Toolkit for Prescribing, Co-Prescribing, and Distributing FDA-Approved Overdose Reversal Drugs (Naloxone) to the New Orleans Community

REVIVE. SURVIVE. OVERDOSE PREVENTION PROGRAM

Helena Likaj, MPH
Lee Reisman, LMSW
Odyssey House Louisiana
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Odyssey House Louisiana (OHL) offers comprehensive and compassionate services that support individuals through their addiction treatment and recovery process; while also advocating for larger access to equitable healthcare throughout Louisiana. Throughout its multiple programs, OHL provides services to over 900 individuals each month. We use research and proven processes to guide our programs and are nationally recognized as a model treatment program.

OHL's Prevention Department supports the agency's mission and vision by providing services directly within communities. We prioritize providing equitable services while creating easily accessible and non-judgmental spaces for all. OHL's **Revive. Survive. OverDose Prevention Program** (**Revive. Survive. ODP**) is a five-year SAMHSA funded grant designed to address and alleviate the opioid epidemic in New Orleans. Developed through evidence-based research, New Orleans specific research conducted by Revive. Survive ODP, pilot overdose prevention trainings, and community outreach, the **Revive. Survive. OverDose Prevention Program** is pleased to provide you with the *Toolkit for Prescribing, Co-Prescribing, and Distributing FDA Approved Overdose Reversal Drugs (Naloxone) to the New Orleans Community*. This toolkit has shaped **Revive. Survive. ODP**'s approach to address and alleviate the opioid epidemic impacting our New Orleans community. We aim to:

- Increase awareness and implementation of the Harm Reduction Approach throughout New Orleans
- Increase access to naloxone
- Develop naloxone distribution workflow recommendations for treatment facilities, Federally Qualified Health Centers (FQHCs), and Community Based Organizations (CBOs)
- Train prescribers, pharmacists, clients, and community members on the overview of the opioid epidemic, naloxone administration and access, and tools to address the needs of individuals suffering with addiction
- Identify and serve priority populations
- Increase access to treatment services
- Facilitate citywide partnerships and capacity with pharmacists, health care providers, social service agencies, community members, and local governance. Together, we can develop and strengthen our strategies, resources, tools, and data collection efforts to address the unique needs of New Orleans.

Through this approach, **Revive. Survive. ODP** is determined to improving the overall health outcomes of all New Orleanians.

Acknowledgements

This work could not be possible without the support of our Advisory Board Members: Sean Ambrose, Dr. Joseph Kantor, MD MPH, Dr. George Singletary, MD MPH, Tulane Medical Student Interns: Mali Wiederkehr, Andrew Curnow, Christopher Nelson and our Community Stakeholders: William Sherman and Laura Collins.

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IINTRODUCTION

Drug overdose fatalities are currently the leading cause of accidental death and have surpassed gun homicides and car crashes combined. The opioid epidemic is considered the worst drug crisis in American history. In response, the U.S. Department of Health and Human Services launched the Opioid Initiative with three core goals: reduce opioid prescription practices, provide medication-assisted treatment, and increase the use of naloxone [89]. This toolkit has been developed to assist the New Orleans community in implementing these nationwide initiatives.

The opioid epidemic has been fueled by prescription medications, specifically in the attempt to treat acute and chronic pain. The National Pain Strategy: A Comprehensive Populations Health-Level Strategy for Pain, has identified underlying challenges influencing current public health concerns: population research, prevention and care, disparities, service delivery and payment, professional education and training, public education and communication, and implementation. This toolkit aims to make recommendations that address these underlying challenges and reduce associated stigma.

This toolkit is designed to assist various stakeholders—including local governance, community leaders, non-profit groups, private sector organizations, public health initiatives, and members of the general public in understanding the current opioid epidemic, its influence on the New Orleans community, and effective strategies to reduce opioid overdose fatalities.

> *'Here is your shot. You probably shouldn't do the whole thing,' he said, passing me the fixed syringe. I had been waiting for him to hurry up and give me my share. I was at the end of my rope and ready for a change. I thought to myself that I didn't care what happened. I knew that I would either get very high or I would die and I didn't care which one so long as something changed. Death or delusion were the only options I could fathom at the time. I did the whole shot. Then, I died.*
> *- Anonymous (former) OHL Client*

NOTE: Language used formally and informally can reduce stigma associated with SUD

To reduce stigma, consider these 5 questions:

1. *Are you using "person first" language?*
   Avoid labeling individuals as problems. Use "a person with substance use disorder" rather than "drug abuser" or "addict".
2. *Are you conflating substance use and substance use disorder?*
   An individual who uses or has used substances in the past does not necessarily experience the symptoms associated with substance use disorder. Avoid assuming that if someone has used heroin for example, that they suffer from SUD or addiction.
3. *Are you using technical language rather than colloquialism or words with inconsistent definitions?*
   Be sure you are up to date with the most current clinical and technical language to avoid perpetuating stigmatizing language. For example, "substitution/replacement treatment" implies that one opioid is being substituted for another and perpetuates the stigma of "once an addict, always an addict". Instead, "medication-assisted treatment" or "pharmacotherapy for opioid use disorder" is more appropriate.
4. *Are you using sensational or fear-based language?*
   Avoid using language that sensationalizes substance use and correlated risks.
5. *Are you unintentionally perpetuating drug related moral panic?*
   Verbiage such as "crack baby" and "junky" places blame on the individual and results in moral panic and marginalization. The fear of judgement and mistreatment by medical professionals often prevents individuals from getting the services they need.

Source: SAMHSA: Words Matter: How Language Choice Can Reduce Stigma

Abstinence: in the context of substance use disorder, abstinence refers to refraining from alcohol or drug use.

Acute Pain: is an expected physiologic experience to harmful stimuli that can become pathologic, is normally sudden in onset, time limited, and motivates behaviors to avoid actual or potential tissue injuries.

Agonist: a substance that acts as a neuronal receptor to produce effects similar to those of a reference drug.

Antagonist: a substance that counteracts the effects of another agent. Pharmacologically, an antagonist interacts with a receptor to inhibit the action of an agonist that produces specific physiological or behavioral effects mediated by that receptor.

Biopsychosocial: refers to a medical problem or intervention that combines biological, psychological, and social elements or aspects.

Buprenorphine: mixed agonist-antagonist analgesic. Exhibits agonist effects at mu and delta opioid receptors and antagonist effects at kappa opioid receptors. Component of Suboxone (burprenorphine/naloxone), a medication used for MAT.

Chronic Pain: is pain that occurs on at least half the days for six months or more.

Delirium: an acute organic cerebral syndrome characterized by concurrent disturbances of consciousness, attention, perception, orientation, thinking, memory, psychomotor behavior, emotion, and sleep-wake cycles. Delirium tremens may occur during alcohol-induced withdrawal.

Dependence: a cluster of physiological, behavioral and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviors that once had greater value.

Depressant: any agent that suppresses, inhibits, or decreases some aspects of central nervous system activity.

Detoxification (Detox): also referred to as a managed withdrawal or supported withdrawal, detox is the supported cessation of a psychoactive substance.

Disparity: in the context of health, is a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantages. Health disparities adversely affect groups of people that have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Fentanyl: a synthetic opioid significantly more potent that morphine or heroine. Evidence of fentanyl has been found in a growing number of overdose fatalities, either mixed with another substance or by itself.

Heroin: an opioid drug synthesized from morphine.

Illicit Drug: a psychoactive substance of which, the production, sale, or use of is prohibited by law. However, it is the actions of production, sale, or use that are illicit, not the drug.

Intoxication: a condition that follows the administration or consumption of a psychoactive substance causing disturbances in the level of consciousness, cognition, perception, judgement, affect or behavior, or other psychophysiological functions and responses.

Medication-Assisted Treatment (MAT): combines behavioral therapy and medications to treat substance use disorders such as opioid addiction. Methadone, buprenorphine/naloxone (Suboxone) and naltrexone (Vivitrol) are some medications used in MAT.

Methadone: a long-acting medication used in MAT for opioid addiction, often taken as an oral solution in specially-designated clinics.

Naloxone: generic name for opioid-overdose reversal medication, also known by the brand name NARCAN. This medication is safe, has no addictive potential, and is appropriate for layperson use. It can be administered as a nasal spray, intramuscular injection, or a brand name auto-injector.

Naltrexone: a medication use in MAT that helps prevent opioid cravings.

Opioid: a compound or drug that binds to receptors in the brain involved in the control of pain.

Overdose: the use of any drug in such an amount that acute adverse physical or mental effects are produced. Overdoses may result in lasting effects or death.

Peer Support Specialist: a person willing to self-identify as having a serious mental health condition or addictive disorder with lived, personal experiences. Specific training and/or specialized certification is typically provided to these individuals. The role of a peer support specialist is to support others in the recovery process.

Psychosocial Intervention: any non-pharmacological intervention carried out in a therapeutic context at an individual, family, or group level. Psychosocial interventions can be structured, professionally-administered interventions such as cognitive behavioral therapy or insight-oriented psychotherapy. They can also be non-professional interventions such as self-help groups, financial support, legal support, employment assistance, information and outreach.

Rebound Toxicity: the re-emergence of respiratory depression and other features of opioid overdose following the temporary reversal of opioid overdose symptoms with an opioid antagonist such as naloxone.

Recovery: a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Individuals with severe and chronic substance use disorder can, with help, overcome their substance use disorder and regain health and social functioning.

Relapse: a return to substance use after a period of abstinence, often accompanied by reinstatement of dependence symptoms. The Stages of Change Model, identifies relapse as a normal process in the cycle of change.

Substance Abuse and Mental Health Services Administration (SAMHSA): the agency within the U.S. Department of Health and Human Services (HHS) that leads public health efforts to advance the behavioral health (mental illness and addiction) of the nation.

Substance Use Disorder (SUD): a medical illness caused by repeated use of a substance or substances causing clinically significant impairments in health, social function, and control over subsequent substance use. Substance use disorders are diagnosed through assessing cognitive, behavioral, psychological symptoms. Severe substance use disorders are commonly referred to as addiction.

Stigma: a mark of disgrace or infamy, a stain or reproach, as on one's reputation. Substance use disorders are stigmatized and as a result, people with SUD are less likely to seek help, and more likely to drop out of treatment programs in which they do enroll.

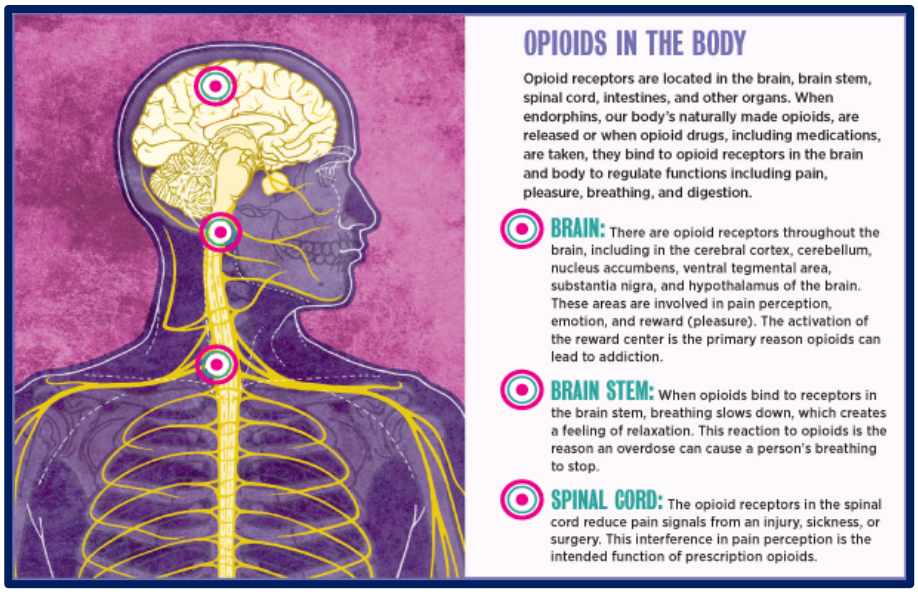
Syringe Service Programs (SSPs): also known as needle-exchange programs, work to reduce the spread of infectious diseases such as Hepatitis C and HIV by removing used injection equipment from circulation. Research shows that through wrap around services and referrals to addiction treatment SSPs reduce the number of active injection drug users in their area.

Tolerance: a condition in which higher doses of a drug are required to produce the same effect achieved previously. Opioids are known for producing physiologic tolerance.

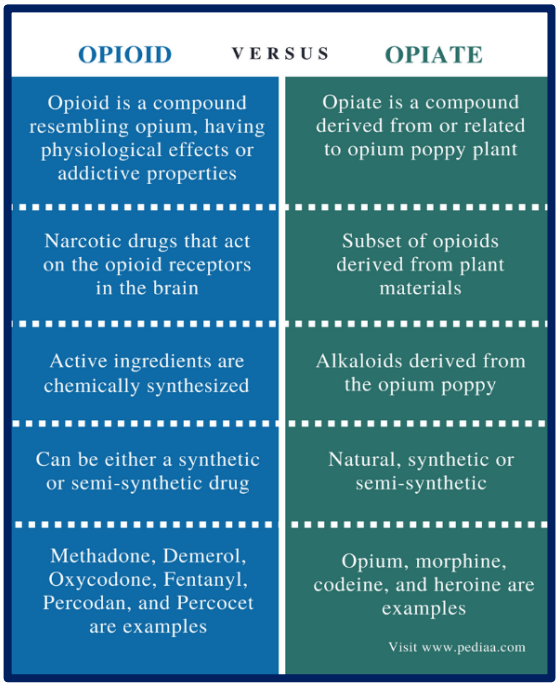
Withdrawal: a group of symptoms of variable clustering and degree of severity that occur on cessation or reduction of the use of a psychoactive substance that has been taken repeatedly. Depending on the substance and level of physiological dependence, withdrawal can be fatal. Opioid withdrawal is not typically fatal, however stress, anxiety, depression, nausea, vomiting, and cramping are typical symptoms.

Opioids

Opioids act by binding to different combinations of the three neuronal transmembrane opioid receptors μ, δ, and Ƙ. Opioids affinity to each of these receptors leads to their inherit differences in physiological outcomes and dependence. Opioids have traditionally been used to treat both acute and chronic pain disorders. However, research has indicated that long term opioid treatment results in increased tolerance, resulting in higher dosages and physiological dependence.



Source: Scholastic and the Scientists of the National Institute on Drug Abuse, National Institute of Health, US Department of Health and Human Services

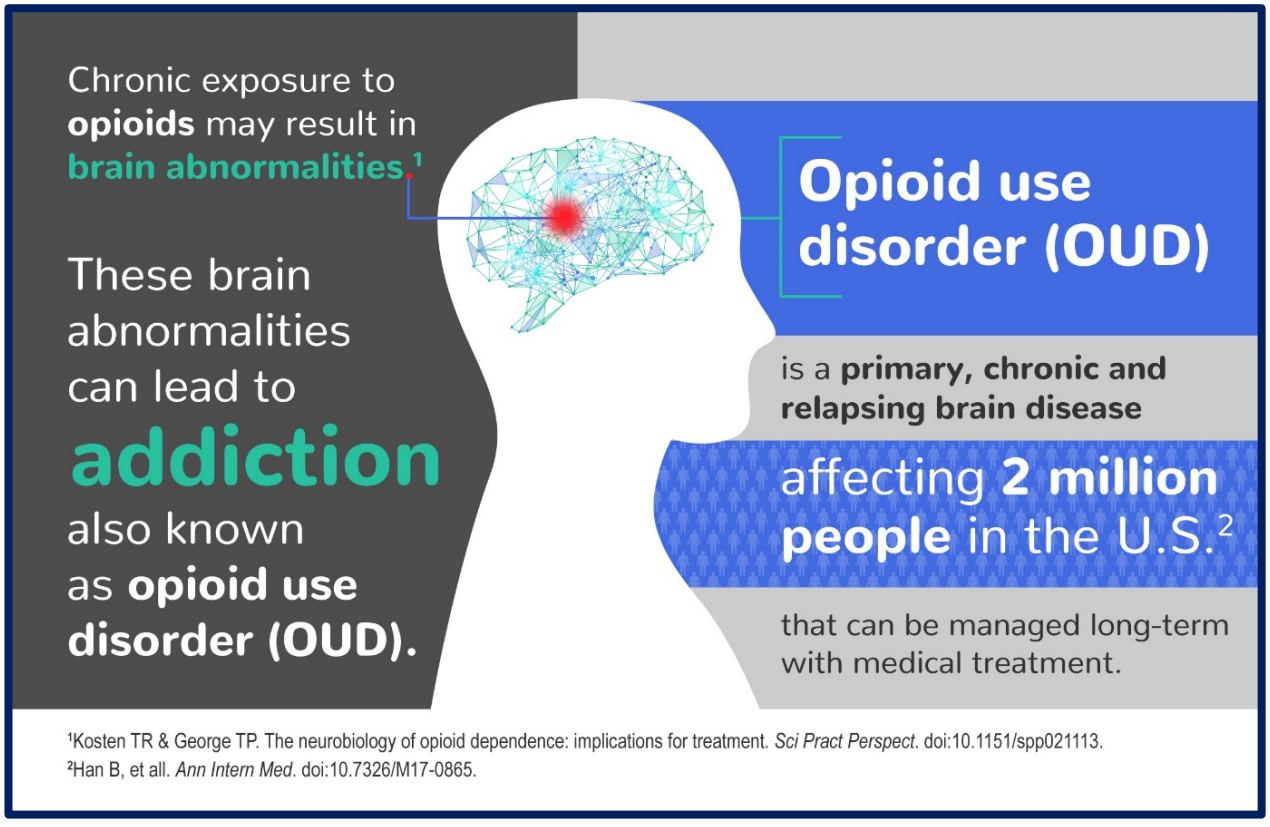


Opioid Use Disorder

The separate entities of opioid abuse vs. opioid dependence in the DSM-IV have been replaced by the single diagnosis of opioid use disorder (OUD) under the DSM-5 criteria. OUD relates to heroin, prescription opioid modifications, and illicitly manufactured synthetic opioids taken alone or in combination. Severity is separated by 11 criteria placing individuals under the categories of mild, moderate, or severe.

OUD, as paraphrased from the DSM-5, [87] includes but is not limited to:

1. Increased amount/duration of opioids than intended
2. Desire/inability to decrease or cease opioid use
3. Large time investment in procuring, using, and recovering
4. Craving/strong desire
5. Opioid use having a negative impact on social life and work
6. Potentially physically dangerous use
7. Continued use despite knowledge of negative impacts physically and mentally
8. Increased tolerance to opioids
9. Withdrawal symptoms



Opioid Overdose

An overdose (OD) occurs when a toxic amount of a drug or combination of drugs impairs the physiological functions of the body. Opioids fit into the same receptors in the brain that signal breathing, and as a result, opioid overdose causes respiratory depression and unresponsiveness. When breathing stops during an overdose, oxygen levels in the blood drop, leading to a process called cyanosis. This is typically identified when an individual's lips and fingers turn blue or ashy. Lack of oxygen in the blood causes vital organs including the heart and brain to stop functioning properly, and within 3-5 minutes damage to the brain begins. If the oxygen levels cannot be regained, an opioid overdose can become fatal. In preventing overdose, it is important to be able to recognize overdose symptoms, administer naloxone if accessible, call for emergency medical services, and provide rescue breaths until they regain normal breathing or EMS has arrived. [35]

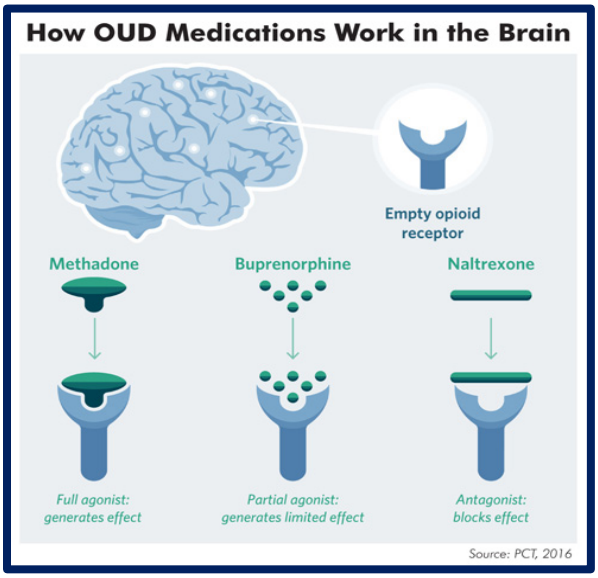
Source:https://www.princeedwardisland.ca/en/information/health-and-

Individuals with the greatest risk of overdose include those who: [96], [35]

- Take high doses of opioids for long-term management of chronic pain
- Receive rotating opioid medication regimes (at risk for incomplete cross-tolerance)
- Are discharged from emergency medical care following opioid intoxication or poisoning
- Are at high risk for overdose because of legitimate medical need for analgesia, coupled with suspected or confirmed history of substance use disorder/nonmedical use of opioids
- Take certain opioid preparations that may increase the risk of overdose such as extended-release or long-acting preparations
- Complete mandatory detoxification or abstinence programs
- Were recently released from incarcerations and have a history of opioid use disorder--high risk of relapse and reduced tolerance. [59,67]

OUD Treatment

Long term treatment for OUD consists of medical and nonmedical options—medical options showing the highest efficacy. [88] Psychosocial treatment is recommended in conjunction with pharmacological treatment, and should include psychosocial needs assessment, supportive counseling, links to existing family supports, and referrals to community services. [79] Depending on the severity of OUD diagnosis, individuals can choose from outpatient, inpatient, or detoxification treatment options. Opioid treatment programs (OTPs) should adhere to the Federal Guidelines for Opioid Treatment Programs administered by SAMHSA.



Source: PEW https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder

Source: National Institute on Drug Abuse https://www.drugabuse.gov/publications/seeking-drug-abuse-

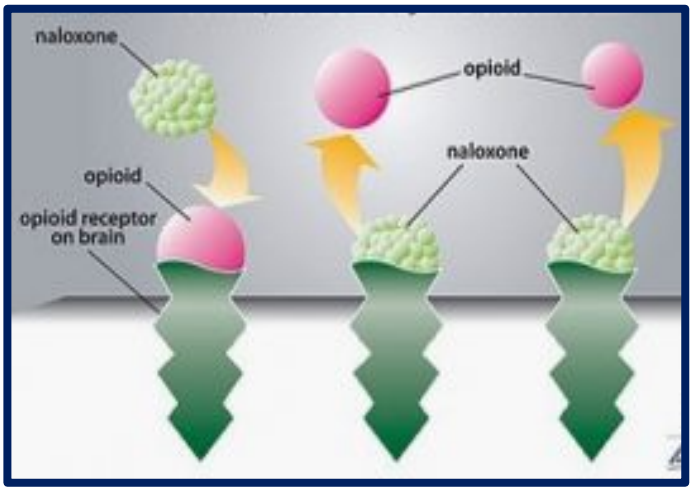
> *I was born this way and into generations of addiction and alcoholism. Some may have considered me hopeless and a lost cause. At times, I would have agreed. After struggling for over 25 years, I have found a new way to live and a purpose that inspires me to abstain from addictive substances.*
> *- Anonymous (former) OHL Client*

Nonmedical OUD Treatment Options	Medical OUD Treatment Options
Psychosocial Interventions Professional interventions include: • Psychotherapy such as Cognitive Behavioral Therapy • Individual, Group, and Family Therapy • Psychoeducational Groups • Case Management and care coordination • Referral to community services Non-professional interventions include: • Support and mutual- help groups such as 12-Step programs (Narcotics Anonymous)	*Agonist Medication* • Methadone– Once to twice daily long-acting μ receptor opioid agonist. Reduces cravings/symptoms for 24+ hours and maintains high tolerance to opioids. First line treatment in pregnant woman. Risk of QT prolongation at higher doses, increased chronic pain, p450 interaction and increased mortality with relapse. [88] • Buprenorphine– Once daily partial μ receptor agonist given in combination with naloxone to decrease misuse potential. Decreased potential mortality from relapse in comparison to Methadone. [88] Increased mortality when taken with alcohol, benzodiazepines or other depressants. [88] *Antagonist Medication* • Naltrexone – Blocks the opioid receptor. Requires patients to be highly motivated and at reduced risk of relapse. Drug leads to a decreased tolerance. Patients must be without opioids in their system or they may suffer from precipitated withdrawal. Rare adverse effect of liver damage at high levels. [88]

Naloxone

Naloxone is a medication that acts as an opioid overdose antidote. It works by displacing opioid molecules from their receptors so that the effects of the opioids are immediately withdrawn. This can be an uncomfortable experience and it is important that the individual receive medical attention immediately after naloxone administration. Naloxone is safe to use on all ages, has no misuse potential, and has minimal negative side-effects if used on someone experiencing something other than an opioid overdose. [97]

With the rise of the opioid epidemic, ADAPT Pharma developed an FDA-approved naloxone nasal spray, NARCAN, which was commercially launched in 2016. Since then, most naloxone products are referred to as Narcan by the general public. However, naloxone has been used to save lives for several decades. First patented in 1961, the Food and Drug Administration (FDA) approved intravenous and intramuscular naloxone for the treatment of opioid overdose in 1971. [1] Paramedics have been using naloxone to reverse the symptoms of opioid overdose in the field for over three decades. [17] As the opioid epidemic started in the 1990s, medical professionals began to experiment with simpler methods to administer naloxone and provide safer access in non-hospital settings. In 2012, an intranasal naloxone applicator was developed and approved for use by the FDA in 2015. Two years later, Evzio the naloxone auto-injector, was approved by the FDA specifically designed for individuals with no medical training, with intended use by family members and caregivers of overdose victims. [42] By 2016, NARCAN nasal spray was launched for use in community settings and made available without prescription to pharmacies across 38 states. [5] Even with the new methods, access to naloxone has been restricted by market pricing, prescription regulations, insurance coverage, poor implementation of Standing Orders, Good Samaritan Laws offering only narrow protection to naloxone administrators, and general stigma associated with substance use.



Source : Stopoverdose.org https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder

When I came to from overdosing, the change I sought was reversed.

Instead, I had road rash down my face, neck, and shoulders

and my lips were busted and swollen.

I was sick and shaking.

I was alone and weary.

I was tired.

It became clear to me that I could not continue to live the way I was.

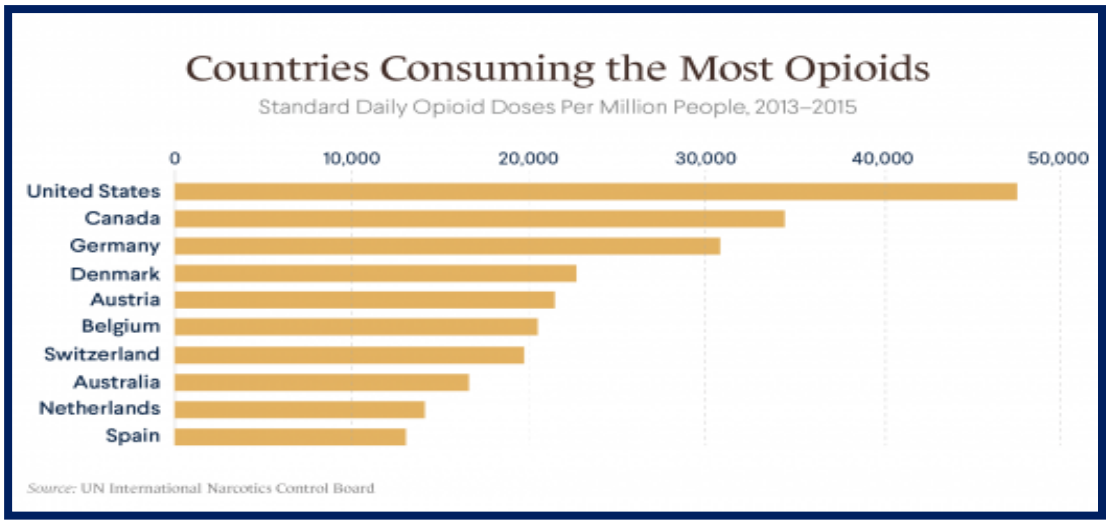
This was Sunday, August 3, 2014.

- Anonymous (former) OHL Client

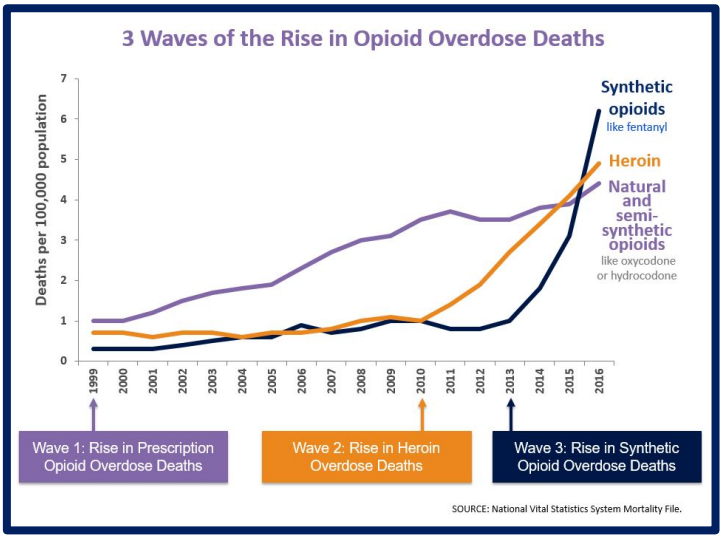
Globally

As the World Health Organization (WHO) has reported, the impacts of the opioid epidemic are felt across the globe. The United Nations Office of Drug and Crimes (UNODC) states that new trends in international drug trafficking have intensified the crisis; including the ease of making fentanyl analogues, availability over the internet, and international mail delivery system and express couriers. A major concern is that individuals who use these substances often are unsure of what they are actually taking and differences in potency of these products. [93]

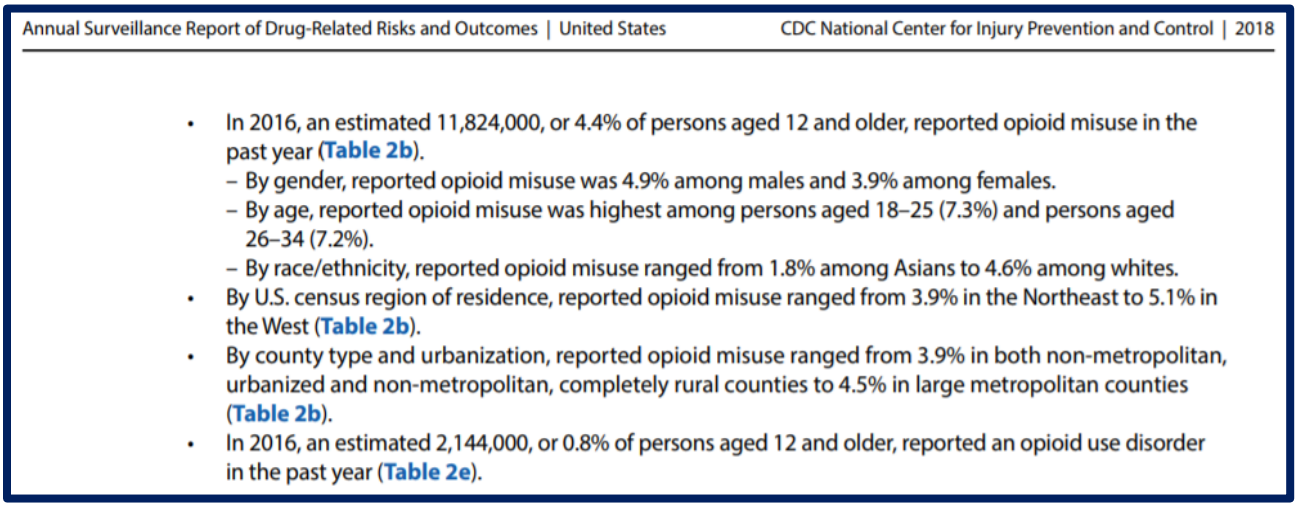
- About 275 million people worldwide (5.6 percent of the global population aged 15–64 years) used drugs at least once during 2016.
- Among them, there were about 34 million people who used opioids and about 19 million who used opiates.
- There were an estimated 27 million people worldwide who suffered from opioid use disorders in 2016.
- The majority of people dependent on opioids used illicitly cultivated and manufactured heroin, but an increasing proportion used prescription opioids.
- Roughly 450,000 people died as a result of drug use in 2015.
- Of those deaths, about 160,000 were directly associated with drug use disorders and about 118,000 with opioid use disorders.
- Overdose deaths contribute to between roughly a third and a half of all drug-related deaths, which are attributable in most cases to opioids.
- Lifetime prevalence of witnessed overdose among drug users is about 70%.
- There are effective treatments for opioid dependence, yet less than 10% of people who need such treatment are receiving it. [92]



Nationally



It is estimated that 174 Americans die every day from an overdose—surpassing motor vehicle fatalities—overdose has become the leading cause of injury death in the United States. [12] For injection drug users (IDUs), overdose is the number one cause of death. Most overdose fatalities occur in the pre-hospital setting; 78% of these are accidental. [12] According to the Center for Disease Control (CDC), national overdose rates have increased five-fold since the 1990's, and the rates are continuously rising. The U.S. experienced a 16.3% increase in overdose deaths between June 2016 and June 2017—66,817 individuals died of overdose in that twelve-month period. [12] The CDC attributes the increase to the increased supply of synthetic opioids, in particular illicitly manufactured fentanyl (IMF). [11] However, the influence of prescription opioids cannot be ignored, cited as the most common cause of opioid addiction. In fact, 83% of heroin users reported the use of prescription opioids before transitioning to illicit drug use, many due to refill denials. [11] Annually, there are enough prescriptions to supply every American with an average of 36 opioid pills. In 2016 alone, the over prescription of post-surgical opioids resulted in 3.3 billion excess pills that flooded the streets. [12]

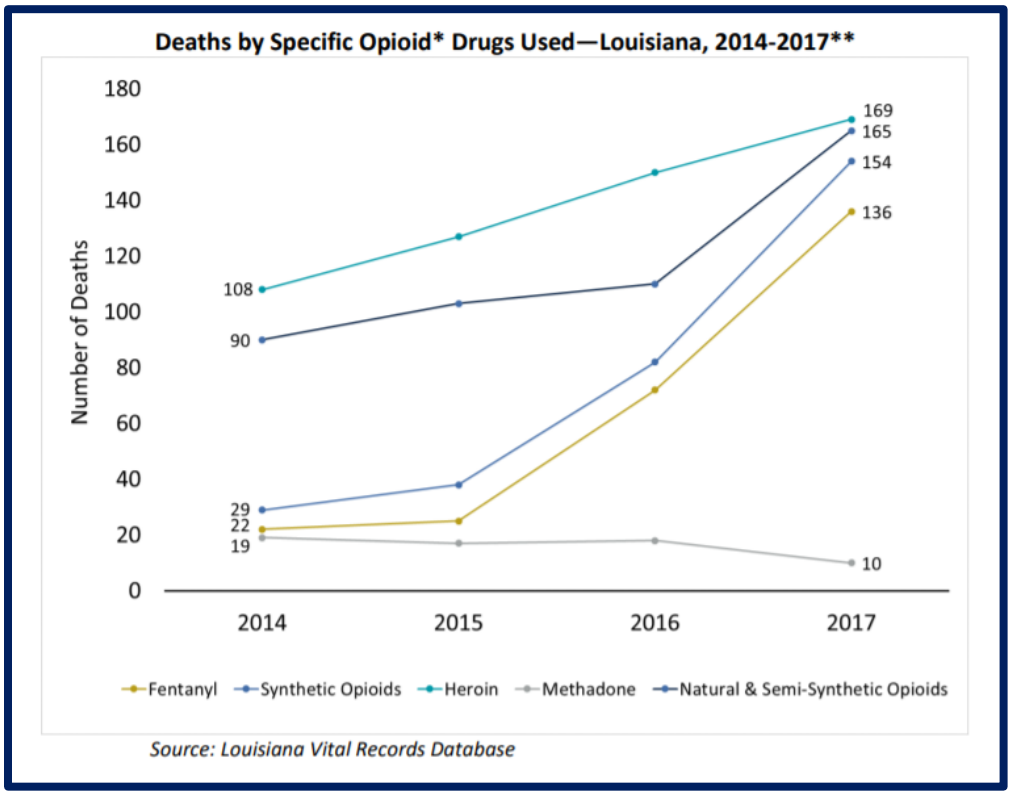


Annual Surveillance Report of Drug-Related Risks and Outcomes | United States — CDC National Center for Injury Prevention and Control | 2018

- In 2016, an estimated 11,824,000, or 4.4% of persons aged 12 and older, reported opioid misuse in the past year (**Table 2b**).
  - By gender, reported opioid misuse was 4.9% among males and 3.9% among females.
  - By age, reported opioid misuse was highest among persons aged 18–25 (7.3%) and persons aged 26–34 (7.2%).
  - By race/ethnicity, reported opioid misuse ranged from 1.8% among Asians to 4.6% among whites.
- By U.S. census region of residence, reported opioid misuse ranged from 3.9% in the Northeast to 5.1% in the West (**Table 2b**).
- By county type and urbanization, reported opioid misuse ranged from 3.9% in both non-metropolitan, urbanized and non-metropolitan, completely rural counties to 4.5% in large metropolitan counties (**Table 2b**).
- In 2016, an estimated 2,144,000, or 0.8% of persons aged 12 and older, reported an opioid use disorder in the past year (**Table 2e**).

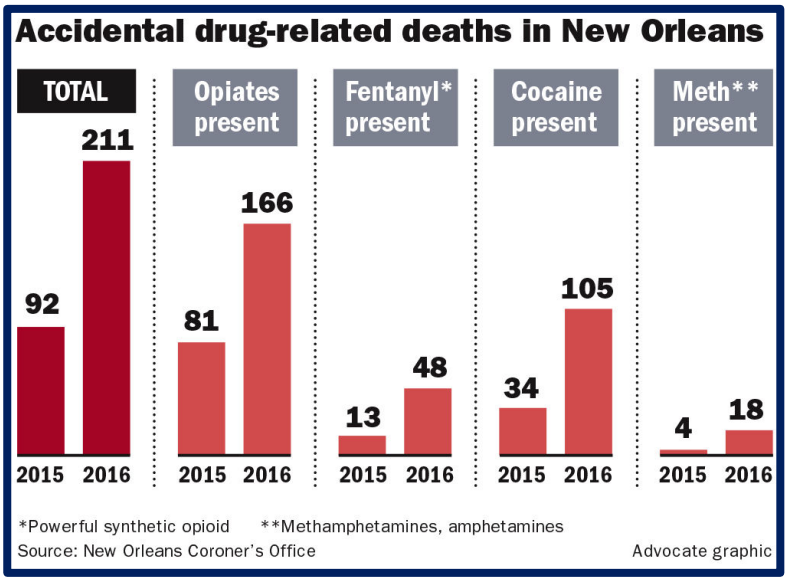
Louisiana

In 2017, 401 opioid fatalities were recorded in Louisiana rising from 346 recorded in 2016. It is important to note, The Louisiana Department of Health (LDH) estimates the true number of opioid involved fatalities is underrepresented by 125%. [49] The challenge of collecting valid statistics illustrates one of the greatest barriers to adequately addressing the epidemic. [49] Through 2012, opioid related deaths were associated primarily with prescription drug use. [90] Louisiana has the 6th highest opioid pain reliever prescribing rate and is one of eight states to have more opioid prescriptions than residents. However, since 2012 the increase of injection opioid use, including heroin and fentanyl, has become the leading cause of opioid related deaths. From 2012 to 2017, heroin-related deaths have increased from 51 to 169, and fentanyl deaths have increased from 19 to 136 [53]. Heroin use more than doubled among young adults ages 18–25 in the past decade. [91] In Louisiana, about 19,000 adolescents aged 12–17 per year in 2013–2014 reported non-medical use of pain relievers within the year prior to being surveyed. [47] The rise of injection drug use led to a rapid increase in overdose deaths, viral hepatitis, and HIV. These crises have become the biggest public health concerns impacting our communities and health care systems across the state.

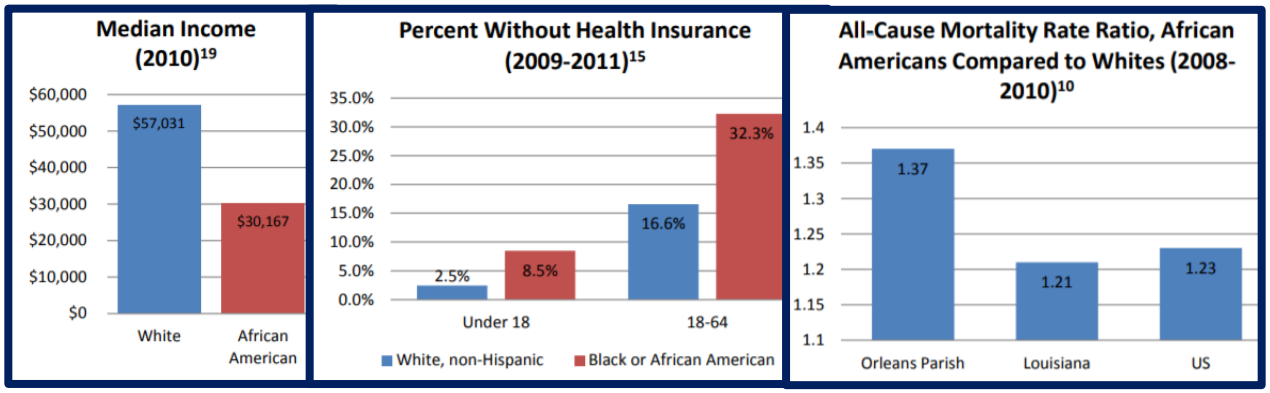


New Orleans

New Orleans has historically been an epicenter for overdose fatalities, and in recent years those numbers have skyrocketed. In 2016, the coroner's office recorded 211 overdose fatalities, which for the first time exceeded the city's homicide rates. Over 50% of those overdose fatalities were the result of opioids, more than double from previous years. [13] Local governance has acknowledged the issue as a public health concern and has begun to implement strategies to combat the opioid epidemic.



In addition, the New Orleans community is significantly impacted by health disparities that must be addressed to adequately meet local needs. According to the New Orleans Health Department, in 2010, 60% of local residents identified as African American, 30% as non-Hispanic white, 5% Hispanic, and 3% Asian. Disparities in income levels, insurance coverage, and mortality rate illustrate underlying systematic barriers to equitable resources and services throughout marginalized communities in New Orleans. [53]



Source: New Orleans Health Department
https://www.nola.gov/health-department/data-and-publications/reports/health-disparities-in-new-orleans-community-2013/

Global

In June of 2018, the UNODC launched a strategy, The UNODC Integrated Strategy on the Global Opioid Crisis, to address the global opioid epidemic which is predominately affecting North America and parts of Africa and the Middle East. The strategy aims to address international control of substances, law enforcement efforts to target supply, and implementation of initiatives to strengthen prevention efforts. The strategy plans on global partnerships including with the World Health Organization and International Narcotics Control Board, along with other international and regional organizations, academic, and civil society. In collaboration with Member States, the UNODC is working to support programs in the areas of synthetic drugs monitoring, early warning and trend analysis, national forensic and counter-narcotic capacity building, law enforcement operational work, and prevention and treatment. [93] Unique strategies have been used across the globe, almost all incorporating harm reduction methods, to address these concerns.

Source: Live4Lali https://www.facebook.com/DiscoverArlingtonHeights/photos/august-31-is-international-overdose-awareness-day-ioad-live4lali-and-glueckert-f/10156046982927804/

Nationally

Because of the escalating opioid crisis, there has been increasing national response and policy implementation attempting to mitigate and reduce opioid overdose fatalities. Notable federal appropriations occurred in 2017. The Consolidated Appropriations Act, 2017 provided HHS with $20 million for CARA-authorized programs, specifying $56 million for SAMHSA's Medication Assisted Treatment for Prescription Drug and Opioid Addiction program. [94] Congress provided $103 million for "comprehensive opioid abuse reduction activities" from the Department of Justice (DOJ). The Department of Veterans Affairs provided $50 million to increase opioid and substance misuse prevention and treatment. [94]

Recent legal trends across states concerning liability, treatment/prevention, and privacy, illustrates a national movement toward reducing opioid misuse and overdose. Good Samaritan Statutes have been increasingly implemented across multiple states, providing immunity from arrest for drug possession when a person dials 911 or seeks medical attention in the event of an overdose. Product Liability has allowed for countless lawsuits against manufacturers and distributors of prescription opioids for fraudulent marketing and negligent distribution. Similar lawsuits have been issued against the Joint Commission, holding them liable for issuing misinformation to prescribers and pharmacy boards for failing to report excessive orders of opioids. [94] There has also been an increase in federal prosecutions through Department of Justice's Opioid Fraud and Abuse Detection Unit against healthcare fraud cases related to wrongful or over-prescription opioids. [39]

Overdose prevention and treatment efforts have seen increasing legal support across the nation as well. Opioid Prescription Limitations are being implemented across numerous states typically permitting only a 5-day supply of opioids for acute pain, or a 7-day supply following surgery. Policies encouraging naloxone expansion are now common among first responders and law enforcement agencies. Statewide Standing Orders authorizing pharmacists to dispense naloxone to individuals 18 or older without prescription have been widely accepted as well. Legislative support for harm reduction programs such as safe disposal programs, syringe exchanges, and safe injection facilities, is growing as research illustrates their effectiveness in reducing overdose and infectious disease rates. Overall, there has been an increase of educational initiatives including the Drug Enforcement Administration's (DEA) partnership with Discovery Education to implement Operation Prevention—offering free educational tools and material for youth to combat opioid misuse. Countless other

governmental, not-for profit, and private resources have been made available to promote educational initiative surrounding the opioid epidemic and linkage to care. [94]

There have also been significant trends in privacy laws to track and monitor data associated with the opioid epidemic. The White House Commission has discussed the possibility of HIPAA regulations requiring health care workers to inform family members when a person is administered naloxone due to opioid overdose. Use of Prescription Drug Monitoring Programs (PDMPs) have grown significantly which allow prescribers to check prescription databases that track individual prescription histories. Taken even further, there have been legislative proposals to allow law enforcement agencies to access the PDMPs, without court orders, to investigate doctor-shopping. [94] While the CDC already practices extensive surveillance, prevention, and research efforts, there is growing federal support for research partnerships that would increase data collection on addiction and overdose.

Source: U.S. Senate https://www.alexander.senate.gov/public/index.cfm/the-opioid-crisis-response-act-of-2018

Timeline: National Opioid Response

March 2016	• CDC published the Opioid Prescribing Guidelines.
Dec. 2016	• CDC reports annual opioid overdose deaths hit record high of over 33,000.
March 2017	• President Trump issues Executive Order establishing White House Commission on Combating Drug Addiction and the Opioid Crisis.
July 2017	• Commission recommends national emergency declaration.
Oct. 2017	• President Trump announces HHS Public Health Emergency (PHE).
Nov. 2017	• Final White House Commission Report issued recommending: ◦ Increasing federally funded initiative to support opioid-related efforts at the state level. The spending bill passed by Congress in March 2018 included $3.3 billion increase for opioid funding. ◦ Media campaigns encouraging affected individuals to seek treatment. ◦ Removing legal barriers to use Prescription Data Monitoring Programs (PDMPs). February 2018, Jeff Sessions announced a plan to use medical data from PDMPs to hold doctors and pharmacies dispensing large amounts of opioid accountable. ◦ Expanding drug courts nationally to embrace MAT. ◦ Developing opioid prescribing guidelines, regulations, and education. April 2018, CMS released final Medicare rule requiring pharmacists to contact prescribers and document discussions before filling prescriptions of over 90 mg of morphine. September 2018, CDC published Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain. ◦ Ensuring greater health care coverage for substance use treatment. Current Administration has continued prior policy of approving waivers to let Medicaid programs pay for addiction and mental health treatment in facilities >16 beds. ◦ Encouraging non-opioid pain treatment. ◦ Raising criminal penalties for illicit drug trafficking, especially for fentanyl. In January 2018, Pres. Trump signed the Interdict Act giving federal agents further tools for detecting synthetic opioids at the border. March 2018, Pres. Trump announced a plan to increase penalties for drug traffickers, including the death penalty. ◦ Implementing naloxone co-prescribing programs and EMT best practices.
March 2018	• Upon appointment as CDC Director, Dr. Robert Redfield Jr lists combating the opioid epidemic as a top priority.
April 2018	• U.S. Surgeon General, Dr. Jerome Adams, issued a Public Health Advisory on Naloxone and Opioid Overdose, encouraging more community members to carry naloxone.

	• Public Health Emergency extended.
June 2018	• Center for Medicare & Medicaid Services (CMS) released guidance on Medicaid detailing reimbursement tools and resources for states that can be used to curb the opioid crisis and highlighting successful practices. • The Comprehensive Opioid Recovery Act of 2018 passed the House. It would grant $10 million to HHS to fund at least 10 new or existing recovery centers. • SAMHSA opened applications for $930 million of funding for states and territories to pursue prevention, treatment, and recovery services. • The SITSA Act passed the House. It classified synthetic opioids above the CSA Schedule 1 and tightens importation checks. • The House passed the SUPPORT for Patients and Communities Act that combined numerous opioid bills for Senate consideration.
July 2018	• Public Health Emergency declaration extended.

Louisiana

Louisiana Department of Health (LDH) has received several federal grants to implement statewide initiatives addressing the opioid epidemic. Most current is the State Opioid Response Grant (LA SOR) awarded for September 2018 for $11 million per year for two years.[50] The grant is aimed at prevention, intervention, treatment and recovery efforts. In addition, the Louisiana Attorney General's Office launched an initiative, End the Epidemic, offering naloxone to first responders, and the Louisiana Department of Corrections is investigating the effectiveness of administering naltrexone to individuals released from state custody.[13]

Timeline: Louisiana Legislation Addressing the Opioid Epidemic

2006	• ACT 676 authorized the Louisiana Board of Pharmacy to develop a Prescription Monitoring Program (PMP).
2013	• ACT 110 strengthened the PMP by allowing an unlimited number of delegated users to access the database.
2014	• ACT 392, the Good Samaritan Law protects individuals calling 911 in the event of an overdose from criminal charges if drug paraphernalia is found at that scene—first responders may administer opioid antagonists without prescription to an individual exhibiting symptoms of overdose. • ACT 472 mandates the reporting of prescription monitoring information; to provide for dispenser (pharmacist) reporting within 24 hours. • ACT 865 limited dispensing of certain controlled substances, Mandates PMP access for Schedule II narcotics for patients' treatment of non-cancer related chronic or intractable pain.
2015	• ACT 192 Opioid Antagonist Administration authorizes a licensed medical practitioner to prescribe or dispense Naloxone without having examined the individual to whom it may be administered. Limits civil and criminal liability for persons who receive or administer opioid antagonist to a person believed to be undergoing an opioid-related drug overdose.
2016	• ACT 370 Naloxone authorizes storage and dispensing of opioid antagonists; authorizes any person to possess an opioid antagonist. Limitation of liability relative to naloxone prescription, dispensing and administration by a third party. • House Concurrent Resolution 113 created the Louisiana Commission on Preventing Opioid Abuse. 1. April 2017- The Opioid Epidemic: Evidence-Based Strategies Legislative Report, recommended strategies for: adopting the Guidelines for Prescribing Opioids for Chronic Pain; alternatives to opioid medications; communication, cooperation, and

	data sharing; improving access for pregnant women, prescriber training needs, alternatives to incarceration.
2017	• ACT 310 authorized a Naloxone Standing Order allowing participating pharmacies to dispense naloxone without prescription. • ACT 76 automatically registered CDS license applicants or renewals in the PMP, mandated PMP review and monitoring prior to opioid prescription, and in order for license renewal, all practitioners with CDS license must take 3 hours of continued education regarding drug diversion, best practices for prescribing controlled substances, addiction treatment, or similar. • ACT 88 established the Advisory Council on Heroin and Opioid Prevention and Education (HOPE) to establish an Interagency Heroin and Opioid Coordination Plan, coordinate parish level data on opioid overdoses and usage of overdose-reversal medication, and coordinate a central online location to disseminate information and resources. • Lawsuit filed: Louisiana Department of Health, Through the Secretary of the Louisiana Department of Health VERSUS Purdue Pharma (and others).

New Orleans

The New Orleans EMS, Fire Department, and Police Department have all implemented first responder naloxone. In January of 2016, the New Orleans Health Department (NOHD) issued a parish-wide standing order allowing residents to access naloxone from participating pharmacies without prescription. [13] LDH expanded the standing order statewide the following year. NOHD is currently establishing the New Orleans Opioid Survival Connection program, where victims of overdose will be directly linked to treatment services. A collection of stakeholders, including OHL, are a part of the Project Advisory Committee, creating a forum to address city-wide concerns. In addition, Metropolitan Human Services District (MHSD) is utilizing the (MAT PDOA) grant funding to increase access to treatment and provide naloxone kits at their clinics and partner addiction treatment centers, including OHL. MHSD has more recently received the State Targeted Response to the Opioid Crisis Grant (STR) to further increase treatment services and overdose prevention efforts. NOHD and MHSD facilitate the Behavioral Health Council to increase behavioral health resources, coordinate interdisciplinary services, and advocate for individuals with addictive disorders. [13] These efforts aim to reduce the stigma surrounding addiction and treatment. Other non-government agencies and community organizations have been implementing harm reduction and overdose prevention services

including NOAIDS Task Force/Crescent Care, TRYSTEREO, and Women with a Vision, along with many other recovery agencies.

Through various partnerships, the city of New Orleans aims to expand media campaigns to educate the community on overdose prevention and treatment services, increase safe medication disposal programs, engage pharmacies to provide opioid counseling, and to link nonfatal overdose victims in emergency departments directly with care.

> *A group of compassionate people brings breakfast to the homeless on the neutral ground in the Upper Ninth Ward every Sunday morning. I inquired about a detox I had heard of through word on the street and one of the young women who helped supply and serve the food pointed the way to the Odyssey House Detox program using Google maps on her phone. Rising early as usual on Monday morning, I walked about a half a mile to the building to find that there was no room for me that day. "Come back tomorrow and I will get you in," they said. I was still sick and weary, tired and beat up. The sun would hit the open wounds on my face like razors, and I was betrayed by my own sweat dripping into my face like boiling water. Somehow, I found a way to "stay well" that day, too. I tried again for Detox Tuesday morning, walking the half mile with my backpack, and they kept their word.*
>
> *-Anonymous, (Former) OHL Client*

Overview of Opioid Overdose and Naloxone Distribution Programs

Source: https://www.cdc.gov/drugoverdose/index.html

To combat the exponential rise in overdose fatalities, opioid overdose and naloxone distribution (OEND) programs have become more common. Not including law enforcement, emergency medical services, or other professional first responders, the CDC has identified approximately 140 organizations offering take-home naloxone kits at 644 sites across the United States. [82] As of July 2014, a survey conducted by the Harm Reduction Coalition (HRC) of these 140 organizations estimated that 152,283 take home naloxone kits were distributed to laypersons, of whom reported approximately 26,463 confirmed overdose reversals [83]. Research supports greater bystander naloxone access to reduce overdose fatalities. The current Surgeon General agreed, making a public health advisory encouraging more individuals, including high risk opioid users, family members, friends, and direct service providers to carry naloxone on their person. [58] A closer look at preliminary OEND programs in other localities offer recommendations and best practices for implementation. Examples across the country illustrate a variety of models that can be used to effectively distribute naloxone:

1. State or City Public Health Department fund and have a role in administering the naloxone program (i.e. Massachusetts, New York, Washington, New Mexico, Ohio, San Francisco, Baltimore)
2. Non-profit community-based organization (CBO) provides overdose prevention services and access to naloxone without state or city involvement using non-governmental grants (i.e. Pennsylvania, Connecticut, Michigan, Wisconsin, Colorado)
3. Naloxone is prescribed during a visit with a care provider and filled at a pharmacy or dispensed during the visit (i.e. Project Lazarus, Duquesne University Pilot)
4. Medical personnel are involved directly- advanced practice nurse or physicians present when naloxone is distributed to "sign-off" on prescriptions, trainings done by medical staff
5. Standing Order- written by medical director of the program to allow distribution by trained non-medical staff

Chicago, IL: Use the Harm Reduction Model

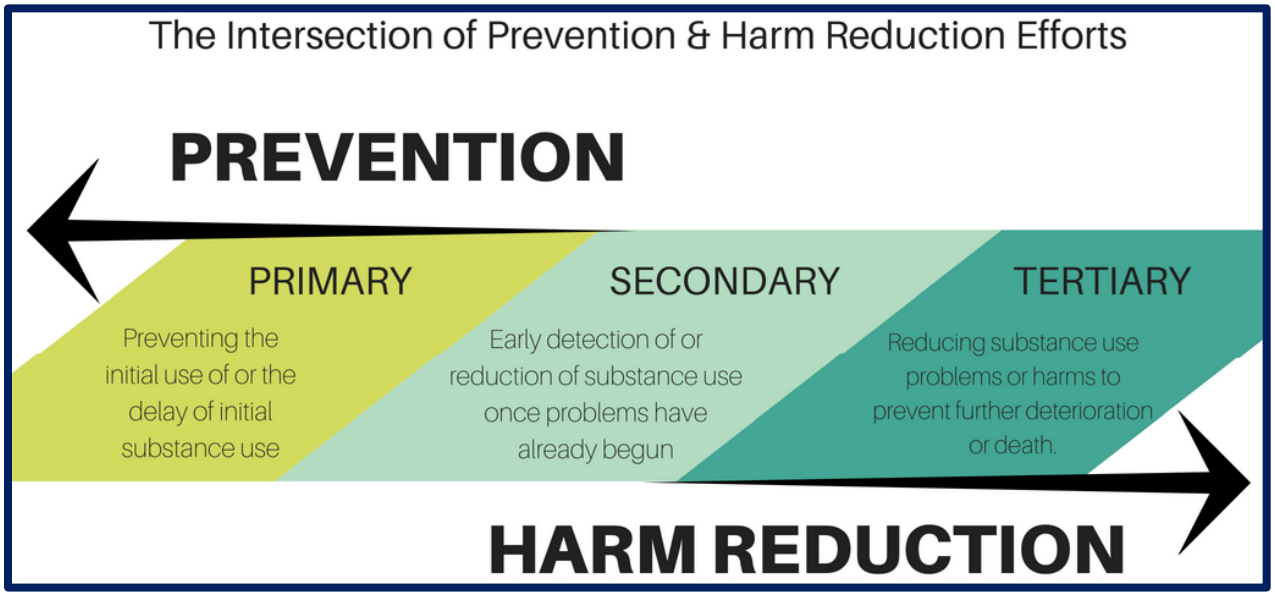
Harm Reduction is a model of practice aimed at reducing negative physical or social consequences associated with particular behaviors. Beginning its efforts in 1992, Chicago Recovery Alliance (CRA) is now one of the largest harm reduction programs. [76] Their initial efforts resulted in providing syringe access and other injection equipment that was otherwise illegal to purchase at the time without a prescription. Community Advisory Groups (CAG) were used to relay program goals and ensure that the CRA focused on the needs of their clients. With the rise of fatal opioid overdoses, CAGs stressed the importance of opiate-related overdose prevention. In 1996, when one of CRA's founders died of a heroin overdose, the agency moved into action. In collaboration with medical professionals, the agency began naloxone trainings and distribution to program participants. In 2001, CRA expanded its overdose prevention efforts beyond program participants, offering staff and volunteers training and expanding naloxone distribution to all program sites. With the collaboration of other stakeholders, CRA was able to advocate for the implementation of the Good Samaritan Law in 2010, protecting naloxone prescribers and administrators from criminal charges. CRA has since become a resource for harm reduction programs across the country, providing guidance and material as new programs emerged. [35]

CRA demonstrates the importance of implementing harm reduction principles in the operations of overdose prevention programs. One of the founding principles of harm reduction is the action of giving power to directly affected individuals. [35] CRA exemplified this principle with the implementation of CAGs that allowed individuals most affected to define the agencies' concerns and program goals. Even with extensive research illustrating the effective treatment methods developed from the harm reduction model, national implementation of these policies has faced considerable resistance in the United States. The resistance can be traced back to a historical trend and philosophy that demonizes drug use. Patterns in national drug policy illustrate that this moral disapproval is also associated with the stigmatization and marginalization of targeted racial and ethnic groups. This was illustrated in the national response to the crack-cocaine epidemic of the 1980s, which was resistant to any policy that was considered to "condone" illicit drug use. Instead, policies reflected increased support for the "War on Drugs" that criminalized addiction rather than treating it. The heavier penalties for crack in comparison to cocaine placed an unequal burden on urban African American communities that has had lasting effects. [24] Similar inequality can be noted in the variation of

penalties between heroin and prescription painkillers. The political pendulum was shifting to support health-based reform, encouraging greater treatment options and the decriminalization of minor drug violations. Interestingly, as the opioid epidemic has reached levels of national public health concern, there has been more support for harm reduction efforts, such as naloxone access and Good Samaritan Laws. Unlike the drug crisis in the past, the influence of legal prescription painkillers has allowed the opioid epidemic to impact individuals across socioeconomic classes. It cannot be ignored that this characteristic has encouraged greater support for national harm reduction efforts.

Recommendation 1

Use the Harm Reduction Model	Include individuals directly impacted in overdose prevention efforts. Work to destigmatize drug use, addition, and treatment. Consider the biopsychosocial influences for clients, patients, and community members that may result in disparities in services. Meet individuals where they are at, respect their autonomy, and offer appropriate services.



Source: Recovery Research Institute https://www.recoveryanswers.org/resource/drug-and-alcohol-harm-reduction/

Wilkes County, NC: Train Prescribers and Implement Co-Prescription Protocols

Many of the first overdose prevention programs targeted injection drug users through harm reduction efforts, such as syringe access programs. However, Project Lazarus of Wilkes County, North Carolina, found that their needs differed. In 2009, their rates of overdose mortality were four times higher than the state average. Further research showed that 80% of the individuals who had died of overdose also had legal prescriptions for the substance that killed them. [35] This information led to an intervention targeting various medical practices, such as long-term pain management and substance use treatment. The initiative trains prescribers to assess and identify patients with a high risk of overdose, and to prescribe or co-prescribe naloxone as needed. [35] The initiative was able to successfully reduce overdose rates by 69% between the years of 2009 and 2011. The outstanding success of their pilot program resulted in additional grant funding, partnership with Community Care North Carolina (CCNC), the state's nonprofit Medicaid managed care plan, and statewide expansion of their initiative including the implementation of a prescription monitoring program. [70] As the program grew, Project Lazarus was able to provide naloxone training to community members, care managers, primary care providers, emergency room physicians, and pharmacists.

Recommendation 2

Train Prescribers and Implement Co-Prescription Protocols	With high prescription rates in Louisiana, implementation of an overdose prevention program that targets training prescribers and encourages the practice of naloxone co-prescription will reduce opioid overdose fatalities.

Pittsburgh, PA and Rhode Island: Build Partnerships with Pharmacists

The Overdose Prevention Project (OPP) of Prevention Point Pittsburgh replicated the initiative pioneered by Project Lazarus of making naloxone available through standard prescription. However, the unique partnership with the Center for Pharmacy Services (CPS) incorporated pharmacists in a new way. Starting in 2011, patients coming to CPS to fill opioid prescriptions were also offered information on opioid safety including signs of overdose and administration of naloxone. If requested, the pharmacist could request a naloxone prescription on behalf of the patient. [35] This trend to incorporate pharmacists directly in overdose prevention efforts was occurring concurrently in other parts of the country as well.

Rhode Island was hit hard by the opioid epidemic, and by 2005, it had the highest rates of illicit drug use per capita. The RI Board of Pharmacy played a critical role in addressing the crisis by approving a collaborative pharmacy practice agreement for naloxone (CPAN) which in collaboration with prescribers, allowed pharmacists to distribute naloxone. Beginning in 2011 with only five Walgreens Pharmacies, the pharmacy-led initiative expanded significantly by 2014. [84] This model of public health and commercial partnership is conceptually similar to Standing Orders that allow pharmacies to distribute naloxone without a prior prescription that began implementation in several states around that same time. [34]

Recommendation 3

Build Partnerships with Pharmacists	In 2016, the New Orleans Health Department also issued a parish-wide Standing Order for naloxone that allows residents to obtain naloxone from participating pharmacies without a prescription.[13] However, many individuals are still unaware that a prescription is not needed to purchase naloxone. Building stronger pharmacy collaborations to increase access to naloxone and reduce overdose fatalities is necessary.

Prevention Point Pittsburgh: Identify Priority Populations

Aside from the collaborative efforts with pharmacists, Prevention Point Pittsburgh (PPP) also established partnerships to target the needs of incarcerated individuals, who experience an especially high risk of overdose within the first two weeks of release. [9] Recognizing the unique needs of inmates, PPP established the Jail Collaborative in 2000 to reduce recidivism and establish better outcomes for inmates following incarceration. The program included hour-long training sessions conducted at different jail pods which focused on overdose, naloxone administration, rescue breathing, along with local harm reduction resources. The initiative successfully disseminated information and participants' feedback illustrated utilization of services upon release. [35]

Recommendation 4

Identify Priority Populations	New Orleans must identify individuals and communities at the greatest risk for opioid overdose. Individuals leaving institutionalization including incarceration, addiction treatment, and hospitalization are at higher risk of overdosing. Programming and distribution should meet the needs of priority populations. [25]

Massachusetts: Build Community Partnerships

The statewide overdose prevention initiative in Massachusetts began in the late 1990s with only a few committed activists working within the injecting drug using (IDU) community. Through their own social capital within the harm reduction community, they obtained naloxone, and began informally distributing to at risk individuals. At the time, their efforts were not sanctioned, and they had growing concern that they were jeopardizing their participants with potential legal complications. To build a case for the initiative, they began tracking their naloxone distribution and reversal rates. They presented this information in a report to the Boston Public Health Commission which was then used as a proposal to implement the distribution of naloxone at the city's needle exchange. By 2005, there was growing interest from several agencies to incorporate overdose prevention and naloxone distribution into their state-funded HIV prevention programs. In 2016, with support from the Mayor, community advocates, medical professionals and drug users, the Board of the Boston Public Health Commission and the City of Boston's Health Department sanctioned a city wide OEND program. The success was contagious and shortly after the Cambridge Public Health Department implemented the same program for their region.[44] By 2007, the Massachusetts Department of Public Health established a plan to address overdose on a statewide level, implementing many of the strategies presented by the founding overdose prevention activists. By 2011, the state initiative successfully trained more than 10,000 drug users, friends, family members, service providers, and first responders on naloxone administration with an estimated 1,200 confirmed reversals. [35]

Recommendation 5

Build Community Partnerships	Strategic collaboration between stakeholders increases program efficiency and effectiveness. Locally, there are community members, harm reduction groups, non-profit organizations, and governmental departments already working to provide overdose prevention services. Their collaboration is critical for successful program implementation city wide.

Baltimore, MD: Collect Accurate Data

The Baltimore Student Harm Reduction Coalition (BSHRC) was Maryland's first state-authorized community program that allowed third-party members to distribute naloxone in 2015. The volunteer-driven program established a training curriculum that educated communities on overdose risk factors, recognizing an overdose, and how to respond. The trainings were targeted at high-risk populations, and participants were eligible to receive a free intramuscular naloxone kit at the end of each session. In its first 8 months, BSHRC was able to reach 285 participants and recorded 3 confirmed overdose reversals. In evaluating the program, two significant limitations were identified.[44] BSHRC was a small agency and only one staff member provided the overdose prevention services. In addition, data collection and participant follow up was identified as a barrier. It was nearly impossible for the program to track overdose reversals as participant follow-up was nearly nonexistent. [44]

Recommendation 6

Collect Accurate Data	Implementing a collaborative practice with participants will encourage more accurate reporting from participants. In addition, accurate data collection will support program evaluation and community impact.

Below are Revive. Survive. ODP's Year 1 findings and lessons learned.

OHL Client and Community Naloxone Trainings

In year one over 1,400 individuals were trained by Revive. Survive. OverDose Prevention Program staff. All individuals trained received a comprehensive overview of the opioid epidemic, naloxone administration and access, and tools to address the needs of individuals suffering with addiction. Individuals trained included OHL Detox and Residential clients, as well as priority community members primarily through the partnership with New Orleans Syringe Access Program (NOSAP).

	OHL Clients	Community	Sum
Trainings	900	592	1492

Naloxone Access Program and Distribution

At each training provided during year one, individuals had the option of enrolling in our Naloxone Access Program, where we either distributed naloxone purchased through our grant, donated to us through partnerships, or we referred individuals to additional access programs. For those already enrolled in the access program who needed a refill, we asked a series of short questions to get an understanding of how the naloxone we distributed was used. Although participant data cannot be validated through other measures, participants have recorded 238 successful overdose reversals, which is approximately one reversal for every refill (note each kit contains 2 doses). As data shows, over 800 Naloxone were distributed. As sustainability of naloxone access is a top priority, the Revive. Survive. OverDose Prevention Program has developed tools and resources to ensure Naloxone access is readily available to community members via various agencies. These resources will be distributed moving forward, and we anticipate greater impact as we developed workflows for internal distribution and capacity building with various partner agencies.

	OHL Clients	Community	Refills	Sum
OHL Grant	30	79	43	152
Donation*	78	307	193	578
Kaleo Cares	30	45	1	76
Evzio2You	12	11	0	23
Sum	150	442	237	829

Community Partnerships

Through the partnerships with city departments, social service agencies, healthcare providers, pharmacists, and individual stakeholders, OHL's Revive. Survive. OverDose Prevention Program is building community awareness regarding the risks of opioid use, treatment options, and how to access and administer naloxone.

Needs Assessment Analysis

Based on the Revive. Survive. OverDose Prevention Program grant goals to train medical staff, pharmaceutical staff, and community members on naloxone, the staff designed and implemented a needs assessment to better understand the needs in New Orleans. A unique survey was designed for medical staff, pharmaceutical staff, and community members to assess general familiarity with the opioid epidemic and naloxone. Distribution sites were located according to geographic and demographic variations across the city to ensure that the surveys collected would be reflective of New Orleans diversity. Between August 28th and September 9th 2018, staff and volunteers distributed and collected the surveys.

Medical staff survey reported:	Pharmaceutical staff survey reported:	Community member survey reported:
•Level of familiarity with national opioid crisis •Level of knowledge and compliance with current regulations •Population served •Level to which harm reduction care is used in practice •Level of knowledge of naloxone and prescribing practice •Perspective on naloxone accessibility •Desire for more information	•Level of familiarity with national opioid crisis •Level of familiarity with naloxone •Use of Standing Order and PMP •Daily encounter with opioids and individuals at risk of overdose •Frequency of naloxone purchase •Perspective on naloxone accessibility •Desire for more information	•Level of familiarity with national opioid crisis •Level of direct impact •Level of familiarity with naloxone •Knowledge and trust for laws regarding naloxone use •Prevalence of prescription opioid use •Prevalence of illicit opioid use •Experience receiving/administering naloxone •Perspective on naloxone accessibility •Desire for more information

Community Results (100 Surveys)

The community survey illustrated that 73 out of 100 people felt informed on the national opioid epidemic and 39 had been directly impacted by it. Only 47 are familiar with naloxone and 9 trained to administer. Most individuals are not familiar with the laws surrounding naloxone access including the Good Samaritan Law and Standing Order. The majority either have no knowledge or disagree that naloxone is easily accessible or affordable.

Question/Justification	# Strongly Disagree	# Disagree	# Neither Agree or Disagree	# Agree	# Strongly Agree	No Response
Understanding of National Crisis						
I am informed on the national opioid epidemic	8	10	7	36	37	2
Level of Direct Impact						
I have been directly impacted by the opioid epidemic	21	24	15	23	16	1
Level of Familiarity with naloxone						
I am familiar with the opioid antagonist, naloxone	23	20	8	24	23	2
I have been trained to administer naloxone	46	23	13	5	4	9
Level of knowledge and trust for laws regarding naloxone use						
I am informed on the Good Samaritan Law protecting prescribers and individuals administering naloxone	32	22	12	26	8	0
I have faith that the Good Samartian Law will protect me from potential crimilar charges when administering naloxone	21	17	30	22	8	2
I am informed on the naloxone Standing Order in Louisiana	35	32	12	13	7	1
Level of prescription opioid use						
I have had an opioid prescription	43	25	4	15	12	1
I have taken prescribed opioids	33	20	6	24	17	0
Level of illicit opioid use						
I have taken non-prescribed/illicit opioids	39	30	11	9	8	3
Familiarity with opioid overdose						
I am aware of the signs and symptoms of opioid overdose	13	24	10	33	20	0
I have experienced/witnessed an opioid overdose	33	28	12	13	14	0
Familiarity with naloxone administration						
I have received/administered naloxone	45	33	11	4	4	3
Accessibility of naloxone						
Naloxone is easily accessible	20	21	43	12	3	1
Naloxone is affordable	17	17	55	7	3	1
Need for further information						
I would like further information on naloxone education and distribution	11	13	20	25	31	0

Pharmacy Staff Results (16 Surveys)

Unsurprisingly the pharmacy staff had a higher familiarity with the understanding of the national crisis (100% reporting "Agree" or "Strongly Agree") and a familiarity/training/comfort with naloxone. However, even with New Orleans high rates of opioid use disorder, less than 50% responded in agreement with "regularly fill naloxone prescriptions" or "customers purchase naloxone without a prescription." Also notable was 9 of 16 participants would like further information on naloxone education and distribution.

Question/Justification	# Strongly Disagree	# Disagree	# Neither Agree or Disagree	# Agree	# Strongly Agree	No Response
Understanding of National Crisis						
I am informed on the national opioid epidemic	0	0	0	6	10	0
Level of familiarity with naloxone						
I am familiar with the opioid antagonist, naloxone	0	0	0	6	10	0
I have been trained to administer naloxone	0	2	1	5	8	0
I feel comfortable training others on how to administer naloxone	0	2	4	3	7	0
Level of familiarity and use of Standing Order and PMP						
I am informed on the naloxone Standing Order in Louisiana	0	1	4	3	8	0
I am informed on the Louisiana Prescription Monitoring Program	0	1	1	2	11	1
I am registered with and use the Louisiana Prescription Monitoring	1	1	0	2	10	2
Level of daily encounter with opioids, individuals at risk of overdose,						
I fill opioid prescriptions daily	0	1	1	2	10	2
I am aware of the signs and symptoms of opioid overdose	0	2	1	4	9	0
I assess customers for overdose risks	1	1	2	5	5	2
I educate customers, who are at risk for overdose, on naloxone	1	3	0	1	10	1
Frequency of naloxone purchase						
Naloxone is regularly stocked at our pharmacy	1	1	2	3	9	0
I regularly fill naloxone prescriptions	3	6	2	3	2	0
Customers purchase naloxone without prescription	4	0	3	5	3	1
Accessibility of naloxone						
I am informed on insurance coverage for naloxone	1	0	1	7	6	1
Naloxone is easily accessible	3	1	1	5	6	0
Naloxone is affordable	6	1	4	3	2	0
Need for further information						
I would like further information on naloxone education and distribution	1	2	4	3	6	0

Medical Staff Results (23 Surveys)

Although more than 90% of medical staff reported an understanding of the current opioid epidemic (21/23), the level of knowledge of naloxone and its prescription practice was low. Only 1 of 23 reported prescribing naloxone for patients at risk of overdose, zero agreed to having prescribed naloxone with opioids, and less than 25% reported naloxone as easily accessible and affordable. Greater than 50% of providers also reported wanting further information on naloxone education and distribution.

Question/Justification	# Strongly Disagree	# Disagree	# Neither Agree or Disagree	# Agree	# Strongly Agree	No Response
Understanding of National Crisis						
I am informed on the national opioid epidemic	0	1	1	8	13	0
Level of knowledge and complaince with current regulations						
I am informed on CDS Prescribers re act 76 of the 2017 Regular Session of	4	4	7	4	3	1
I am informed on the Louisiana Prescription Monitoring Program	2	3	3	8	7	0
I am registered with and use the Louisiana Prescription Monitoring	6	6	6	1	4	0
I am informed on CDS license continued education requirements	3	7	5	3	4	1
I have completed 3 hours of continuing education pertaining to drug	6	4	3	3	6	1
I am informed on the naloxone Standing Order in Louisiana	6	1	2	7	7	0
Is priority population served here						
I serve clients suffering with pain	0	2	1	8	11	1
Level to which harm reduction/trauma informed care is used in practice						
I incorporate harm reduction and trauma informed care in my practice	0	0	4	5	14	0
I assess patients for Substance Use Disorder (SUB)	1	3	5	7	7	0
I refer patients with SUD to treatment	2	2	5	7	7	0
I assess patients for overdose risks	1	3	3	8	7	1
I offer opioid treatment for pain	9	1	4	5	1	3
I offer non-opioid treatment for pain	8	1	2	4	6	2
Level of knowledge of naloxone and its prescription practice						
I am familiar with the opioid antagonist, naloxone	1	1	5	6	9	1
I prescribe naloxone for patients at risk for overdose or who have	11	3	6	0	1	2
I co-prescribe naloxone when prescribing opioids	11	2	7	0	0	3
I educate patients, who are at risk for overdose, on naloxone	5	3	4	4	7	0
Accessibility of naloxone						
Naloxone is easily accessible	1	4	13	1	4	0
Naloxone is affordable	2	4	13	2	1	1
Need for further information						
I would like further information on naloxone education and distribution	1	0	6	8	8	0

Incorporate Evidence Based Models in Medical Practice

Harm Reduction Model: Naloxone access programs can be helpful in any medical clinic and especially in community clinics, federally qualified health centers (FQHC), opioid treatment programs, and pain management clinics. Naloxone access programs can be as simple as prescribing naloxone upon request, or more in-depth to include take home naloxone kits and training classes. Clinics may consider purchasing naloxone directly from manufacturer or distributors, to eliminate additional access barriers for patients. Harm reduction principles can also be incorporated by simply providing education on overdose risk factors, developing an emergency overdose action plan, identifying overdose symptoms, and providing tools to prevent overdose fatality. [37]

Source: Terhan Times https://www.tehrantimes.com/news/426120/Harm-reduction-prevents-spread-of-HIV-says-official

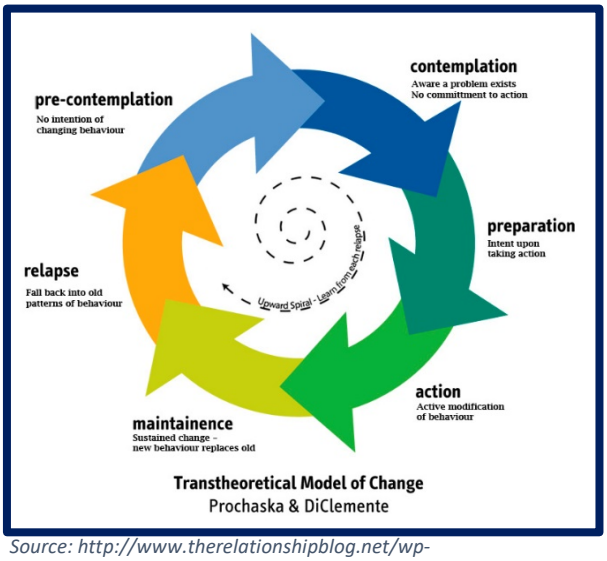
Trauma Informed Approach:

The Adverse Childhood Experience Questionnaire can be used as a tool to assess an individual's experience with trauma and allows the provider to offer appropriate care. SAMHSA recommends health care providers to offer trauma informed care through:

1. Realizing the widespread impact of trauma and understands potential paths for recovery;
2. Recognizing the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. Responding by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeking to actively resist re-traumatization.

Stages of Change Model:

To offer both appropriate referral and clinical services, healthcare providers should be familiar with the Stages of Change Model, tool to assess level of change provided in Appendix. Techniques such as Motivational Interviewing can be used to assess a client's readiness for change.



Source: http://www.therelationshipblog.net/wp-content/uploads/2016/06/change_l.jpg

> *I walked into the detoxification program in great need of some respite and relief. I needed a medical detox from an often deadly combination of alcohol and heroin dependency.*
>
> *I needed a shower, a safe place to rest, and healthy food to eat.*
>
> *I was not thinking about any wonderful, sober life.*
>
> *I simply needed relief.*
>
> *- Anonymous, (Former) OHL Client*

Use CDC Guideline for Prescribing Opioids

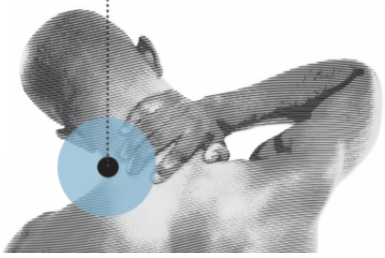
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



CLINICAL REMINDERS

- **Use immediate-release opioids when starting**
- **Start low and go slow**
- **When opioids are needed for acute pain, prescribe no more than needed**
- **Do not prescribe ER/LA opioids for acute pain**
- **Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed**

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- **Evaluate risk factors for opioid-related harms**
- **Check PDMP for high dosages and prescriptions from other providers**
- **Use urine drug testing to identify prescribed substances and undisclosed use**
- **Avoid concurrent benzodiazepine and opioid prescribing**
- **Arrange treatment for opioid use disorder if needed**

Source: https://www.cdc.gov/drugoverdose/prescribing/guideline.html

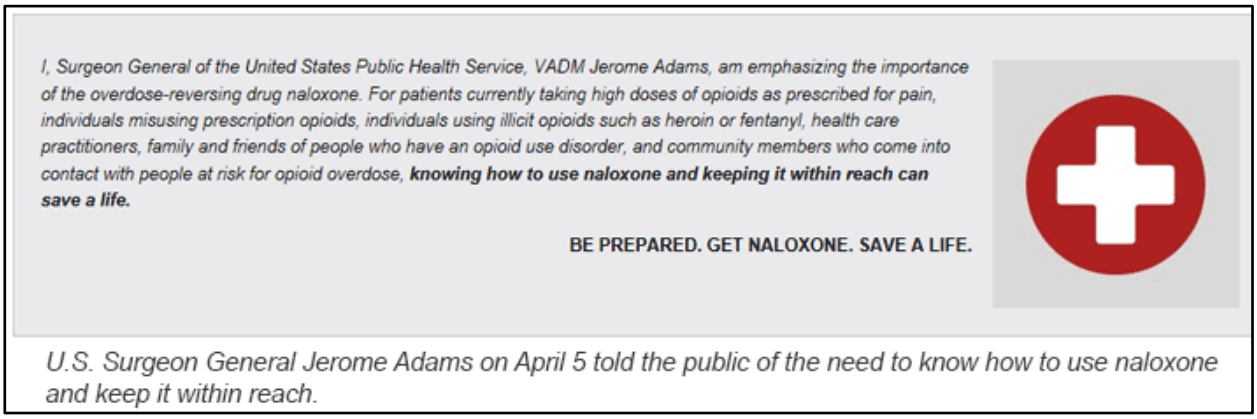
Assess Patient Risk for Opioid Overdose

Use evidence-based screening and assessment tools to determine potential risks for overdose:

Risk Assessments Prior to Initiating Opioid Therapy	Risk Monitoring Assessments in Patients Receiving Opioid Therapy
• Opioid Risk Tool (ORT) – patient self-administered 5 item questionnaire designed to predict the risk of problematic drug-related behaviors; a score of 8+ is considered high risk for opioid misuse • Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R) – well validated 24 item instrument to predict the development of problematic drug-related behaviors; a score of 18+ indicates a patient is at risk for misusing prescribed opioids • Screening Instrument for Substance Abuse Potential (SISAP) – 5 item questionnaire developed to predict the risk of opioid misuse; used less frequently than the ORT or the SOAPP-R • Diagnosis, Intractability, Risk, and Efficacy (DIRE) – clinician-rated instrument used by primary care physicians to predict the efficacy of analgesia and adherence with long-term opioid therapy; scores range from 7-21; a score of 13 or below suggests that a patient is not suitable for long-term opioid therapy • Drug Abuse Screening Test (DAST-10) – 5-minute self-reported tool to identify a wide range of potential drug use problems	• Prescription Drug Use Questionnaire-patient version (PDUQ-p) – patient self-administered 31 item tool intended to predict the potential for harmful opioid use; cutoff value of 10+ • Current Opioid Misuse Measure (COMM) – patient self-administered 17 item questionnaire meant to identify patients who may be misusing opioids; a score of 9+ suggests problematic drug-related behaviors; one of the most commonly used tools for patients receiving long-term opioid therapy • Patient Medication Questionnaire (PMQ) – patient self-administered 26 item instrument that identifies patients misusing opioids; higher scores suggest patient's likely to misuse • Pain Assessment and Documentation Tool (PADT) – clinician administered 41 item tool developed to identify patient misuse, no cutoff score • Addiction Behavior Checklist (ABC) – clinician-completed 20 item questionnaire to determine problematic drug-related behaviors; a score of 3+ suggests problematic drug-related behaviors

Source: https://www.affirmhealth.com/blog/identifying-and-assessing-patient-risk-a-must-for-opioid-prescribers

Patients Who Benefit From Naloxone Prescription



Source: https://www.ashp.org/news/2018/06/27/pain-clinics-grapple-with-naloxone-issues

Naloxone is not a controlled substance and can be prescribed routinely to patients at risk of an opioid overdose or family, friends, and caregivers of individuals at risk of an opioid overdose. Patients who could benefit from naloxone prescription include those who: [4], [67], [15]

1. Have received emergency medical care for opioid detoxification or overdose
2. Have just been released from incarceration or institutionalization with a history of opioid addiction
3. Have reported or suspected history of harmful substance use or non-medical opioid use
4. Have a known severe psychiatric illness or history of suicide attempt
5. Are on medication assisted therapy for opiate addiction (such as methadone or buprenorphine)
6. Are prescribed long-acting opioids
7. Are on a higher dose (>50 mg morphine equivalent/day) opioid prescription or have used opioids for greater than 30 days
8. Have a history of current poly-opioid use
9. Have received opioid pain prescription plus:
    a. Have rotated from one opioid to another because of possible incomplete cross-tolerance
    b. Are smoking or have COPD, emphysema, asthma, sleep apnea, respiratory infection, other respiratory illness
    c. Have been diagnosed with renal dysfunction, hepatic disease, cardiac illness, HIV/AIDS
    d. Have known or suspected current alcohol use
    e. Have concurrent prescription or OTC medication that could potentiate the CNS and respiratory depressant properties of opioid medication such as benzodiazepines or other sedative medications, antipsychotics, carisoprodol or antihistamine use
    f. Have concurrent antidepressant prescription

10. Have difficulty accessing emergency medical services (distance, remoteness, lack of transportation, homelessness and/or without phone services)
11. Are from households with people at risk of overdose, such as children or someone with a substance use disorder
12. Are elderly (>65) receiving an opioid prescription
13. Are teens receiving an opioid prescription
14. Have requested naloxone

Prescribe/ Co-Prescribe Naloxone

Current Louisiana laws protect providers who write prescriptions for naloxone to laypersons. When prescribing naloxone:

1. Educate patients on how to recognize an overdose, how to respond with naloxone, and how changes in tolerance can increase the risk of opioid overdose. Overdose prevention education could be a part of a Screening, Brief Intervention, or Referral to Treatment (SBIRT), which can be billed as CPT 99408, G0396, or H0050. [98]
2. Consider insurance coverage and pricing to meet patient access needs when prescribing:
    a. NARCAN® (naloxone hydrochloride) nasal spray: Nasal spray- 2 mg and 4 mg of naloxone hydrochloride
    b. EVZIO® (naloxone hydrochloride injection) Auto-Injector for intramuscular or subcutaneous use 2 mg
    c. Nasal naloxone: 2x 2mg/2ml prefilled Luer-Lock ready needleless syringes. The atomization device can be purchased by patients through a pharmacy
    d. Intramuscular naloxone: 2x 0.4mg/ml single dose 1 ml vials and 2x intramuscular syringes
3. Assess for patient's interest in behavior changes and as appropriate introduce and refer to treatment services.
4. Alert local pharmacy before sending naloxone prescription to ensure it is properly stocked.[15]

CONCLUSION

As opioid overdose fatalities continue to rise, stakeholders must work to destigmatize addiction and treatment services in order to combat the opioid epidemic. One method to accomplish this is through overdose prevention education and naloxone distribution. Individuals can access naloxone through their prescribers, pharmacists, and community access programs. Increasing awareness and partnership between agencies providing such services is critical to maximizing effectiveness and efficiency. Service providers and community members must be on the forefront of implementing harm reduction principles of collaboration, respect, acceptance, empowerment, and compassion when working with the individuals they serve. In many cases there may be a fundamental change of perception, illustrated by use of new language that removes stigmatizing labels from individuals and allows for more equitable services. We must address the disparity of access to quality resources and resulting impacts on vulnerable populations. Through professional and public education we can remove stigma, provide more equitable services and access to naloxone, link individuals to appropriate addiction services, and reduce opioid fatalities.

> *Over four years later, I do have a wonderful, sober life.*
> *Not only am I a tax-paying citizen, a sober and active member of an anonymous twelve step program, and a responsible member of society, I also make every effort to contribute positively to my community through volunteering, activism, and even some monetary donations.*
> *None of this would be possible had I died that night.*
> *Fortunately, the person who handed me that shot also carried Narcan. He saved my life. Without that life-saving drug, I would not have had the opportunity to detox, to rehabilitate, to change.*
>
> ***Where there is Life, there is Hope.***

Resources for Prescribers:

- National Pain Strategy: A Comprehensive Population Health-Level Strategy for Pain: https://iprcc.nih.gov/sites/default/files/HHSNational_Pain_Strategy_508C.pdf
- Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain: www.cdc.gov/drugoverdose/prescribing/qi-cc.html
- Up-to-date: www.uptodate.com/contents/naloxone-drug-information
- Prescribe to Prevent: Prescribetoprevent.org

Resources for Individuals Treating Substance Use Disorder:

- Words Matter: How language Choice Can Reduce Stigma: https://www.samhsa.gov/capt/sites/default/files/resources/sud-stigma-tool.pdf
- Opioid Overdose Prevention and Related Trauma: Incorporating Overdose Prevention, Responses, and Experience into Substance Use Disorder Treatment: http://prescribetoprevent.org/wp2015/wp-content/uploads/Incorporating-OD-into-SUD-Tx-12.141.pdf

Resources for Stakeholders:

- Prescription Drug Abuse Policy System: http://www.pdaps.org/
- Louisiana Opioid Surveillance Portal: https://lodss.ldh.la.gov/
- Naloxone Info: NaloxoneInfo.org
- Harm Reduction Coalition: Harmreduction.org
- Project Lazarus: Projectlazarus.org
- Overdose Prevention Alliance: Overdosepreventionalliance.org
- SAMHSA Opioid Overdose Prevention Toolkit: https://store.samhsa.gov/shin/content//SMA18-4742/SMA18-4742.pdf

Resources for People Who Use Drugs (PWUD):

- Getting Off Write: A Safety Manual for Injection Drug Users Harm Reduction Coalition
- Treatment Options: www.findtreatment.samhsa.gov

Naloxone Access Programs:

- LADOJ Naloxone Request Form: https://www.ag.state.la.us/Article/2408/5
- Evzio2You Enrollment Form: For commercial insurance carriers
- Kaleo Cares Patient Assistance Program: For uninsured or government insurance carriers
- EVZIO® (naloxone HCl injection) Product Donation Grant Program: To apply for the EVZIO product donation grant please visit: https://external-kaleo.idea-point.com/Submit.aspx?groupid=GRANTS

Local Pharmacies Known to Carry Naloxone:

- Any Walgreens
- Avita Pharmacy: Marine Building, 3308 Tulane Ave #102, New Orleans 504-758-3718
- Crescent City Pharmacy: 2240 Simon Blvd, New Orleans 504-267-4113
- University Medical Center Pharmacy : 2000 Canal St New Orleans 504-702-3000

LOCAL ADDICTION SERVICE AGENCIES

Agency	Service	Payment	Location	Telephone
211- Via Link	24/7 telephone resource for counseling and social services	Free	http://www.vialink.org/	211
Addictions Counseling & Educational Resources (ACER)	Réveiller | to wake up Intensive Outpatient Program Outpatient Program Medication Assisted Recovery Pregnant Women's Track Aftercare Group Rapid Screen	Medicaid, Private, Payment Plans, Grants	Slidell Office 115 Christian Lane Slidell LA 701458 Metairie Office 2321 North Hullen St Suite B Metairie, LA 70001 Chalmette Office 2611 Jackson Blvd Chalmette, LA 70043	985.690.6622 504.941.7580 504.682.9550
Avenues Recovery	Residential treatment Intensive outpatient Continuing care	Medicaid, Tricare, Private	Metairie Office 4933 A Wabash St Suite 203 Metairie, LA 70001	504.780.2766
Alcoholics Anonymous	Peer Support Group (12-step Program) Sponsor services	Free	24 hr Hotline Central Office 638 Papworth Ave Metairie, LA 70005 www.aaneworleans.org	504.838.3399 504.836.0507

BHG Clinic	Medication-Assisted Treatment Addiction Counseling	Tricare, Private, Grants for eligible individuals	Downtown Office 2235 Poydras St. Suite B New Orleans, LA 70119 West Bank Office 1141 Whitney Ave Gretna, LA 70056	504.524.7205 504.347.1120
Bridge House/ Grace House	Bridge House: Long term residential substance use treatment for males Grace House: Long term residential substance use treatment for Females Pregnant women are PRIORITY	Free if qualified, Medicaid, Medicare	4150 Earhart Blvd. New Orleans, LA 70125	504.821.7120
CrescentCare *New Orleans Syringe Access Program*	Safe Sterile Syringes Safe Injection Materials Authorized Syringe Disposal	Free	1631 Elysian Fields Ave New Orleans, LA 70117	504.945.4000
CrescentCare *RecoveryWorks*	Intensive Outpatient Program	Most insurances and sliding scale discount eligible patients, Medicaid, Medicare, private insurance	2601 Tulane 5th Floor Suite 500 New Orleans, LA 70119 (will be relocating to 1631 Elysian Fields Ave in December)	504.821.2601
Duracare Counseling	Addiction and recovery counseling Substance Abuse Play therapy Psychological services	Medicaid Plans	4323 Division St Suite 102 Metairie, LA 70002	504.327.5753

Gateway Recovery Systems	Substance Abuse Services Domiciliary IOP services IOP Housing Transportation to appointments	Private Pay, Medicaid plans	4103 Lac Couture Drive Harvey, Louisiana 70058	504.368.9935
Jefferson Parish Human Services Authority	Ambulatory detox services at Westbank Location Adult outpatient addiction treatment, Crisis intervention Referral to detox and inpatient programs. Primary care Behavioral health community base services Developmental disability services	Medicaid, Medicare, some Private Insurance, safety net for uninsured Jefferson Parish residence, federal insurance for sliding scale according to federal guidelines	Westbank Location 5001 Westbank Expressway Marrero, LA 70072 Eastbank Location 3616 South I-10 Service Rd Metairie, LA 70001	504.349.8708 504.838.5257 504.846.6901
Jesus Miracle Power	One-year faith-based residential addiction treatment services ONLY offer services to men DO NOT serve patients that take mind- altering medications (Anti-depressants, Pain medications, Sleeping medications)	Free	8309 Apple St New Orleans, LA 70118	504.931.5179
Living Witness Church of God in Christ, Inc	1 year faith-based male addiction treatment services	$100 weekly payment or $400 monthly payment	1528 Oretha Castle Haley Blvd New Orleans, LA 70113	504.524.2959

Metropolitan Human Services District	Children, youth, and adult services including intellectual/developmental disability and behavioral health services	Uninsured, Medicaid, Medicare	Main Office 3100 General De Gaulle Dr. New Orleans, LA 70114 24/hr Crisis Line	504-568-3130 504.826.2675
Narcotics Anonymous	Peer support group (12-step program)	Free	www.nona.org	504.899.6262
New Orleans Harm Reduction Network Trystereo	Sterile injection equipment Overdose prevention Harm reduction training	Free	http://nolaharmreduction.tumblr.com/	504.535.4766
Odyssey House Louisiana	Detox Short term adult residential program Long term housing Intensive Outpatient Community Health Center Housing Programs OHMEGA LEAD Program iPrevent Revive.Survive OverDose Prevention	Medicaid or Uninsured	Detox 4730 Washington Ave New Orleans, LA 70125 Residential & Community Health Clinic 1125 N. Tonti St New Orleans, LA 70119 Prevention Department 2830 Bell St New Orleans, LA 70119	504.324.3710 504.821.9211 504.383.8559 504.913.6776

Palmetto Addiction Recovery Center	Intensive Outpatient Outpatient Care	Most insurance accepted Do not take Medicare or Medicaid	2955 Ridgelake Dr #105, Metairie, LA 70001 Intake Information	504.308.1454 866.848.3001
Responsibility House	Residential treatment program, outpatient treatment program, housing program	Medicaid, HIV positive individuals in Jefferson Parish (verified by state ID)	Residential Treatment Program Outpatient Treatment Program Supportive Housing Program	504.367.4234 504.367.4234 504.366.6217
River Oaks Hospital	Adult Behavioral Health Services, Adolescent Behavioral Health Services, Eating Disorders Treatment, Addictive Disorders/Dual Diagnosis Program, Military Mental Health Program, The New Orleans Institute, Outpatient Treatment Mental Health Programs, People with Homicide Ideation and Suicide Ideation are accepted	Accepts most insurance TRICARE, V.A. Benefits, Medicare, Medicaid	1525 River Oaks Rd W New Orleans, LA 70123	800.366.1740 Or 504.734.1740

Townsend Outpatient Addiction Treatment **Townsend Inpatient Addiction Treatment**	Residential, outpatient treatment services, and detox	Most commercial insurance	Metairie Office: 4330 Loveland St Ste A. Metairie, LA 70006 New Orleans Office:5620 Read Blvd. New Orleans, LA 70127 Consultation	504.454.5174 504-513-4200 888.979.7493

APPENDIX

For All Audiences:
Tool 1: Survive. Revive. OverDose Prevention Language Guide
Tool 2: Assessing Your Stage of Change Worksheet
Tool 3: Harm Reduction Coalition- Overdose Prevention Worksheet

Naloxone Access Program Enrollment Forms:
Enrollment Form 1: Ezvio 2 You Enrollment Form- For commercial insurance carriers who are concerned about risk of an overdose from opioid use for chronic pain.
Enrollment Form 2: Ezvio 2 You Enrollment Form- For commercial insurance carriers who are concerned about risk of an overdose from opioid misuse or dependence.
Enrollment Form 3: Kaleo Cares Patient Assistance Program- For individuals who are uninsured or have government insurance

Enrollment forms can be faxed to 5 pharmacies servicing Louisiana:
Avella of Austin- phone: (877) 470-7608 fax: (877) 480-1746
Avella of Deer Valley- Phone (877) 546-5779 Fax (877) 546-5780
Evzio Direct- Phone (844) 805-8884 Fax: (844) 805-8885
Palliative Pharmacy Solutions- Phone (337) 262-9777 Fax (844) 200-9771
Walker- Phone (225) 243-4852 Fax (225) 243-7983

For Community Service Providers:
Assessment Tool 1: Adverse Childhood Experiences Questionnaire

For First Responders:
Request Form 1: State of Louisiana- Department of Justice Naloxone Request Form

For Health Care Prescribers:
Assessment Tool 2: Opioid Risk Tool
Assessment Tool 3: Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R) Sample
Assessment Tool 4: Screening Instrument for Substance Abuse Potential (SISAP) Questionnaire
Assessment Tool 5: DIRE Score- Patient Selection for Chronic Opioid Analgesia
Assessment Tool 6: Drug Abuse Screening Test- DAST-10
Assessment Tool 7: Current Opioid Misuse Measure (COMM)
Assessment Tool 8: Pain Medication Questionnaire (PMQ)- Information Sheet
Assessment Tool 9: Pain Assessment and Documentation Tool (PADT)

For Pharmacist:
Protocol 1: State of Louisiana- Standing Order for the Distribution and Dispensing of Naloxone or Other Opioid Antagonists

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