



**Local Opioid Overdose
Prevention and Response**
A Primer for Local Health Departments
May 2019

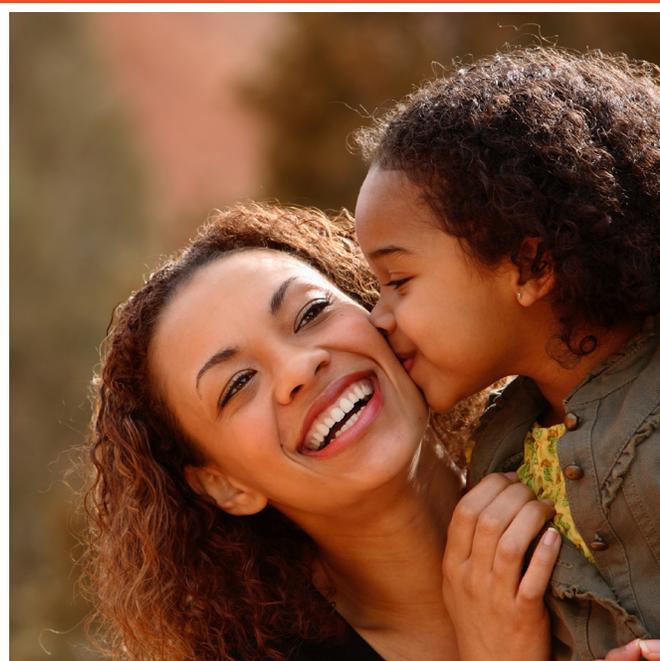
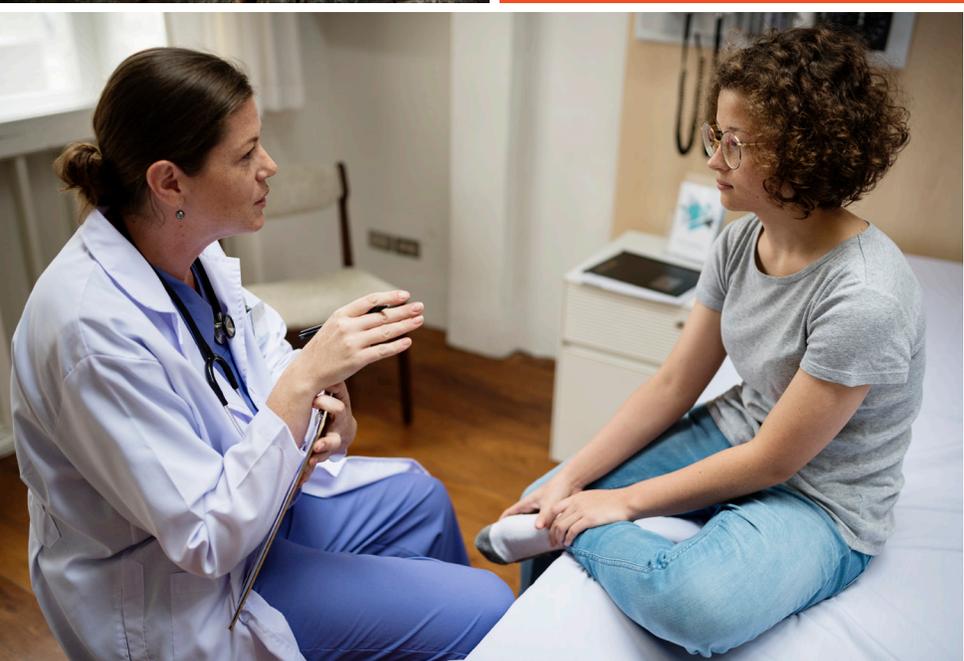


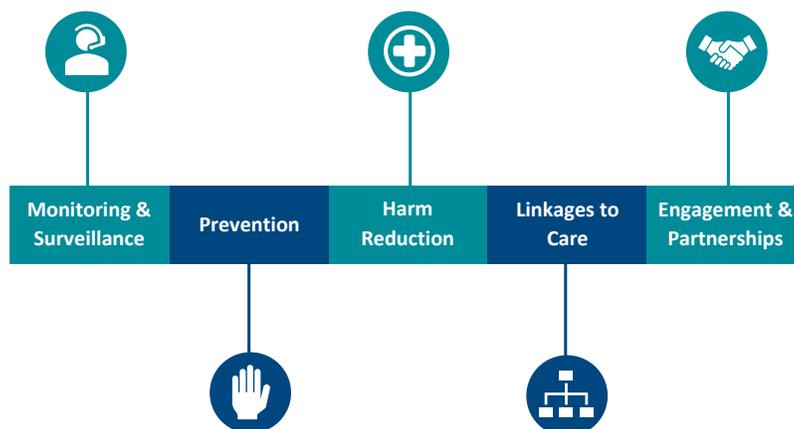
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Purpose

This primer is intended for local health departments (LHDs) and partnering agencies seeking guidance to develop evidence-based responses to the opioid epidemic in their communities. Information provided in this document includes history; background information; law and policies; and sample practices for monitoring and surveillance, prevention, harm reduction, linkages to care, stakeholder engagement, and community partnerships.

Introduction

With opioid use as a leading cause of injury and death, it is undeniable that the United States is experiencing an opioid epidemic. The Centers for Disease Control and Prevention (CDC) reports that an average of 130 Americans die every day from opioid overdoses,¹ as cited in "Understanding the Epidemic." In 2017, drug overdoses led to an estimated 70,200 deaths.² During that year, opioids were specifically involved in over two-thirds of these deaths.³ The opioid epidemic has also contributed to increases in non-fatal overdoses and emergency room visits, widespread outbreaks of infectious diseases linked to intravenous drug use, and the increasing financial burden.^{4,5,6} As impacts of the opioid epidemic continue to mount, we have to wonder: How did we get here?

Historical Opioid Use

In the late 1800s, morphine, which is a natural opiate that provides pain relief, became popular as a cure for pain management.⁷ Its use was particularly common among Civil War veterans seeking treatment for their injuries, and it was also used as a cure

for alcohol and opium addiction.⁸ By the early 1900s, heroin, another natural opiate, became commercially available and was quickly hailed as a “wonder drug,” widely available for use as a pain reliever and a cough suppressant.⁹ At a time when pain relief options were very limited, heroin provided a new and convenient option for many Americans.

The 1970s, 1980s, and 1990s

By the 1970s, the medical community recognized the highly addictive nature of opioids, and heroin addiction had become a full-blown epidemic.¹⁰ However, this did not slow the development of new semi-synthetic opioid medications for pain relief, such as Percocet and Vicodin.¹¹ Pharmaceutical companies and researchers debated the nature of opioid addiction, but a growing priority on pain relief for American patients dominated conversations, and prescription opioid use for pain relief continued.¹²

In the early 1990s, Purdue Pharma began marketing yet another prescription opioid, known commercially as OxyContin. They made what would ultimately be considered brazen claims about the product’s extended-release formula, which they claimed improved its ability to provide longer-lasting pain relief, while also lowering its abuse and addiction potential.¹³ Towards the end of the decade, other pharmaceutical companies joined this narrative, assuring the medical community that patients would not become addicted to prescription opioids.^{14,15} The spread of this misinformation, coupled with a continual emphasis in the medical community on the necessity of alleviating patients’ pain, set the stage for the continued expansion of opioid misuse.¹⁶

1999 and Beyond

Overdose deaths involving prescription opioids have increased almost six times since 1999, and prescribing rates for opioids remain inconsistent and high across the United States.¹⁷ In 2013, providers wrote nearly a quarter of a billion opioid prescriptions, enough for every American adult to have their own bottle of prescription opioid pills.¹⁸ Rates of prescription painkiller misuse and overdose death are highest among persons aged 25 to 54 years, non-Hispanic white and living in a rural area.¹⁹ Although men are more likely to die from a prescription opioid overdose, death rates among women have increased more than 400% since 1999.²⁰

In addition to prescription opioids, a recent contributing factor in the increase in opioid overdose deaths since 2010 is heroin and its synthetic analogues. Heroin-related deaths have more than quadrupled since 2010, and death rates from synthetic opioid overdoses, including fentanyl and its analogues, increased more than 70% from 2014 to 2015, and have continued to climb ever since.²¹ With a continued supply of illicitly manufactured fentanyl in the domestic drug supply, opioid overdoses and deaths continue to rise across the country. Nearly nine in ten people who need treatment for substance use disorder are not receiving it, and the costs of the epidemic continue to increase, along with its impacts on infectious disease prevalence, life expectancy, and workforce recruitment and retention.²²



The Local Perspective

The National Association of County and City Health Officials (NACCHO) recognizes prescription and illicit opioid misuse as a national emergency and a significant public health threat. LHDs play a critical role in responding to our nation's opioid epidemic, and NACCHO supports their efforts to implement evidence-based policies and programs to prevent and treat opioid use disorder (OUD), a problematic pattern of opioid use that causes significant impairment or distress,²³ and its related health consequences. Local strategies include improved surveillance and monitoring, increased prevention and education, promotion of appropriate opioid prescribing practices, and improvement and expansion of treatment and recovery services for opioid misuse and OUD.

Since fall 2017, NACCHO has been working with the CDC's National Center for Injury Prevention and Control to support LHDs developing local prevention and response strategies to opioid overdoses as part of a pilot project. While the pilot sites'²⁴ efforts are ongoing, examples from their broad range of response strategies are included throughout this document.

Background on Opioids

What exactly are opioids? Simply put, they are a class of drugs, either natural or artificial, that act on specific receptors in the brain and are typically used for pain relief.²⁵ Natural opioids, derived from opium poppies, can be traced back to opium in 3400 BCE, and include common substances including codeine, morphine, and heroin.^{26,27} Semi-synthetic and synthetic opioids include prescription opioids, such as hydrocodone and oxycodone, as well as illicit opioids like fentanyl.²⁸

Natural Opioids	Semi-Synthetic Opioids	Synthetic Opioids
Opium	Oxycodone	Methadone
Morphine	Hydrocodone	Fentanyl
Codeine	Methadone	Carfentanil
Heroin		

Opioid Use and the Law

Legislation is a key tool in addressing opioid use, as it can shape behaviors, the environment in which drug use occurs, and the unintended consequences of opioid use, such as infectious disease transmission. Implementing drug use laws can lead to both positive and negative structural or environmental changes that shape the health and wellbeing of people who use drugs. LHDs engage with policymakers at the state and federal level, serving as essential resources, and participate in local policy development to effect and enforce public health ordinance and regulation. In its 2016 National Profile of Local Health Departments, NACCHO found that more than one-fifth (22%) of all LHDs were involved in policies to increase use of medications to prevent opioid overdose, such as naloxone.²⁹

How does legislation have varying levels of impact?

Direct Impact	Indirect Impact	Normative Impact
Shapes access to resources or provides a legal basis for public health prevention programs.	Shapes the behaviors of people who use drugs.	Has an impact on the environment and the societal response to drug use.
		
How? A law can give legal access to syringes or restrict funding for a syringe service program.	How? A law that leads to incarceration for drug use can drive riskier drug use behaviors that increase disease transmission among people who use drugs.	How? A law that criminalizes certain behaviors creates stigma of those behaviors, which can marginalize populations and lead to further discrimination.



Many states still lack sufficient legislation to address the opioid epidemic, have legislation at risk for repeal, or are awaiting passage of any legislation at all.^{30,31} Many existing laws struggle with implementation, reflecting the reality that laws “on the books” can vary drastically from laws “on the street.” Creating realistic, actionable laws is vital for improving the risk environment for people who use drugs.³²

For opioids, implementing formal legislation often falls upon law enforcement, which can have both a positive and negative impact on drug use environments. Law enforcement can support and facilitate harm reduction, but also have the potential to increase risk behavior and risk for infectious disease transmission through punitive encounters with people who use drugs or interference with public health services for these populations. Changes in institutional policies – along with comprehensive police trainings using the public health model of drug use and harm reduction – have been shown to increase positive impacts of law enforcement on people who use drugs and to lower the risk environment for consequences of drug use.³³

Public health can succeed if legislation shifts its focus towards effective implementation, such as the use of drug diversion and rehabilitation programs, to ensure that legislation enables, instead of hinders, the improvement of opioid-related health outcomes.

Opioid Legislative Timeline

FEDERAL LEGISLATION

1970: The Controlled Substances Act regulates the manufacture and distribution of narcotics, stimulants, depressants, hallucinogens, anabolic steroids, and chemicals.³⁴

2000: The Drug Addiction Treatment Act (DATA) allows physicians to prescribe/dispense opioid dependency medication.³⁵

2008: Mental Health Parity and Addiction Equity Act requires large employers (50+) to offer health insurance coverage for substance use treatment benefits that is similar to coverage for physical health conditions.³⁶

2010: The Affordable Care Act allows for **Medicaid expansion** to cover mental health and substance-abuse treatment, specifically OUD treatment.³⁷

Consolidated Appropriations Act lifts **federal funding ban for syringe service programs**, however, federal funds cannot be used to purchase needles.³⁸

Comprehensive Addiction and Recovery Act (CARA) amends the Controlled Substances Act of 1970, expands buprenorphine prescription authority to Nurse Practitioners and Physician Assistants, and includes legislation for opioid prevention, treatment, recovery, law enforcement, criminal justice reform, and overdose reversal.³⁹

21st Century Cures Act accelerates and promotes medical product development and innovation and includes \$1 billion in opioid grant programming via SAMHSA.^{40, 41}

Federal Public Health Emergency declared for the opioid crisis and its consequences.⁴²

Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act signed into law including provisions for treatment, prevention, recovery, and enforcement.⁴³

STATE LEGISLATION

1998: Kentucky HB 115 creates the Kentucky All-Schedules Prescription Electronic Reporting (KASPER) system, the “gold standard” of **prescription drug monitoring programs (PDMP)**. There is no current federal legislation or standardization for PDMPs.⁴⁵

2004: Kentucky SB 14 expands ability to share PDMP data with other organizations including law enforcement and Medicaid.⁴⁴

2010: West Virginia SB 81 creates the **Official Prescription Program Act**, requiring use of official tamper-proof prescription pads.⁴⁶

2011: Ohio’s Governor issues Executive Order authorizing expansion of **Medication-Assisted Treatment (MAT)**.⁴⁷

2014: Massachusetts is the first state to issue a **public health emergency declaration** after 140 overdose deaths in four months.⁴⁸

Kentucky’s **Landmark Anti-Heroin Bill** creates harsher drug trafficking penalties, funding for addiction treatment services, overdose reversal kits for first responders, etc.⁴⁹

New Hampshire **Good Samaritan Law**, HB 270, grants immunity to people requesting medical assistance to save the life of an overdose victim.⁵⁰

New Hampshire SB 234 authorizes creation of **Syringe Service Programs (SSP)** across the state.⁵¹

Kentucky HB 333 **ACT Relating to Controlled Substances** limits the prescription of Schedule II controlled substances to 72-hours.⁵²

Ohio ruling **limits opioid prescriptions** for acute pain to seven days for adults and five days for minors.⁵³

West Virginia passes comprehensive **Opioid Reduction Act** to limit opioid prescribing practices with specific exemptions; amend licensing for chronic pain clinics and MAT programs, etc.⁵⁴

Monitoring and Surveillance

Monitoring and surveillance are important components to improve an LHD's understanding of the impacts of the opioid epidemic at the community level for public health investigation and response. LHDs can expand their capacity for identifying fatal and non-fatal overdoses, illicit drug use, opioid prescribing rates, and unintended consequences of the opioid epidemic, such as neonatal abstinence syndrome (NAS) or infectious disease transmission. Improving surveillance and monitoring of opioid-related indicators can be accomplished by increasing coordination of data collection and sharing across multiple sectors, promoting use of a state prescription drug monitoring program (PDMP) to track opioids prescriptions, or connecting with local stakeholders, like law enforcement or emergency personnel. Data sources can include but are not limited to emergency department visits, EMS call records, vital statistics, naloxone distribution and use, High Intensity Drug Trafficking Area's (HIDTA) [Overdose Detection Mapping Application Program](#), including national and state level sources.

What is naloxone, and why do we need to track its distribution and use?

Naloxone, also known under the brand name Narcan, is an opioid antagonist that is used to completely or partially reverse an opioid overdose. By binding to opioid receptors in the brain, it blocks the effects of opioids and can restore normal breathing to someone experiencing respiratory depression (slowed or stopped breathing). Tracking naloxone helps us to see where non-fatal overdoses are occurring, and who is responding to an overdose, which can help inform understanding of where resources should be allocated.





**Drug Monitoring Initiative
and Local Surveillance
Methods
Manchester, New Hampshire**

**Public Dashboard for
Accidental Overdose Death
Totals
Montgomery County, Ohio**

The state of New Hampshire tracks drug overdoses, EMS naloxone administrations, opioid-related emergency department visits, and treatment admissions through a monthly report that provides statewide situational awareness. The City of Manchester also releases reports through coordinated efforts across fire departments, EMS services, and the health department, which track overdoses by time of occurrence, basic demographic data, and resources used (naloxone, ambulance hours). It also includes statistics on their nationally recognized [Safe Station initiative](#) for access to care. Although these reports require daily communication and weekly meetings to cross-check data, they help develop stronger situational awareness and cooperation among services in the city that serve people using opioids.

At Public Health – Dayton & Montgomery County (PHDMC) the epidemiologists work in collaboration with area hospitals and the county coroner’s office to gather data about accidental overdose deaths for its public dashboard. Compiled into easily understandable charts and tables to demonstrate location, timing, and year-to-year trends, the data is displayed prominently on Public Health’s website: <https://www.phdmc.org/coat/158-accidental-overdose-death-totals>. In addition, Public Health also coordinates further data collection with local law enforcement and first responders. By conducting surveillance and monitoring, Public Health is better able to identify local needs, as well as provide the public with accountable and up-to-date information.

Prevention

Prevention activities aim to avert a health condition through interventions prior to the condition (primary), during early onset (secondary), and post-diagnosis (tertiary). In the context of the opioid epidemic, prevention efforts aim to delay or stop the onset of opioid use, misuse, overdose, or opioid use disorder.

LHDs can expand and promote education for providers, partners, and the public about opioid use and misuse to reduce stigma and improve access to services for prevention, treatment, and recovery. Partners and the public can be taught to recognize and respond to signs of an overdose, become more aware of the dangers of opioid misuse and addiction, and gain skills to properly store and dispose of prescription opioids. Providers should be provided with up-to-date prescribing guidelines and be encouraged to leverage relationships with patients to spread information and prevent future opioid misuse and addiction.



Academic Detailing:
Bell County, Kentucky
Boone County, West Virginia
Manchester, New Hampshire

Academic detailing is an outreach education technique that emphasizes a one-on-one interaction to provide clinicians with the knowledge and resources to provide evidence-based care to their patients. In partnership with NACCHO, the National Resource Center for Academic Detailing (NaRCAD) trained local detailers on the academic detailing technique, including how to conduct visits, follow up with appropriate resources, and adapt their content to each clinician's needs or interests. Trainings were held at pilot sites experiencing a heavy opioid overdose burden with the aim of improving clinician education, awareness, and confidence around the opioid epidemic. Key messages for detailers varied by location and included the following topics adapted from CDC prescriber recommendations: using non-opioid treatments for chronic pain, reviewing PDMPs before prescribing opioids, offering treatment for OUD, starting with low doses and increasing slowly, and avoiding concurrent prescribing.

Community Awareness and Education Campaign
Bell County, Kentucky

In Bell County (KY), a large barrier to improving opioid overdose outcomes is community stigma and misunderstanding of opioid misuse and treatment. The Bell County Health Department is adapting the [Rx Awareness](#) campaign to address stigma, clarify misconceptions, and provide information and resources to residents seeking care for themselves, a family member, or a friend. The campaign will be widely disseminated throughout the county via print materials, radio spots, and in-person events.

What is a PDMP, and how can it help prevent Opioid Use Disorder (OUD)?

A Prescription Drug Monitoring Program (PDMP) is a system that tracks prescribing and dispensing of certain substances. By tracking the type, frequency, and location of an individual's prescriptions, PDMPs can identify suspicious or inappropriate behavior and help flag individuals who may be intentionally or unintentionally receiving an inappropriate dosage or frequency of prescription opioids. PDMPs also provide useful information about a prescriber's habits, which can be used to identify inappropriate prescribing practices or help a provider understand more about their habits around opioid prescribing.

Harm Reduction

Harm reduction refers to strategies that reduce the negative consequences of a health risk behavior, such as opioid use. Acknowledging that a behavior will occur, harm reduction aims to mitigate the physical, mental, and other consequences of the health risk behavior, such as opioid misuse or injection drug use.

LHDs can act as the front-line response and improve outcomes for people who use opioids or have OUD by providing services and resources to reduce the harms associated with opioid misuse. Examples of these services include providing training on and distributing opioid reversal drugs like naloxone, advocating for legislation or guidelines to lower barriers to reporting and responding to overdoses, and declaring public health emergencies to increase funding and local awareness. Additionally, harm reduction services such as syringe exchange, infectious disease testing, and drug testing can lower unintended consequences of opioid use.



Naloxone Training Boone County, West Virginia

With the high burden of fatal and non-fatal opioid overdoses in its jurisdiction, the Boone County Health Department prioritized expanding its naloxone initiative to get more of the overdose-reversal drug into the hands of law enforcement and the public. The health department hosts trainings to teach about signs of overdose, how to respond, and how to accurately use naloxone. Participants include interested community members, friends and family of people who use opioids, and local law enforcement officials. Trainings end with the distribution of naloxone so that more residents of Boone County will be equipped to save a life.

Why are we concerned about infectious diseases in the opioid epidemic?

Some infectious diseases, such as HIV and Hepatitis C (HCV), can be spread by contact with bodily fluids. When people who inject drugs share equipment, like needles or syringes, they raise the likelihood of transmitting or acquiring an infectious disease through this type of drug use. Reports have demonstrated that many areas where people inject drugs are at high risk for infectious disease outbreaks related to drug use.^{55,56} With the rise in heroin use, the opioid epidemic has contributed to a rise in injection drug use, and infectious disease outbreaks occurring among people who inject drugs are considered an unintended, but deadly and costly, consequence of the opioid epidemic.



Syringe Service Program Bell County, Kentucky

Due to growing community consequences and health system burdens of opioid use in their communities, the health department in Bell County (KY) worked to establish the foundations for a syringe service program (SSPs) within its jurisdiction. The Public Health Director demonstrated the county's lack of available treatment services for substance use disorder and increasing health consequences for the community's injection drug use population in order to gain approval from Bell County's Board of Health as a first step in developing the country's first SSP.

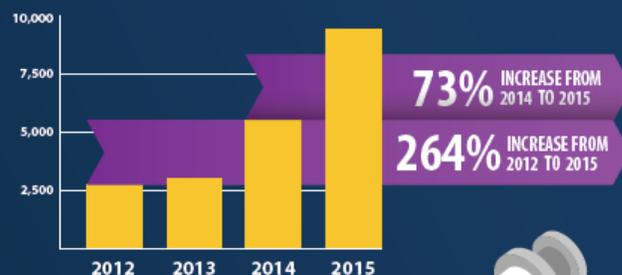


FENTANYL: Overdoses On The Rise

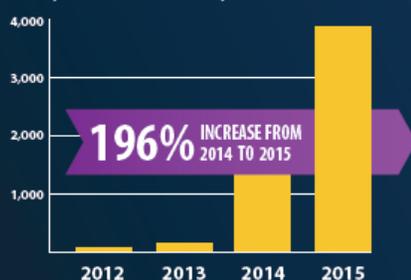
Fentanyl is a synthetic opioid approved for treating severe pain, such as advanced cancer pain. Illicitly manufactured fentanyl is the main driver of recent increases in synthetic opioid deaths.



SYNTHETIC OPIOID DEATHS ACROSS THE U.S.

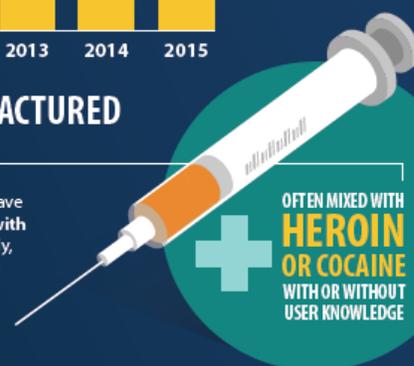


Ohio Drug Submissions Testing Positive for Illicitly Manufactured Fentanyl



ILLICITLY MANUFACTURED FENTANYL

Although prescription rates have fallen, overdoses associated with fentanyl have risen dramatically, contributing to a sharp spike in synthetic opioid deaths.



Prescription Behavior Surveillance System (PBSS) Issue Brief. CDC National Center for Injury Prevention and Control. July 2017. <https://www.cdc.gov/drugoverdose/pdf/pbss/PBSS-Report-072017.pdf>

What is fentanyl, and how does it differ from heroin?

Heroin and fentanyl are both opioids, a class of drugs typically used for pain relief that act on opioid receptors in the brain. Heroin is a natural opiate, whereas fentanyl is synthetic, meaning it is manufactured by chemical synthesis to produce the same effect. Fentanyl is considered to be about 50 to 100 times more powerful than heroin, causing similar effects with smaller doses. Since fentanyl can more rapidly depress breathing than heroin, it has been identified as the major force behind recent increases in overdose deaths, especially in the Northeast and Appalachian regions. Fentanyl can also be modified chemically to create analogues, compounds that produce similar effects despite slightly altered chemical structures. One analogue, carfentanil, is estimated to be 100 times more potent than fentanyl and has become commercially available as an illicit opioid.

Linkages to Care

Linkages to care improve access to and availability of services for people seeking care. For an individual with opioid use disorder, linkages to care can improve the timeliness, appropriateness, and quality of their care. Within communities, better linkages lead to increased collaboration, communication, and effectiveness across agencies, treatment providers, and recovery support services.

LHDs are well positioned to facilitate linkages to care for people who experience an overdose or choose to seek treatment for OUD. Increasing availability of and access to effective treatment, along with increasing capacity of and access to various recovery support services, can improve outcomes for seeking treatment and care. For example, medication-assisted treatment (MAT) is a comprehensive way to address the needs of individuals through the combined use of medication and behavioral therapies.⁵⁷

What does MAT stand for, and why is it used to treat OUD?

Medication-assisted treatment (MAT) is the use of a medication (methadone, buprenorphine, or naltrexone) for OUD in conjunction with counseling and behavioral therapies, such as cognitive-behavioral therapy or motivational interviewing.⁵⁸ It addresses the seeking and use of opioid drugs by reducing the negative effects of withdrawal and cravings for opioids, which also leads to other positive outcomes. People treated with MAT have shown reduced criminal behavior, greater reception to effective behavioral treatments, increased likelihood of remaining in treatment, and lower likelihood of experiencing a fatal overdose.

Medication-Assisted Treatment (MAT)			
Medication	Methadone	Buprenorphine	Naltrexone
Brand Name	Methadone	Suboxone	Vivitrol
Mechanism of Action*	Opioid agonist	Partial opioid agonist	Opioid antagonist
Typical Dosing	Oral (daily)	Sublingual (daily), injectable (monthly)	Pill (daily), injectable (monthly)
Dispensing Location	Clinic-based	Office-based	Office-based
Considerations	Does not require withdrawal for induction but must be dispensed at a methadone clinic and has some potential for abuse/diversion.	Does not require withdrawal for induction and can be dispensed at a doctor's office, but prescriber must obtain a specific waiver to prescribe.	No potential for abuse/diversion but requires withdrawal prior to induction and does not maintain opioid tolerance, which can result in increased risk for overdose.
*Opioid agonists work by binding to opioid receptors to eliminate withdrawal symptoms and relieve drug cravings. Opioid antagonists work by blocking the activation of opioid receptors to treat OUD by preventing any opioid from producing euphoric effects. ⁵⁹			

Engaging people with lived experience to connect those who have overdosed into treatment can strengthen a local recovery community and improve support for healthcare providers to better connect people with appropriate and accessible services. While linkages can be made from an outpatient setting (i.e., at home following a non-fatal overdose) and hospital setting (i.e., at an emergency department), it is important to assess the barriers to treatment for people with OUD.



**Safe Station for People Seeking Treatment
Manchester, New Hampshire**

When a firefighter in Manchester found nowhere to turn for a friend who was seeking OUD treatment, he worked with the Manchester Fire Department Chief to design and open a Safe Station, an innovative idea that has become a nationally recognized model. Safe Station designates all fire stations within the city as 24/7 access points for individuals seeking assistance or looking for treatment for OUD or other substance use disorders. Individuals arrive at a station and are greeted by a firefighter, who determines whether they need direct medical attention or can be transported to a local treatment facility for further assessment. At this treatment facility, participants are matched with appropriate services for their individual needs. Since opening in May 2016, Manchester's Safe Station has served thousands of people and is proud to provide a link to care for every person who walks through its doors. The Safe Station Program continues to expand and demonstrate positive outcomes and has already been successfully adopted by another nearby city in New Hampshire.

Stakeholder Engagement and Community Partnerships

LHDs are vital to prevention and response efforts because they are neutral conveners of crosscutting community partners, and they can highlight the benefit of collaboration at the local level to address this multifaceted epidemic. By bringing together partners from various sectors, LHDs can leverage resources and knowledge, spur innovation, and build and maintain support for local activities, interventions, and services.

How can LHDs engage stakeholders to build and maintain partnerships?

LHDs can engage stakeholders by inviting them to be a part of the process to conceptualize, create, implement, and evaluate their local response. One method is to bring diverse stakeholders together to develop a Community Action Plan, which lists an LHDs' priorities, goals, activities and resources, and intended outcomes. To maintain partnerships, LHDs must actively keep stakeholders informed and aware of new activities, ongoing evaluation, and changes in priorities or goals.



Saving Bell Task Force Bell County, Kentucky

Located in a rural jurisdiction, the Bell County Health Department has faced longstanding challenges with developing and maintaining partnerships among stakeholders passionate about combatting the local opioid epidemic. Led by Director Teresa Hunter, the health department took the lead in convening partners to identify strategies to reduce fatal and non-fatal overdoses in their county. The county-wide meetings invite partners to the discussion table and sustain momentum to develop an impactful and highly committed task force with a shared vision. Within months, the task force, Saving Bell, prioritized the need to educate and destigmatize their community and provided valuable insight on the strengths and gaps in the county's resources and response, including supporting the health department's proposal to explore harm reduction services.

Boone County Stop Watch Boone County, West Virginia

Boone County residents wanted a productive way to respond to the opioid epidemic within their community. The Boone County Stop Watch, a group that meets monthly to discuss community issues, is addressing the impact of substance use and its devastating effects on their county. To work more closely with its county's residents, the Boone County Health Department formed a partnership with Stop Watch and has used the personal and passionate stories of the group's members to guide its activities and programmatic priorities. Over time, the group has grown in numbers and in impact, and has become a dominant force within the county.

Community Overdose Action Team (COAT) Montgomery County, Dayton, Ohio

Coordinated by Public Health – Dayton & Montgomery County and Montgomery County's Alcohol, Drug Addiction and Mental Health Services (ADAMHS), the Community Overdose Action Team (COAT) is a collective impact model that aims to work collaboratively across agencies to reduce the number of people dying from drug overdoses. Using an Incident Command System (ICS) structure, the COAT is led by a Backbone Committee that oversees eight goal-oriented branches. With its comprehensive management system, the COAT delivers numerous services and brings together community agencies and citizens to participate in its many branches. It also provides accountability to the county's residents by publishing notes and reports and has helped to coordinate wide-ranging and impactful programs throughout the county.

What stakeholders should LHDs engage to build a local response?

There is no “official list” for stakeholders that LHDs can engage in building a response to the opioid epidemic. Stakeholders can be drawn from a wide set of industries, interests, and experiences. Common stakeholders are listed below, but LHDs should engage anyone who has resources, interest, or involvement with the epidemic:

- State and neighboring health departments
- First responders
- Law enforcement
- Healthcare systems/hospitals
- Addiction specialists and treatment providers
- Behavioral health services
- Judicial system
- Social services
- People with lived experience and recovery communities
- Community-based and faith-based organizations
- Education system
- Epidemiologists
- Federal partners
- Harm reduction coalitions
- Government and local leaders
- Families and friends of people who use opioids





Naloxone is a drug that can reverse the effects of opioid overdose and can be life-saving if administered in time.



Medication-assisted treatment (MAT) for opioid use disorder (OUD) can aid in preventing repeat overdoses. MAT combines the use of medication (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.

- Offer naloxone and training to patient's family and friends, in case the patient has another overdose.
- Connect patients with hospital case managers or peer navigators to link them to follow-up treatment and services.
- Plan for the increasing number of patients with opioid-related conditions, including overdose, injection-related concerns, and withdrawal.

Local Emergency Department



First Responders | Public Safety | Law Enforcement Officers



- Get adequate supply and training for naloxone administration.
- Identify changes in illicit drug supply and work with state and local health departments to respond effectively.
- Collaborate with public health departments and health systems to enhance linkage to treatment and services.

Mental Health and Substance Abuse Treatment Providers



- Increase treatment services, including MAT for OUD.
- Increase and coordinate mental health services for conditions that often occur with OUD.

Coordinated, informed efforts can better prevent opioid overdoses and deaths

Community Members



- Connect with organizations in the community that provide public health services, treatment, counseling, and naloxone distribution.

Community-Based Organizations



- Assist in mobilizing a community response to those most at risk.
- Provide resources to reduce harms that can occur when injecting drugs, including ones that offer screening for HIV and hepatitis B and C, in combination with referral to treatment and naloxone provision.

Local Health Departments



- Alert the community to the rapid increase in opioid overdoses seen in emergency departments and inform strategic plans and timely responses.
- Ensure an adequate naloxone supply.
- Increase availability and access to necessary services.
- Coordinate with key community groups to detect and respond to any changes in illicit drug use.

SOURCE: CDC Vital Signs, March 2018.

Opioid Overdoses Treated in Emergency Departments webpage. CDC National Center for Injury Prevention and Control. March 2018. <https://www.cdc.gov/vitalsigns/opioid-overdoses/infographic.html>

Resources

For questions or to suggest resources, contact opioidepidemic@naccho.org

NACCHO Resources

- NACCHO Opioid Epidemic Webpage
<https://www.naccho.org/programs/community-health/injury-and-violence/opioid-epidemic>
- Opioid Epidemic Toolkit for Local Health Departments
<https://www.naccho.org/programs/community-health/injury-and-violence/opioid-epidemic/local-health-departments-and-the-opioid-epidemic-a-toolkit>
- Opioid Project One-pager
<https://www.naccho.org/uploads/downloadable-resources/Opioid-Project-One-Pager-Year-2-V5.pdf>
- Opioid Crisis by the Numbers: A Case for Prevention
<https://www.naccho.org/uploads/downloadable-resources/Opioid-Infographic-4-17-2018.pdf>
- Mobilizing for Action through Planning and Partnerships (MAPP) Resources
 - Organizing and Engaging Partners
<https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp/phase-1-organize-for-success-partnership-development>
 - Developing Goals, Strategies, and an Action Plan
<https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp/phase-5-formulate-goals-strategies>

External Resources

- CDC Opioid Overdose Webpage
<https://www.cdc.gov/drugoverdose/index.html>
- SAMHSA Opioids Webpage
<https://www.samhsa.gov/atod/opioids>
- Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States
<https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf>
- National Organization of State Offices of Rural Health: Rural Opioid Epidemic Resources
<https://nosorh.org/rural-opioid-resources/>
- HHS Opioids Webpage
<https://www.hhs.gov/opioids/>

Footnotes

- ¹ Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2017. Available at <http://wonder.cdc.gov>.
- ² Ibid.
- ³ Ibid.
- ⁴ Substance Abuse and Mental Health Services Administration. (2013). The DAWN report: Highlights of the 2011 Drug Abuse Warning Network (DAWN) findings on drug-related emergency department visits. Available at <http://www.samhsa.gov/data/2k13/dawn127/sr127-dawn-highlights.htm>
- ⁵ Centers for Disease Control and Prevention. (2017). Increase in hepatitis C infections linked to worsening opioid crisis. Available at <https://www.cdc.gov/nchhstp/newsroom/2017/hepatitis-c-and-opioid-injection-pressrelease.html>
- ⁶ Frank, R. G. (2017). Ending Medicaid expansion will leave people struggling with addiction without care. The Hill. Available at <http://thehill.com/blogs/pundits-blog/healthcare/338579-endingmedicaid-expansion-will-leave-people-struggling-with>
- ⁷ Foundations Recovery Network. (2019). History of the Opioid Epidemic. Available at <https://www.dualdiagnosis.org/infographics/history-of-the-opioid-epidemic/>
- ⁸ Ibid.
- ⁹ United Nations Office on Drugs and Crime. (1953). History of Heroin. Available at https://www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1953-01-01_2_page004.html
- ¹⁰ Foundations Recovery Network. (2019). History of the Opioid Epidemic. Available at <https://www.dualdiagnosis.org/infographics/history-of-the-opioid-epidemic/>
- ¹¹ Meier, Barry. 2018. Origins of an Epidemic: Purdue Pharma Knew Its Opioids Were Widely Abused. The New York Times. Available at <https://www.nytimes.com/2018/05/29/health/purdue-opioids-oxycontin.html>.
- ¹² Ibid.
- ¹³ Ibid.
- ¹⁴ Morone, N. E. & Weiner, D. K. (2013). Pain as the 5th vital sign: Exposing the vital need for pain education. *Clinical Therapeutics*, 35(11), 1728-32. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3888154/>
- ¹⁵ Van Zee, A. (2009). The promotion and marketing of OxyContin: Commercial triumph, public health tragedy. *American Journal of Public Health*, 99(2), 221-7). Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2622774/>
- ¹⁶ Ibid.
- ¹⁷ Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2017. Available at <http://wonder.cdc.gov>.
- ¹⁸ Centers for Disease Control and Prevention. (2014). Opioid painkiller prescribing: where you live makes a difference webpage. Available at <https://www.cdc.gov/vitalsigns/opioid-prescribing>
- ¹⁹ Centers for Disease Control and Prevention. (2012). CDC Grand rounds: Prescription drug overdoses – a U.S. epidemic. *Morbidity and Mortality Weekly Report*, 61(01). Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a3.htm>
- ²⁰ Centers for Disease Control and Prevention. (2013). Prescription painkiller overdoses: A growing epidemic, especially among women webpage. Available at <http://www.cdc.gov/vitalsigns/prescriptionpainkilleroverdoses/>
- ²¹ Rudd, R. A., Seth, P., David, F., & Scholl, L. (2016). Increases in drug and opioid-involved overdose deaths – United States, 2010-2015. *Morbidity and Mortality Weekly Report*, 65, 1445-52. Available at <https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm>
- ²² Trust for America’s Health. (2013). Prescription drug abuse: Strategies to stop the epidemic. Retrieved January 8, 2018, from <http://healthyamericans.org/assets/files/TFAH2013RxDrugAbuseRptFINAL.pdf>

- ²³ Prevent Opioid Use Disorder. Atlanta, GA: CDC, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention; 2017. Available at <https://www.cdc.gov/drugoverdose/prevention/opioid-use-disorder.html>.
- ²⁴ 2017 NACCHO CDC Local Opioid Overdose Prevention and Response Pilot Sites: Bell County, Kentucky; Boone County, West Virginia; Dayton, Ohio; and, Manchester, New Hampshire.
- ²⁵ National Institute on Drug Abuse. (2018). Prescription opioids. Available at <https://www.drugabuse.gov/publications/drugfacts/prescription-opioids>
- ²⁶ Duarte, D. F. (2005). Opium and opioids: a brief history. National Center for Biotechnology Information. Available at <https://www.ncbi.nlm.nih.gov/pubmed/19471817>
- ²⁷ National Institute on Drug Abuse. (2018). Prescription opioids. Available at <https://www.drugabuse.gov/publications/drugfacts/prescription-opioids>
- ²⁸ Ibid.
- ²⁹ 2016 National Profile of Local Health Departments. (2016). National Association of County and City Health Officials. Available at http://nacchoprofilestudy.org/wp-content/uploads/2017/10/ProfileReport_Aug2017_final.pdf
- ³⁰ . Shopov, V. L. (2017). State-by-state breakdown of opioid regulations. AthenaInsight. Available at <https://www.athenahealth.com/insight/infographic-opioid-regulations-state-by-state>
- ³¹ Beletsky, L. (2018). Use of the law as a tool to address the consequences of infectious disease and addiction. National Academies of Science, Engineering, and Medicine. Available at <https://www.tamhsc.edu/community/opioid-task-force/documents/opioids-and-id.pdf>
- ³² Ibid.
- ³³ Ibid.
- ³⁴ Controlled Substance Law: Controlled Substances Act (CSA). (2019). HG.org. Available at <https://www.hg.org/control.html>.
- ³⁵ H.R.2634 – Drug Addiction Treatment Act of 2000. (2000). Congress.gov. Available at <https://www.congress.gov/bill/106th-congress/house-bill/2634>.
- ³⁶ Pathway to full Parity. US Department of Labor Secretary R. Alexander Acosta. Report to Congress. Available at <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-2018-pathway-to-full-parity.pdf>.
- ³⁷ Broaddus, M. Bailey, P. Aron-Dine, A. Medicaid Expansion Dramatically Increased Coverage for People with Opioid-Use Disorders Latest Data Show. Center on Budget and Policy Priorities. Available at <https://www.cbpp.org/research/health/medicaid-expansion-dramatically-increased-coverage-for-people-with-opioid-use>.
- ³⁸ About Syringe Services Programs. Rural Syringe Services Programs. (2019). Harm Reduction Coalition. Available at <https://harmreduction.org/ruralsyringe/about-syringe-services-programs/>.
- ³⁹ About Syringe Services Programs. Rural Syringe Services Programs. (2019). Harm Reduction Coalition. Available at <https://harmreduction.org/ruralsyringe/about-syringe-services-programs/>.
- ⁴⁰ H.R.34 21st Century Cures Act. (2016). Congress.gov. Available at <https://www.congress.gov/114/bills/hr34/BILLS-114hr34enr.pdf>.
- ⁴¹ HHS, SAMHSA to maintain funding formula for \$1B opioid grant program. (2017). Substance Abuse and Mental Health Services Administration. Available at <https://www.samhsa.gov/newsroom/press-announcements/201710300530>.
- ⁴² HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis. (2017). HHS.gov. Available at <https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html>.
- ⁴³ H.R.6 – SUPPORT for Patients and Communities. (2018). Congress.gov. Available at <https://www.congress.gov/bill/115th-congress/house-bill/6>.
- ⁴⁴ Information Systems Can Help Prevent, but Not Eliminate, Health Care Fraud and Abuse. (2006). Legislative Research Commission. Frankfort, Kentucky. Available at https://apps.legislature.ky.gov/lrc/publications/ResearchReports/RR%20333_forweb.pdf.
- ⁴⁵ Kentucky Meets the Gold Standard for Prescription Drug Monitoring Programs. (2017). Substance Abuse and Mental Health Services Administration. Available at

<https://www.samhsa.gov/capt/tools-learning-resources/kentucky-meets-gold-standard-prescription-drug-monitoring-programs>.

⁴⁶ West Virginia Official Prescription Program Act. (2010). West Virginia Legislature. Available at http://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=SB81%20SUB1.htm&yr=2010&sesstype=RS&i=81.

⁴⁷ Combating the Opiate Crisis in Ohio. (2018). Ohio Governor's Cabinet, Opiate Action Team. Available at https://odh.ohio.gov/wps/wcm/connect/gov/af5ce9f5-0838-41c3-8c09-e9cef0b9960f/Combating-the-Opiate-Crisis-SEPT-2018.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-af5ce9f5-0838-41c3-8c09-e9cef0b9960f-moxN2R4.

⁴⁸ Declaration of Public Health Emergency Update. (2014). Commissioner Cheryl Bartlett. Massachusetts Department of Public Health. Available at <http://blog.mass.gov/publichealth/wp-content/uploads/sites/11/2014/04/Commissioner-Update-Public-Health-Emergency-FINAL.pdf>.

⁴⁹ Gov. Beshear Signs Landmark Anti-Heroin Bill. (2015). Kentucky.gov. Available at <https://kentucky.gov/Pages/Activity-Stream.aspx?viewMode=ViewDetailInNewPage&eventID=%7B3B6958E7-F44D-4293-A774-F3670DF3DF24%7D&activityType=PressRelease>.

⁵⁰ HB 270 – Final Version. (2015). New Hampshire 2015 Session. Available at <http://www.gencourt.state.nh.us/legislation/2015/hb0270.html>.

⁵¹ Information for Organizations Operating a Syringe Service Program. (2017). New Hampshire Department of Health and Human Services. Available at <https://www.dhhs.nh.gov/dphs/bchs/std/operating-syringe-program.htm>.

⁵² Cronan, S. House Bill 333 Makes Changes to Prescribing – What You Need to Know. (2017). Kentucky Medical Association. Available at <https://kyma.org/2017/07/10/house-bill-333-makes-changes-to-prescribing-what-you-need-to-know/>.

⁵³ Ohio Gov. John Kasich Limits Opioid Prescriptions to Just Seven Days. (2017). NBC News. Available at <https://www.nbcnews.com/storyline/americas-heroin-epidemic/ohio-limits-opioid-prescriptions-just-seven-days-n740531>.

⁵⁴ SB273 SUB1. West Virginia Legislature 2018 Regular Session. (2018). West Virginia Legislature. Available at http://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=SB273%20SUB1.htm&yr=2018&sesstype=RS&i=273.

⁵⁵ Vital Signs. (2016, December). Syringe services programs for HIV prevention. Centers for Disease Control and Prevention. Available at <https://www.cdc.gov/hiv/images/risk/Syringe-Services-Programsfor-HIV-Prevention.jpg>

⁵⁶ Centers for Disease Control and Prevention. (2018, July). Vulnerable Counties and Jurisdictions Experiencing or At-Risk of Outbreaks. Available at <https://www.cdc.gov/pwid/vulnerable-counties-data.html>

⁵⁷ Treat Opioid Use Disorder. Atlanta, GA: CDC, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention; 2017. Available at <https://www.cdc.gov/drugoverdose/prevention/treatment.html>.

⁵⁸ Ibid.

⁵⁹ How do medications to treat opioid use disorder work? Bethesda, MD: NIH, National Institute on Drug Abuse; 2018. Available at <https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-do-medications-to-treat-opioid-addiction-work>.

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