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Clinical Responses to the Opioid Crisis: A Resource Guide

APA CROSS-DIVISIONAL TASK FORCE ON
CLINICAL RESPONSES TO THE OPIOID CRISIS



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INTRODUCTION

Prescription opioid use and misuse increased dramatically over the past two decades. Use of heroin has also been on the rise, in part due to its greater strength and lower cost. Recently, the increased availability of highly potent synthetic opioids such as fentanyl (50-100 times more potent than morphine) and carfentanil (10,000 times more potent than morphine) has significantly increased the risk for fatal and nonfatal overdose. Because of the devastating impact of opioid misuse on families, communities, and the health-care system, the U.S. federal government declared the opioid crisis a national emergency in 2017.

Addressing this epidemic will require efforts at all levels of the health-care system, ranging from careful opioid prescribing practices to adequate emergency response and improved access to effective detection, referral, and treatment for individuals with opioid use disorder.

Psychologists can play an important role in addressing this epidemic.

Psychologists, like primary care physicians, have the potential to be on the front lines of opioid misuse detection, in part through educating and assisting families and loved ones, as well as intervening directly with those misusing opioids. Educating families about early intervention, rescue interventions, and strategies to engage those with opioid use disorder in treatment is a crucial component of addressing the opioid epidemic. Also, psychologists can play a key role in substance use disorder treatment, including behavioral interventions for adherence to front-line medication therapies as well as the provision of evidence-based psychosocial interventions and the treatment of co-occurring conditions, such as anxiety, depression, and chronic pain.

In this guide, we provide resources to help psychologists respond to the opioid crisis. The scope and nature of opioid misuse have rapidly evolved throughout this crisis and continue to evolve. For example, overdose increases have occurred in three waves since the late 1990s, characterized by increases in deaths attributable to prescription opioids, followed by a steep increase in heroin deaths, and most recently by a tremendous spike in synthetic opioid overdose deaths. Although we aim to provide the most current information on the opioid epidemic in this guide, we encourage readers to follow local and national trends closely, as the epidemic will likely continue to evolve and will be subject to regional variation.

Opioid misuse* has reached an epidemic level in the United States. In 2016 alone:

OVER

42,000

people died of opioid overdose

APPROXIMATELY

11.5M

people misused prescription opioid painkillers

ALMOST

950,000

people used heroin

2.1M

people suffered from opioid use disorder

***A note on use of terms.** There is debate about the optimal terms for accurately describing the use of opioids for purposes other than those guided by a prescribing health professional for a legitimate medical indication. The removal of stigmatizing language such as *abuse* and *addiction* is strongly recommended. Here we use the term **misuse** to succinctly capture the broad range of behaviors that characterize the opioid epidemic, including using opioids at a dose or frequency greater than prescribed, the use of opioids without a prescription, and the use of prescription or illicit opioids for a purpose other than its medical use (e.g., to feel euphoria).

APA CROSS-DIVISIONAL (DIVISION 12, DIVISION 28, DIVISION 50) TASK FORCE ON CLINICAL RESPONSES TO THE OPIOID CRISIS

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Understanding Opioids

Opioids are a class of drug that have been used for pain relief for centuries. Opioids include multiple types of medications available by prescription, as well as illicitly produced or distributed drugs, such as heroin, fentanyl, or “look-alike” opioid pills. Opioids can be safe and effective for certain types of pain when prescribed and monitored carefully; however, they also come with potential risks, such as the development of physical tolerance (needing higher doses to achieve the same pain relief) and the development of opioid use disorder. Opioid use disorder is an illness characterized by continued use of opioids despite negative effects on health and functioning. This can be a devastating and chronic illness; however, effective treatment is available.

HEROIN AND FENTANYL

Heroin is an opioid derived from morphine. Heroin is typically available in powdered form and may vary in color, usually appearing to be white or brown, but it also can take the form of a hard, sticky substance known as “black tar” heroin. Powdered heroin may be ingested by inhaling it (through the nose, i.e., “snorting”), smoking it, or injecting it into a muscle or a vein. This latter process requires boiling the powdered heroin into a liquid to draw into a syringe to inject.



In recent years, fatalities have dramatically spiked, largely because of the increased availability of highly potent synthetic opioids.

Fentanyl is a synthetic opioid that can be 50 to 100 times stronger than morphine. Fentanyl can be prescribed by a doctor to treat pain but has increasingly become available for illegal purchase, often either mixed with heroin or as a substitute for heroin. The presence of fentanyl, either alone or mixed with other substances such as heroin or cocaine, can dramatically increase the risk for overdose because of its potency. The increased availability of fentanyl (and similar synthetic opioids) has been a major driver of the rapid increase in overdose deaths since 2014. Other highly potent synthetic opioids, such as carfentanil (roughly 10,000 times more powerful than morphine), have also been found in some regions of the United States.

Heroin has long been thought of as a risky drug, serving as a barrier to wide-scale use. However, prescription opioids are seen as much less risky, which has lowered the bar for initiating opioid use. In recent years, fatalities have dramatically spiked, largely because of the increased availability of highly potent synthetic opioids (such as fentanyl and carfentanil) spreading through the drug supply. These highly potent opioids may be substituted into illicit drugs sold as powder heroin and are also being “pressed” into illicitly sold pills that look similar to pills sold by a pharmacy (but are far stronger).

PRESCRIPTION OPIOID ANALGESICS

Prescription opioids, such as oxycodone, are sold in a variety of formulations (e.g., combined with aspirin or acetaminophen and in immediate or slow-release pills). These pills may be swallowed or crushed into a powder to be snorted or prepared for injection. Most people who misuse prescription opioids obtain them from friends or family members, although people may also obtain them from a doctor or buy them illegally. Illegally manufactured opioid pills may be mixed with other substances, including fentanyl, even if they are indistinguishable from

Most people who misuse prescription opioids obtain them from friends or family members, although people may also obtain them from a doctor, or buy them illegally.



FENTANYL can be roughly
50-100x
more powerful than morphine

CARFENTANIL can be roughly
10,000x
more powerful than morphine

those purchased at a pharmacy. These pills are highly dangerous and can lead to overdose, particularly when the dose of opioid received far exceeds what is expected by the person consuming it.

Given the multiple formulations and illegal manufacturing of prescription opioids, unidentified pills can raise concerns. The internet provides a number of resources for identifying what a pill might be. For example, Web MD provides a tool called the Pill Identifier (www.webmd.com/pill-identification) that offers three features to help people identify a drug from the pill design: the numerical or letter imprint information, the color of the pill, and the shape of the pill. However, this will not help to identify “look-alike” pills that contain fentanyl. Only pills obtained directly from a pharmacy can be confidently identified.



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Safe Management and Disposal of Medications

Over 214 million opioid prescriptions were dispensed by pharmacies in the United States in 2016. Opioids in the home present risk for both misuse and accidental exposure. More than 70% of those who misuse prescription opioids obtained them from a prescription or from a friend or family member. Thus, the safe management and disposal of these medications are critical components of addressing the opioid epidemic.

Discussion of medication storage and disposal is indicated for all patients, not only for those with concerns about potential misuse. Here are a few guidelines:

- Prescribed medications should not be shared with anyone else.
- If an opioid prescription is needed, store it in a location that is not easily accessible by others.
- Medications should be stored out of the reach of children and should be locked if possible.
- Medications should be closely monitored to ensure pills are not missing, especially if someone who lives in or has access to the home has a known substance use disorder.



*More than **70%** of those who misuse prescription opioids obtained them from a prescription or from a friend or family member.*

Once a prescription is no longer needed or expired, it should be disposed of as soon as possible. Pharmacies have implemented a number of new programs for medication disposal; contact your local pharmacy to ask about these options. For example, in January 2018, Walmart began providing a free kit for safe disposal of opioid medications to anyone filling an opioid prescription. Other national pharmacy chains have also added options, such as confidential drop-off locations (see more below).



There are several options for safe prescription disposal

SAFE DISPOSAL LOCATIONS

An array of public locations will accept unused medications for safe disposal, such as pharmacies, police stations, and health clinics. To find a location in your area you can either (a) call your local pharmacy or law enforcement agency or (b) use web resources such as disposemy meds.org or search for “safe medication disposal” in your favorite search engine.

CONFIDENTIAL SELF-DROP-OFF LOCATIONS

A number of organizations such as state and local public health departments sponsor confidential kiosks where medications can be safely disposed. Information about such kiosks should be available on your state or local government’s public health department page. Confidential kiosks are also available at some pharmacies, such as Walgreens and CVS.

MAIL-BACK PROGRAMS

Some pharmacies will also provide envelopes for mailing unused medications for safe disposal. Call your local pharmacy for more information on whether this is an option.

MEDICATION TAKE-BACK EVENTS

A number of organizations such as the Drug Enforcement Agency, local law enforcement, and local pharmacies frequently sponsor medication take-back days when you can bring unused medications to a preidentified collection site. These events can be identified using local news sources or through a web search.

AT-HOME DISPOSAL

Disposing of medications via a safe disposal location is strongly recommended. Flushing medications down a toilet or other drain presents potential environmental risks and should be avoided. However, the FDA also has recommendations for at-home disposal in the trash if such locations are not available or if use of a safe disposal location is not feasible.

Follow these simple steps to dispose of medicines in the household trash



MIX

Mix medicines (do not crush tablets or capsules) **with an unpalatable substance** such as dirt, cat litter, or used coffee grounds.



PLACE

Place the mixture **in a container** such as a sealed plastic bag.



THROW

Throw the container **in your household trash**.



SCRATCH OUT

Scratch out **all personal information** on the prescription label of your empty pill bottle or empty medicine packaging to make it unreadable; then dispose of the container.



Identifying Opioid Misuse and Opioid Use Disorder

Early identification of an opioid problem can help stop the progression from misuse of opioids to the development of an opioid use disorder. In short, early identification helps prevent a poor prognosis. And when it comes to substance use, clinicians need to ask; people may not disclose substance use without the clinician providing a specific and safe opportunity to discuss this issue. Accordingly, screening for opioid (and other drug) misuse should be included as standard practice in any clinical setting.

INITIAL SCREENING

- All patients should be asked about current or past prescriptions for opioids (as well as other medications with misuse potential, such as benzodiazepines). This provides an opportunity to educate patients about safe medication management and disposal.
- A simple universal screening question that can be used in any clinical setting is: “How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons (e.g., because of the experience or feeling it caused)?”¹ If the answer to this screening question is yes, detailed screening is indicated (see below).
- Three types of answers indicate concerning drug use patterns: (a) use of the medication for the express purpose of getting high or changing how one feels, (b) use of more medication than prescribed or for a longer time than prescribed, or (c) purchasing the medication illegally or via “doctor shopping” (going to multiple doctors to renew or gain additional prescriptions).

Clinicians in practice are on the front lines of early detection of opioid use patterns. This detection requires an active (asking) rather than a passive (waiting to be told) assessment style.

¹McNeely, J., Cleland, C. M., Strauss, S. M., Palamar, J. J., Rotrosen, J., & Saitz, R. (2015). Validation of self-administered single-item screening questions (SISQs) for unhealthy alcohol and drug use in primary care patients. *Journal of General Internal Medicine*, 30(12), 1757-1764. doi:10.1007/s11606-015-3391-6

DETAILED SCREENING

The National Institute on Drug Abuse Modified ASSIST Screening Tool is a free, readily available, brief, and useful detailed screening: www.drugabuse.gov/nmassist. This web-based screening tool assesses for problematic alcohol, tobacco, and prescription and illicit drug use. Results are stratified into risk categories, with corresponding clinical guidance and downloadable materials for referral and treatment.

CONSIDERING FAMILY INVOLVEMENT

Opioid misuse is highly stigmatized, which can be a barrier to reporting. Much like the assessment of any psychiatric disorder, ancillary information from other data sources can be helpful for identifying problematic opioid use. Multimethod assessment will minimize the weaknesses of any one approach. Family involvement is an obvious option; yet family involvement can be complex, as opioid use progresses toward a disorder due to issues such as stigma and interpersonal conflict. Involvement of family members in assessment needs to be carefully considered in collaboration with the patient.

Clinicians are in an excellent position to model and role play how a patient can have a conversation with a family member about opioid use.

Sometimes the request for assessment comes from a concerned family member, either directly or indirectly, with such statements as:

- “I fear my son is using drugs.”
- “My father told me his pain pills were missing after my family visited his house.”
- “I found some pills hidden, and I think they are oxycodone.”



The most important response to such queries is to treat them seriously and to communicate the importance of early detection. Your job is not to make the concerned family member into a detective but to share relevant information on opioids and their dangers. Furthermore, clinicians are in an excellent position to model and role play how a patient can have a conversation with the family member about opioid use.

Family members can also benefit from talking with others who are impacted by opioid use disorder in their family (see the Resources for Families resource sheet in this series). Family members may find that attending mutual help support groups can improve mental health, quality of life, and coping with addiction, as well as reduce self-blame and stress. Mutual help support groups for family members include:

NAR-ANON

www.nar-anon.org

SMART RECOVERY FAMILY & FRIENDS

www.smartrecovery.org/resources/family.htm

LEARN TO COPE

www.Learn2Cope.org

USE OF OBJECTIVE SCREENING

Objective screening (drug assays) is another method for gaining information on drug use patterns. Metabolites of substances can be detected in fluids such as urine, blood, and saliva. In addition to hospital- or clinic-based facilities for drug screens, some simple kits for drug screens can be purchased at drugstores (allowing private practice clinicians to arrange for simple testing, if needed). However, each method varies in its reliability and effectiveness. Of critical importance when interpreting drug assay data is to consider:

- **The detectable time frame** of the substance (e.g., for some opioids, the window of detection can be as brief as 3 days).
- **The range of substances** assessed—a thorough opioid panel will include separate tests for opiates, oxycodone, methadone, buprenorphine, and fentanyl.
- **The possibility of test manipulation**, such as use of someone else's urine. Use of occasional objective screening, in addition to providing direct evidence of drug use, may also have the beneficial effect of enhancing the veracity of self-report.

SUMMARY

Clinicians in practice are on the front lines of early detection of opioid use patterns. This detection requires an active (asking) rather than a passive (waiting to be told) assessment style. The pathway to early detection may be through the patient directly or through a concerned family member. Either way—early detection means a better prognosis.





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How to Find a Treatment Program for Opioid Use Disorder

There are a number of treatment options for opioid misuse and opioid use disorder. The intensity of treatment depends on the severity of the problem. Once an opioid problem has been identified, referral to a substance use disorder treatment specialist can help to determine the right level of care (e.g., inpatient medical detoxification, medication, behavior therapy). Although treatment for opioid use disorder has not historically been available in primary care settings, efforts to increase access to treatment for opioid use disorder in primary care are underway, and some primary care offices offer treatment for opioid use disorder.

In the treatment of opioid use disorder, detoxification and “rehab” **alone** is not the most effective approach; in fact, outpatient approaches that include buprenorphine, methadone, or naltrexone are most effective and often much less expensive. Although research has not identified an optimal duration of care (i.e., how long someone should stay on medication), relapse is highly common after treatment is discontinued, and ongoing care is associated with the best outcomes.

*Relapse is highly common after treatment is discontinued, and **ongoing care** is associated with the best outcomes.*

SELECTING A TREATMENT PROGRAM OR PROVIDER

Treatment programs vary in the quality of services they provide. Higher quality programs:

- Are certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and accredited by the Joint Commission or Commission on Accreditation of Rehabilitation Facilities
- Offer medication-assisted treatment (methadone, buprenorphine, naltrexone) in combination with counseling and behavioral therapies
- Offer family support
- If residential or inpatient level of care, offer detailed discharge planning for the transition back to the community

In addition, look for a program that is transparent and is willing to answer any and all questions you have about the treatment process.

HOW TO FIND A PROGRAM OR PROVIDER NEAR YOU

Both national and local agencies have databases of treatment programs that can be used to identify a local treatment program. There are some limitations to these databases (including challenges in keeping them up-to-date and lack of quality ratings), so vetting the agency using the criteria mentioned previously is recommended.

National Resources

SAMHSA TREATMENT LOCATOR

findtreatment.samhsa.gov

SAMHSA BUPRENORPHINE PROVIDER LOCATOR

www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator

State and Local Resources

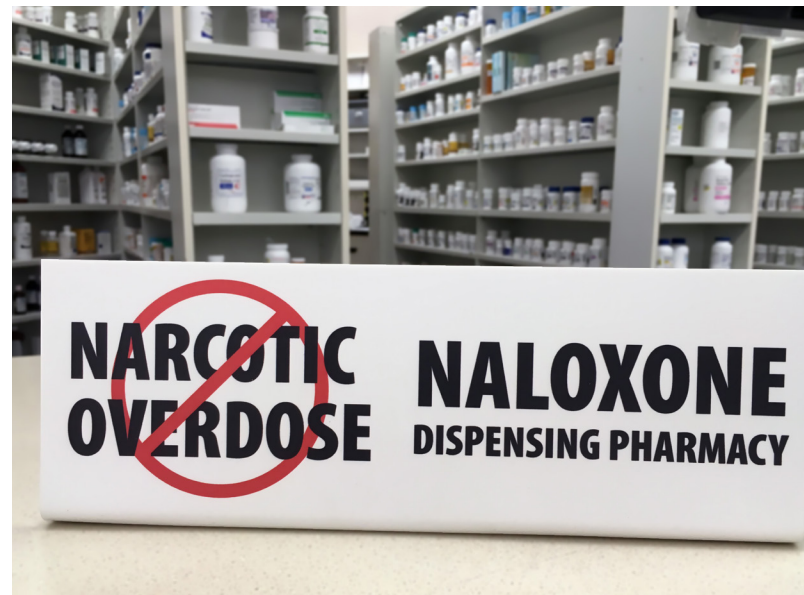
Many state agencies that address substance use disorders provide treatment locator resources. For example, the Bureau of Substance Abuse Services in Massachusetts has a treatment locator for the state: helplinema.org

To locate your local resources, check your state government's health or public health department website. The Addiction Policy Forum's Addiction Resource Center portal is a web-based resource that is compiling location resource lists for each state at the time of this writing: www.addictionresourcecenter.org



OBTAINING NALOXONE FOR OVERDOSE REVERSAL

- In most states, naloxone (also known by the brand name Narcan) is available without a prescription.
- Naloxone/Narcan can be obtained from many pharmacies.
- In states requiring a prescription, primary care physicians can provide a prescription.
- The cost of naloxone varies but can be a significant concern. Many insurers will cover its costs, and some agencies can provide it for free (e.g., some towns heavily impacted by the opioid crisis have offerings for free naloxone kits).



TREATMENT PROGRAMS OF CONCERN

In recent years, a disturbing new issue has emerged for the treatment of substance use disorders: predatory treatment programs. Predatory treatment programs are those that are oriented to maximizing billing of patients while minimizing effective treatment. Some characteristics of predatory treatment centers include offers to pay for travel and facilitate insurance coverage, the use of features unrelated to treatment to “sell” the program, use of multiple high-cost lab tests (as compared to standard substance use monitoring), little direct assessment of the patient, and lack of specialty in opioid use disorder treatment. Be especially careful with those that use aggressive marketing tactics or suggest suspiciously high “success rates.” It may be useful to ask specifically about which evidence-based practices they use and the basis on which they make those claims of success.

Predatory treatment programs are those that are oriented to maximizing billing of patients while minimizing effective treatment.



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Evidence-Based Treatment for Opioid Use Disorder

MEDICATION

Medication is an essential part of the treatment of opioid use disorder. Medication treatment is effective for two key purposes: for the short term to treat withdrawal symptoms during detoxification (opioid detoxification) and on an ongoing basis to prevent relapse (maintenance).

Opioid Detoxification

- Medications may be used to treat withdrawal symptoms for individuals undergoing detoxification. This is often done in inpatient settings where withdrawal symptoms can be closely monitored.
- Medications for opioid detoxification may include opioids (such as buprenorphine) used in a tapering fashion (with successively lower doses given over a period of days/weeks) and/or ancillary medications to treat withdrawal symptoms (e.g., nonopioid pain relievers, antinausea medication).
- Detoxification **alone** is not a sufficient treatment and actually increases the risk for overdose.



*Following short-term detoxification, upwards of **90%** of individuals relapse.*

Maintenance Treatment

There are three medications approved by the FDA specifically for the ongoing treatment of opioid use disorder, each of which exerts its effects through the mu opioid receptor system: methadone, buprenorphine, and naltrexone.

METHADONE

ABOUT

Methadone is a mu opioid agonist. Due to its long duration of action (i.e., half-life of about 24 hours), methadone is able to suppress opioid withdrawal symptoms from emerging and reduce the need/urge to use opioids.

FORMULATIONS

Methadone is used orally daily and is available in pills, diskettes, and a liquid formulation that is intended to aid in prevention of diversion.

WHERE TO GET IT

In the United States, methadone is a Schedule II drug and can only be used in the context of a special federally licensed opioid treatment program (OTP); it is illegal to prescribe methadone for the treatment of opioid use disorder in any other context with the exception of 3-day emergency treatment within an inpatient hospital setting (methadone can be prescribed as an analgesic in other settings). Patients receiving methadone typically begin treatment by coming every day to a clinic.

CHALLENGES

Because methadone can only be prescribed in an OTP, this can present logistical challenges, such as needing to travel to the program daily (or near daily) for dosing. Methadone also has several side effects, such as constipation and sedation, and can be diverted (e.g., selling or giving one's prescription to others).



Methadone has a half-life of about 24 hours and is able to suppress opioid withdrawal symptoms from emerging and reduce the need/urge to use opioids.

BUPRENORPHINE

ABOUT

Buprenorphine is a partial mu opioid agonist and, like methadone, is effective at suppressing opioid withdrawal symptoms and opioid craving. It also produces a functional opioid blockade whereby its occupancy of the mu opioid receptors can prevent other opioids from binding and exerting effects. As a partial opioid agonist, there is a limit to the magnitude of effects that buprenorphine can produce (and these are less than a full agonist); this “ceiling” on the effects of buprenorphine leads to an improved safety profile in contrast to methadone.

OTHER NAMES

Suboxone, Subutex, Sublocade, Probuphine

FORMULATIONS

Buprenorphine is typically taken by mouth (sublingual/transmucosal tablets and films).

The FDA recently approved a 6-month buprenorphine implant and a monthly subcutaneous injection that produces comparatively high plasma concentrations (≥ 24 mg/day).

WHERE TO GET IT

Buprenorphine may be prescribed by physicians (and, more recently, nurse practitioners and physician assistants, depending on state law) who have received specialized training and fulfilled the requirements to obtain a waiver from the DEA for their DEA license (known as the DEA-x license, because an “x” appears after the provider’s DEA number on their license).

CHALLENGES

Resistance to opioid agonist medications (such as the claim that you are simply “replacing a drug with a drug”) has had a negative impact on the use of buprenorphine. Diversion (e.g., selling or giving one’s prescription to others) also has been documented.

NALTREXONE

ABOUT

Naltrexone works by occupying mu opioid receptors and thereby preventing other opioids (such as heroin) from binding to those receptors and producing their euphoric effects.

OTHER NAMES

Vivitrol, Revia

FORMULATIONS

Naltrexone was initially introduced as an oral formulation to be dosed once daily. A sustained-release formulation of naltrexone was approved by the FDA that provides one month of coverage after a single administration. The formulation is a depot that is injected intramuscularly in the gluteal muscle.

WHERE TO GET IT

Naltrexone is not a scheduled drug, does not exert direct psychoactive effects, and can be prescribed by any licensed physician in a regular office setting.

CHALLENGES

Despite its safety and desirable pharmacological profile, oral naltrexone has had very limited clinical use because it is challenging to initiate treatment and patients are commonly nonadherent to taking the medication. Sustained-release naltrexone (Vivitrol) can increase compliance and has demonstrated comparable outcomes to buprenorphine once successfully initiated. Because naltrexone is an opioid antagonist, individuals who are physically dependent on opioids must first achieve an opioid-free state before they can initiate naltrexone. If they are not completely abstinent, naltrexone will precipitate a robust and sustained withdrawal syndrome. Thus, individuals who are physically dependent but seeking treatment with naltrexone must first undergo detoxification; this is often challenging and sometimes impossible for some individuals. A longer period of abstinence before initiating treatment with naltrexone is more likely to lead to a successful and comfortable transition to naltrexone.

BEHAVIORAL THERAPIES

In general, behavioral therapies, when delivered alone, have limited efficacy in addressing the complex symptoms and physical aspects of opioid use disorder. Hence, behavioral therapies for opioid use disorder have been delivered in the context of structured approaches (e.g., residential programs) or after completion of detoxification and stabilization to prevent relapse and, most effectively, in combination with a medication such as methadone, buprenorphine, or naltrexone.

Behavioral therapies in addition to medication treatment can help to:

- Improve adherence to the medication
- Address aspects of the disorder not addressed by medication (e.g., social influences, stress)
- Address specific weaknesses of the medication

The specific types of behavioral therapy that enhance efficacy of medication are somewhat controversial; however, those with the strongest levels of empirical support include:

- Contingency management approaches
- Cognitive behavioral approaches
- Motivational interviewing
- Structured family approaches

Although little research has investigated the efficacy of behavioral therapy for the treatment of co-occurring disorders (e.g., anxiety, depression) in people with opioid use disorder, behavioral therapy is a promising strategy for addressing these conditions.



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Resources for Families and Concerned Significant Others

Many family members and concerned significant others of individuals with an opioid use disorder suffer greatly. Family members and significant others may experience:

- Feelings of betrayal
- Fears of loss or death
- Financial challenges
- Guilt or anger
- Confusion about setting limits
- Shame or embarrassment

Nonetheless, family members may be able to play key roles in helping individuals with opioid use disorder seek treatment or have greater success in ongoing treatments. Furthermore, family members and concerned significant others can benefit from treatment that supports their own well-being, resilience, and improved mental health and quality of life.

The opioid epidemic has impacted millions of families across the United States, including through devastating increases in:

- Opioid use disorder
- Opioid overdoses
- Maternal opioid use and neonatal abstinence syndrome
- Infectious diseases
- Cases of child abuse and neglect
- Children requiring foster care

FAMILY-BASED TREATMENTS

Research studies have shown that involving family members and concerned significant others in treatment is helpful to individuals with substance use disorders in general, and there is specific evidence that involving family and concerned significant others in treatment for opioid use disorder can improve treatment engagement and outcomes.

Accessing family-based services can be a challenge because of poor service availability, logistical challenges (insurance, hours of clinic operations), or stigma, among other barriers. *Get Your Loved One Sober: Alternatives to Nagging, Pleading, and Threatening* by Robert Meyers and Brenda Wolfe is a self-help book based on an evidence-based family behavioral intervention for substance use disorders. It can be useful as an adjunct to in-person services or for those who cannot currently access such services.

Family members can also benefit from education on overdose, including recognizing and responding to a potential overdose. Trainings in overdose recognition and response are also available for family members (see the Recognizing and Responding to Opioid Overdose resource sheet in this series).

MUTUAL HELP RESOURCES FOR FAMILIES

Family members and concerned significant others can also benefit from talking with others who are struggling with the volatility of opioid use disorder. Research indicates that attending mutual help support groups can improve mental health, quality of life, and coping with addiction and may also reduce self-blame and stress. Mutual help support groups include:

NAR-ANON

www.nar-anon.org

SMART RECOVERY FAMILY & FRIENDS

www.smartrecovery.org/resources/family.htm

LEARN TO COPE

www.Learn2Cope.org

Many of these groups offer online and/or in-person support groups. Learn to Cope also offers naloxone administration training at meetings; members of Learn to Cope recently reported using naloxone to reverse 44 opioid overdoses. Thus, connecting family members and concerned significant others with mutual support organizations can not only improve the lives of family members and concerned significant others but also provide life-saving training in overdose reversal.



Families and concerned significant others can be involved directly in family treatment sessions or through monitoring and shared decision making in treatment for opioid use disorder.



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Self-Help for Opioid Use Disorder

Mutual help groups (often referred to as “self-help” groups) are widely available in the United States and many places across the world for the treatment of substance use disorders, including opioid use disorder.

Research emphasizes that attendance alone is less effective than active engagement in mutual help. Specifically, activities like having a “sponsor” (someone also in recovery who can serve as a mentor and support), utilizing tools and skills (e.g., following “the steps”), and other engagement (e.g., organizing events, making coffee) are associated with better outcomes.

Mutual help groups have a number of potential benefits including:

- 1.** Providing social support
- 2.** Providing reinforcement for recovery goals
- 3.** Teaching skills in support of recovery
- 4.** Providing structure and a drug-free activity

Mutual help can, however, be a challenge for people with opioid use disorder in particular because of the perception in many mutual help communities that medication is inappropriate for substance use disorder treatment and that it equates to “replacing a drug with a drug.” Thus, people receiving medications such as buprenorphine can feel stigmatized and rejected by this community. Not all meetings will emphasize this perspective, and finding a meeting that fits the person is an essential step in using mutual help effectively.

Selection of mutual help groups should be based on the individual’s preference. There are many types of mutual help groups, such as those targeted to specific subgroups (e.g., youth/young adults, professionals, emergency responders/law enforcement, women) and those that allow family members and other concerned significant others. Individual mutual help groups will also vary in the level of emphasis on spirituality and perspectives on medication acceptability.



SELF-HELP RESOURCES

Alcoholics Anonymous

www.aa.org

Narcotics Anonymous

www.na.org

SMART Recovery

www.smartrecovery.org

Women for Sobriety

www.womenforsobriety.org

CheckUp & Choices

checkupandchoices.com

Decisions in Recovery

mat-decisions-in-recovery.samhsa.gov



Cultural Competency in Assessing and Treating Opioid Use Disorder

Disparities in health care, which are complex and pervasive, have implications for the assessment and treatment of opioid use disorder. Awareness of some of the core disparities provides clinicians with an opportunity to educate others, advocate assertively on behalf of patients, and anticipate treatment challenges.

Contributors to health-care disparities at the provider and systems levels include the following:

- Explicit and implicit clinician biases, such as misperceptions that African Americans experience less pain and may have greater addiction propensity.
- A lower probability of receiving buprenorphine treatment among people of color relative to higher income and non-Hispanic white counterparts.
- Misperceptions that patients with low health literacy, limited English language fluency, or who do not understand medication instructions will be less compliant, leading to attributions of patient noncompliance.
- Lack of culturally specific services.

Patient-level contributors to health-care disparities include:

- Hesitation to seek or accept professional intervention due to concerns regarding misdiagnosis, cultural mistrust, and cultural norms that may be inconsistent with treatment (e.g., self-reliance, beliefs that pain is inevitable and can be managed without prescription medication, fear of substance use disorders, and use of complementary or alternative treatments).
- Greater reticence to report opioid use due to fears of criminal prosecution or removal of parental rights (people of color are more likely to experience punitive criminal justice outcomes).

Given these and other biases, the following recommendations are provided for consideration as part of an integrated approach to the complex interactions between race, ethnicity, socioeconomic status, cultural context, and geography.

RECOMMENDATION 1

Develop a working knowledge of possible treatment barriers among racial/ethnic minorities, with consideration of health-care system, provider, and patient factors.

Barriers may include lack of adequate medical insurance and health system policies (e.g., hours of operation, cost, location of services); provider bias (e.g., inhumanization, stereotypes) toward certain groups or a lack of cultural humility; lack of culturally specific services; and patient hesitation to seek or accept professional intervention due to concerns regarding misdiagnosis, cultural mistrust, and cultural norms that may be inconsistent with treatment (e.g., self-reliance, a focus on religion). Moreover, disparities in the risk of criminal justice involvement for opioid misuse can result in concerns among people of color about confidentiality and the consequences of self-disclosure to a clinician.

RECOMMENDATION 2

Assess beliefs and expectancies regarding opioid use disorder treatment.

Enhance the standard intake and/or assessment with additional inquiries about treatment preferences and barriers to uptake and adherence, and provide feedback during the initial meeting. Knowledge of factors that may influence the care of racial/ethnic minority patients with opioid use disorder contributes to accurate cultural formulation of cases, proactive addressing of barriers, and satisfactory clinical encounters.



Disparities in the risk of criminal justice involvement for opioid misuse can result in concerns among people of color about confidentiality and the consequences of self-disclosure to a clinician.

For example, a 50-year old Hispanic male diagnosed with opioid use disorder who presents in a psychiatric clinic may believe that receiving treatment is a sign of vulnerability. He may also be hesitant to take a medication to treat his opioid use disorder. A brief assessment of beliefs regarding medications and counseling would allow a “teachable moment” regarding opioid use disorder and the benefits of buprenorphine. Assessment items might include: “Describe your experience in health-care settings. Overall, have they been positive or negative?” “What would you expect from another medication to help reduce your use of opioid?” Normalizing language intended to assess barriers can also be used, including “Some people may be worried about using a new medication to help them stop using opioids. What do you think?” Such questions can help providers determine whether potential ethnocultural concerns are relevant for individual patients.



Asking questions can help providers determine whether potential ethnocultural concerns are relevant for individual patients.

RECOMMENDATION 3

Deliver culturally appropriate care for opioid use disorder.

Culturally competent clinicians are aware of their own biases and stereotypes, as well as cultural factors that may influence patients’ opioid use, maintenance, abstinence, and relapse. In addition, culturally competent clinicians seek to gain the knowledge and skills to address these individual difference variables. Provider–patient communication should follow a model of shared decision-making to reduce unmet provider communication needs and increase adherence. Finally, shared decision-making processes should include significant others (e.g., family members, religious leaders), where appropriate.

Important note. There are significant individual differences in cultural beliefs and practices within racial/ethnic groups. These recommendations are offered as guidelines to consider as a component of a holistic approach while recognizing the potential importance of within-group heterogeneity across interrelated variables, such as race, ethnicity, socioeconomic status, cultural context, and geography.



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Opioid Use Among Adolescents

The nonmedical use of prescription opioids and heroin/fentanyl has decreased among adolescents in recent years. This is consistent with the recent overall decrease in substance use in youth (with the exception of marijuana use, which is increasing). However, hospitalizations and emergency department visits for opioid poisoning among adolescents have significantly increased. For example, opioid-related overdose deaths among 15–19-year-olds increased 19% from 2014 to 2015. An increasing proportion of those deaths were attributed to synthetic opioids, including fentanyl.

Misusing prescription opioids is a risk factor for transition to heroin use. Youth who start to misuse prescription opioids early appear to have the highest risk of transitioning to heroin use. Although some teens will receive a prescription for an opioid from a doctor, **many adolescents report first taking an opioid from a friend or family member**. Safe medication storage and removal are essential practices in homes with teens.



*Opioid-related
overdose
deaths among
15–19-year-olds
increased 19%
from 2014 to 2015.*

SCREENING

There are screening tools for the detection of opioid and other substance use specifically designed for adolescents. The National Institute on Drug Abuse provides a free, brief, easy-to-use screening tool for providers that can be found at:

drugabuse.gov/adolescent-substance-use-screening-tools

TREATMENT

In 2016, the American Academy of Pediatrics recommended that all youth with a severe opioid use disorder should be offered medication treatment in addition to behavioral therapy. Little research is available on the effectiveness of medication in youth; however, there are a few randomized controlled trials suggesting that buprenorphine is effective for opioid abstinence and treatment retention among youth.

Other modalities such as cognitive behavioral therapy, adolescent community reinforcement approach, and contingency management should be part of treatment plans for youth based on individual needs.

For youth with opioid use disorder, redefining social networks and finding new ways to have fun without substances can be a challenging task. Additional recovery support services such as youth-focused mutual help groups, recovery high schools, or collegiate recovery programs can be important components of optimizing treatment goals. Helping to facilitate reconnecting to sober friends or identifying sober activities should also be part of an overall treatment plan, especially in communities with limited formal recovery support services.

For youth with opioid use disorder, redefining social networks and finding new ways to have fun without substances can be a challenging task.



SPECIAL CONSIDERATIONS IN WORKING WITH YOUTH

FAMILY

Ideally, families are included in the treatment plan for youth with opioid use disorder. This can range from psychoeducation visits about opioids and treatment options to family therapy. All families should be trained in how to reduce risk for opioid overdose and have access to naloxone.

HARM REDUCTION

Although abstinence is the goal, some youth may exhibit ambivalence about completely stopping. Harm reduction services such as access to clean needles, overdose education and naloxone, and sexually transmitted infection screening and prevention should be part of any treatment plan.

PROTECTIVE CONCERNS

Maintaining confidentiality is a critical part of the therapeutic relationship. There will be times, however, when it is not possible to maintain confidentiality because of protective concerns and high-risk behavior. Adolescents under the age of 18 should be aware that clinicians may have to break confidentiality by notifying parents/guardians.



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Pain Control and Pathways to Opioid Misuse

Opioids are potent pain relievers and are often prescribed for acute pain, particularly in emergency departments and following surgical procedures. Moreover, millions of adults are currently prescribed opioids for chronic pain (typically defined as pain of at least moderate intensity lasting longer than 3 months), which impacts approximately 11% of adults in the United States. The result is that health-care providers have to struggle to balance the goal of providing appropriate pain relief with the goal of minimizing the number of people who transition to opioid misuse and opioid use disorder.

Current strategies to achieve this balance include the identification of risk factors for opioid misuse, best practices for surgery recovery, and enhanced use of nonopioid pain control strategies.



*Chronic pain impacts approximately **11%** of adults in the United States.*

RISK FACTORS FOR OPIOID MISUSE

Concerted research efforts have been devoted to identifying individuals at risk for misuse of prescription opioids. These include:

- Family history of substance use disorder
- Personal history of substance use disorder
- Younger age
- History of criminal activity and/or legal problems including DUIs
- Regular contact with risky environments or situations (e.g., exposure to other people misusing opioids)
- Interpersonal problems with past employers, family members, and friends
- Risk taking or thrill-seeking behavior
- Heavy tobacco use
- History of severe depression or anxiety
- Psychosocial stressors

RISK ASSESSMENT TOOLS

A number of regulatory and professional organizations have provided recommendations and guidelines for the use of opioids among patients with chronic pain. These guidelines emphasize the importance of opioid risk assessment before initiation of long-term opioid therapy.

In addition to performing a thorough history and a review of past medical records, conducting an opioid risk assessment using validated screening tools is recommended. Structured interview measures based on *Diagnostic and Statistical Manual of Mental Disorders*

criteria have been useful in assessing substance use disorders, but these measures often lack validation with persons with chronic pain. Using traditional substance use disorder measures increases the likelihood that physiological tolerance and dependence (i.e., requiring more opioids to achieve the same effect and/or withdrawal symptoms when the medication is decreased or discontinued) will be identified when no misuse exists. Several screening tools are available that are specifically developed for people with pain:

MEASURE	PURPOSE	WHERE TO FIND IT
 Screener and Opioid Assessment for Patients With Pain-Revised (SOAPP-R)	Self-report measure designed to predict aberrant medication-related behaviors for chronic pain patients being considered for long-term opioid therapy.	www.inflexxion.com/soapp-comm
Current Opioid Misuse Measure (COMM)	Self-report measure developed for identifying prescription opioid medication misuse among people with chronic pain.	www.inflexxion.com/soapp-comm
Opioid Risk Tool (ORT)	Five-item clinician checklist to determine risk for opioid medication misuse.	www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf

ALTERNATIVES TO OPIOIDS FOR PAIN MANAGEMENT

Nonpharmacological Alternatives for Acute and Chronic Pain

- The most widely studied and efficacious interventions for chronic pain include cognitive behavioral therapy and other behavioral interventions (e.g., acceptance and commitment therapy, exposure to feared movements), exercise, physical therapy, and interdisciplinary rehabilitation. Depending on the pain condition, other therapies with evidence of efficacy include mindfulness-based interventions, yoga, biofeedback, tai chi, acupuncture, spinal manipulations, and massage. Ongoing research is needed to identify new postsurgery strategies such as immersive distraction techniques to further reduce the need for other pain control.
- Superficial heat and cryotherapy can help reduce the intensity of both acute and chronic pain.
- Transcutaneous electrical nerve stimulation (TENS) has also been shown to be effective for acute pain, and there is mixed evidence of TENS efficacy as a treatment for chronic pain. Relaxation and distraction have been used to good effect in medical and dental settings involving acute pain or discomfort, such as injections or teeth cleaning.



The World Health Organization recommends nonopioid pain relievers, including acetaminophen or ibuprofen, as the preferred first step for providing pain relief.

Nonopioid Pharmacological Alternatives for Acute Pain

- Several recent studies have found combinations of acetaminophen and ibuprofen, as well as other nonsteroidal anti-inflammatory medications, to be as effective as opioid medications for managing acute pain in multiple settings where opioids are often used as the primary treatment option.
- Even in palliative care for patients with cancer, the World Health Organization recommends nonopioid pain relievers, including acetaminophen or ibuprofen, as the preferred first step for providing pain relief.
- Other pharmacological options for acute pain include a low dose of ketamine, nitrous oxide, intravenous lidocaine, or gabapentin and pregabalin.



Recent research has indicated that nonopioid alternatives are at least as efficacious as opioids for low back pain and are less associated with adverse events.

Nonopioid Pharmacological Alternatives for Chronic Pain

- There is little evidence to support the use of long-term opioid therapy in the treatment of chronic noncancer pain. Based on the lack of evidence in support of opioids for chronic noncancer pain and the considerable risks of harm posed by misuse of opioid prescriptions, the Centers for Disease Control and Prevention recommends nonpharmacological treatments or nonopioid pharmacological treatments be considered as the initial treatment approach for chronic pain (www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf).
- Nonopioid alternatives include, but are not limited to, acetaminophen, nonsteroidal anti-inflammatory drugs (e.g., ibuprofen, naproxen), amine reuptake inhibitors (e.g., fluoxetine, paroxetine), membrane stabilizers (e.g., gabapentin, pregabalin), and muscle relaxants (for short-term relief). Lidocaine patches, topical capsaicin cream, and subcutaneous injections of botulinum toxin type A have also been shown to provide pain relief for some chronic pain conditions. Recent research has indicated that these nonopioid alternatives are at least as efficacious as opioids for low back pain and are less associated with adverse events.



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Opioid Overdose Risk

An average of 115 people die from opioid overdose every day in the United States. Deaths from drug overdoses are more frequent than motor vehicle-related deaths in some U.S. states, and around the world the most common cause of death for opioid users is overdose.

WHAT IS AN OPIOID OVERDOSE?

An opioid overdose occurs if more of an opioid is ingested than a person's body can handle at that moment. In this case, the opioid **slows down the breathing** so that the person does not get enough oxygen. Breathing can also stop completely, and the heart can stop. If intervention measures are not taken, the overdose victim may become unconscious, fall into a coma, have long-term brain/nerve or physical damage, or even die. Most opioid overdose deaths are not instantaneous; they usually occur over 1-3 hours after use, so even if the person is not breathing or is unresponsive, an intervention can still help.

115

*An average of **115**
people die from opioid
overdose every day in
the United States.*

RISK FACTORS FOR AN OVERDOSE

TOLERANCE SHIFT

Individuals with decreased tolerance due to recent release from incarceration, drug treatment/detoxification, hospitalization, abstinence, or intermittent nondaily use of opioids are at risk.

MIXING DRUGS

Combining opioids with other legal or illegal substances may enhance their effects and thus increase the overdose risk. Combining opioids with alcohol, benzodiazepines, barbiturates, or other psychotropic medications, such as antidepressants, is very dangerous.

PREVIOUS HISTORY OF OVERDOSE

Individuals who have had a prior overdose event at any point in their lifetime are more likely to experience another overdose.

PHYSICAL HEALTH

If a person's body is already burdened with an acute or chronic illness (e.g. asthma, other substance use disorder, HIV, etc.), the person is more vulnerable to overdose.

VARIATION IN OPIOID STRENGTH/CONTENT

Illegally purchased substances vary greatly in their strength (e.g., one bag of heroin or fentanyl might not be as strong as another bag even when obtained from the same seller).

SWITCHING FROM SNORTING/SMOKING TO INJECTION

How a person ingests a substance plays an important role in overdose risk. Injecting is usually riskier than other forms of administration, but an overdose can also occur when a person just swallows a single pill.

USING ALONE

If no one is there, no one can help. Overdose reversal can be effective 1-3 hours after use of the opioid, but the risk of fatality is high if the user is alone.



Combining opioids with other legal or illegal substances may enhance their effects and thus increase the overdose risk.

POPULATIONS AT RISK OF OPIOID OVERDOSE

PERSONS WITH CONCURRENT MEDICAL ILLNESSES THAT INCREASE BREATHING DIFFICULTY (PARTICULARLY HEART AND PULMONARY PROBLEMS, OR SLEEP APNEA)

Any medical problem that independently impairs respiration or increases the risk of respiratory depression will increase the risk that opioid consumption may result in an overdose.

PERSONS WITH CHRONIC PAIN

Persons with chronic pain who are exposed to high-dose opioids for extended periods of time have an increased opportunity for an overdose event to occur. This population is also highly likely to be coprescribed other medications that could interact with or increase the risk of respiratory depression and/or have concurrent medical illnesses that could further increase their risk.

OLDER INDIVIDUALS

The rate of overdose among older persons continues to increase. This is likely due to the presence of concurrent medical illnesses and concurrent prescriptions that reduce their threshold for respiratory depression. Not adhering to medication dosing schedules (e.g., doubling up medications or taking them too close together in time) could also increase the risk of an overdose.

CHILDREN

The incidence of opioid overdose among children under 2 years of age who are accidentally exposed to opioids has steadily increased over the past decade. It is important for opioids to be kept in childproof containers and stored in secure places to minimize the risk of accidental exposure.

WOMEN

Data suggest that the rate of overdose between 1999 and 2010 tripled among women in comparison to men. Although the basis for this growing discrepancy in risk is not well understood, it suggests women may have unique risk factors contributing to opioid overdose.

PERSONS LIVING IN URBAN AREAS

A recent large-scale evaluation of the National Survey on Drug Use and Health and the National Vital Statistics System reported that in 2015, there were six times more overdoses among persons living in metropolitan (45,059 overdoses) versus rural (7,345 overdoses) areas. The rate of fatal overdoses remained relatively similar among the metropolitan (17/100,000) and rural (16.2/100,000) settings.

IN 2015, there were

6x more overdoses

among persons living in metropolitan than in rural areas.



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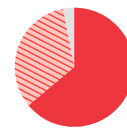
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Recognizing and Responding to Opioid Overdose

Overdose occurs when the body ingests more of a substance than it can handle. This can be very dangerous, even fatal. However, this event is entirely preventable. Most opioid users (64-97%) report that they have witnessed at least one overdose, so the opportunity for rescue exists.

HOW TO RECOGNIZE AN OPIOID OVERDOSE

- The skin is blue—usually the lips and fingertips turn blue first.
- The body is very limp.
- The face is very pale.
- The person is conscious but unable to respond.
- The person makes choking sounds or a gurgling/snoring noise.
- Breathing is very slow, irregular, or has stopped.
- The pulse (heartbeat) is slow, erratic, or not there at all.
- Vomiting occurs.
- The person loses consciousness.



Most opioid users (64-97%) report that they have witnessed at least one overdose.

WHAT IS THE DIFFERENCE BETWEEN BEING HIGH AND AN OVERDOSE?

BEING HIGH ON OPIOIDS	OPIOID OVERDOSE
Muscles become relaxed.	Breathing is very infrequent or has stopped and the pulse is slow.
Speech is slow/slurred.	Deep snoring or gurgling (death rattle) is present.
The person is sleepy looking.	The skin is pale and clammy.
The person is nodding.	The person exhibits heavy nodding.
The person will respond to stimulation like yelling, sternal rub, pinching.	The person is not responsive to stimulation.

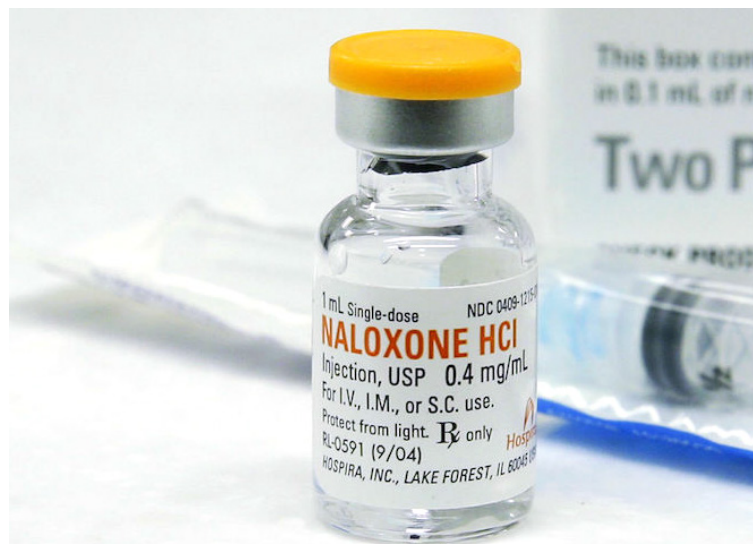
NALOXONE (NARCAN, ENVISIO) FOR OVERDOSE

- Naloxone is a medication that reverses opioid overdose. It is an opioid **antagonist**, which blocks heroin and other opioids from binding to receptors in the brain and reverses the respiratory depression caused by an opioid.
- It can be safely administered by the intranasal, intravenous, intramuscular, or subcutaneous routes.
- It works quickly (2-8 minutes), but this depends on an individual's metabolism, the type of opioid used (i.e., a short-acting opioid like heroin or longer acting opioid like methadone), and the amount of drug used.
- Naloxone usually wears off before the heroin or other opioid that was taken, so a person must be monitored closely even after naloxone is given. This is especially important for someone who has overdosed on a longer acting opioid. In this case, it may be necessary for an intravenous continuous infusion of naloxone to be given in a hospital setting. This is why it is important to activate the emergency response system by calling 911.
- Naloxone has no abuse potential; people cannot get high on naloxone.
- Naloxone has NO effect if opioids are not present.
- Naloxone has practically no side effects. If opioids are present, the overdose is reversed and the person starts breathing again. However, due to the antagonist effect, opioid withdrawal signs and symptoms will emerge. Opioid withdrawal symptoms are unpleasant but not life threatening.
- Videos of naloxone rescue:
www.youtube.com/watch?v=bgU2s9fwNjU
www.youtube.com/watch?v=xH04qvoKkhk

RESCUE PROCEDURES

Listed on the next page are common recommendations for action when someone is suspected of having overdosed. This summary is no substitute for formal training in identifying and responding to an opioid overdose. Formal training can be obtained through a number of local resources, such as www.getnaloxonenow.org or from www.addictionpolicy.org. Counseling family members to receive such training is an important component of family intervention. Information on local regulations for naloxone (e.g., whether a prescription is required) can be found at www.pdaps.org.

Please see next page for printable handout on the five-step rescue procedures for preventing opioid overdose.



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5-STEP RESCUE PROCEDURES FOR OPIOID OVERDOSE

STEP 1

Stimulate—give sternal rub

Sternal rub: Rub knuckles hard up and down on the breast bone:

- It hurts, but will not cause damage.
- It can help to assess whether the person is conscious.
- It may make the person breathe, even if it doesn't wake the person up.
- Check for breathing:
Chest rising and falling
Nostrils moving in and out

STEP 2

Call 911

Call 911 and tell them that someone is not breathing or is unresponsive.

STEP 3

Administer rescue breathing

Rescue breathing alone can sustain someone until emergency personnel arrive:

- First make sure there is nothing in the mouth/throat. Clear the throat before beginning rescue breathing.
- Tilt the head to open the airway by lifting the neck or chin.
- Pinch the nose shut.
- Make a seal over the mouth with your mouth.
- Give 2 quick breaths.
- Then give 1 breath every 5 seconds until emergency personnel arrive or the person breathes on his/her own.

STEP 4

Administer naloxone

INTRANASAL ADMINISTRATION:

- Tilt the victim's head back.
- Spray into one nostril *until all of the liquid has been expelled*.
- Continue rescue breathing until EMS arrives or the person breathes on his/her own.

INTRAMUSCULAR ADMINISTRATION:

- Put on the provided gloves.
- Uncap the syringe in the kit.
- Uncap the naloxone vial.
- Pierce the membrane on the vial and pull up the entire contents of the vial into the syringe.
- Inject the full amount of naloxone into the shoulder or thigh—just like a flu shot.

STEP 5

Continue rescue breathing for 3–5 minutes, and if the person is not responding, give the second dose of naloxone

Continue rescue breathing for 3–5 minutes, and if the person is not responding, give the second dose of naloxone that is included in the overdose kit (exactly like the first dose) and stay with the person until help arrives.

AFTER THE OVERDOSE REVERSAL:

Once naloxone begins working, the person may show signs of opioid withdrawal:

- Don't leave the person alone, as sedation may return; if you must leave, put the person on his/her side and call 911.
- Wait for emergency personnel to arrive, or encourage the person to seek medical care.
- Reassure the person that the naloxone will wear off and the effects of the opioids may return. Do not let the person use more opioids.



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