaged in existing efforts to lend your support. You might live in a state that does not make it simple and easy for people

to get naloxone in their own community. You might live in a state that doesn't yet have a law protecting people who call to report a drug overdose in progress from arrest for drug law violations—or that has such a law, but it doesn't go far enough in terms of who it protects. Ask your lawmakers to do more—and if you really want to start a major conversation about great policy, ask your lawmaker to follow the bold lead of Maryland Del. Dan K. Morhaim's visionary plan.

6. Start talking with young people about **boredom, self-esteem, jobs, trauma and opportunity**. It's so easy to point the finger at heroin as being the root cause of all the problems, but of course it's not. Chaotic drug use is not itself always the root problem—**it's often the highly visible and distressing symptom of deeper issues.** Those issues for many young people can often include boredom, low self-esteem and poor self-concept, a lack of meaningful work at a living wage, and the absence of any evidence that their lives will unfold and blossom into something bigger. And for many young people, sexual, physical or emotional trauma can drive them to self-medicate their distress with drugs. Those are all big problems to solve. They will take time. But the conversation with young people about what's driving drug use in your community should start today.

7. Encourage all drug treatment providers to make **medication-assisted treatment, overdose prevention education and naloxone available to their clients.** We all need to live in the 21st century, where research and science and medicine can help us achieve the best possible outcomes. Relapse is a reality for many, many people leaving treatment. Let's work within that reality. Legislation might be effective, but right now, we can start asking our local treatment providers if they provide those lifesaving things to their clients and encourage them to do so. And while we're at it, let's have those same conversations with correctional facilities.

8. Talk to our kids about drugs. I mean, really talk to them. Be open, candid, vulnerable, compassionate and smart. Teach them about polydrug overdose and how easy it is to accidentally overdose when you mix things like alcohol and prescription opioid painkillers. Teach them to avoid powders if possible, because it's easier for someone to mess with a powder than a pill. Teach them to never swallow or smoke or inhale something if they don't know exactly what it is, how it will affect them, and where it came from. Teach them that you don't want them making stupid choices that can kill them and that more than anything, you just want them to be safe and alive. If they feel they can be really honest with you, and there are no negative consequences for their honesty, you're already halfway there.

9. Support **your local syringe access program.** Those hardworking folks have dedicated their professional lives to promoting the health, safety and dignity of people who use drugs. They distribute naloxone, they teach overdose prevention, they provide support for all of those young people injecting heroin and other opioids. Their work greatly reduces HIV and hepatitis C transmission. They help keep people alive during their darkest times. None of them are rich, but all of them are good. Go meet them. And bring them cookies.

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10. Learn more about **harm reduction,** a health-centered approach to drug use. Harm reduction advocates are a thriving, international community of people from all walks of life and all professions that believes that nothing could be more important than helping people who use drugs reduce their risks of things like contracting diseases and dying. We also have strong feelings about ending the war on drugs. Talk to us and learn more.

Meghan Ralston is a drug policy consultant in Palm Springs, CA. She is the former harm reduction manager for the Drug Policy Alliance.

POLITICO recently convened a group of policymakers and stakeholders to explore the opportunities and obstacles to changing the culture around prescribing. Participants included the U.S. surgeon general, leaders from HHS, CDC, the National Institutes of Health and the Food and Drug Administration, payers — and doctors and pharmacists on the front lines of prescribing.

Read more:
http://www.politico.com/story/2016/03/opioid-crisis-prescriptions-working-group-221350#ixzz44Whpw16P

Public Education

The working group strongly emphasized the need to address patient demand, not just physician supply, for opioids. It compared the necessary education to the campaign to reduce demand for antibiotics. The public needs to learn about the harms as well as the benefits of these powerful painkillers, and patients must understand that their pain can be treated with less-dangerous medications, or nonpharmacological interventions like physical therapy or acupuncture. Such education could be spearheaded by various physician associations and advocacy groups, with support from government agencies and officials at HHS and elsewhere.

“I have fear of these drugs … [W]e need to broadcast the way we feel about it to our [patients]."

“This isn't just a question of clinicians or health departments or emergency departments. We really want to do all we can to reinforce that conversation between the patient and clinician about safe prescribing.”

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“I'm really worried that when I give you this prescription you're going to think this is the only thing that can treat your pain.”

Read more:
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The abuse of opioids continues to have a devastating effect throughout the United States, as 2 recent studies highlight.

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The first study, a national poll by the Harvard T. H. Chan School of Public Health and the Boston Globe, found that about 40% of respondents personally knew someone who had abused or misused prescription pain medicines such as hydrocodone in the past 45 years (http://bit.ly/1JHYqtd). Only about 45% believed that long-lasting treatment was effective for opioid dependency.

The second study, from the Centers for Disease Control and Prevention and the Food and Drug Administration (FDA), found that heroin abuse, traditionally more common among men and the poor, is now rising rapidly in groups such as women, the privately insured, and those of higher income (http://1.usa.gov/1Fo8QtT).

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These findings represent just the tip of the iceberg. From 2001-2013, the annual number of overdose deaths rose 3-fold for prescription opioid analgesics (to more than 16 200) and 5-fold for heroin (to more than 8200 deaths) (http://1.usa.gov/1znaUDW). Such trends parallel the steady increase in opioid analgesics to 259 million prescriptions a year, enough for each American adult (http://1.usa.gov/1JFmWJg).

People can readily access and misuse legal drugs in the medicine cabinet prescribed for others. Three-quarters of new users of heroin, a cheaper and more readily available opioid, initially began using prescription painkillers for nonmedical reasons. Researchers cite additional factors, such as aggressive pain treatment as a desired feature of quality care, availability of new formulations, pharmaceutical marketing, and previous underappreciation of addiction risk by professionals and public alike, as contributing to these trends.

The crisis has triggered a dramatic response nationwide. Federal agencies, such as the White House Office of National Drug Control Policy (ONDCP) and the US Department of Health and Human Services, have offered comprehensive strategies to prevent opioid abuse and overdose. State and local leaders, including elected officials, have led a surge of community activity on the following fronts:

REDUCING SUPPLY

REDUCING SUPPLY | MONITORING USE AND POTENTIAL MISUSE | REVERSING OVERDOSES | ACCESSING TREATMENT AND PREVENTION | HUMANIZING THE EPIDEMIC | ARTICLE INFORMATION

Clinicians are striving for a finer balance that meets the patient's need for pain relief while minimizing chances for abuse. Updated professional education efforts promote state-based and specialty society-based prescribing guidelines that encourage separate treatment approaches for acute and chronic pain; careful consideration of abuse risk before prescribing; "contracts" that clarify expectations, goals, and responsibilities for patients and prescribers; and use of the lowest effective dose for the shortest possible duration.

In addition, community public education efforts have encouraged safer disposal of unused medicines from the home. Research to reduce the supply of unsafe analgesics has prioritized creating deterrent forms of pills that cannot be crushed and abused, as well as novel painkillers with little or no abuse potential.

MONITORING USE AND POTENTIAL MISUSE

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Prescription drug monitoring programs (PDMPs), which electronically track prescriptions of all controlled drugs, now operate in 49 states (except Missouri) and Washington, DC

(http://nyti.ms/1u8aKxQ). PDMPs can identify possible nonmedical use and diversion. Physicians can connect to them as part of prescribing while pharmacists can check them before dispensing.

A preliminary analysis of mandated PDMP use in Kentucky, Tennessee, and New York showed fewer episodes of patients seeking prescription opioids from multiple providers (http://bit.ly/1IP9kJP). Nonetheless, many PDMPs still need substantial improvements to reach the ideal in which they are easy to use, offer standardized content, update information in real time, and demonstrate interstate accessibility. Also, a new national initiative pairs law enforcement with public health officials to better trace and monitor trafficking of heroin, which in some states is now often laced with fentanyl, a powerful synthetic opioid.

REVERSING OVERDOSES

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Naloxone (Narcan), which temporarily reverses the respiratory depression associated with opiate overdose, can prevent opioid-related death. Although it is traditionally administered intravenously in the medical setting, the availability of an intranasal formulation now allows ready use in the field by laypersons and first responders—fire and police department personnel. A recent survey notes that expanded naloxone use by laypersons, viewed as safe and cost-effective, has now reached 30 states and Washington, DC (http://1.usa.gov/1NgErFz). In 2014, the FDA approved a naloxone autoinjector that could further expand usage.

ACCESSING TREATMENT AND PREVENTION

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Tocounter public misperceptions about treatment futility, ONDCP Director Michael Botticelli, MEd, emphasizes showing “hope on the other side” of addiction (http://bit.ly/1OiADRA). Citing his personal perspective as a person in recovery, Botticelli promotes the proven value of linking people to care through a continuum of services, including medication-assisted treatment (including buprenorphine, methadone, and naltrexone), counseling, and behavioral therapy. Promising approaches also include using the emergency department setting to initiate buprenorphine for opioid-dependent patients (as opposed to brief intervention and referral), as well as to connect with recovery coaches (http://bit.ly/1bSDRxm).

Long-term success requires substantially improving treatment capacity that has been chronically underresourced with respect to facilities and trained clinicians. The Affordable Care Act (2010) and the Mental Health Parity and Addiction Equity Act (2008) offer major opportunities to improve insurance coverage and treatment, but barriers for smooth implementation remain. Meanwhile, community-based coalitions, involving local schools, youth groups, law enforcement

and faith-based organizations, among others, have heightened public education about the power of prevention.

HUMANIZING THE EPIDEMIC

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Media stories about how the opioid crisis cuts short promising lives are renewing public attention, commitment, and concern. Viewing substance use disorders as a chronic disease that waxes and wanes, not as a moral failing, may help overcome stigma that prevents affected people from seeking treatment. Encouraging public dialogue that refers to a “person with a substance use disorder” (instead of “addict”) and “person in recovery” (instead of “former addict”) can medicalize what many still view as primarily a criminal problem.

The heightened national response to the current opioid crisis, although noteworthy, must be deepened and sustained. Although prescription opioid-related deaths have leveled in the last several years, the country has not yet documented the progress seen with other substance abuse areas, such as tobacco dependence and underage drinking. Overcoming the opioid crisis will require the highest level of commitment of communities, clinicians, public health, and public safety for many years to come.

ARTICLE INFORMATION

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