



**Office of Alcoholism and  
Substance Abuse Services**

# **Overdose Prevention and Response in Behavioral Health Settings**

**September 2018**

**[www.oasas.ny.gov](http://www.oasas.ny.gov)**

This document was modified from the original, “Opioid overdose prevention and related trauma: incorporating overdose prevention, response, and experience into substance use disorder treatment,” by New York State’s Office of Alcoholism and Substance Abuse Services (OASAS) with the permission of Illinois Co-Occurring Center for Excellence, a program of Heartland Health Outreach.



# Office of Alcoholism and Substance Abuse Services

## I. Introduction

The opioid epidemic has resulted in record high rates of fatal overdose around the country. Efforts to contain the overdose mortality rate continue to be at the forefront of federal, statewide, and local initiatives. Additionally, Behavioral Health agencies have reported dramatic increases in rates of fatal overdose among their client population in the past decade. As a result, there is an urgent need to provide life-saving information and tools to agencies, communities, and consumers regarding opioid overdose prevention.

This guide is intended to support providers and the individuals they serve through a multi-pronged approach to addressing overdose, from prevention strategies and services to postvention response. The guide outlines various procedures in overdose prevention. While a comprehensive and holistic approach would include implementation of all applicable strategies outlined in the guide, the primary intent of this guide is to support providers to engage in a meaningful dialogue surrounding overdose risk and fatalities and to create an opportunity to develop and implement various pre/postvention protocols.

There are two core components of addressing incidents of overdose that should be incorporated into all discussion and planning:

1. Past trauma and post-traumatic symptoms related to overdose events— surviving an overdose or witnessing someone else’s overdose, whether fatal or non-fatal. Many individuals living with a Substance Use Disorder (SUD) or in recovery from SUD have experienced traumatic events or symptoms related to overdose, making trauma-informed care (TIC) essential;
2. Potential future overdoses—one’s own or someone else’s—can be prevented or effectively managed to avoid a fatality. The primary goal is that individuals at risk for overdose, as well as members of their support system, are provided with the necessary tools to prevent fatal overdose.

Incorporating these elements of past and potential future overdose into pre/postvention planning can enhance outcomes in the following ways:

1. Increase likelihood for survival and improved health among individuals at risk for overdose;
2. Improve individual-provider relationships;

3. Affirm individuals with SUD as valuable community members able to provide lifesaving education and response within communities;
4. Enhance a behavioral health agency's prevention, treatment, and recovery system's capacity to address trauma in a holistic and meaningful way;
5. Support behavioral health providers by expanding knowledge and confidence to address overdose in the client population, as well as provide strategies to support staff vulnerable to or currently experiencing emotional trauma after incidents of overdose.

## II. Overdose Prevention

### The Overdose-Treatment Paradox

According to the Centers for Disease Control (CDC), drug overdose deaths have increased at a rate of approximately 5.5<sup>1</sup>% over the past 20 years. Most of these deaths involve opioids (Oxycontin, heroin, and Fentanyl). These fatalities are particularly tragic because they are largely preventable. Many at risk of opioid overdose will make contact with a Behavioral Health program. This contact, however brief, allows programs to provide effective prevention in the form of overdose education and naloxone distribution. The agency's overdose prevention protocols can be formalized as an Opioid Overdose Prevention Program (OOPP). Implementation of overdose prevention protocols is a vital element in reducing overdose fatalities.

Engagement in SUD treatment presents a paradoxical problem: while treatment can help individuals eliminate or reduce substance use (thereby decreasing overdose risk), abstinence reduces an individual's tolerance level, making even a single episode of use more likely to result in a fatality. Additionally, individuals are at an increased risk for overdose due to the following reasons:

1. Medically supervised withdrawal procedures (detox) often include the use of medications like benzodiazepines (e.g., Klonopin or Valium), which depress the Central Nervous System (CNS) and may increase the risk of synergistic overdose if a person uses other substances while under its effects;
2. Transitions to different levels of care are periods of high risk. For example, the period immediately following discharge from treatment is one of high overdose risk. Opioid tolerance is decreased, while level of support is decreased and access to substances may increase.

Several forms of approved Medication Assisted Treatments (MAT) like methadone, buprenorphine (Subutex), buprenorphine-naloxone (Suboxone), and long-acting injectable naltrexone (Vivitrol) have shown high rates of success in treating Opioid Use Disorder (OUD) and decreasing rates of opioid use disorder relapse, criminal activity associated with OUD, HIV transmission, and incidents of overdose for individuals. However, if the medication contains an opioid agonist (e.g. buprenorphine or methadone), the medication half-life is highly variable and

---

<sup>1</sup> <https://www.cdc.gov/nchs/products/databriefs/db273.htm>

risk of over-sedation and overdose can increase during dosing changes (e.g., during methadone induction or discharge) or when combined with other sedating substances (e.g., benzodiazepines or alcohol).

While treatment for OUD offers great potential positive benefit, the risk of fatal overdose makes it essential to include practical, achievable survival strategies to mitigate this risk.

### **Discussing Overdose with Consumers and Communities: Changing the Dialogue**

Many providers are hesitant to discuss overdose with individuals, believing that discussing it could unintentionally normalize the topic and lead to an individual using again. However, research shows that comprehensive overdose prevention efforts, including the use of an opioid risk assessment tool, can decrease overdose risk.<sup>2</sup> Discussion of overdose risk should begin once the individual presents for assessment, and continue through the duration of treatment.

The therapeutic relationship between an individual and provider is critical. Addressing overdose and incorporating OOPP services can enhance the therapeutic relationship between individuals and providers in the following ways:

1. By focusing on safety and risk reduction, the provider sends the message that the priority is the individual's survival, even during an exacerbation of symptoms;
2. By educating individuals on overdose recognition and response, the provider validates individuals as contributing members of the community and potential life savers in an overdose situation.
3. Overdose is the number one cause of fatality among people who use opioids; overdoses lead to more fatalities than HIV and Hepatitis C related causes combined. Providers can build rapport by demonstrating an understanding of the significance of this issue;
4. Acknowledging the traumatic impact of fatal or non-fatal overdose can play a powerful role in therapeutic engagement;
5. Framing overdose as avoidable, preventable, and survivable encourages hope and strength;
6. Trauma responses to witnessing fatal or nonfatal overdoses are common among people in treatment. Creating openings to express feelings related to overdose events may reveal significant traumas which should be addressed on par with any other trauma experiences.

Discussion of overdose throughout systems of care and with friends, family, and community enhances a robust trauma informed approach to SUD treatment. Integrated discussions should include the impact of trauma and historical trauma on an individual's physical, behavioral, and spiritual health, with an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.”

---

<sup>2</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5193264/>

## **Collateral Benefits of Provider Support**

Incorporating overdose prevention and response into SUD treatment can increase support to staff by providing the opportunity to address grief that staff members can experience. A study conducted with SUD treatment staff found that grief reactions, workplace stress, and traumatic reactions were common among those who had a current or former individual fall victim to a drug overdose death.<sup>3</sup>

### **III. Implementing Prevention in a Behavioral Health Setting**

#### **Opportunities to address overdose in treatment**

Agencies that adopt overdose prevention in their standard operating procedures support trauma-informed care for people with OUD and/or anyone who may have been involved in an overdose event. In addition, overdose prevention can be incorporated into both individual clinical practice and an organization's standard operating procedures.

#### **Waitlists**

Individuals can be particularly vulnerable to overdose when there is a delay in accessing treatment. People who are placed on a treatment waitlist are likely to continue to use substances. Therefore, it is essential that anyone placed on a waiting list be given information on opioid safety, overdose prevention, and response. This should include: information on factors that increase risk of overdose; signs and symptoms of overdose; and effective response to overdose, including calling 911 and rescue breathing. Additionally, always provide information on how to obtain naloxone if this is available in your area, and about the Good Samaritan law in New York State. Many people seeking treatment also engage in poly-drug use. People who use multiple substances (particularly central nervous system depressants) are at an increased risk for synergistic overdose. Overdose prevention information and materials should be available to everyone on a waitlist, regardless of their reported "drug of choice."

Please note that All OASAS-funded prevention and treatment providers, regardless of whether they receive Federal SAPT Block Grant funds, are subject to the provisions of 45 CFR Part 96 Subpart L:

*Admission Requirements Intravenous Substance Abusers. Treatment providers must ensure timely access to treatment services for intravenous substance abusers and establish and maintain an Applicant Waiting List. Each individual who requests, and is in need of treatment for intravenous substance abuse, is to be admitted into the program within 14 days of making the request. In instances where the intravenous substance abuser cannot be admitted into the program within 14 days, the applicant must be provided with interim services within 48 hours and must be placed on a waiting list. The*

---

<sup>3</sup> Mcauley, A., & Forsyth, A. J. (2011). The impact of drug-related death on staff who have experienced it as part of their caseload: An exploratory study. *Journal of Substance Use*, 16(1), 68–78.

*provider must make efforts to place the applicant in treatment and under no circumstance should an applicant remain on a waiting list for more than 120 days.<sup>4</sup>*

### **Screening/Assessment/Intake**

Risk assessment should be first conducted during an initial assessment with a client. Additionally, the client should be reassessed for overdose risk throughout their entire treatment episode. The initial intake phase represents one of a few times of highest reported risk for overdose; the other times include transfers from different levels of care or agencies; and while waiting for MAT induction.

Behavioral healthcare operates on the triage model, in which any potentially life-threatening issues are assessed and treated first (e.g., suicide risk). This is a natural place to talk about overdose risk with anyone who reports use of opioids. If individual presents as at-risk for overdose, develop a plan to keep the individual safe. The specific that can include overdose prevention education and naloxone.

Sample language to be added to intake forms:

*Have you ever overdosed? What happened as a result?*

*Have you ever witnessed an overdose?*

*What would you do in a situation where someone was overdosing in your presence?*

The first two questions deserve further exploration after initial intake, during counseling, and as the therapeutic relationship is established. The last question gauges the individual's knowledge of safe methods to overdose response. Take time to listen to the client's response and provide additional information where needed.

If a person describes a response that is NOT recommended, this is an opportunity to suggest more effective alternatives. Regardless of level of knowledge about overdose response, be prepared to give additional information and naloxone, if possible (or prescription). If an individual doesn't return after intake, this may be the only opportunity to make sure that they have reliable information about what to do, what to tell others to do, and the materials to maximize safety.

### **Trauma Informed Care: Acknowledging grief and loss**

Historically, overdose has often been viewed as an unavoidable consequence of illicit opioid use, rather than a preventable trauma. Providing a safe environment where grief, regret, and traumatic symptoms related to overdose can be expressed and addressed is essential.

According to SAMHSA:<sup>5</sup>

<sup>4</sup> <https://www.oasas.ny.gov/mis/bulletins/LSB2012-01.cfm>

<sup>5</sup> <https://www.samhsa.gov/ntic/trauma-interventions>

*A trauma-informed approach incorporates three key elements: (1) realizing the **prevalence of trauma**; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, **including its own workforce**; and (3) responding by putting this **knowledge into practice**. [emphases added]*

Frequent exposure to sudden, preventable overdose deaths constitutes a traumatic event for individuals. However, some Behavioral Health providers and support organizations have often lacked the necessary training and education to correctly assess for overdose-related traumatic symptoms, and to deliver effective trauma-informed care for individuals affected by trauma. To enhance the effective delivery of care, it is important to acknowledge and celebrate resiliencies that can mitigate the effects of trauma. Discussing personal strengths that have helped an individual survive can be a useful exercise in the preparation and action stages of behavior change.

A holistic treatment and recovery approach means addressing overdose prevention throughout the continuum of care, remembering those who did not survive, and recognizing the imprint of trauma for survivors. Additional information on overdose prevention, including agency response to client death, can be found in the OASAS guidance document, **“Clinical Response Following Opioid Overdose: A Guide for Managers.”**

### **Trauma screening**

Screening for overdose-related trauma, grief, shame and regret can facilitate individualization of care and identification of co-occurring disorders. Recording overdose experience in an individual’s chart during the assessment provides important information to counselors and enhances the foundation of the treatment relationship.

In the past, overdose was not typically regarded as a traumatic event. This view leads to underrepresentation of overdose in regular trauma screening protocols. Minor modifications of existing trauma screening tools can assess for trauma reactions related to overdose experiences.

Some examples of minor modifications are included below (additions are underlined, deletions are struck through):

*Life Events Checklist (LEC):* <sup>67</sup>

- 12. Life-threatening illness, ~~or~~ injury, or accident, including overdose.
- 14. Sudden, ~~violent~~ death (for example, homicide, suicide, overdose)

*The Veterans Administration’s Trauma History Screen (THS)*<sup>10</sup>:

- J. Sudden death, including from overdose, of close family or friend
- K. Seeing someone die suddenly, including by overdose, or get badly hurt or killed

<sup>6</sup> [http://www.ptsd.va.gov/professional/assessment/te-measures/life\\_events\\_checklist.asp](http://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp)

<sup>7</sup> <http://www.ptsd.va.gov/professional/assessment/te-measures/th.asp>

Response to trauma is highly individual and influenced by numerous variables. Not everyone who has been involved in an overdose, either as a survivor or witness, will experience trauma. However, when traumatic experiences slip through cracks during screening, we miss an opportunity to provide resources for healing.

### **Overdose & Traumatic Brain Injury (TBI)**

A hypoxic-anoxic injury that occurs during overdose can mark the onset of a TBI. It is a challenging task to identify an individual that may be suffering from brain injury. TBI is considered an “invisible disease,” but can impact a person’s ability to function in many aspects of their lives, including their ability to regulate emotions and process information. The connection between opiate use, overdose, and brain injury is more prevalent today than any time in history, due to the significant increase in OUD. Overdose has a highly deleterious effect on the brain, which is deprived of oxygen anywhere between a few seconds to hours during overdose.

TBI can be determined by an individual’s self-disclosure, the use of comprehensive assessment, hospital records, and the HELPS screening tool. Visual monitoring of behaviors and actions can also be a helpful tool. Once it is determined that a TBI is present, clinical services should be adapted to the individual’s ability. For instance, there may be verbalization issues, memory, and impulsivity-control problems. Client education can be conducted on frontal lobe deficiencies, or behavior modification worksheets or assignments could be given. Please see the Brain Injury Association of NYS for more information or resources: <https://bianys.org/>.

### **Medication Assisted Treatment Induction or Orientation Phase**

Some programs discuss the potential for recurrence of use from the very beginning. It can be useful to acknowledge that addiction and recovery are not linear paths. Affirming the individual’s survival as paramount, and stressing that they will not be judged if they return to treatment following resumed use, expresses concern and support for individuals as human beings, and can help establish a strong connection right away.

The first few weeks of Medication Assisted Treatment involving buprenorphine or methadone are considered the induction phase. During this phase, the dosage is adjusted until the clinician and the individual agree they have achieved a therapeutic dose. Typically, the provider will start the service recipient on a low dose and gradually increase until the therapeutic threshold is reached. Some poly-substance use is common during this induction period, where the patient may supplement treatment with heroin, other opioids, or benzodiazepines to reduce discomfort until therapeutic dose is achieved.

Sample language that can be used during the induction phase:

- *If you were to have even a single instance of use at some point, we want to make sure that you stay alive to get back on track. Everyone should know what to do in an overdose situation.*

- *We are committed to your safety, which is why we gradually increase your methadone dose, observe your reaction to it, and discuss overdose prevention and management with you (and, with your permission, your loved ones).*
- *We hope that you are here tomorrow, and next week, and next month, but if for some reason you're not, our foremost concern is that you stay alive, so that we can see you again down the road.*

If your program provides naloxone upon discharge, it is helpful to state this from the beginning. This reinforces the necessity of overdose prevention at all stages of treatment. Many agencies also have an orientation group, which can be a good time to outline prevention resources, protocols, and training for new clients. There are also addresses provided for several thought-provoking videos on the subject, located under the **Resources** section.

## Counseling

### Individual counseling

Counseling sessions provide an opportunity to expand on information about overdose the client disclosed during intake. Additional experiences may also come to light, as individuals begin to feel safe. The goals should be to understand social network dynamics; establish individual strengths, assets, and resiliencies that contributed to the person's survival; and identifying trauma, PTSD, anxiety, depression or potential suicidal ideation. These conditions may impact treatment outcomes, and warrant focused or specialized treatment.

The Stages of Change model is commonly used in behavioral health, to identify the client's stage of readiness and tailor services to an individual's situation<sup>8</sup>. Consider harm reduction activities, particularly overdose prevention, as part of the clinical focus when working with patients in Pre-Contemplation, Contemplation, Preparation, and Action Stages of Change. Active substance use, *by definition*, is expected in these stages. A clinician adept at providing harm reduction strategies or referrals conveys willingness and ability to work with individuals across all stages of a change process, affirming that being alive and healthy is more important than substance using status.

When information about overdose prevention, risks, and effective response is provided, individuals may reveal concerns about risk of overdose for themselves or others. Concern expressed for others may also be indirect expression of concern for themselves and counseling is an opportunity to provide individuals with the information and resources that they need. This gives the strong message that you care **MOST** about them staying alive. Counselors should address the individual's risk either directly or indirectly.

Sample language to identify strengths and resiliencies and explore trauma:

---

<sup>8</sup> SAMHSA's TIP #35 Center for Substance Abuse Treatment. Enhancing Motivation for Change in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 35. SAMHSA, 1999.

- *Have you ever OD'd? [If yes] How did you survive? Who was with you and helped you? How did that affect the ways you used after the overdose? How do you protect yourself from it happening again? [If no] More than half of people who use opioids have an overdose- what did you do to avoid being part of that group? What other ways did you keep yourself safe from the risks of drug use?*
- *Have you ever witnessed an OD? [If yes] What did you do? What did others do? Did the person live? Do you think about that event(s) often? How do you feel about it? [If no] Most people say that they have seen an overdose- what do you think was different about your experience that you have not? How do you talk with friends about preventing overdose? How do you and your friends protect each other from other dangerous or difficult situations?*

## **Group counseling**

### ***Psychoeducational groups***

There are numerous approaches to incorporating overdose prevention into psychoeducational groups. One approach is to focus on general information about opioid safety. It is important to communicate that any time anyone takes opioids, whether getting high or for pain, they may be at risk.

Another approach is to incorporate overdose risk and response into HIV counseling groups or services. A recent study showed that people living with HIV/AIDS (PLWHA) are twice as likely to die of overdose as people who are HIV negative.<sup>9</sup> While the reasons behind this are unclear, possible reasons for this disparity may be: reduced pulmonary function; reduced hepatic (liver) function; different levels of engagement in high-risk behaviors; and/or interactions between antiretroviral medications and opioids (particularly methadone, possibly heroin) that may lead to differences in metabolizing substances or patterns of use. In this study, one of the most important protective factors for PLWHA against overdose was determined to be engagement in methadone assisted treatment. On the other hand, poverty and incarceration both increased overdose risk.

Sample language:

- *What are the risk factors for overdose?*
- *How does HIV medicine interact with different drugs?*
  - *People living with HIV/AIDS are at higher risk for overdose- does anyone have thoughts on why this might be?*
- *What do you do if you are with someone who overdoses?*
  - *What are some less effective ways to respond? [Individuals may tell stories of previous responses that are less effective strategies. This is a good opportunity to provide accurate information.]*

---

<sup>9</sup> Green, T. HIV infection and risk of overdose: a systematic review and meta-analysis. AIDS. Feb 20, 2012; 26(4): 403–417.

- *While putting ice on someone may wake them up, if they are able to wake up, sternal scrub is quicker (and less messy) and you can get the same result. If someone isn't breathing, they need oxygen (breathe for them) and/or naloxone.*
- *Has anyone used naloxone or had it used on them?*
- *Do you know where to get naloxone?*
- *Do you now or have you ever had an “overdose plan”?*
- *What are the risks and benefits of responding to someone's overdose?*
- *You may not need this information yourself, but do you know others who do?*

### ***Relapse Prevention groups***

Relapse prevention groups are a natural point to discuss overdose. Relapse prevention groups focus on helping individuals develop coping skills and support networks that may keep a single or limited instance of resumed use from becoming a full-blown relapse. This can help to counter “abstinence violation effect” feelings of guilt, shame, and loss of control after an episode of use that can lead to higher levels of consumption. Focusing on health and safety, rather than a goal of absolute abstinence, can minimize damage that resumed use after abstinence may impose on a person's identification as “a person in recovery.” It is crucial not to underestimate the overdose risk of a lapse. Indeed, a limited instance of resumed use may very well be more dangerous for survival than a period of resumed regular use. This is because tolerance is lower and a person is more vulnerable to fluctuations in purity of illegal substances.

Sample language:

- *How has your experience with overdose (yours or other's) affected your use? How has it influenced your recovery?*
- *How do you think your family/community will react to your interest in preventing overdose (and carrying naloxone)? How has overdose affected your friendships or family relationships?*
- *How would you help a friend who has had a recurrence of symptoms? How would you want your recovery coach to support you if you were worried about a lapse? How would you want your sponsor (or similar) to support you if you were worried about a lapse? How do you feel about making an “overdose plan”?*

### ***Psychotherapy groups***

Psychotherapy groups can be a good context to explore feelings of isolation, shame, regret, anger, betrayal, survivor guilt and/or grief related to overdose. Normalizing overdose as an inextricable part of opioid use may help counter these emotions and provide the context for people to express feelings they may have.

Scripted facilitator language in psychotherapy groups is not ideal. However, the following themes may come up:

*Many times, in discussing overdose prevention or learning about naloxone availability, people reflect on how things may have been different for friends, family, or acquaintances. This could*

*bring up traumatic events in the past, or reframe events that a person thought they had reconciled. This can elicit acute negative feelings. People who have been present at an overdose scene that resulted in death may feel they tacitly or overtly contributed to that death, or bear some responsibility for it. The sense of responsibility or guilt is common in relation to any type of death, but can be more pronounced with overdose deaths because of the stigma involved.*

*Rather than trying to sort out the details of what “really” happened, it can be useful to frame these feelings as a common part of the grief process.*

*Feelings of anger and betrayal may also be expressed. Anger may be directed at the attention that overdose is currently getting in public health and media settings, or the change in tone in society. Statements may reflect the underlying pain and grief of individual loss and/or of experiencing a lack of public acknowledgement or sympathy during previous drug crises in the United States.*

### ***Groups for family members***

Many programs incorporate family members and loved ones into the treatment process. Family members may be acutely aware of the risk of overdose that individuals face when they leave or complete treatment. For our clients, the transition back to their home and community can be challenging. Parents often experience great fear. Providing them with information about what overdose looks like and how to respond effectively can relieve some anxiety. Informing them about the potential for relapse and overdose can be essential in making sure family members are not blindsided if this were to happen.

Because of the stigma associated with SUDs, families may feel isolated in their grief, fear, or confusion. Providing opportunities to connect with others in the context of a family group can be useful, as well as providing information or referrals for other community-based initiatives. Some family members may feel a sense of connection, accomplishment, or action by getting involved in advocacy efforts or volunteering with a local overdose prevention program.

Sample language:

- *We encourage every family to make an overdose plan. It can serve as an important way to have deeper conversations, illustrate how your loved one’s use is affecting the whole family unit, and set rules and expectations.*
- *Elements of an overdose plan could include training on naloxone use; discussing where the naloxone is kept; learning rescue breathing; learning signs and symptoms of an overdose; discussing not locking bedroom or bathroom doors; agreeing to check in if relapse happens; agreeing to a discussion before making major decisions if a relapse happens.*

Behavioral Health organizations may consider establishing, hosting, or collaborating with a grief support group for family and loved ones of those lost to overdose. Families may have several members who have substance use disorders, some of whom may not have survived an overdose.

Grief support can enhance a family's ability to be present and supportive of a living family member's recovery.

**Important Consideration:** A support group for people who have loved ones struggling to find recovery may be painful for members whose loved ones died in the process of finding recovery. It may be better to have a separate support group to address this. Furthermore, people who have lost a family member to overdose or other drug-related harms often experience judgment, marginalization, or scolding in general bereavement groups. Access to grief groups- including on-line options- specifically for those who have lost someone to overdose is very important. Several options are mentioned in the resource section.

### **Upon Positive Drug Screen Results**

Drug screens are typically used for therapeutic purposes, but can inadvertently create adversarial feelings on the part of the individual if not handled appropriately. Discussing concerns about overdose in the event of a positive drug screen may help to reduce tensions by framing the process in terms of concern for the individual's survival and the need to implement additional strategies.

Sample language:

- *I care about you and I do not want anything to happen to you.*
- *It is my job to make sure you have access to the skills & information to help you survive, no matter what happens.*
- *You are more at risk of overdose if you use alone. Do you and your friends have an overdose plan? Let's figure out how/where to get you naloxone.*

### **Transitions in Care/Post Treatment**

Transitions in treatment from one level of care to another are high-risk times for clients. Clinicians should ensure that individuals have the best skills, information, tools, and materials prior to the transition. The best way to do this is to weave overdose prevention information into the treatment episode, as presented in this paper. In the case of a non-routine or unsuccessful discharge, the individual should be re-trained on the administration of naloxone and provided with a naloxone kit or a prescription. Additionally, they should be given information on local Syringe Exchange Programs and Drug User Health Hubs ([https://www.health.ny.gov/diseases/aids/general/about/substance\\_user\\_health.htm](https://www.health.ny.gov/diseases/aids/general/about/substance_user_health.htm)). Having information and material "kits" readily available is helpful.

Sample language:

- *I hope that you never are in this situation, but with so many people dying of overdose, it's important that you know what to do if you are ever with someone who has an overdose. You may be able to save their life.*
- *Whether someone is getting high or taking opioids for pain, anyone who uses opioids can be at risk of overdose and people with lower tolerance are at higher risk.*

## IV: Reducing Drug Related Harm

### Overview of Opioid Overdose Prevention Programs (OOPP).

Providing naloxone rescue kits to individuals who use either illicit or prescribed opioids, as well as members of their social network, can effectively prevent fatal opioid overdose. Naloxone is an opioid antagonist and has no abuse potential. The medication works by reversing respiratory depression, and restores consciousness and breathing during an opioid overdose within a few minutes. Naloxone can be provided by prescription during regular medical care, by pharmacist-initiated collaborative practice agreement, by community-based overdose education with Opioid Overdose Prevention Programs (OOPP), or over the counter in pharmacies across New York State if a prescription is not available. Community organizations, local government units, treatment & prevention organizations, schools, etc. are encouraged to become registered as OOPPs under Public Health Law 3309. Requirements are relatively easy to establish and meet.

<sup>10</sup>These programs target people at risk of opioid overdose and those likely to be bystanders. OOPP educate on overdose risk reduction, including: calling for emergency medical assistance, performing rescue breathing, and administering naloxone. The New York State Department of Health (NYSDOH) community overdose prevention and naloxone distribution program began in 2006. As of December 31, 2015, 550 programs are registered and active. Through these programs, 48,473 likely witnesses and responders to overdose (i.e., law enforcement and firefighters) were trained in overdose reversal.<sup>11</sup> . These bystanders reversed over 1,608 opioid overdoses with naloxone in 2015, alone, and 2,942 since the program's inception.<sup>12</sup>

An analysis of OOPP demonstrated decreased overdose deaths in communities that implemented OOPP, as compared against communities that did not utilize the programs<sup>13</sup>. Additionally, OOPP intervention has been endorsed by the United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO), US President's Emergency Plan for AIDS Relief (PEPFAR), the American Public Health Association (APHA), the Substance Abuse and Mental Health Administration (SAMHSA), NYS OASAS, NYSDOH, DCJS, SEMAC, DFPC, as well as state legislatures, and public health departments.

Several widely-used overdose prevention and naloxone educational curricula are available (see resources section). Some examples are Skills and Knowledge on Overdose Prevention (SKOOP), developed by the Harm Reduction Coalition and the Drug Overdose Prevention and Education (DOPE) Project. The Chicago Recovery Alliance has several training videos. The Center for Prisoner Health & Human Rights developed an award-winning video targeting individual

---

<sup>10</sup> [https://www.health.ny.gov/diseases/aids/general/opioid\\_overdose\\_prevention/become\\_a\\_program.htm](https://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/become_a_program.htm)

<sup>11</sup> NYSDOH, AIDS Institute, March 2016, as cited in New York State Opioid Poisoning, Overdose and Prevention: 2016 Report to the Governor and NYS Legislature

[https://www.health.ny.gov/diseases/aids/general/opioid\\_overdose\\_prevention/docs/annual\\_report2015.pdf](https://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/docs/annual_report2015.pdf)

<sup>12</sup> NYSDOH, AIDS Institute, December 2015, as cited in New York State Opioid Poisoning, Overdose and Prevention: 2016 Report to the Governor and NYS Legislature

[https://www.health.ny.gov/diseases/aids/general/opioid\\_overdose\\_prevention/docs/annual\\_report2015.pdf](https://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/docs/annual_report2015.pdf)

<sup>13</sup> Giglio, R. E., Li, G., & Dimaggio, C. J. (2015). Effectiveness of bystander naloxone administration and overdose education programs: A meta-analysis. *Injury Epidemiology*, 2(1). doi:10.1186/s40621-015-0041-8

released from prison called “Staying Alive on the Outside” and Prevention Point Pittsburgh & Project Lazarus produced a video on opioid safety for patients and others, “Opiate Safety: The Role of Naloxone.” The makers of Narcan have also produced a training video<sup>14</sup>. SAMHSA has also produced an Overdose Education and Prevention Toolkit<sup>15</sup>.

Successful incorporation of OOPP into a treatment program hinges on providing effective training for management and staff. People are often referred to treatment by drug courts and other agencies, regardless of their stage of change or motivation to participate. This can leave providers feeling frustrated or pessimistic about their ability to meaningfully engage individuals. Addressing overdose risk and providing tools to prevent overdose death is an opportunity to engage individuals by providing tools and information that are valuable to them whether or not they commit to a program of treatment.

In choosing the curriculum that best fits an agency’s needs and local context, keep in mind that an effective curriculum should include techniques in overdose prevention (i.e. minimizing poly-substance use, awareness of tolerance change) and response, such as how to assess for overdose, seek help, deliver rescue breathing, administer naloxone, post administration support, and specific techniques to avoid. Generally, the curriculum is delivered by trained nonmedical agency staff.

If an organization is unable to directly provide OOPP services, providers can refer individuals to an agency that does provide services or to their health care provider to prescribe a naloxone rescue kit. See **Resources** section for the web address of the national naloxone program locator and prescribing and dispensing support.

### **Considerations for overdose prevention training**

There are several different ways<sup>16</sup> that people potentially at risk for overdose might access opioid safety information and overdose management training (i.e.: rescue breathing and naloxone) if they are receiving SUD treatment services:

1. Staff of a treatment program provide all OOPP components for individuals on-site;
2. People from an outside collaborating organization invited to provide OOPP on-site at the treatment program on a regular basis;
3. Treatment staff provide education on-site, and provide a prescription for naloxone.

### **Dual Roles During an Opioid Overdose Emergency**

#### **Overdose victim**

Addressing the increased risk for overdose that individuals with tolerance changes may face can be a sensitive topic in the early stages of building a relationship. Intentions can be misinterpreted

---

<sup>14</sup> <https://www.narcan.com/>

<sup>15</sup> <https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2016/All-New-Products/SMA16-4742>

<sup>16</sup> \*Adapted from Walley et al. JSAT 2013; 44:241-7

(“You’re acting like I’ve *already* relapsed!”) or the risk can be minimized (“I’m done with using and ready to be done with dope- this doesn’t apply to me”). Be prepared to address these concerns. If the individuals resume opioid use, after even a *brief period of abstinence*, they are at high risk of overdose. To avoid implication that some individuals are “higher risk” or less likely to complete treatment, discussing the topic universally, with emphasis on gaining life-saving skills, can minimize misinterpretation and has the potential to decrease stigma.

Some sample language:

- *If someone has stopped using opioids after daily use due to entering treatment, becoming incarcerated or stopping prescribed pain medication due to a decrease in pain, their tolerance is lower.*
- *If they start using opioids again, it takes less to get high, less to get effective pain relief, and less to overdose. So, if you stop using opioids and then start again, for whatever reason, this is a high-risk time for possible overdose, so it’s important to have a plan for what to do in that situation.*

Additionally, Fentanyl—an opioid used in medicine as part of a surgical anesthetic and pain medication that is significantly more potent than heroin or morphine—has become more prevalent in recent years and is tied to increased risk of overdose death (due to its potency). Overdose deaths from synthetic opioids, such as Fentanyl,<sup>17</sup> increased by 151.5% from 2015-2016 in New York State.

### **Trained Overdose Responder**

Another message to convey is that learning how to prevent and respond to overdose is a valuable skill for anyone.

The first step in responding to overdose is calling 911. The New York State 911 Good Samaritan Law<sup>18</sup> provides significant legal protection against criminal charge and prosecution for possession of controlled substances, as well as possession of marijuana and drug paraphernalia, both to the person seeking assistance in good faith as well as to the person who has overdosed.

People may have family members, spouses, children, or community members who continue to be at risk of overdose. In some situations, an informed overdose responder might be the only one who knows what to do to save a life. Communicating to individuals that these skills can help them contribute positively to the community, and that they can be counted on in an overdose emergency, is a way of giving back to the community. In addition, they may want to learn to be a trainer and teach these skills to others, or become an activist by helping to disseminate information or working to adopt policy changes to address the problem.

### **Unexpected collaborators: Overdose stakeholders are varied & expanding**

<sup>17</sup> <https://www.oasas.ny.gov/CombatAddiction/Fentanyl.cfm>

<sup>18</sup> [NY State 911 Good Samaritan Law](#)

More and more community-based groups and government offices are acting against overdose by working to prevent it and facilitate recovery from fatal overdoses. These include groups not traditionally thought of as part of the system that supports people with a substance use disorder to remain healthy and alive while engaging in the recovery process. Private foundations, faith-based groups, ad hoc coalitions, fire departments, needle exchange programs, and community advocates can recognize SUD treatment and recovery support services as partners in preventing overdose. Collaboration on this topic can highlight overlapping priorities and create or strengthen relationships. Ultimately, these processes may help reduce stigma by establishing common goals.

## **V. Overdose Postvention**

### **Overdose Response in the treatment community**

When a person overdoses, it is likely that the news will reach everyone at an agency. Yet, all too often it is not directly discussed. Sometimes comments imply that the person deserved it (for example: “if you play with fire...” or “I knew they weren’t *actually* ‘ready’”), or the event is used as a cautionary tale. Directly acknowledging that someone has overdosed and encouraging some remembrance, celebration, or honoring of their life is important. Clear acknowledgement should be made that an important community member has passed and recognition of this as a sad event where feelings of grief are natural. It is important to reassure individuals and staff that individuals will be remembered. Organizationally, this is an opportunity to review what happened, what could have been done differently, or what was done right that saved the person.

### **Clinician perspectives & supervision**

#### **Preventing future overdose**

Despite awareness of statistics regarding risk of overdose and injection among those leaving or completing treatment, clinicians sometimes struggle with concern that prevention messages, may communicate that they are “giving up on [individual]” or “don’t have faith in the strength of [individual’s] recovery.” This can be reframed as, “I care about this person and want them to be alive whether or not they start using again.” This approach requires an organizational commitment and the support of coworkers and supervisors.

In the absence of this support, it can be unrealistic to expect staff to adopt effective overdose prevention strategies. When staff members feel there is no genuine acceptance of a new approach from peers or a supervisor, voicing concern and care as described above can leave them feeling vulnerable to criticism. A trauma informed approach looks at the impact on all those involved, including staff.<sup>19</sup> Regularly addressing this issue in staff meeting or clinical supervision and providing an opportunity for staff members to process concerns and reservations in a safe environment, can help to reduce tensions among staff as they adapt to new ways of working with individuals, changing the organizational culture and perspective in the process.

---

<sup>19</sup> <https://www.store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>

## Addressing past overdose experiences

A study of staff members working at several different SUD treatment programs found that between 38% and 45% had witnessed a client overdose in their lifetime.<sup>20</sup> In another study, nearly 90% of SUD treatment staff who had an individual on their caseload die from drug related causes reported grief reactions, such as sadness, guilt, and anger. Staff and individuals alike have a tremendous burden of overdose experiences.<sup>21</sup>

An event that memorializes people lost to overdose can be beneficial for individuals and staff. The pervasive misconception that drug related deaths are a common “natural” consequence of a SUD can create an expectation that people working in the field should be able to cope and reconcile loss without difficulty. While loss is a component of any kind of medical or therapeutic work, staff will be healthier and more productive if the agency they work for builds in time and space to support staff as they cope with a client’s passing. Establishing a regular or ongoing opportunity to remember people can provide an important opportunity to have a dialogue and express emotions associated with the loss.

International Overdose Awareness Day originated in Melbourne, Australia in 2001, and is recognized every August 31<sup>st</sup>. The theme is prevention and remembrance, and it provides a welcome opportunity to mourn, celebrate, and remember those who have been lost to overdose, and serves as an important vehicle to advocate for hope and change. In the US, September is Recovery Month, which makes International Overdose Awareness Day- August 31- a powerful way to kick off Recovery Month and provides the opportunity to continue the discussion. This time of the year may be a good time to have a memorial for individuals lost to overdose and to celebrate recovery successes.

*“Every death opens all the old graves,” they used to tell us in early HIV training in the 1990s. They told us this to make us realize that going forward, with each loss we faced, feelings were going to flow from any number of memories...Time blurs between experiences with AIDS, overdose, and other premature, untimely departures. Each are similar and unique. While it may seem peculiar to put them side by side, the experience of other kinds of early and seemingly preventable death, this is also true with homicide, suicide, and crazy accidents that just shouldn’t happen, all tend to blend together. Yet coping with them is part of this work. The feelings around these losses becomes part of our inner life and memory, just below the surface of our daily life, ready to bubble upward with the touch of another loss.*

-Shepard, Harm Reduction Journal, 2013

## Supervision

Because overdose prevention and postvention are relatively recent additions for many healthcare disciplines, there can be some confusion or ambiguity regarding the supervisor’s role in creating

---

<sup>20</sup> Walley et al. Opioid overdose prevention with intranasal naloxone among people who take methadone. J Subst Abuse Treat. 2013 Feb;44(2):241-7 25

<sup>21</sup> Mcauley, A., & Forsyth, A. J. (2011). The impact of drug-related death on staff who have experienced it as part of their caseload: An exploratory study. Journal of Substance Use, 16(1), 68–78.

effective postvention protocols. The following are some important considerations for professionals coping with the loss of a client:

- Experiencing and reacting to grief does not reflect a lack of professional ethics or boundaries. When a staff member experiences grief and loss in their personal life, there is an assumption that supervisors and staff provide support. When the loss happens as part of one's job, support mechanisms must be built in to the work environment.
- Staff need to have channels to address emotional distress in ways that build the work community.
- If you learn that several employees are particularly affected by an overdose, coordinating group supervision with them may be a way to facilitate cross dialogue, support, and brainstorming.
- Create and promote venues for staff and individuals to remember people who have been lost to drug related deaths.
- Provide opportunities for staff to access training on the topic- everything that an organization or a supervisor can do to help address feelings of guilt or responsibility is individually and organizationally important.

## References and Resources<sup>22</sup>

### Opioid Overdose Prevention Provider Resources:

- **The Chicago Recovery Alliance** started the first organized overdose project in the USA in 1996 and has some great resources on their Information Downloads section. Some realistic video training materials available, in particular LIVE! from Sawbuck Productions. <http://www.anypositivechange.org/menu.html>
- **GetNaloxoneNow.org** is the home of the first web-based overdose recognition and management training modules- one for lay bystanders and one for uniformed first responders such as police and fire. NOTE: You cannot order naloxone directly from this site. Animated & interactive trainings that include tests. <http://www.getnaloxonenow.org/>
- **Staying Alive on the Outside** is the only overdose prevention training video we know of that is specifically targeted toward prisons, but, don't forget that the other risky time period for overdose is after being discharged from SUD treatment! This award-winning production is from the Center for Prisoner Health and Human Rights at Brown University. <https://vimeo.com/164337787>
- **SAMHSA Opioid Overdose Prevention Toolkit** This toolkit offers strategies to health care providers, communities, and local governments for developing practices and policies to help prevent opioid-related overdoses and deaths. Access reports for community members, prescribers, patients and families, and those recovering from opioid overdose. <https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA16-4742>
- **The Harm Reduction Coalition** is the USA's national harm reduction network, and has operated overdose programs in San Francisco and New York City for many years. Their site includes a great deal of information and resources on overdose in the Issues tab. <http://harmreduction.org/>

---

<sup>22</sup> Resources courtesy of the Opioid Safety & Naloxone Network

- **The Guide to Developing & Managing Overdose Prevention and Take-Home Naloxone Projects** is a reference for anyone doing overdose work and there is a large collection of training and advocacy videos. <http://harmreduction.org/issues/overdose-prevention/tools-best-practices/manuals-best-practice/od-manual/>
- **Opioid Overdose Prevention Program Inventory** checklist. <http://center4si.com/wp-content/uploads/2016/05/OOP-Program-Inventory-.pdf>
- **PrescribeToPrevent.org** contains resources directed toward health care providers such as doctors, nurses, and pharmacists, who are interested in prescribing naloxone to patients. Tailored provider support tools, like a free CPE course for pharmacists and an education video for patients receiving pain medicine or an animated overdose responder training video. <http://prescribetoprevent.org/>
- **Project Lazarus** is a unique effort to reduce overdose from prescribed opioids that unites health researchers, treatment providers, preventionists, activists, county officials, military, and local communities in North Carolina. *Don't miss feature:* Toolkit for implementing a community coalition-based model for addressing overdose concerns about prescription medicines. <https://www.projectlazarus.org/>
- **BSAS Practice Guidance:** <http://prescribetoprevent.org/wp2015/wp-content/uploads/MA-BSAS.care-principles-guidance-opioid-overdose.pdf>

#### **Grief and support groups specifically for those affected by opioid use and overdose:**

- **Grief Recovery After a Substance Passing (GRASP)** is for those who have lost a loved one <http://grasphelp.org/>
- **Learn 2 Cope** is for families with loved ones who have a substance use disorder. <https://www.learn2cope.org/>
- **Moms United** and **Broken No More** are activist groups for parents of people who use drugs advocating for change. There are many groups that are appropriate for loved ones and family members. <https://www.momsunited.net/>

#### **Trauma Informed Care Training Resources:**

- OASAS Free Regional Trainings: <https://www.oasas.ny.gov/workforce/training/oasastraining.cfm>
- Seeking Safety: <https://www.treatment-innovations.org/seeking-safety.html>

#### **New York State Resources:**

- [NY OASAS Training and Other Initiatives](#)
- [NY Department of Health Opioid Epidemic Initiatives](#)
- [NY Department of Health Opioid Overdose Initiatives](#)
- [NY Department of Health Harm Reduction Programs](#)
- [Rockefeller Institute Tracking Map](#)
- [First Aid/CPR Training](#)
- [N-CAP Program](#)
- [NY Good Samaritan Laws](#)
- [Good Samaritan Law Analysis & Information](#)

- [Fentanyl](#)
- [Morphine Equivalents](#)