Partnership for a Drug-Free New Jersey
In Cooperation with the Governor's Council on Substance Use Disorder and the NJ Dept. of Human Services

OPIOID EDUCATION FOUNDATION OF AMERICA

OFFICE OF ALTERNATIVE & COMMUNITY RESPONSES

NJCARES.gov
New Jersey Coordinator for Addiction Responses and Enforcement Strategies

Knock Out Opioid Abuse Day: Looking Back & Looking Ahead

October 3, 2024

Partnership for a Drug-Free New Jersey
In Cooperation with the Governor's Council on Substance Use Disorder and the NJ Dept. of Human Services

In support of improving patient care, this activity has been planned and implemented by American Academy of CME, Inc. and Partnership for a Drug-Free New Jersey. American Academy of CME, Inc. is Jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Physicians

American Academy of CME, Inc., designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credits. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Nurse Practitioners and Nurses

American Academy of CME, Inc., designates this educational activity for 1.0 ANCC contact hours.

Pharmacists

This activity provides 1.0 ACPE contact hours (0.1 CEUs) of continuing education credit. Universal Activity Number: JA4008191-9999-24-024-L01-P, Knowledge

Physician Assistants

American Academy of CME, Inc. has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for 1.0 AAPA Category 1 CME credits. PAs should only claim credit commensurate with the extent of their participation.

Dentists

American Academy of CME, Inc. is an ADA CERP Recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry. Concerns or complaints about a CE provider may be directed to the provider or to the Commission for Continuing Education Provider Recognition at ADA.org/CERP.

American Academy of CME, Inc. designates this activity for 1.0 continuing education credits.

Other HCPs

Other members of the care team will receive a certificate of participation.

EMT

This webinar has been approved by NJ OEMS for 1 EMT Elective CEU.

Certified Health Education Specialists (CHES)/Master Certified Health Education Specialists (MCHES)

This program is designated for Certified Health Education Specialists (CHES) and/or Master Certified Health Education Specialists (MCHES) to receive up to one (1) total Category I continuing education contact hours.

Optometrists

This course has been approved by the New Jersey Board of Optometrists for 1 regular credit. Board Course Number: 3910-2025

Social Workers

This course, Knock Out Opioid Abuse Day: Looking Back & Looking Ahead, Approval #09202024-02, provided by Partnership for a Drug-Free New Jersey is approved for continuing education by the New Jersey Social Work Continuing Education Approval Collaborative, which is administered by NASW-NJ. CE Approval Collaborative Approval Period: Friday, September 20, 2024 through August 31, 2026. New Jersey social workers will receive 1 CE credits for participating in this course.

Athletic Trainers

Partnership for a Drug-Free New Jersey (BOC AP#: P12171) is approved by the Board of Certification, Inc. to provide continuing education to Athletic Trainers (ATs). This program is eligible for a maximum of one (1) Category A hours/CEUs.

Additional Information About Continuing Education

- You must apply to receive continuing education credit. It will not be sent to you just for attending this webinar.

- WHERE CAN YOU FIND THE LINK TO APPLY FOR CREDIT?
  - The last slide of this webinar
  - The chat at the end of the program
  - The follow-up email you will receive tomorrow

- The poll at the end of today's webinar IS NOT the evaluation for continuing education credit. The evaluation will be available through the link mentioned above.

- The links will be active for 30 days after today's event.

PA Planner Dean Barone discloses that he serves on the speakers bureaus of Ethicon and Johnson & Johnson.

Featured Presenter

Christopher M. Jones, PharmD, DrPH, MPH
CAPT, US Public Health Service
Director, Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Christopher M. Jones, Pharm.D., Dr.P.H., M.P.H. (CAPT U.S. Public Health Service) currently serves as Director of the Center for Substance Abuse Prevention (CSAP) at the Substance Abuse and Mental Health Services Administration (SAMHSA). CAPT Jones brings a wealth of experience to SAMHSA having led substance use, mental health, and injury and violence prevention policy, program, and research activities for more than a decade. Prior to becoming Director of CSAP, CAPT Jones served as the director of the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention. During his career, CAPT Jones has served in a variety of leadership roles in the U.S. Department of Health and Human Services (HHS).

Addressing the Substance Use and Overdose Crisis: Putting Prevention Front and Center

Christopher M. Jones, PharmD, DrPH, MPH
CAPT, US Public Health Service
Director, Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

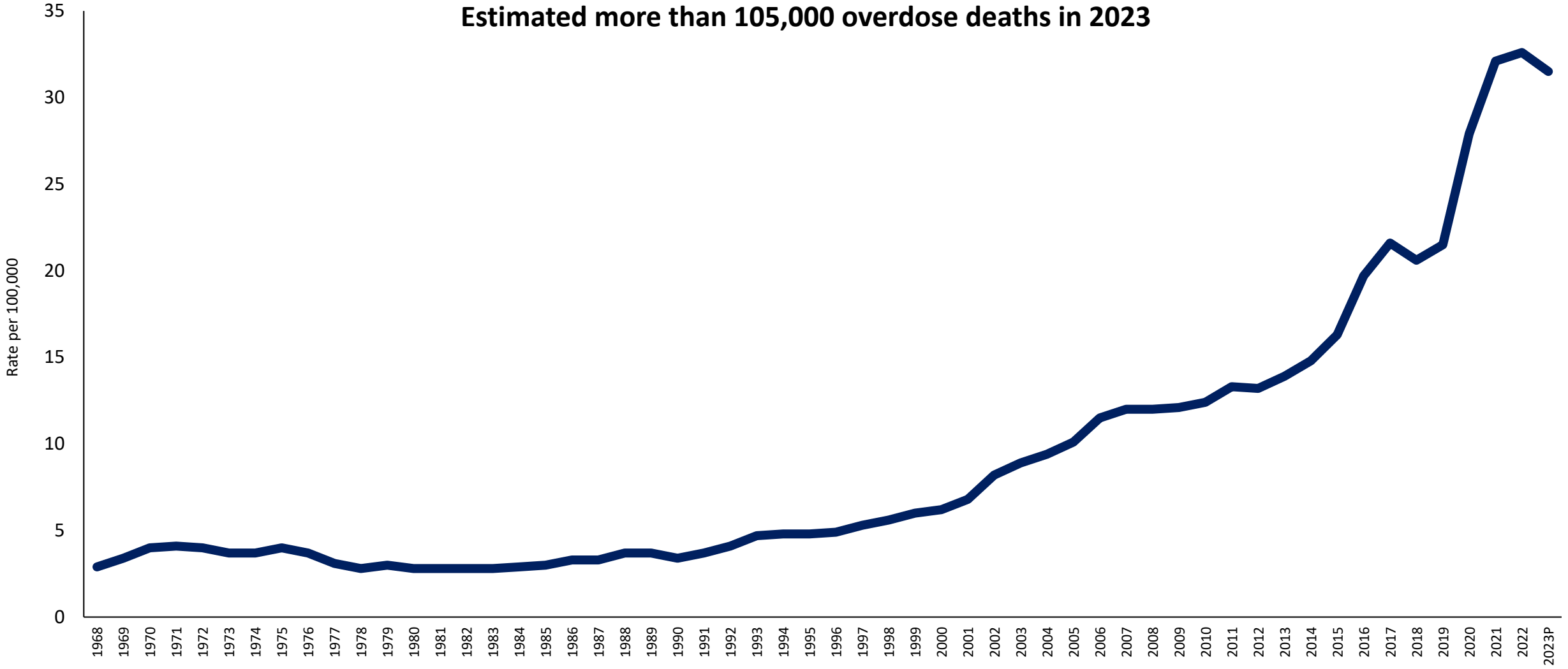
SAMHSA
Substance Abuse and Mental Health Services Administration

Learning Objectives

- Characterize the current landscape of substance use in the nation.
- Describe the importance of prevention in the context of today's drug threats and its role within the continuum of care.
- Examine how established and emerging prevention strategies can be utilized to address the ever-changing drug landscape.
- Present a rationale for a comprehensive prevention strategy.

Data, Data, Data

Historically High Overdose Deaths in the U.S., 1968-2023P



Source: CDC

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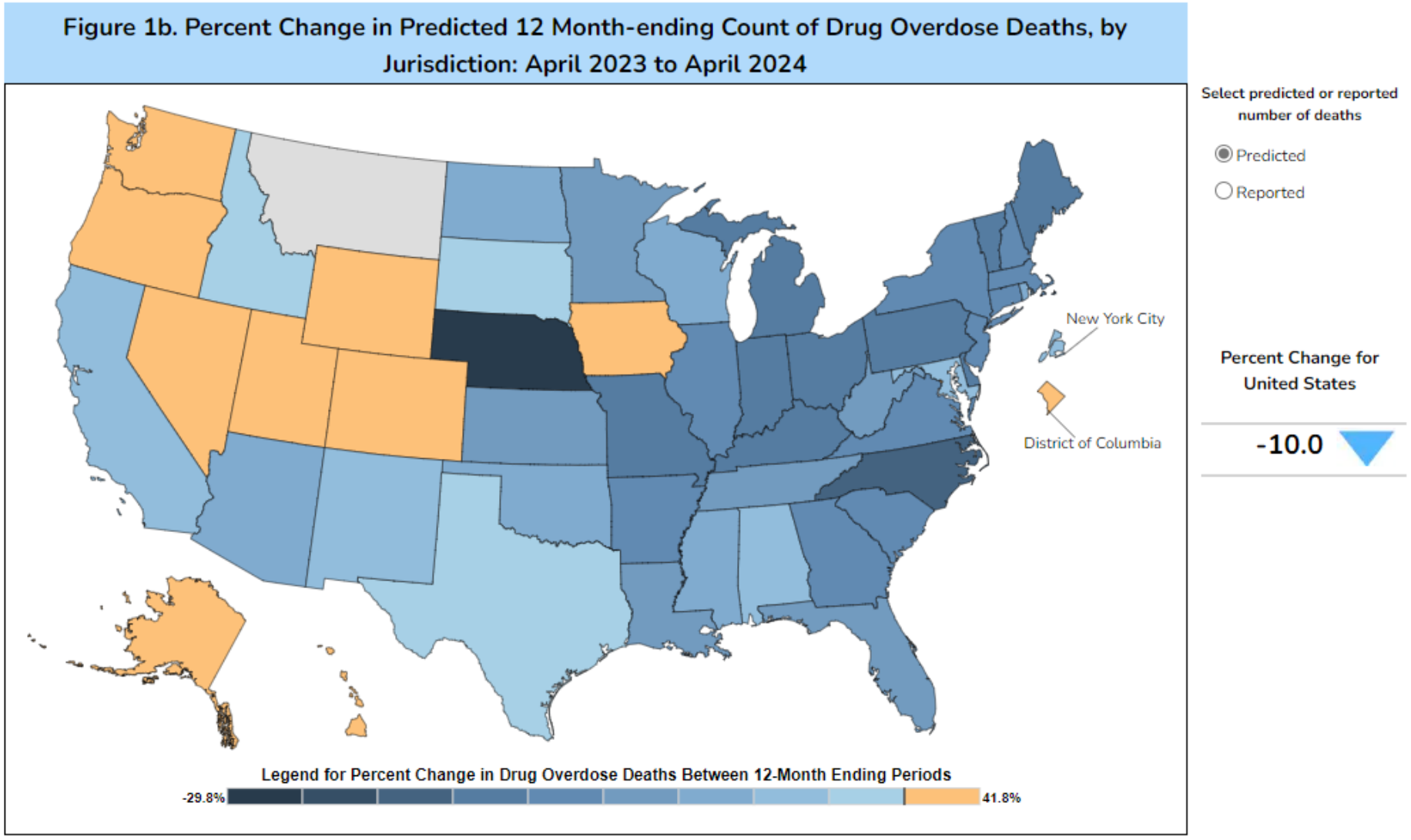
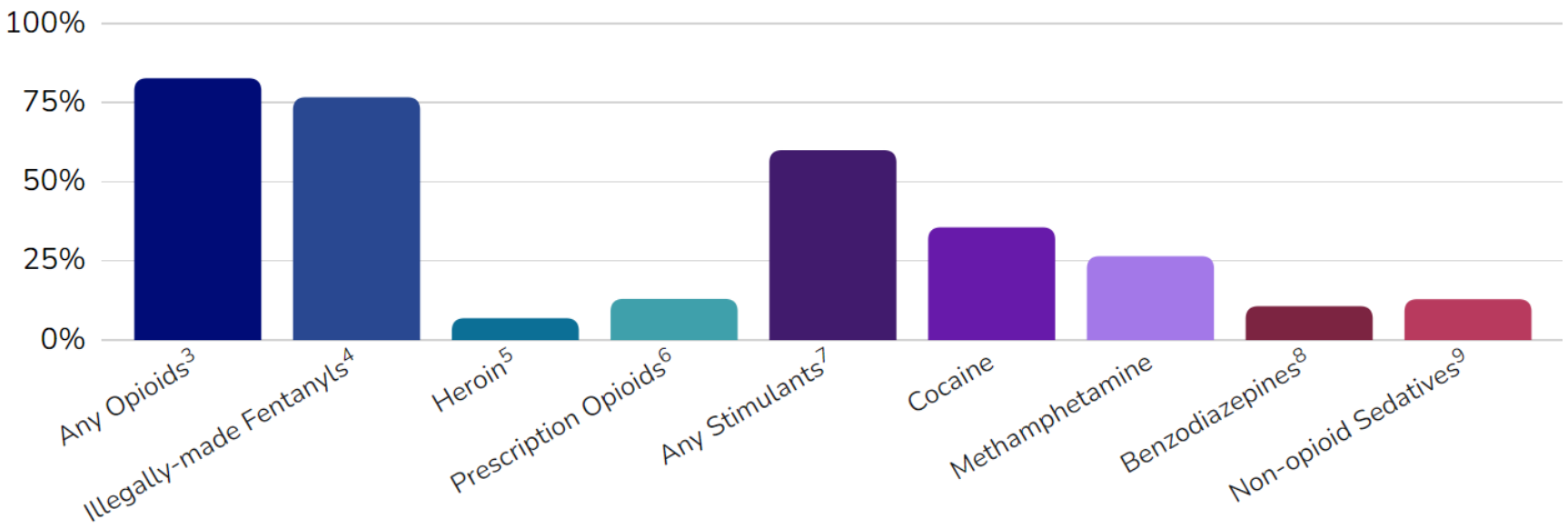
Latest Provisional Data



[Products - Vital Statistics Rapid Release - Provisional Drug Overdose Data (cdc.gov)]

Deaths Driven by Illicit Synthetic Opioids and Stimulants



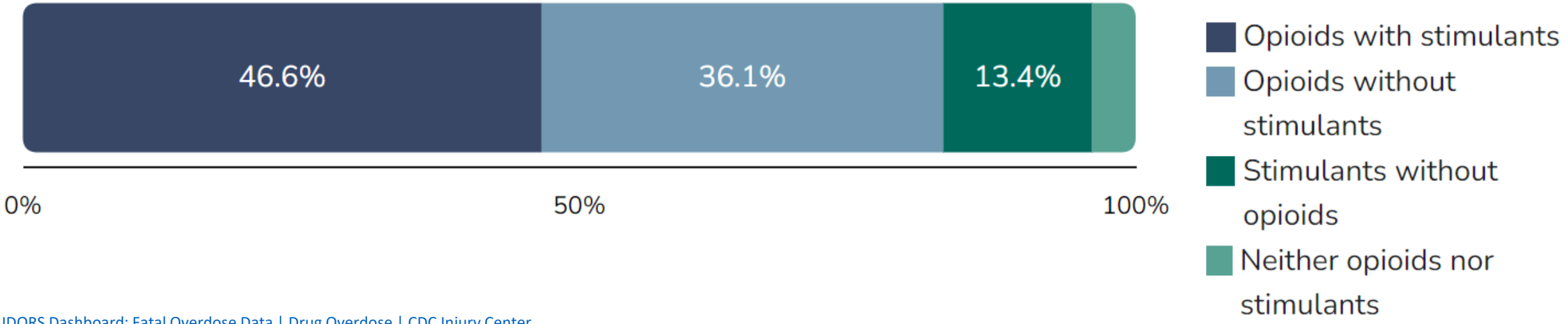
25.6%
Illegally-made Fentanyls with no other opioids or stimulants

21.4%
Illegally-made Fentanyls and Cocaine

13.4%
Illegally-made Fentanyls and Methamphetamine

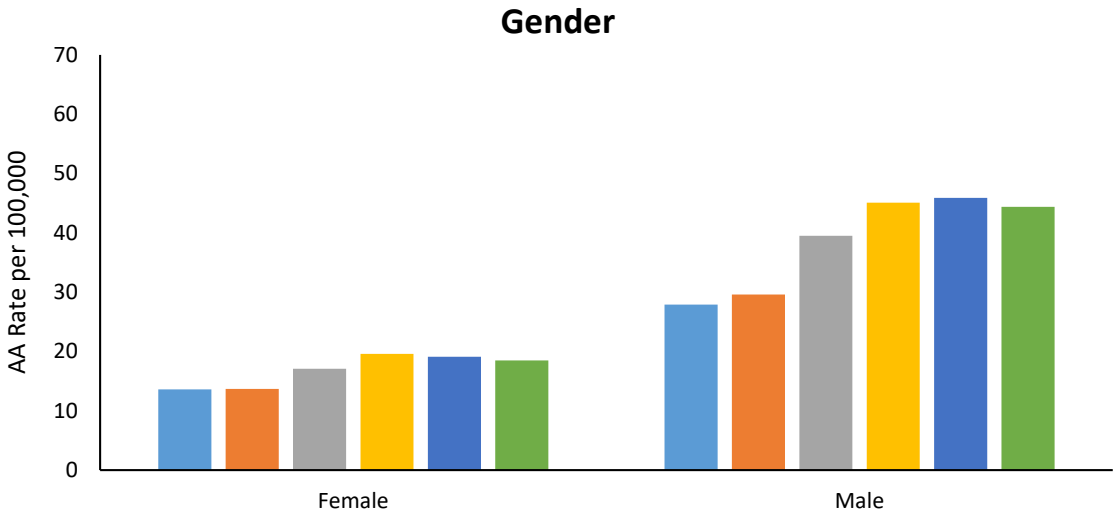
5.5%
Cocaine with no other stimulants or opioids

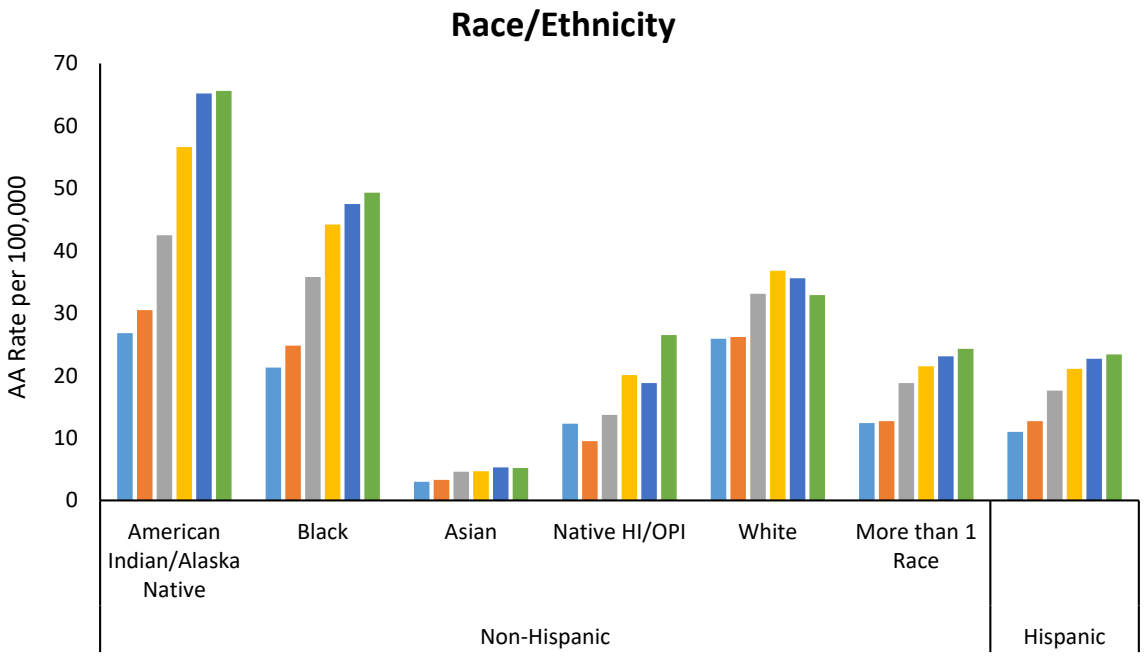
5.0%
Methamphetamine with no other stimulants or opioids

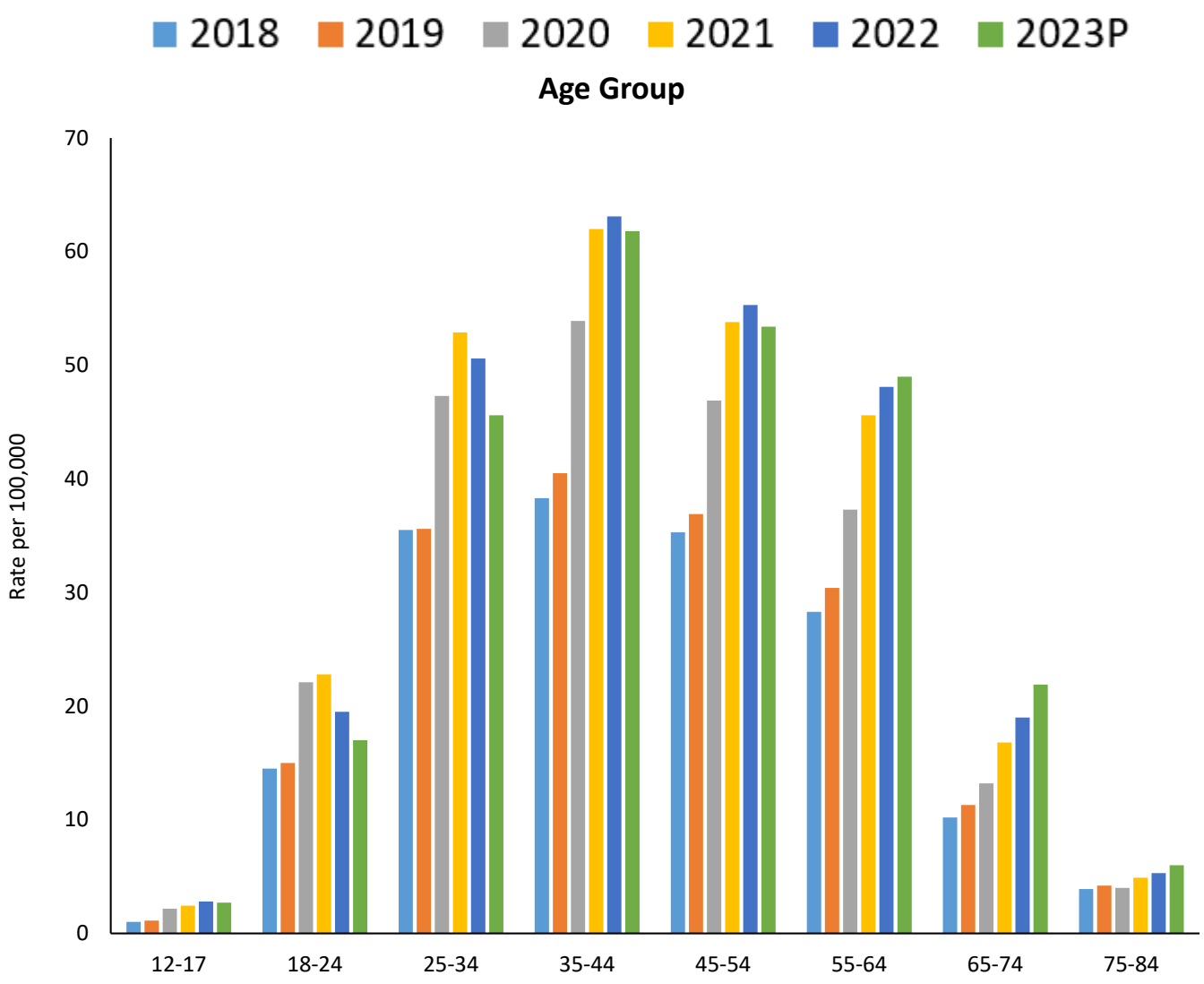


SUDORS Dashboard: Fatal Overdose Data | Drug Overdose | CDC Injury Center

Changing Epidemiology of Overdose

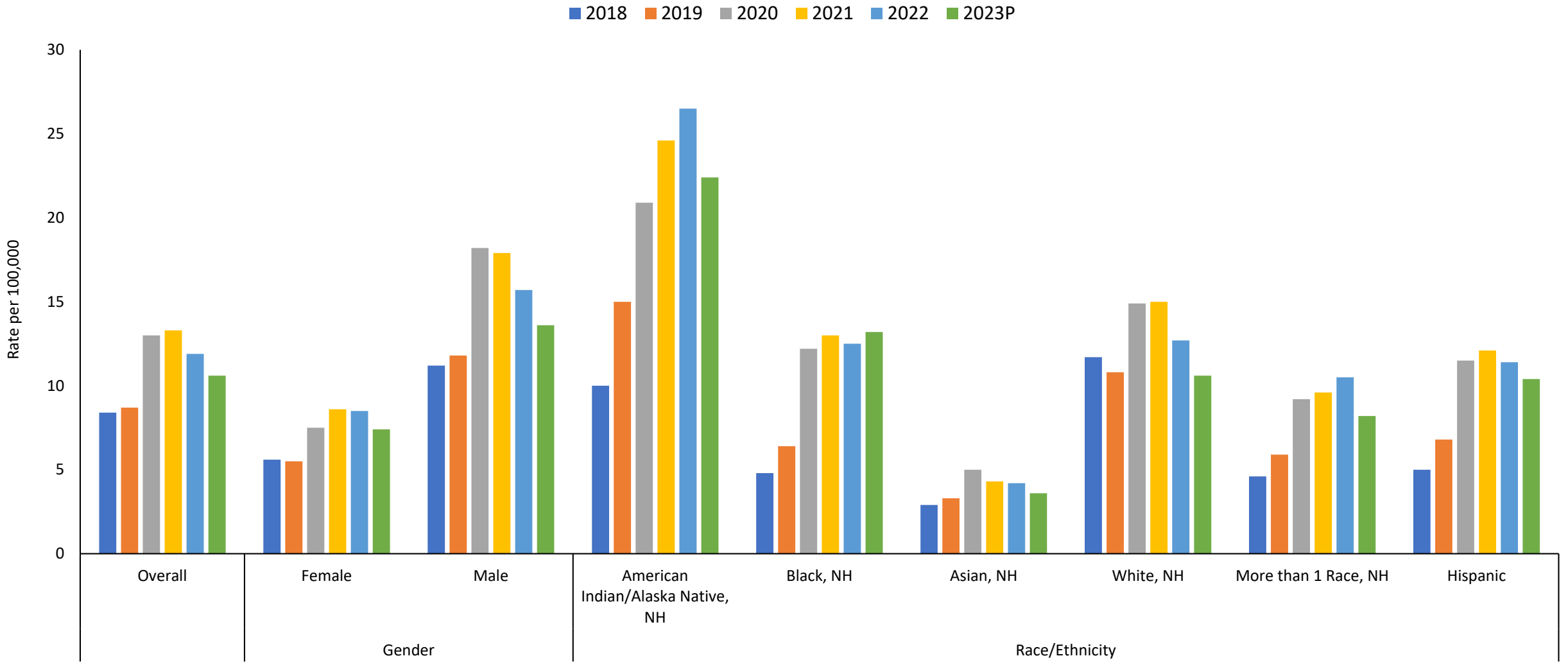






Source: CDC NCHS. NVSS/WONDER, 2024.

Disparities in Overdose Deaths Among Youth and Young Adults by Race/Ethnicity, 12-24 Year Olds, U.S.



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Illicit Drug Supply Has Never Been Riskier and Patterns of Use Are Changing

Illicitly Manufactured Fentanyl–Involved Overdose Deaths with Detected Xylazine — United States, January 2019–June 2022

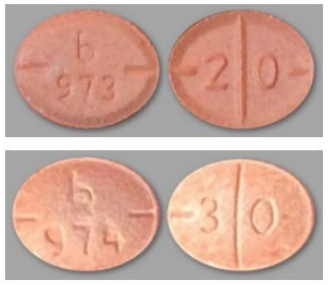
Mbabazi Kariisa, PhD[1]; Julie O'Donnell, PhD[1]; Sagar Kumar, MPH[1]; Christine L. Mattson, PhD[1]; Bruce A. Goldberger, PhD[2]

Trends in Nonfatal and Fatal Overdoses Involving Benzodiazepines — 38 States and the District of Columbia, 2019–2020

Stephen Liu, PhD[1]; Julie O'Donnell, PhD[1]; R. Matt Gladden, PhD[1]; Londell McGlone, MPH[1]; Farnaz Chowdhury[2]

Illicit Benzodiazepines Detected in Patients Evaluated in Emergency Departments for Suspected Opioid Overdose — Four States, October 6, 2020–March 9, 2021

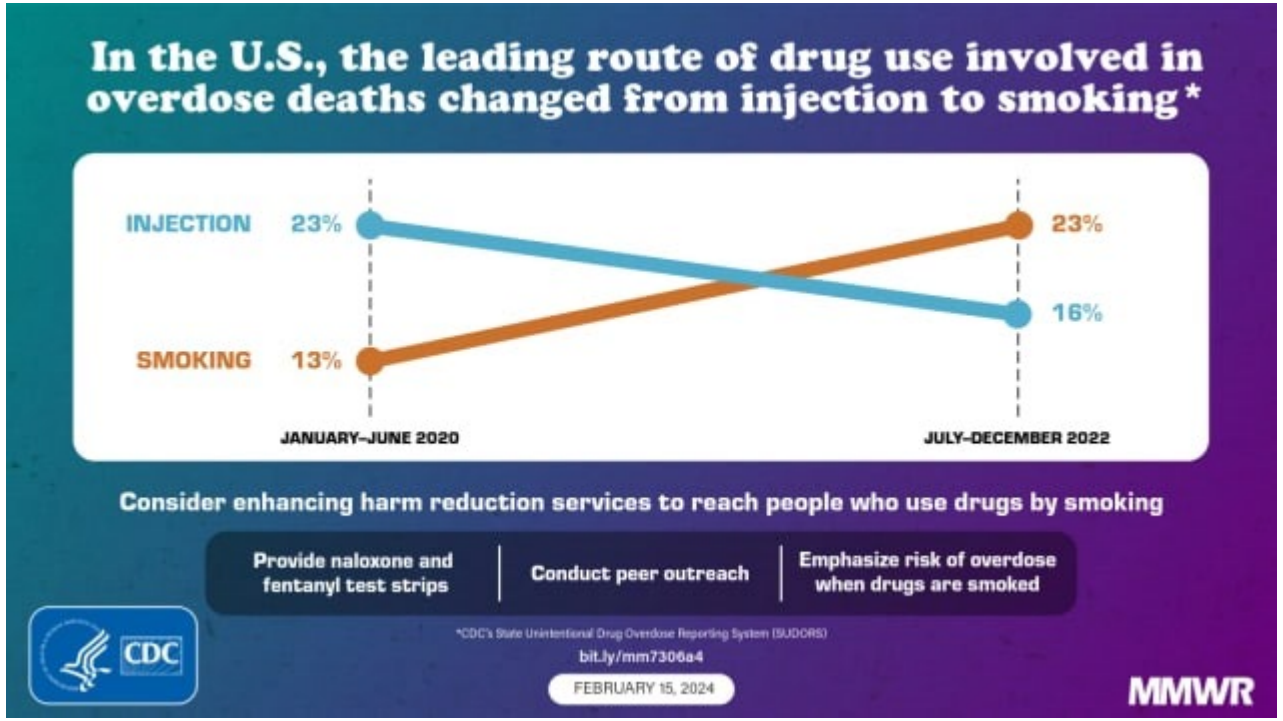
Kim Aldy, DO[1,2]; Desiree Mustaquim, PhD[3]; Sharan Campleman, PhD[1]; Alison Meyn, MPH[1]; Stephanie Abston[1]; Alex Krotulski, PhD[4]; Barry Logan, PhD[4,5]; Matthew R. Gladden, PhD[3]; Adrienne Hughes, MD[6]; Alexandra Amaducci, DO[7]; Joshua Shulman, MD[8]; Evan Schwarz, MD[9]; Paul Wax, MD[1,2]; Jeffrey Brent, MD, PhD[10]; Alex Manini, MD[11]; the Toxicology Investigators Consortium Fentalog Study Group



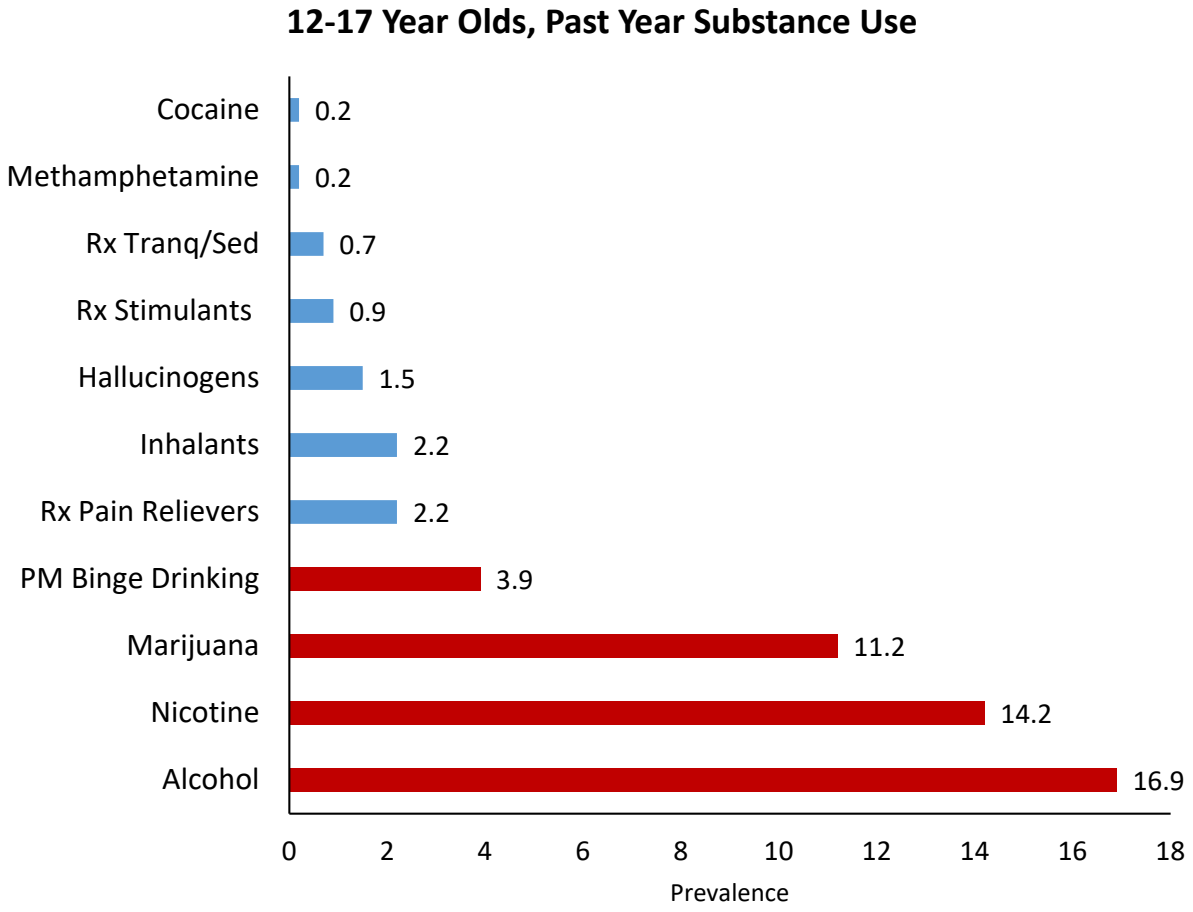
RESEARCH Open Access

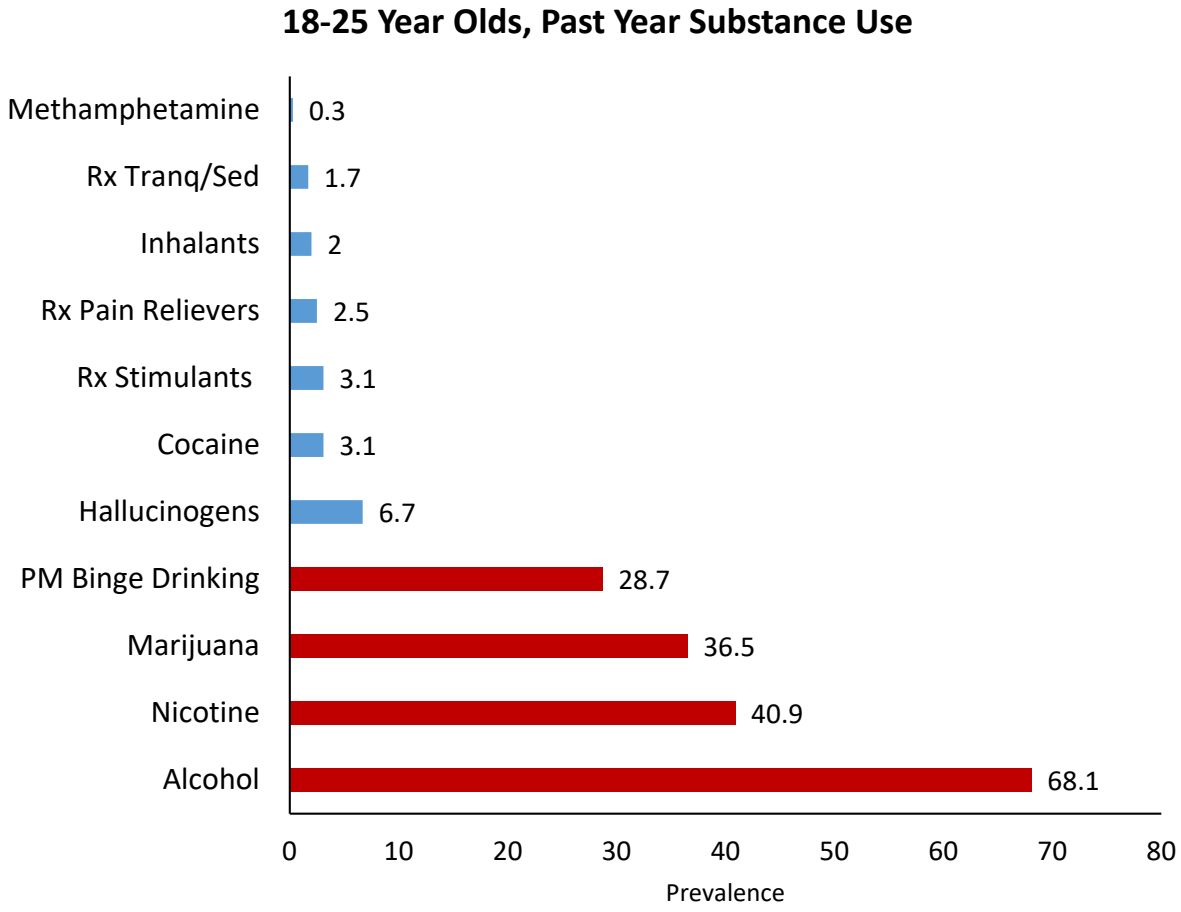
Signals of increasing co-use of stimulants and opioids from online drug forum data

Abeed Sarker[1*], Mohammed Ali Al-Garadi[1], Yao Ge[1], Nisha Nataraj[2], Christopher M. Jones[2] and Steven A. Sumner[2]



Alcohol, Nicotine, and Cannabis Remain Most Commonly Used Substances by Youth & Young Adults





Data Source: Substance Abuse and Mental Health Services Administration. (2023). Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health (HHS Publication No. PEP23-07-01-006, NSDUH Series H-58). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report

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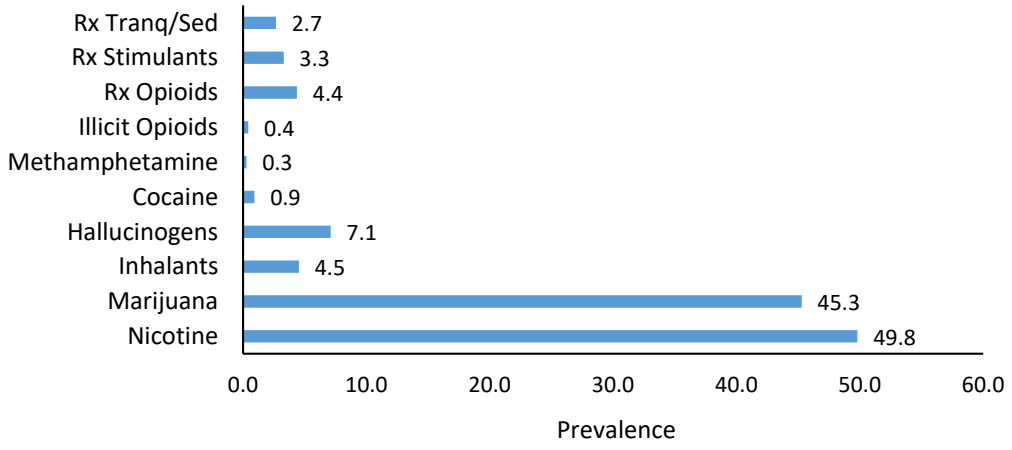
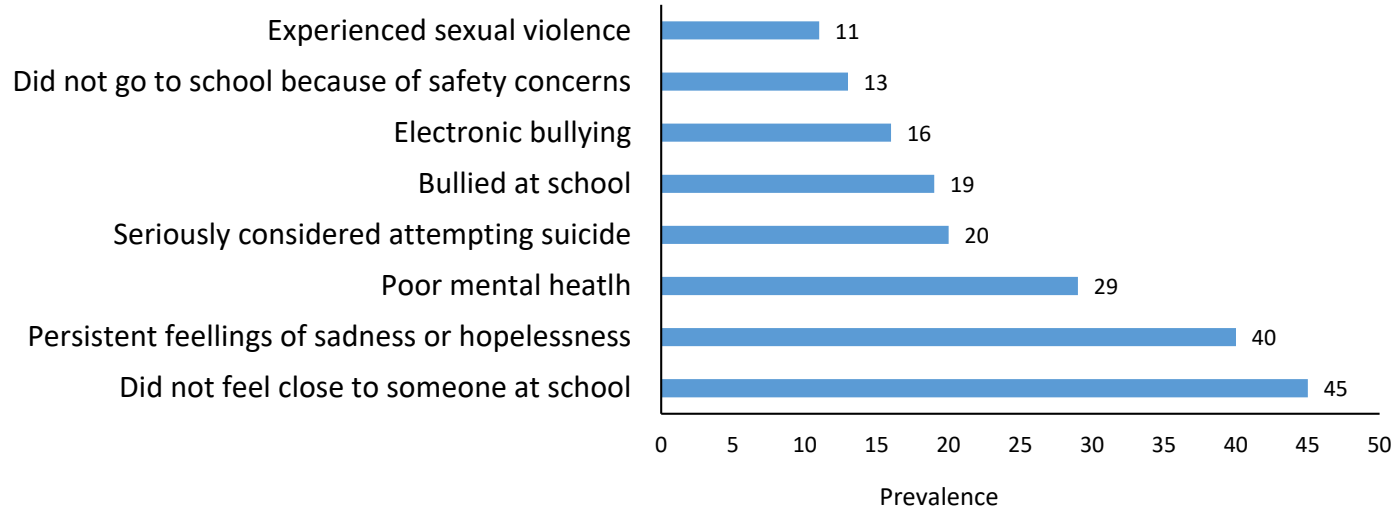
Youth Substance Use Doesn't Happen in a Vacuum

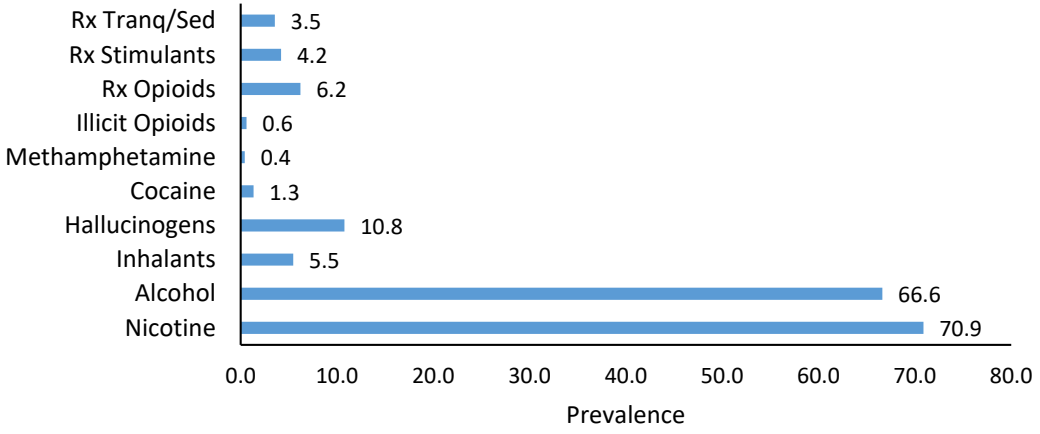
Other Substance Use Among Youth Aged 12-17 Using Alcohol in Past Year, 2023



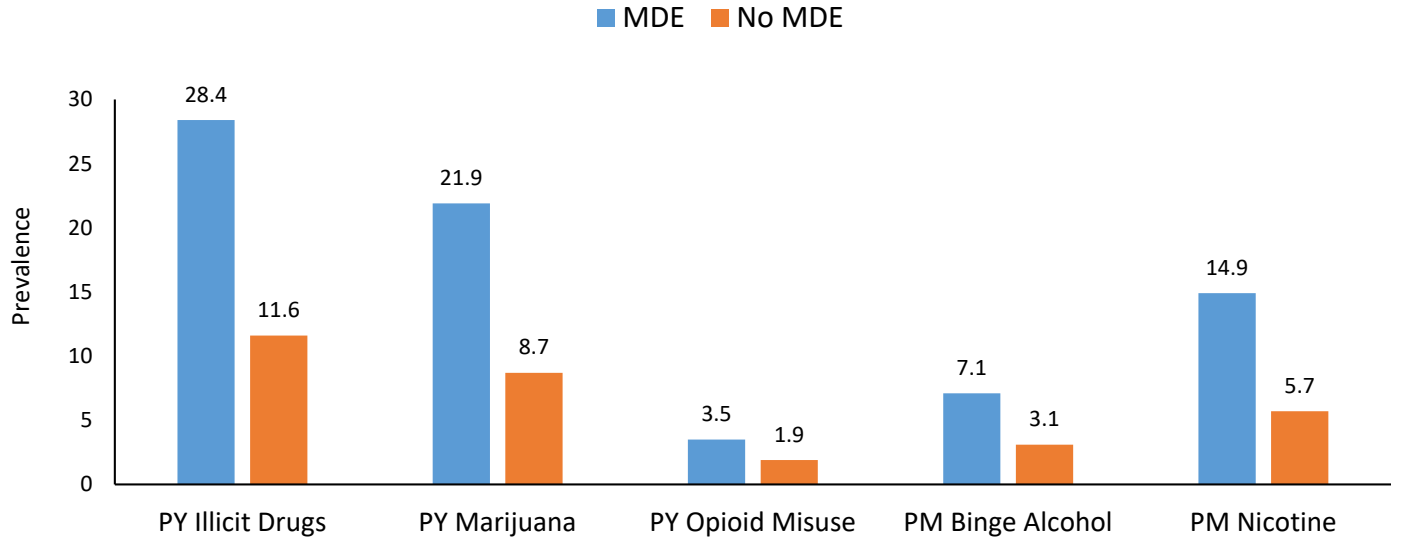
Other Challenges Among High School Students, YRBS 2023



Other Substance Use Among Youth Aged 12-17 Using Marijuana in Past Year, 2023



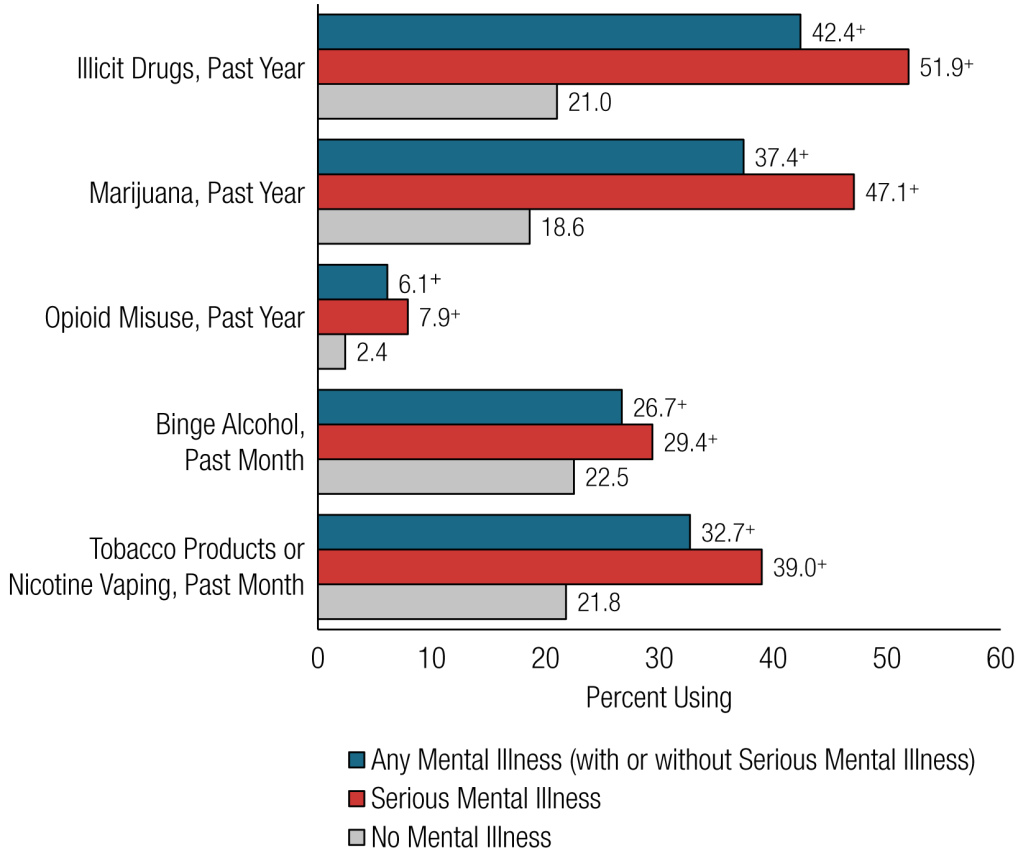
Substance Use by Major Depressive Episode Status 12-17, 2023



Source: SAMHSA NSDUH, 2023 and CDC YRBS, 2023

Mental Health and Substance Use and Overdose Among Adults

Past Year Substance Use by Mental Health Status



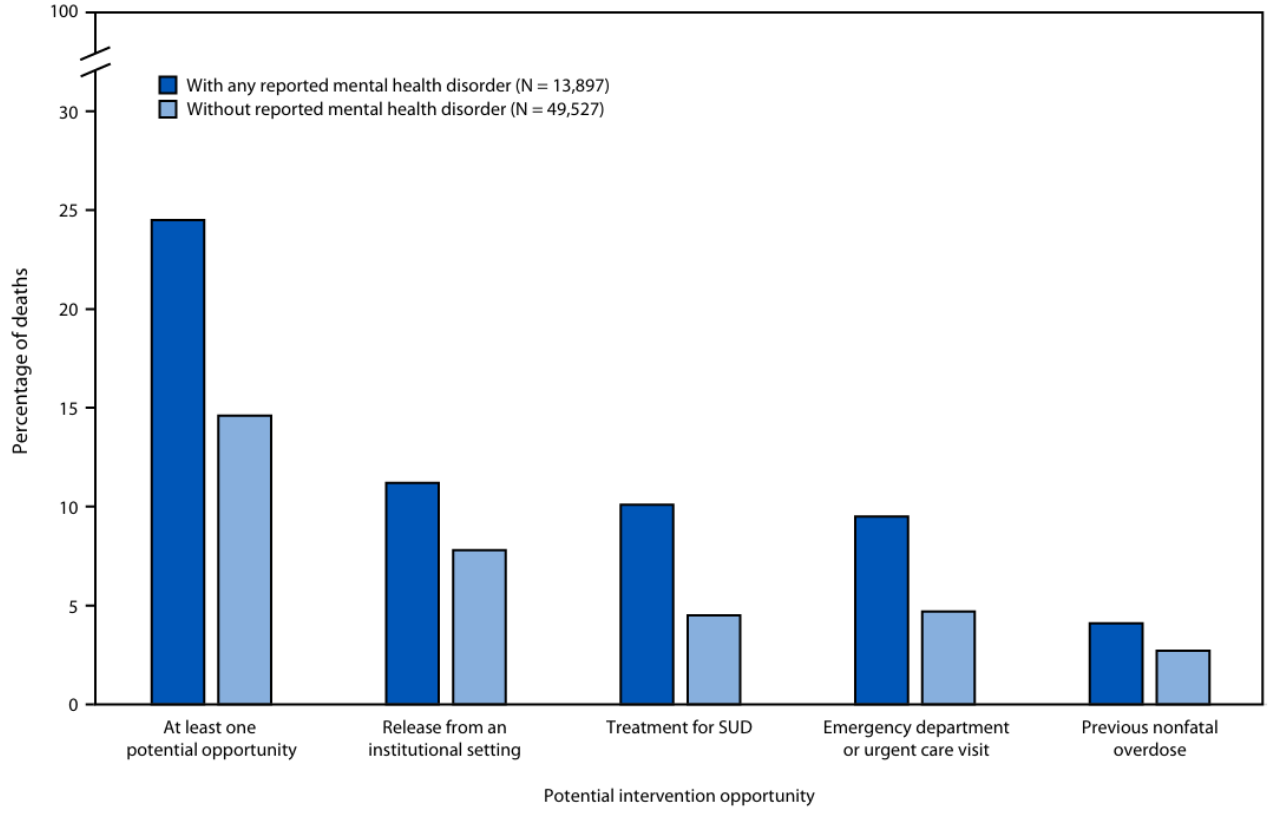
Source; NSDUH, CDC SUDORS

Morbidity and Mortality Weekly Report

Reported Non–Substance-Related Mental Health Disorders Among Persons Who Died of Drug Overdose — United States, 2022

Amanda T. Dinwiddie, MPH[1]; Stephanie Gupta, MPH[1]; Christine L. Mattson, PhD[1]; Julie O'Donnell, PhD[1]; Puja Seth, PhD[1]

FIGURE. Potential opportunities for intervention* within 1 month of death among persons who died of unintentional or undetermined intent drug overdose, by non–substance-related mental health disorder status† — State Unintentional Drug Overdose Reporting System, United States,§ 2022¶



Prevention Has Never Been More Important

JAMA Psychiatry | Original Investigation

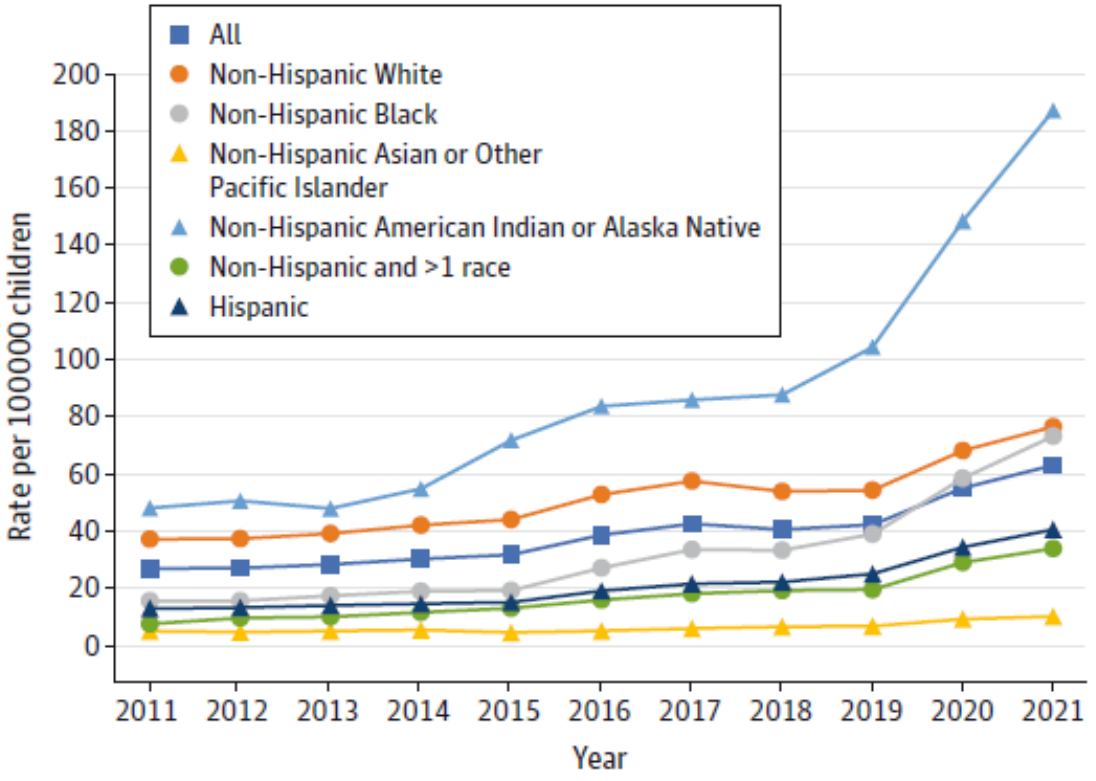
Estimated Number of Children Who Lost a Parent to Drug Overdose in the US From 2011 to 2021

Christopher M. Jones, PharmD, DrPH, MPH; Kun Zhang, PhD; Beth Han, MD, PhD, MPH; Gery P. Guy, PhD, MPH; Jan Losby, PhD; Emily B. Einstein, PhD; Miriam Delphin-Rittmon, PhD; Nora D. Volkow, MD; Wilson M. Compton, MD, MPE

- Multi-generational impacts of the overdose crisis
- Connected to economic and other stressors in homes and communities
- If not addressed, we will continuously be playing catch up rather than getting ahead of the crisis

More than 320,000 kids lost a parent to a drug overdose between 2011 -2021

Figure 1. Estimated Rate of Community-Dwelling Children Who Lost a Parent to Drug Overdose per 100 000 Children in the US, 2011-2021, by Parental Race and Ethnicity



Comprehensive Prevention Approach for Substance Use & Overdose

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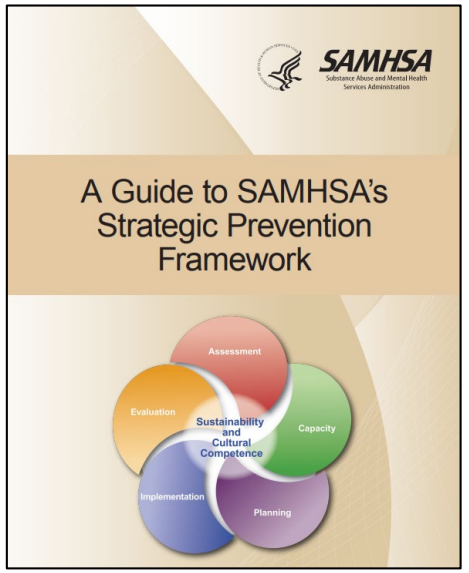
The Future We Envision

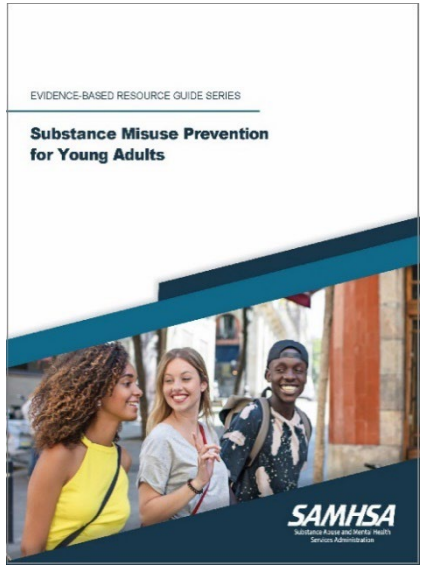
- **CSAP's Vision**
  - A future where individuals, families, and communities are healthy and thriving

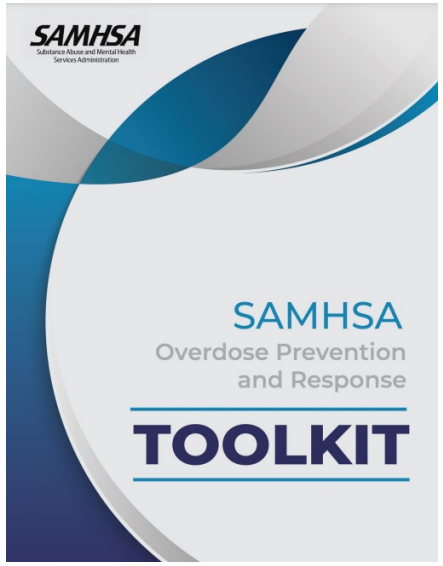
- **CSAP's Mission**
  - Provides leadership and collaborates across sectors to advance prevention across the lifespan.
  - We aim to:
    - Prevent substance use initiation
    - Prevent progression of substance use
    - Prevent and reduce harms associated with substance use

- **Strategic Priorities**
  - Analyzing and Disseminating Information on the Latest Data, Trends, and What Works in Prevention
  - Building Prevention Capacity at the National, State, Tribal, Territorial, and Local Levels
  - Advancing Prevention through Strategic Collaborations and Partnerships
  - Raising Awareness and Catalyzing Prevention Action

talk they hear you®



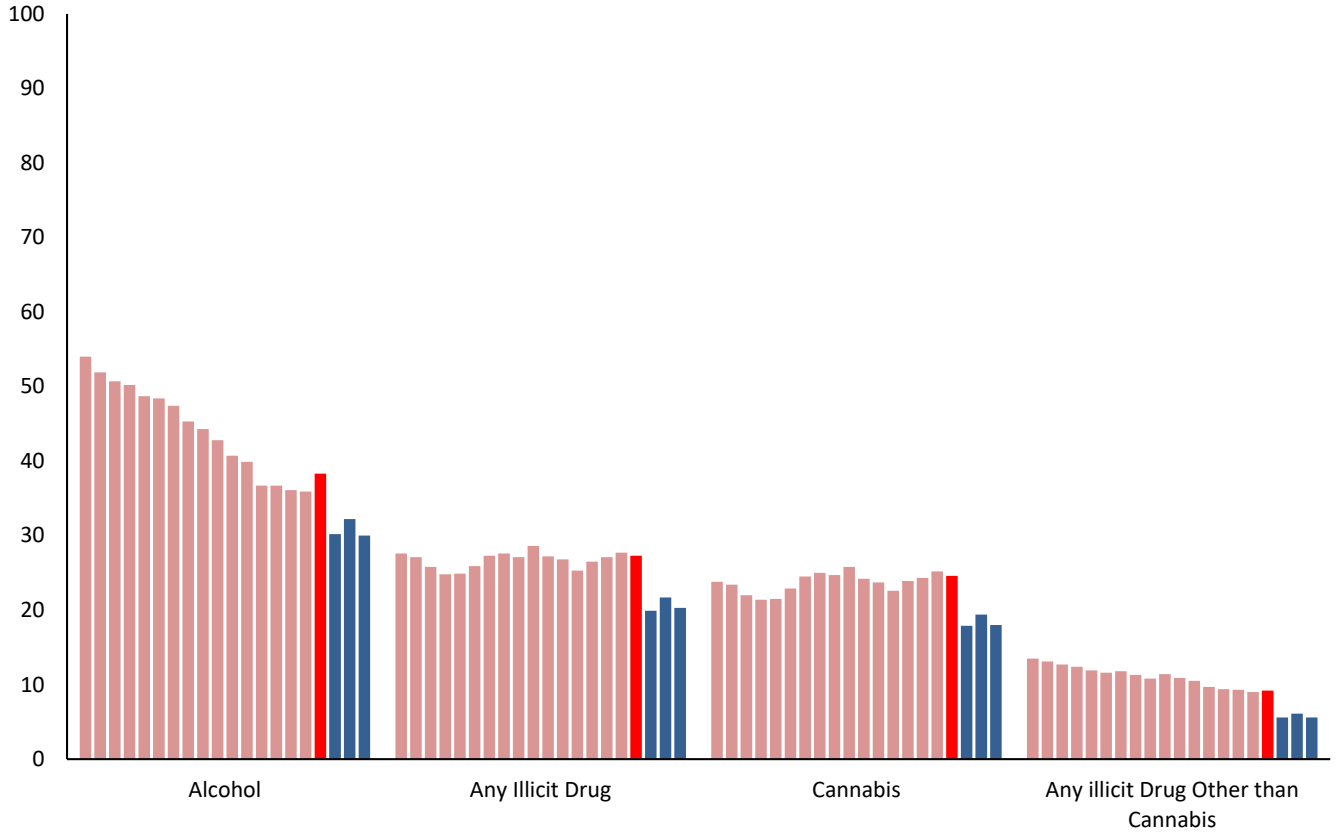




CSAP Guiding Principles
Data-Driven
Innovative
Community Informed
Grounded in Cultural Humility
Focused on Health Equity
Inclusive of Social Determinants of Health

Substance Use Among Youth – Setting the Stage

Prevalence of Past-Year Use Among 8th, 10th, 12th Grade Students
Monitoring the Future – 2004-2023



Alcohol – down 44% since 2004; down 16% since 2019

Any illicit drug – down 26% since 2004; down 27% since 2019

Cannabis – down 24% since 2004; down 29% since 2019

Any illicit drug other than cannabis – down 59% since 2004; down 38% since 2019

- Youth substance use rates heading in right direction
- Yet, overdose deaths among young people remain high – driven by proliferation of fake pills and toxic illicit drug market
  - 1 in 12 deaths, 12-17 year-olds
  - 1 in 5 deaths, 18-24 year-olds
- Need a comprehensive approach to address range of risk and protective factors long-term while also addressing acute issues of increasing overdose risk and harms

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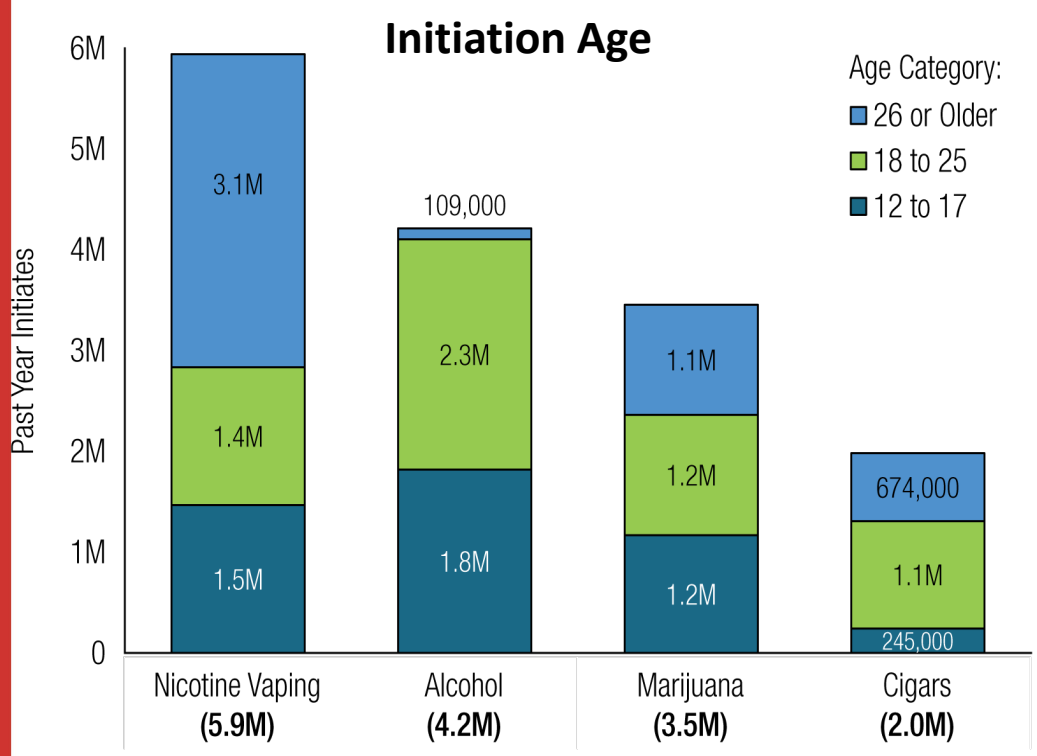
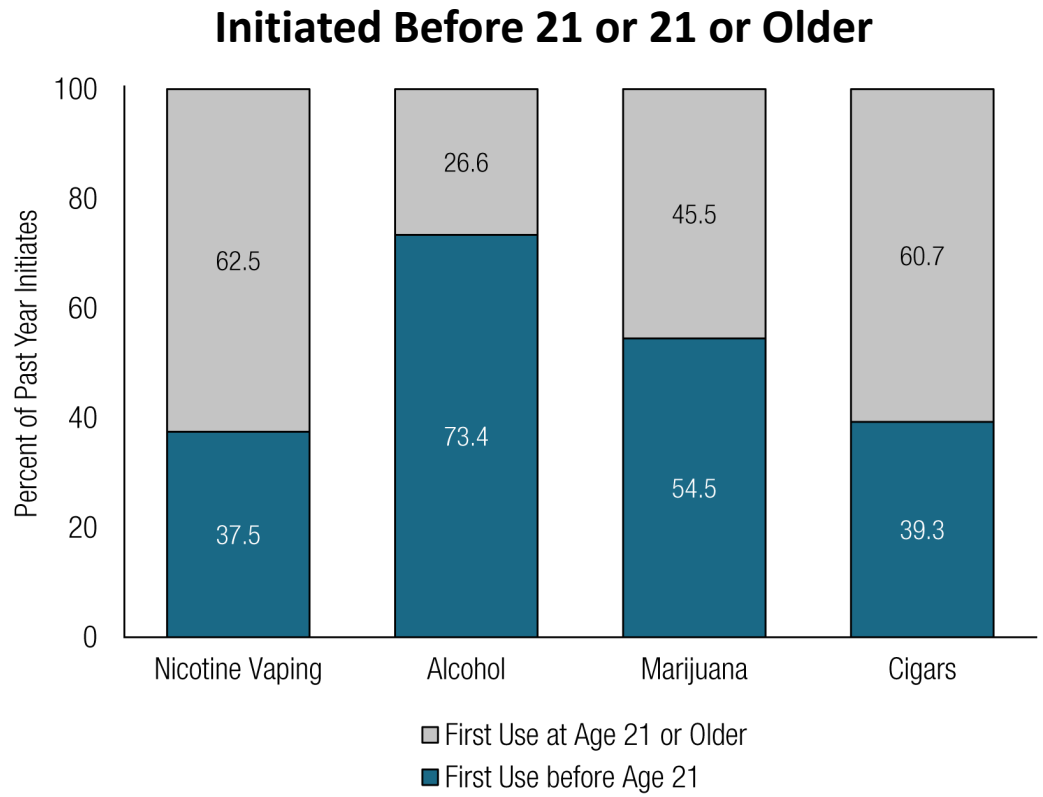
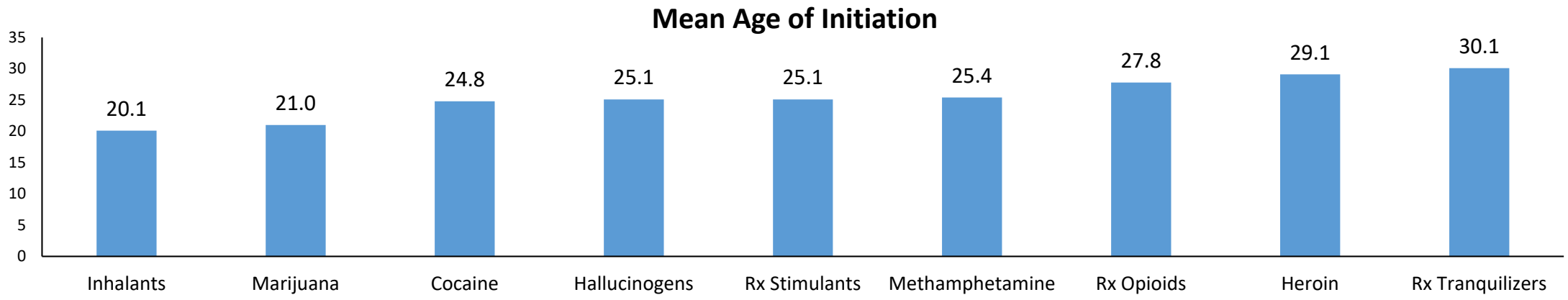
Substance Abuse and Mental Health Services Administration

Prevention Opportunities Across the Lifespan

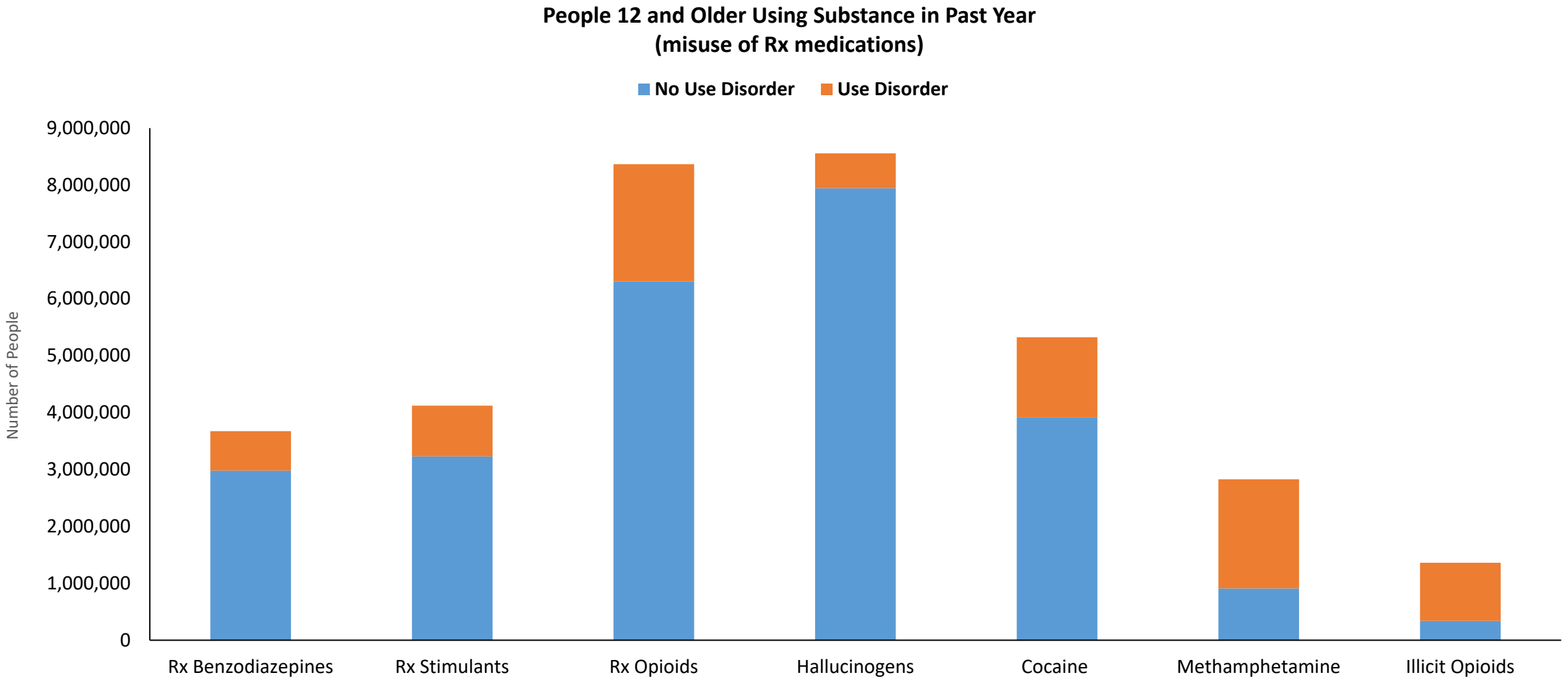






SOURCE: 2023 NSDUH

Many People Who Use Substances Do Not Have SUD But Still At Risk for Harms and Progression to SUD



Data from 2022 NSDUH Public Use File. Jones CM Analysis 8.3.24

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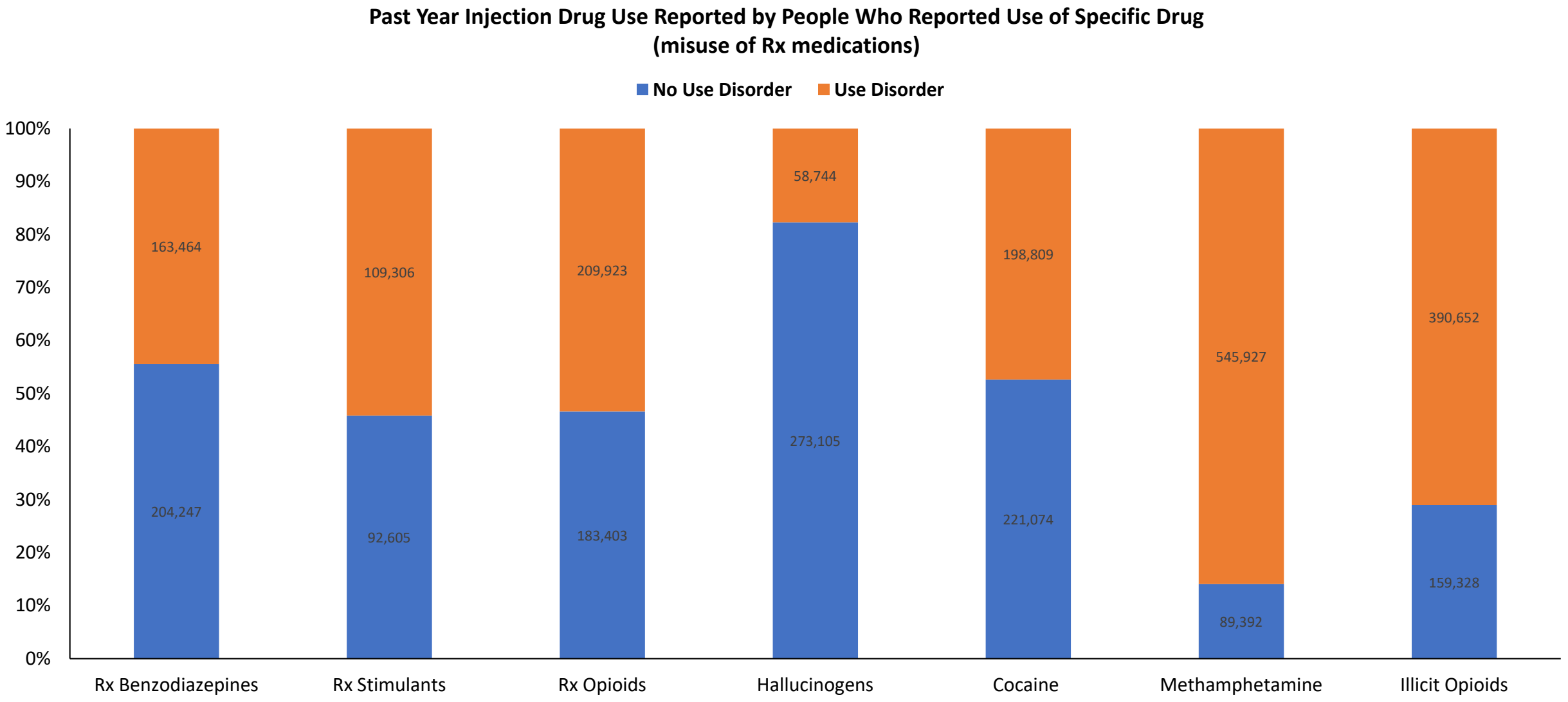
Many People Who Use Substances Do Not Have SUD But Still At Risk for Harms – Past Year Injection Drug Use



Data from 2022 NSDUH Public Use File. Jones CM Analysis 8.3.24

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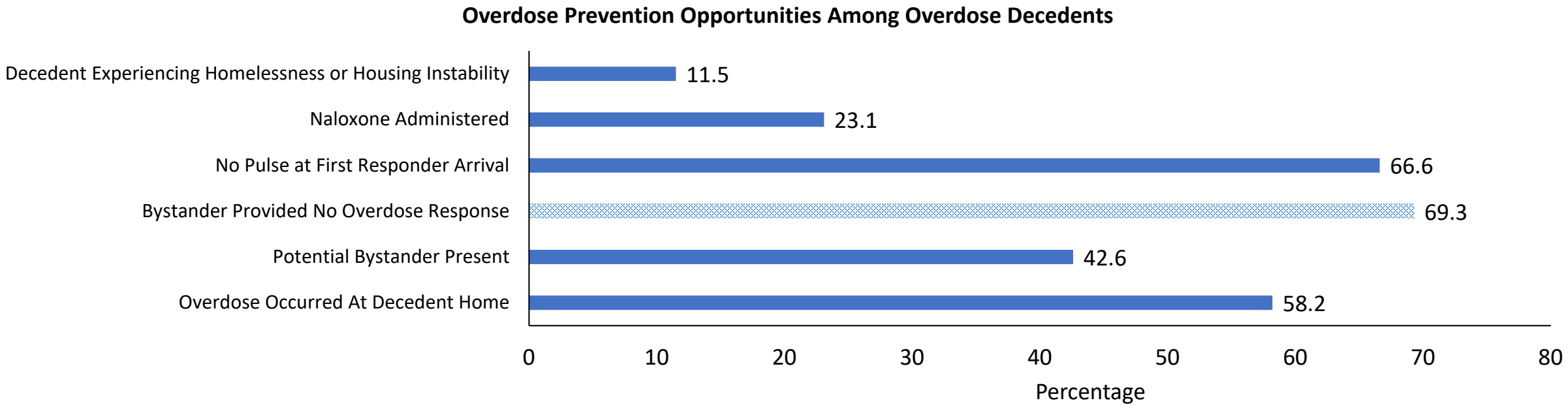
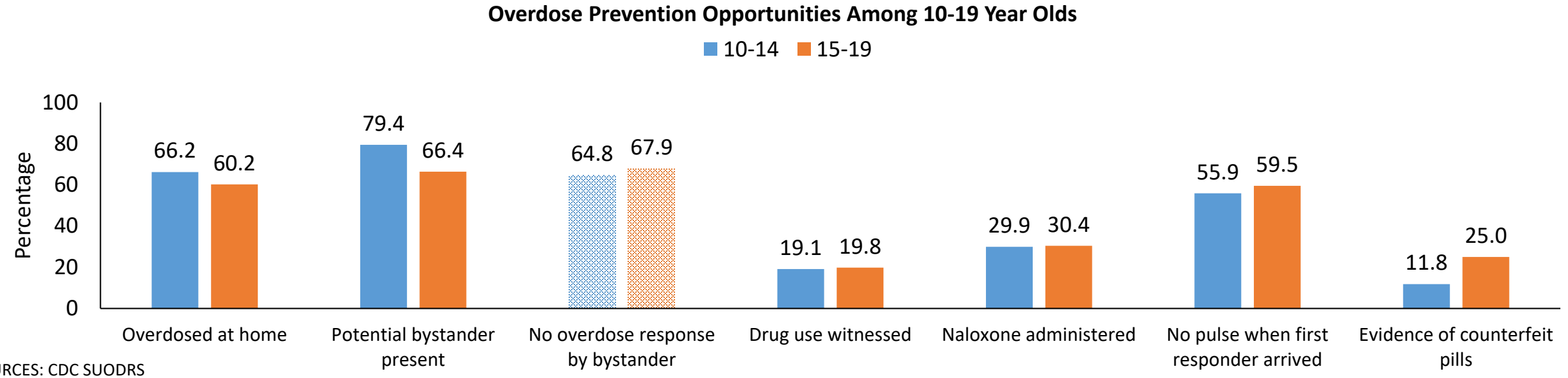
Substance Abuse and Mental Health Services Administration

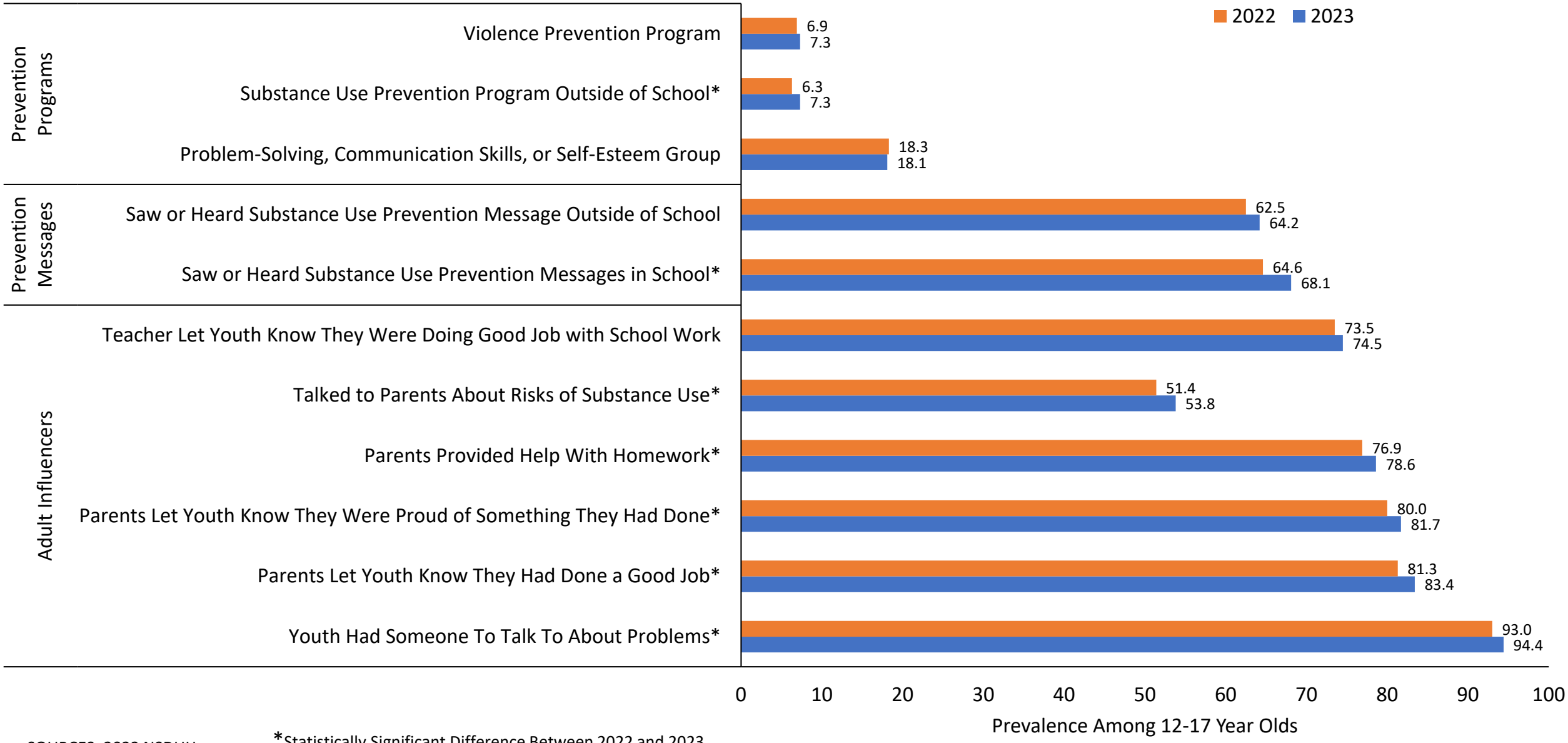
Prevention Opportunities – Acute Overdose Response





SOURCES: CDC SUODRS

Opportunities to Increase Youth Exposure to Prevention Programming, Messages and Select Protective Factors



SOURCES: 2023 NSDUH

*Statistically Significant Difference Between 2022 and 2023

Moving Upstream to Get Ahead of Substance Use Challenges

Adverse Childhood Experiences

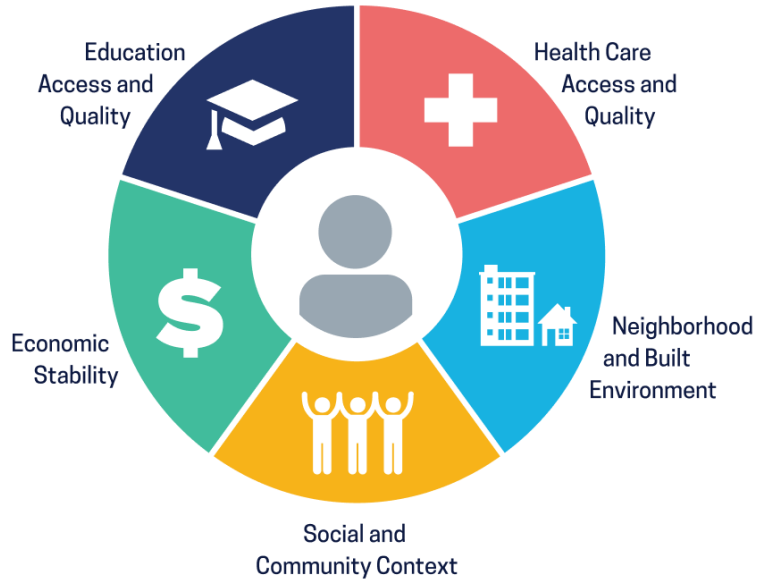
ABUSE | **NEGLECT** | **HOUSEHOLD CHALLENGES**

- Physical (Abuse)
- Physical (Neglect)
- Mental Illness
- Divorce
- Emotional (Abuse)
- Emotional (Neglect)
- Parent Treated Violently
- Incarcerated Relative
- Sexual
- Substance Abuse

ACEs not included in the traditional measure:

- Bullying
- Teen dating violence
- Peer to peer violence
- Violence in community or school
- Experiencing homelessness
- Death of a parent

Social Determinants of Health



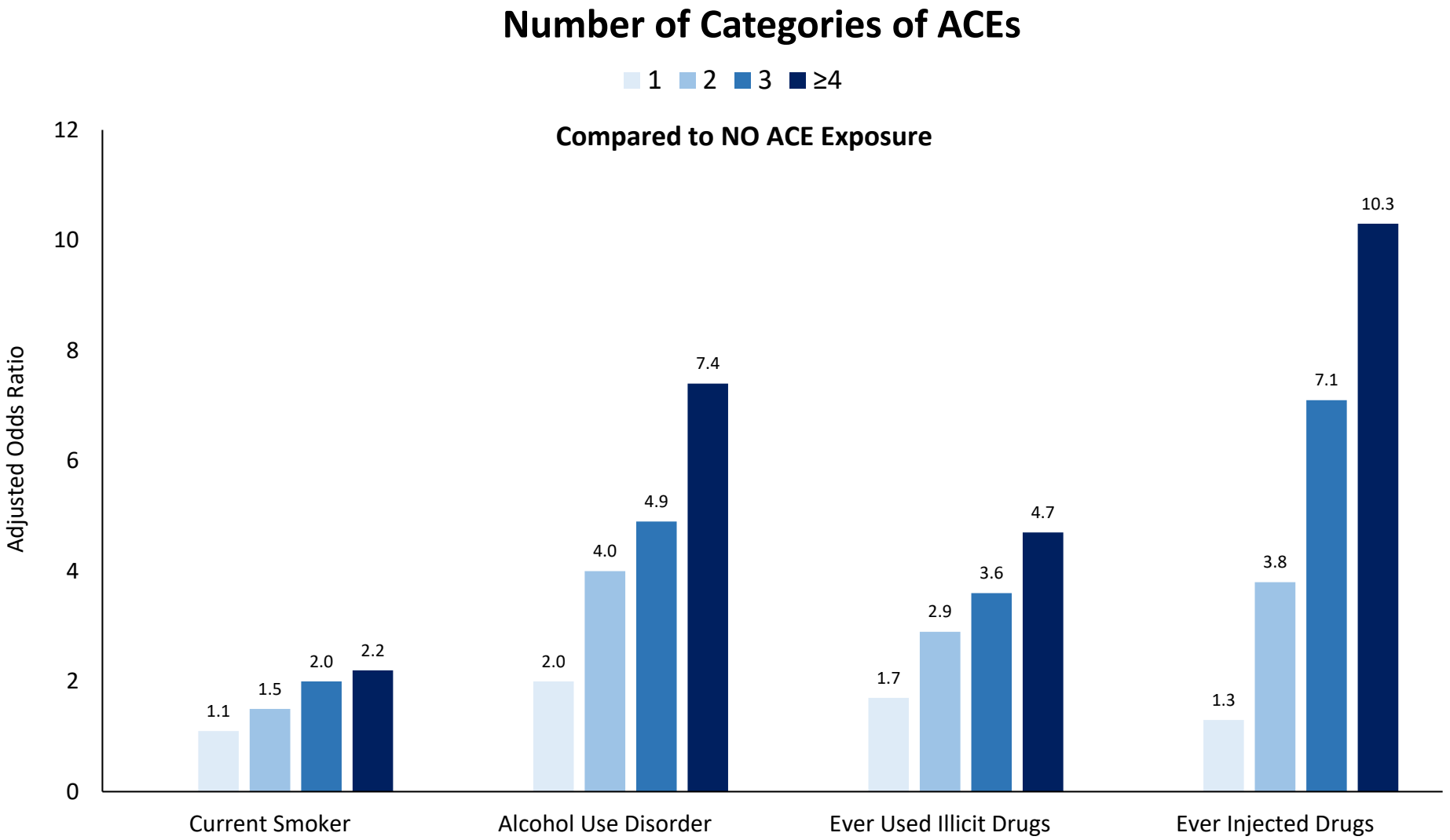
Social Determinants of Health
Copyright-free
Healthy People 2030

61%

adults report experiencing **at least 1 ACE**

1 in **6** adults report experiencing **4+ ACEs**

ACEs and Risk for Substance Use



Research shows ACEs increase risk for:

- **Rx opioid misuse, illicit opioid use, opioid use disorder, opioid injection**
- **Cocaine and amphetamine use and use disorder**
- **Earlier age of initiation of substances**

Source: Felitti, Vincent J., et al. *American journal of preventive medicine* 14.4 (1998): 245-258.

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Social Determinants of Health and Substance Use

- SDOHs have been directly associated with an increased risk of substance use and others are associated with increased rates of stress and anxiety, which can increase the likelihood of substance use

BRIEF REPORT

Social determinants of health, substance use, and drug overdose prevention

Farideh Sistani, Magaly Rodriguez de Bittner, Fadia T. Shaya*

Association between individual, interpersonal, community, and societal level variables, and drug overdose mortality in unadjusted and adjusted models

Characteristic	Unadjusted		Adjusted	
	Percent change (95% CI)	*P* value	Percent change (95% CI)	*P* value
Individual-level variables[a]				
Demographics				
African American	3.04 (2.0–4.25)	< 0.001[b]	1.0 (0.03–2.21)	0.043[b]
Male	−17.3 (−21.1 to −13.7)	< 0.001[b]	3.05 (−1.7 to 8.5)	0.204
Age > 65 y	−3.92 (−6.6 to −0.6)	0.020[b]	−3.92 (−6.9 to −0.33)	0.032[b]
Median age	−14.8 (−17.0 to −12.0)	< 0.001[b]	−1.98 (−5.8 to 2.3)	0.388
Education				
Less than ninth grade	−19.7 (−25.4 to −14.0)	< 0.001[b]	5.1 (−3.1 to 13.5)	0.242
Interpersonal, community, and societal level variables[c]				
Health				
Opioid prescription rate	0.7 (−0.07 to 1.4)	0.077	−0.1 (−0.33 to 0.14)	0.412
Having a PCP	12.7 (9.2–16.6)	< 0.001[b]	19.7 (15.9–24.5)	< 0.001[b]
Quality of life				
Violent crimes rate	0.3 (0.19–0.36)	< 0.001[b]	0.1 (0.07–0.20)	< 0.001[b]
SVI	58.4 (−10.8 to 184.2)	0.116	334.9 (86.1–907.3)	0.001[b]
Internet access	13.9 (11.0–15.9)	< 0.001[b]	7.3 (3.7–9.9)	< 0.001[b]
Economy/income				
Poverty	−1.4 (−3.78 to 1.03)	0.254	2.0 (−2.1 to 5.3)	0.419
Income, $	0.01 (0.01–0.01)	< 0.001[b]	0.0 (0.0–0.01)	<0.001[b]
Housing				
Average household size	222.2 (37.1–662.0)	0.007[b]	−40.0 (−70.5 to 19.7)	0.146
Vacancy rate	−5.8 (−6.8 to −4.8)	< 0.001[b]	−2.96 (−4.2 to −1.4)	< 0.001[b]

Abbreviations used: PCP, primary care physician; SVI, social vulnerability index.

- Greater community-level social vulnerability, violent crime, per capita income, access to health care, and access to the Internet were all associated with increased risk for drug overdose
- Having a lower housing vacancy rate was associated with lower risk for drug overdose

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Substance Use Risk Factors – Social-Ecological Model

Individual

- Genetic factors
- Initiating substance use early
- Low risk perception of use
- Peers who use substances
- Perception of substance use among peers is high
- Early emotional distress or aggressiveness
- Mental health challenges
- ACEs/Trauma

Relationship

- Substance use in the family and home
- Parental mental health challenges
- Family conflict, abuse, or neglect, other ACEs
- Parents who favorably view or approve of substance use
- Lack of family connectedness

Community

- Lack of community connectedness and supports
- Community norms favorable toward alcohol and drugs
- Violence in schools or community
- Availability of, access to, and costs of drugs and alcohol
- Lack of access to health and behavioral health services
- Poverty

Societal

- Lack of economic and educational opportunities
- Inadequate housing
- Disinvestment
- Discrimination
- Social norms
- Laws and policy environment

BUILDING INDIVIDUAL AND COMMUNITY RESILIENCE

Focuses on promoting positive situational, social, and individual characteristics

1) Healthy development of social & emotional competencies; 2) Presence of positive relationships; 3) Safe, protective, & equitable environments

Example Prevention Strategies to Address Risk and Protective Factors Across the Social Ecology

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Individual-Level Strategies

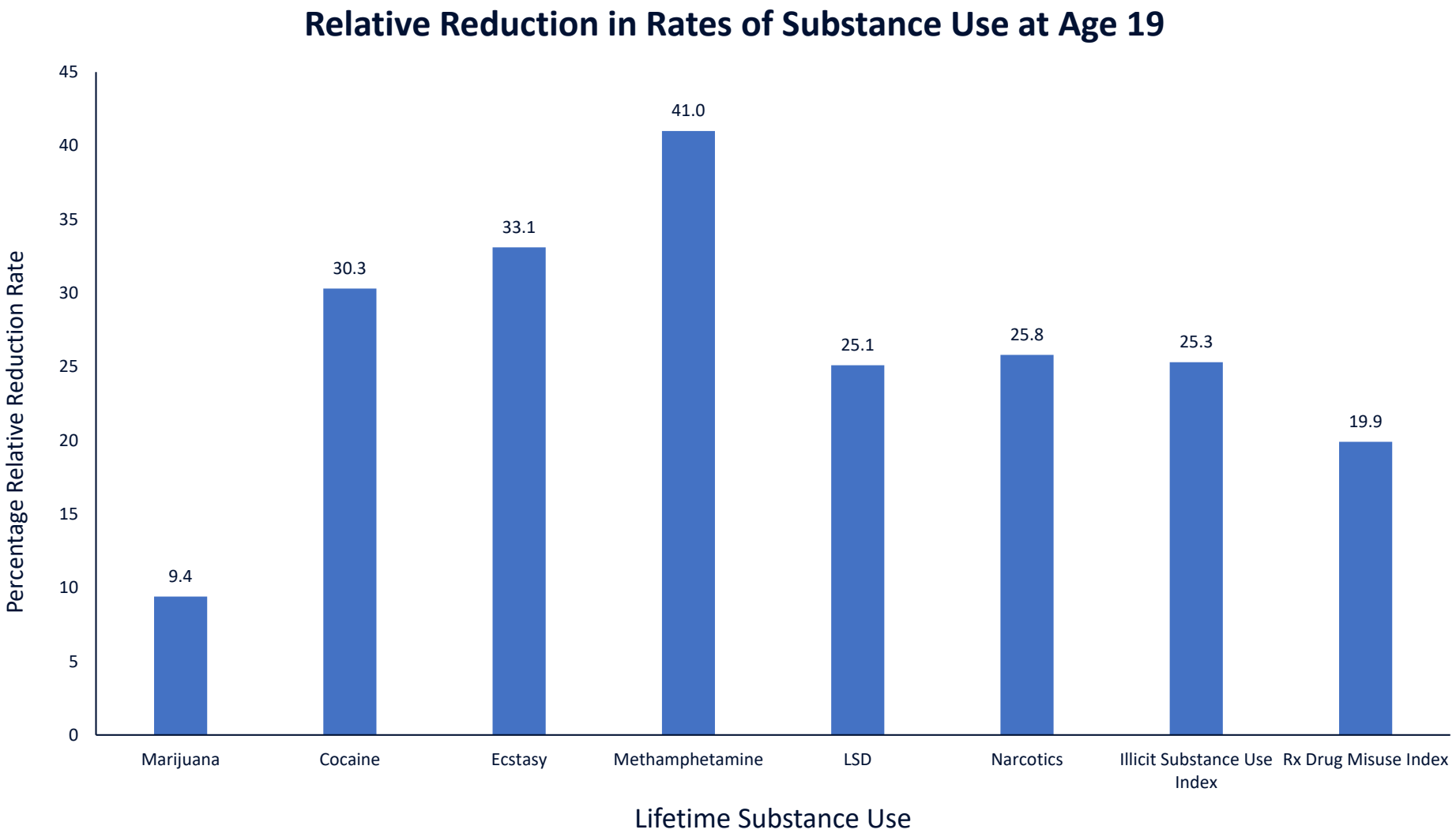
Risk Factors

- Genetic factors
- Initiating substance use early
- Low risk perception of use
- Peers who use substances
- Perception that use of substances among peers is high
- Early and persistent problem behavior
- Mental health challenges

Prevention Strategies

- Life-skills development
- Problem solving skills
- Conflict resolution
- Strengthening resiliency
- Empowerment opportunities
- Exposing youth to positive adult role models
- Raising awareness about risks associated with substance use and overdose prevention and response
- Treatment for health and behavioral health conditions

Universal Skills-Based Prevention Program



- 28 public school districts randomized to intervention or control
- Family focused intervention in 6th grade (SFP 10-14)
- School-based intervention in 7th grade (Life Skills Training)
- Examined changes in outcomes at age 19

Source: Spoth et al., 2017, Psychological Medicine

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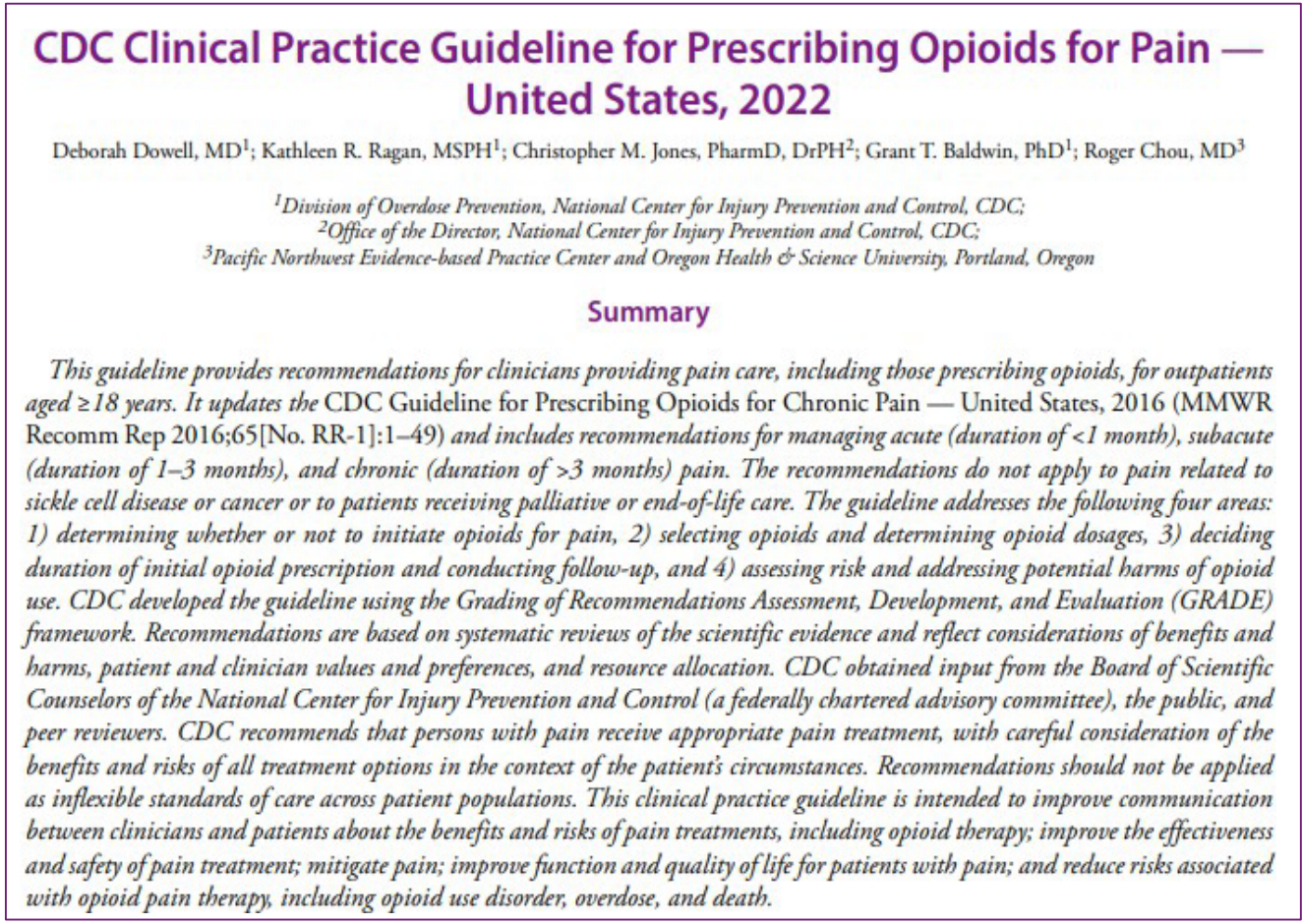
CDC Opioid Prescribing Guidelines

- Reflects new evidence and research
- Provides recommendations for clinicians treating **acute, subacute, and chronic pain** for outpatients aged 18 years or older
- Recommendations exclude pain care related to sickle cell disease, cancer- related pain treatment, palliative care, and end-of-life care



CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022

Deborah Dowell, MD[1]; Kathleen R. Ragan, MSPH[1]; Christopher M. Jones, PharmD, DrPH[2]; Grant T. Baldwin, PhD[1]; Roger Chou, MD[3]

[1]Division of Overdose Prevention, National Center for Injury Prevention and Control, CDC;
[2]Office of the Director, National Center for Injury Prevention and Control, CDC;
[3]Pacific Northwest Evidence-based Practice Center and Oregon Health & Science University, Portland, Oregon

Summary

This guideline provides recommendations for clinicians providing pain care, including those prescribing opioids, for outpatients aged ≥18 years. It updates the CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 (MMWR Recomm Rep 2016;65[No. RR-1]:1–49) *and includes recommendations for managing acute (duration of <1 month), subacute (duration of 1–3 months), and chronic (duration of >3 months) pain. The recommendations do not apply to pain related to sickle cell disease or cancer or to patients receiving palliative or end-of-life care. The guideline addresses the following four areas: 1) determining whether or not to initiate opioids for pain, 2) selecting opioids and determining opioid dosages, 3) deciding duration of initial opioid prescription and conducting follow-up, and 4) assessing risk and addressing potential harms of opioid use. CDC developed the guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework. Recommendations are based on systematic reviews of the scientific evidence and reflect considerations of benefits and harms, patient and clinician values and preferences, and resource allocation. CDC obtained input from the Board of Scientific Counselors of the National Center for Injury Prevention and Control (a federally chartered advisory committee), the public, and peer reviewers. CDC recommends that persons with pain receive appropriate pain treatment, with careful consideration of the benefits and risks of all treatment options in the context of the patient's circumstances. Recommendations should not be applied as inflexible standards of care across patient populations. This clinical practice guideline is intended to improve communication between clinicians and patients about the benefits and risks of pain treatments, including opioid therapy; improve the effectiveness and safety of pain treatment; mitigate pain; improve function and quality of life for patients with pain; and reduce risks associated with opioid pain therapy, including opioid use disorder, overdose, and death.*

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Relationship-Level Strategies

Risk Factors

- Substance use in family or home
- Parental mental health challenges
- Family conflict, abuse, or neglect
- Parents who favorably view or approve of substance use
- Lack of family connectedness

Prevention Strategies

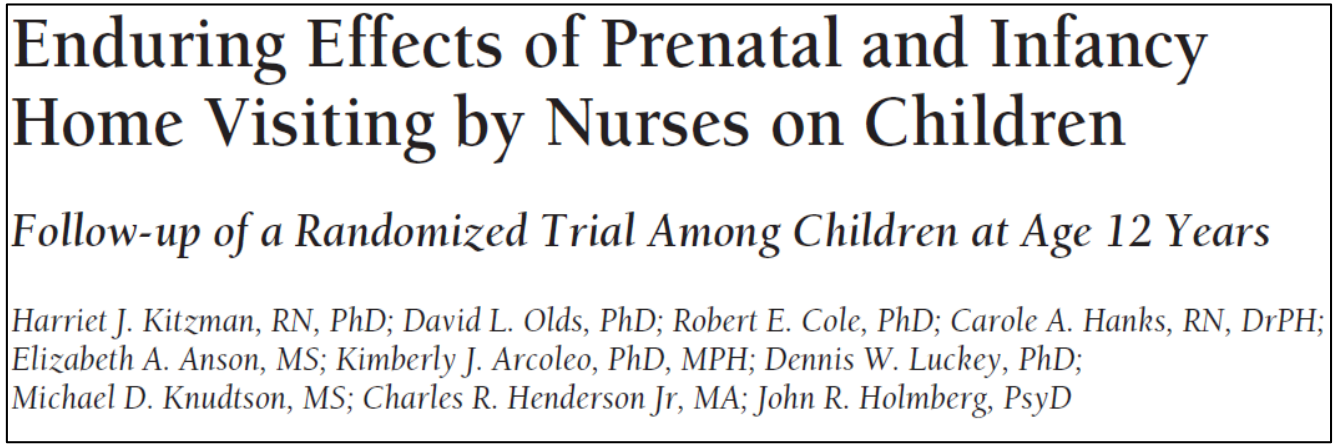
- Healthy relationship skills programs
- Creating opportunities for positive social involvement with family
- Positive parenting skills programs
- Strengthening parent-child relationship and communication
- Addressing household challenges that contribute to stress and other risk factors
- Treatment for parental/caregiver substance use, mental health challenges

Long-term Impacts of Home Visitation Program

Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect

Fifteen-Year Follow-up of a Randomized Trial

David L. Olds, PhD; John Eckenrode, PhD; Charles R. Henderson, Jr; Harriet Kitzman, RN, PhD; Jane Powers, PhD; Robert Cole, PhD; Kimberly Sidora, MPH; Pamela Morris; Lisa M. Pettitt; Dennis Luckey, PhD



Enduring Effects of Prenatal and Infancy Home Visiting by Nurses on Children

Follow-up of a Randomized Trial Among Children at Age 12 Years

Harriet J. Kitzman, RN, PhD; David L. Olds, PhD; Robert E. Cole, PhD; Carole A. Hanks, RN, DrPH; Elizabeth A. Anson, MS; Kimberly J. Arcoleo, PhD, MPH; Dennis W. Luckey, PhD; Michael D. Knudtson, MS; Charles R. Henderson Jr, MA; John R. Holmberg, PsyD

- During the 15-year period after index birth, women in the program had reduced rates of verified reports of child abuse
- Among women from low-SES households, exposure to the program resulted in fewer subsequent childbirths, months receiving government assistance, behavioral impairments from substance use, arrests, convictions, and number of days jailed.
- Among children of women exposed to the program, at the age of 12 years this group reported fewer days of cigarette, alcohol and marijuana use, and were less likely to have internalizing disorders
- Academic outcomes were also improved.

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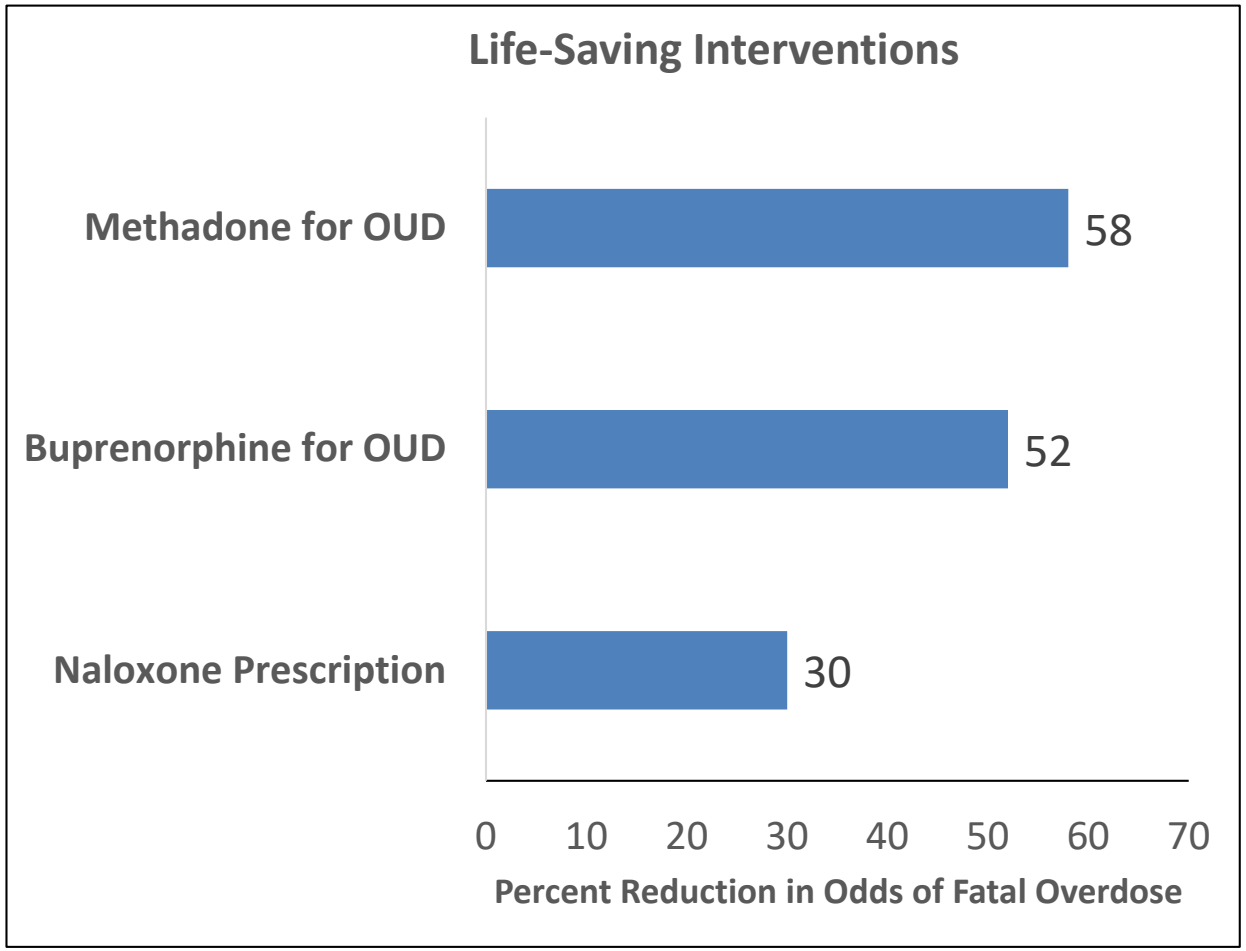
MOUD for OUD and Opioid Overdose Reversal Medications

JAMA Internal Medicine | Original Investigation

Overdose, Behavioral Health Services, and Medications for Opioid Use Disorder After a Nonfatal Overdose

Christopher M. Jones, PharmD, DrPH; Carla Shoff, PhD; Carlos Blanco, MD, PhD; Jan L. Losby, PhD, MSW; Shari M. Ling, MD; Wilson M. Compton, MD, MPE

- 136,762 Medicare beneficiaries who experienced an index nonfatal drug overdose in
- In the 12 months after their index nonfatal drug overdose, 17.4% experienced at least 1 subsequent nonfatal drug overdose and 1.0% died of a fatal drug overdose
- Opioids were involved in 72.2% of fatal drug overdoses.
- Receiving MOUD and naloxone reduced risk for fatal overdose



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School and Community-Level Strategies

Risk Factors

- Lack of school, community connectedness and supports
- Community norms favorable towards alcohol and drugs
- Violence in schools or community
- Availability and costs of drugs and alcohol
- Lack of commitment to school
- Poverty

Prevention Strategies

- Creating opportunities for positive social involvement with school and community
- Positive and supportive school environments and policies
- Student assistance programs
- Raising awareness at the community level about substance use and impacts on communities
- Drug checking and awareness about illicit drug supply
- Promoting help-seeking
- Combatting stigma
- Built environment
- Access to health and behavioral healthcare
- Access to overdose reversal interventions

Communities That Care Prevention System

Long-term Impacts and Benefit–cost Analysis of the Communities That Care Prevention System at Age 23, Twelve Years After Baseline

Margaret R. Kuklinski[1], Sabrina Oesterle[2], John S. Briney[1], J. David Hawkins[1]

- Community-based prevention system tested in the Community Youth Development Study (CYDS), a 5-year randomized trial involving 24 communities in 7 states
- 12 CYDS communities randomly assigned to the intervention condition implemented 2-5 EBPs targeting youth in Grades 6 – 9
- Control communities carried out "prevention as usual"
- Using data from a panel of youth followed from Grade 5 baseline, this study assessed CTC's impact on primary and secondary behavioral outcomes 12 years later when the panel were, on average, age 23.

- Young adults from CTC communities continued to report greater abstinence from alcohol, cigarette, marijuana, and other drug use, and antisocial behavior.
- Abstinence improved in relative terms by about 15% (though alcohol abstinence improved by 55%)
- CTC led to a 20% relative improvement in college completion.

Society-Level Strategies

Risk Factors

- Lack of economic and educational opportunities
- Inadequate housing
- Disinvestment
- Discrimination
- High rates of transition or instability

Prevention Strategies

- Strengthening economic supports for individuals and families
- Improving access to education, including early childcare to ensure a strong start for kids
- Housing and food security policies and programs
- Environmental strategies related to access and availability of substances
- Societal norms around substance use

SNAP Benefits and Substance Use

State Supplemental Nutrition Assistance Program Policies and Substance Use Rates

Rebecca B. Naumann, PhD,[1,2] Madeline Frank, BA,[2,3,4] Meghan E. Shanahan, PhD,[2,3] H. Luz McNaughton Reyes, PhD,[2,5] Alice S. Ammerman, DrPH,[6,7] Giselle Corbie, MD,[8] Anna E. Austin, PhD[2,5,7]

https://www.ajpmonline.org/action/showPdf?pii=S0749-3797%2823%2900435-X

- Results showed that state adoption of policies that expanded Supplemental Nutrition Assistance Program (SNAP) eligibility were associated with lower rates of Alcohol Use Disorder, Opioid Misuse, Illicit Drug Use Disorder, and Substance Use Disorder overall
- Rates were lower in states that both opted out of the federal felony drug disqualification and adopted at least one broad-based categorical eligibility (BBCE) policy compared to states that did not expand SNAP eligibility through either policy option.

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SAMHSA's Programmatic Investments

State Block Grants

- Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant
- Mental Health Block Grant

State & community discretionary programs

- Strategic Prevention Framework – Partnerships for Success (PFS)
- Project Aware
- Resiliency in Communities After Stress and Trauma
- Building Communities of Recovery
- CCBHCs

Tribal discretionary funding

- Tribal Opioid Response
- Tribal Behavioral Health (Native Connections)

Opioid discretionary programs

- State Opioid Response
- Strategic Prevention Framework for Prescription Drugs (SPF-Rx)
- Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths
- First Responders (FR-CARA)
- Improving Access to Overdose Treatment (OD-Tx)
- Preventing Youth Overdose: Treatment, Recovery, Education, Awareness and Training (PYO-Treat)

Harm Reduction Grant Program

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Incorporating SDOH into Substance Use Prevention Digital Toolkit

Incorporating the Social Determinants of Health into Substance Use Prevention

This interactive, digital toolkit is designed to educate SAMHSA grantees and prevention professionals on the social determinants of health (SDOH) and how they impact the risk of substance use. Leveraging up-to-date scholarly research and aligned with HHS's five core domains, the toolkit offers an in-depth examination of the specific SDOH linked to substance misuse outcomes.

View Resource

- Digital Toolkit to help grantees and prevention professionals understand SDOH and how they impact substance use risk
- In-depth information by type of SDOH and its impact on substance use and overdose

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TALK. THEY HEAR YOU. CAMPAIGN UPDATES

National Adult Oriented Campaign

GET INFORMED. BE PREPARED. TAKE ACTION.

talk they hear you®

10th ANNIVERSARY

A Decade of Youth Substance Use Prevention

TTHY 10TH ANNIVERSARY

DISCUSSION STARTER VIDEOS

"This Life for Us" Product Suite

MOBILE APP

"COMMUNITIES THAT CARE"

PARENTS' NIGHT OUT

STRENGTHEN PARENT AWARENESS, RAPPORT, COMMUNICATIONS (SPARC)

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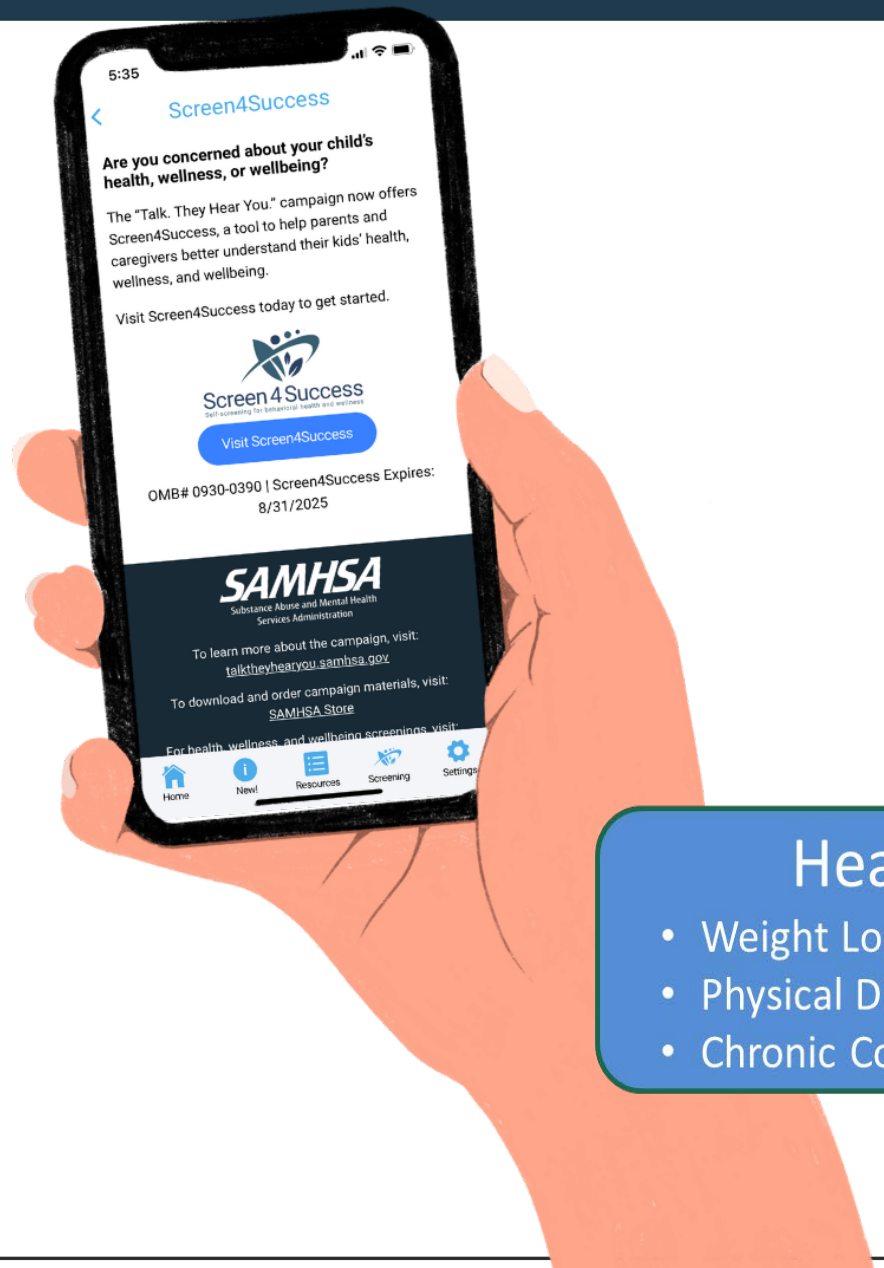
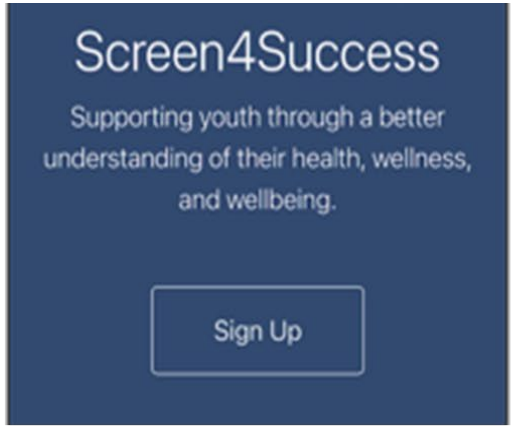
New Resources: Screening as a Prevention Strategy





Live Now!

Phase 1:

Personal Implementation (Parents & Caregivers)

Summer 2024!

Phase 2:

Professional Implementation (Organizations & Entities)

Elevated risk for potential problems (12-20 years old)

Health
- Weight Loss/Gain
- Physical Discomfort
- Chronic Conditions

Wellness
- Mental Health
- Substance Use
- Family Environment

Wellbeing
- Life Satisfaction
- Quality of life
- Community Connectedness

www.samhsa.gov/talk-they-hear-you/screen4success

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SAMHSA Overdose Prevention and Response Toolkit

- Updated to reflect latest overdose trends
- Practical tips for preventing, recognizing, and responding to an overdose
- Information on available opioid overdose reversal medications (OORM)
- Information for specific audiences
  - People who use drugs
  - People who take prescription opioids
  - Practitioners and health systems
  - First Responders
  - Policy and systems considerations

Overdose Prevention and Response Toolkit (Spanish Version) | SAMHSA Publications and Digital Products

Specifics on OORM and Harm Reduction Strategies

OORM	Brand	Formulation	Dosage	Availability	Considerations
Naloxone	N/A	Adaptable Nasal Spray	2 mg/ml	Rx, community naloxone distribition, harm reduction organizations	Assembly required to attach nasal spray adapter to needle-less syringe. Not approved by FDA. Possible to titrate to meet the needs of the patient and facilitate a gentler overdose reversal with potential for less severe withdrawal in people with opioids in their body.
Naloxone	RiVive ™	Single-use Nasal Spray	3 mg	Rx, OTC, community naloxone distribition, harm reduction organizations	Lower dose can facilitate a gentler overdose reversal with less severe withdrawal in people with opioids in their body.
Naloxone	Narcan, generic	Single-use Nasal Spray	4 mg/0.1 ml	Rx, OTC, community naloxone distribition, harm reduction organizations	May cause withdrawal symptoms in people who have opioids in their body.
Naloxone	N/A	Single-dose Vial Intramuscular Injection; can also be given intravenously or subcutaneously	0.4 mg/ml	Rx, community naloxone distribition, harm reduction organizations	Has been studied and used in the real world to reverse overdoses for decades; cheapest naloxone available; easy to use.
Naloxone	Zimhi®	Intramuscular or subcutaneous Auto-Injection	5 mg/ml	Rx, community naloxone distribition, harm reduction organizations	Accessible product format that auto-injects the medication; high dose compared to other products; may cause severe withdrawal symptoms in people with opioids in their body.
Naloxone	Kloxxado®	Single-use Nasal Spray	8mg/0.1 ml	Rx, community naloxone distribition, harm reduction organizations	High dose compared to other products; may cause severe withdrawal symptoms in people with opioids in their body.
Nalmefene	Opvee	Single-use Nasal Spray	2.7 mg/0.1 ml	Rx, community naloxone distribition, harm reduction organizations	Longer lasting than naloxone, but may cause severe extended withdrawal in people with opioids in their body.

RISK FACTOR AND ASSOCIATED HARM REDUCTION STRATEGY

Overdose Risk Factor	Harm Reduction Strategy to Reduce Risk of Overdose
You experience a recent period of not taking any opioids, such as an emergency department stay, jail, or detox, or you are starting to use opioids again after a period of non-use or administration of an opioid antagonist such as naloxone.	• Never use drugs alone, tell a friend or call 988 to talk about overdose risk with a professional or peer counselor. • Start with the lowest possible amount of drug. • Use or consume drugs slowly and observe their effects. • Test unregulated drugs purchased on the street for fentanyl. • **If you took medications such as methadone or buprenorphine while incarcerated but then stopped, starting to use street drugs upon release increases risk of overdose.**
You are using any kind of drug.	• **Start low and go slow.** Start with a low dose and only increase gradually. • **Do not use alone.** Use with a trusted person who is alert and can respond in the event of overdose or let a trusted person know to check on you. Look up a local "never use alone" hotline. • **Stagger your use.** If you are using with a group, be sure that someone is alert and can respond in the event of overdose. • **Avoid using drugs, including opioids, with alcohol.** Taking opioids in combination with alcohol and/or other depressant medications like benzodiazepines or tranquilizers can greatly increase the risk of overdose. • **Always carry an OORM.** Be familiar with signs of an overdose and be prepared to respond with an OORM. See earlier section on OORM and responding to an overdose. • **Test it.** Using test strips or other drug checking equipment to determine the presence of fentanyl and other drugs can help you decide how to use a drug to reduce risk for overdose. • **Listen to your body.** Overall health can impact overdose risk. Rest, eat, and hydrate [15,16]
You are changing your method of administration of an opioid, altering the opioid by crushing it, or taking opioids differently from how they were prescribed.	• If you obtain unregulated opioids on the street, consider the increased risk of switching between different types and strengths of opioids, and test drugs to know the contents. • Your risk of overdose increases when injecting or smoking opioids as compared to snorting or swallowing them. You can reduce risk by using alternatives to injecting or smoking. • Crushing or otherwise manipulating prescription opioids can make the dose unpredictable, and risk of overdose increases if you snort instead of swallowing a drug.

Overdose Response Dos and Don'ts

STEP 1 – ADMINISTER AN OPIOID OVERDOSE REVERSAL MEDICATION
STEP 2 – SUPPORT THE PERSON'S BREATHING, PLACE THE PERSON IN THE RECOVERY POSITION, AND CALL 911
STEP 3 – WAIT FOR EMS TO ARRIVE

DO attend to the person's breathing and cardiovascular needs by performing rescue breathing and/or chest compressions. Rescue breathing can be lifesaving itself. If you have access to it, administering supplemental oxygen can also be helpful.

DO administer an opioid overdose reversal medication if the person is not breathing. Give an additional dose if there is no response within 2-3 minutes of each dose.

DO put the person in the "recovery position" on their side, if you must leave them unattended for any reason, or if their breathing has returned but they are still not fully awake. In this case, monitor breathing closely.

DO stay with the person and keep the person warm.

DON'T slap or forcefully try to stimulate the person; it will only cause further injury. If you cannot wake the person by shouting or rubbing your knuckles on the sternum (center of the chest or rib cage), the person may be unconscious.

DON'T put the person into a cold bath or shower. This increases the risk of falling, drowning, or going into shock.

DON'T inject the person with any substance (e.g., saltwater, milk, stimulants). The only safe and appropriate treatment is an opioid overdose reversal medication.

DON'T try to make the person vomit drugs that may have been swallowed. Choking or inhaling vomit into the lungs can cause a fatal injury.

Tips for Healthcare Providers

APPENDIX 3: PRACTITIONERS & HEALTH SYSTEMS

Research shows that people at risk of overdose frequently interact with the health system.[35] Whether they are prescribed opioids or obtain them from an illicit source, they may seek medical attention for various needs. Moreover, they may have been treated for a previous nonfatal overdose. Healthcare providers can support people at risk of overdose and are uniquely positioned to significantly impact overdose prevention and response efforts in their community.

IF YOU ARE A MEDICAL PROVIDER:

- Use every interaction with a patient as an opportunity to discuss medication management and substance use, create an open dialogue about opioids and overdose risk, screen for substance use, and offer support.
- Create a practice of open dialogue with patients, encouraging them to share their questions and concerns about opioids. Respond to their questions and concerns using non-judgmental and non-stigmatizing language, sharing factual information, seeking understanding of the patient's goals and experiences, refraining from lecturing or patronizing, and approaching the interaction through a lens of shared decision-making.
- If a patient screens positive for and/or discloses substance use, assess for a potential diagnosis of a SUD and related treatment needs in a nonjudgmental manner. Not all patients are ready for or desire treatment. You can direct patients to local harm reduction programs e.g., syringe service program, offer linkage to treatment that includes MOUD, prescribe buprenorphine, or refer to local support groups (e.g., recovery community organizations).
- Familiarize yourself with addiction developmental theories, risk and protective factors, and the role Adverse Childhood Experiences and trauma play in risk for substance use disorders.
- Understanding the Stages of Change/Transtheoretical Model and Motivational Interviewing (MI) can also help providers engage with patients. MI is a practical technique for patient engagement across many chronic health conditions, including SUD. With awareness of what causes or contributes to substance use and SUDs, providers can challenge their assumptions about a person and treat them with greater compassion, dignity, and respect.
- Practice trauma-informed care and consider the possibility that a patient might feel stress during an appointment. This may prevent them from opening up about their needs.
- Integrate peer recovery specialists into the medical team.

IF YOU ARE A PRESCRIBER OF OPIOIDS:

- Practice proper opioid stewardship by familiarizing yourself with the CDC's latest opioid prescribing guidelines.
- Provide this Toolkit to patients and direct them to where they can learn more about the risks and benefits of opioid use, whether prescribed or obtained illicitly.
- Prescribe an OORM when you prescribe an opioid and encourage patients to have it on hand.
- Seek out education on medications for OUD, such as buprenorphine and methadone.

Federally funded continuing medical education courses are available at no charge at https://pcssnow.org/ and https://attcnetwork.org/.

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Harm Reduction Framework

- First document to comprehensively outline harm reduction and its role within HHS
- Provides a roadmap of best practices, 12 principles, and 6 pillars that anyone can apply to their work.
- Will inform SAMHSA's harm reduction activities moving forward, as well as related policies, programs, and practices

Core Practice Areas

- **Safer Practices:** Education and support describing how to reduce risk; provision of risk reduction supplies and materials
- **Safer Settings:** Access to safe environments to live, find respite, practice safer use, and receive supports that are trauma-informed and stigma-free
- **Safer Access to Healthcare:** Ensuring access to person-centered and non-stigmatizing healthcare that is trauma informed, including FDA-approved medications
- **Safer Transitions to Care:** Connections and access to harm-reduction-Informed and trauma-informed care and services
- **Sustainable Workforce and Field:** Resources for maintaining a skilled, well-supported, and appropriately managed workforce and for sustaining community-based programs
- **Sustainable Infrastructure:** Resources for building and maintaining a revitalized and community-led infrastructure to support harm reduction best practices and the needs of PWUD

Harm reduction activities in SAMHSA grants

- Many SAMHSA grants and programs now allow or require grantees to integrate harm reduction activities into their services.
- These include:
  - Naloxone and other opioid overdose reversal medications
  - Fentanyl and Xylazine test strips
  - Syringe services program supports and services*
  - Overdose prevention and response education
  - Infectious diseases screening and referral
  - Culturally appropriate education activities

**Grants include explicit prohibitions of federal funds to be used to purchase drug paraphernalia.*

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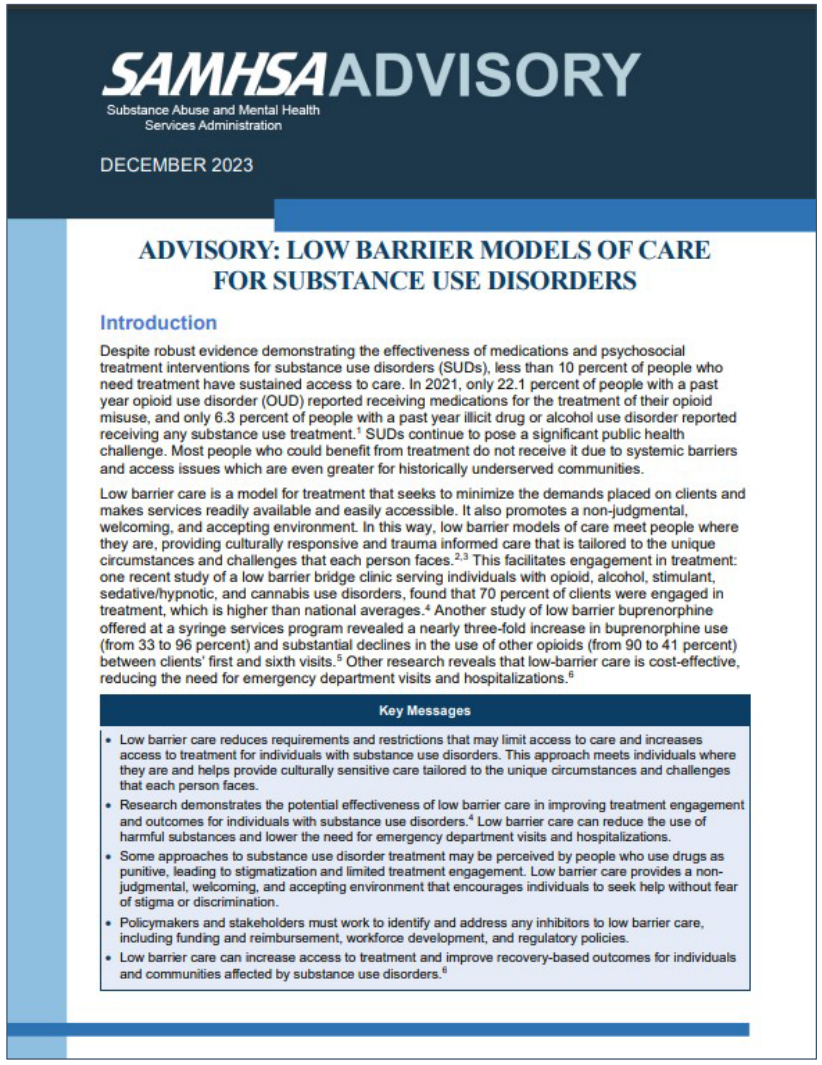
Substance Abuse and Mental Health Services Administration

Making Care Easily Accessible



SAMHSA ADVISORY

Substance Abuse and Mental Health Services Administration

DECEMBER 2023

ADVISORY: LOW BARRIER MODELS OF CARE FOR SUBSTANCE USE DISORDERS

Introduction

Despite robust evidence demonstrating the effectiveness of medications and psychosocial treatment interventions for substance use disorders (SUDs), less than 10 percent of people who need treatment have sustained access to care. In 2021, only 22.1 percent of people with a past year opioid use disorder (OUD) reported receiving medications for the treatment of their opioid misuse, and only 6.3 percent of people with a past year illicit drug or alcohol use disorder reported receiving any substance use treatment.[1] SUDs continue to pose a significant public health challenge. Most people who could benefit from treatment do not receive it due to systemic barriers and access issues which are even greater for historically underserved communities.

Low barrier care is a model for treatment that seeks to minimize the demands placed on clients and makes services readily available and easily accessible. It also promotes a non-judgmental, welcoming, and accepting environment. In this way, low barrier models of care meet people where they are, providing culturally responsive and trauma informed care that is tailored to the unique circumstances and challenges that each person faces.[2,3] This facilitates engagement in treatment: one recent study of a low barrier bridge clinic serving individuals with opioid, alcohol, stimulant, sedative/hypnotic, and cannabis use disorders, found that 70 percent of clients were engaged in treatment, which is higher than national averages.[4] Another study of low barrier buprenorphine offered at a syringe services program revealed a nearly three-fold increase in buprenorphine use (from 33 to 96 percent) and substantial declines in the use of other opioids (from 90 to 41 percent) between clients' first and sixth visits.[5] Other research reveals that low-barrier care is cost-effective, reducing the need for emergency department visits and hospitalizations.[6]

Key Messages

- Low barrier care reduces requirements and restrictions that may limit access to care and increases access to treatment for individuals with substance use disorders. This approach meets individuals where they are and helps provide culturally sensitive care tailored to the unique circumstances and challenges that each person faces.
- Research demonstrates the potential effectiveness of low barrier care in improving treatment engagement and outcomes for individuals with substance use disorders.[4] Low barrier care can reduce the use of harmful substances and lower the need for emergency department visits and hospitalizations.
- Some approaches to substance use disorder treatment may be perceived by people who use drugs as punitive, leading to stigmatization and limited treatment engagement. Low barrier care provides a non-judgmental, welcoming, and accepting environment that encourages individuals to seek help without fear of stigma or discrimination.
- Policymakers and stakeholders must work to identify and address any inhibitors to low barrier care, including funding and reimbursement, workforce development, and regulatory policies.
- Low barrier care can increase access to treatment and improve recovery-based outcomes for individuals and communities affected by substance use disorders.[6]

December 2023, SAMHSA published an advisory: Low Barrier Models of Care for Substance Use Disorder

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A Comprehensive Path Forward to Meet the Moment

- Data-driven and nimble incorporating the changing substance landscape
- Centered in the voices and experiences of community(ies) being served
- Holistic and Comprehensive – Addressing Spectrum of Risk & Protective Factors
  - Individual
  - Relationship
  - Community
  - Societal
- Evidence-based policies, programs and practices as well as integrating practice-based evidence and community-defined evidence
- Evaluating, innovating, and continuing to build the knowledge of what works in communities
- Opportunity to broaden tent of partners

PREVENTION…

- ***Supports healthy social & emotional development***
- ***Strengthens problem solving, conflict, & relationship skills***
- ***Supports parents, caregivers, & strengthens families***
- ***Increases exposure to positive role models & youth empowerment opportunities***
- ***Expands evidence-based strategies across settings and risk populations***
- ***Prevents & addresses ACES & trauma***
- ***Addresses structural & social determinants of health***
- ***Meets individuals and communities where they are***
- ***Embraces the lived & living experiences and voices of communities***
- ***Improves the safety, stability, & livability of community environments***

…SO INDIVDIUALS, FAMILIES & COMMUNITIES ARE HEALTHY AND THRIVING

Thank You!

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

Grant Opportunities
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Partnership for a Drug-Free New Jersey
In Cooperation with the Governor's Council on Substance Use Disorder and the NJ Dept. of Human Services

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UPCOMING WEBINAR

Building Resiliency Among Healthcare Professionals

11 a.m. Thursday, November 14, 2024

Register at KnockOutDay.DrugFreeNJ.org/events

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