

Opioid overdose prevention and related trauma:  
incorporating overdose prevention, response, and  
experience into substance use disorder treatment

Produced by the **Illinois Co-Occurring Center for  
Excellence**, a program of **Heartland Health Outreach**

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## **Substance use disorder (SUD) treatment & overdose prevention: Strengthening relationships, enhancing outcomes**

Overdose is an ever present issue in substance use disorder treatment, yet it is rarely directly addressed. There are two significant aspects: 1) Past trauma related to overdose events- a client's own or witnessing someone else. Healing from /coping with traumatic events and effects may affect recovery outcomes. 2) Future overdoses- a client's own or someone else's- can be prevented or managed to avoid death. The essential intent is that clients and people in their social network live for another day.

Incorporating the topics of past and potential future overdose into substance use disorder (SUD) treatment can enhance outcomes in the following ways:

1. Increase likelihood for survival and health among clients
2. Improve patient-provider relationship
3. Affirm clients as valuable community members able to provide lifesaving education and response within communities
4. Enhance a holistic prevention, treatment and recovery system's capacity to address trauma
5. Support treatment providers by expanding skills and addressing emotional burden

**We discuss a wide range of opportunities to incorporate overdose as an important topic into substance use disorder treatment. While a robust and holistic approach would include most of the strategies contained here, even incorporating one or two can be valuable. We invite you to pick and choose those that seem appropriate or feasible, adapt portions to your local context, and engage in a dialogue about lessons learned.**

### **Survival and wellbeing of our clients: The overdose-treatment paradox**

The number one cause of injury related death in the country is drug overdose. A majority of these deaths involve opioids (prescription pain relievers and heroin). These fatalities are particularly tragic because they are largely preventable. Many of those at risk of opioid overdose will pass through the doors of an SUD treatment program, positioning these programs to provide effective prevention in the form of overdose education and naloxone distribution (OEND). Implementation of overdose prevention protocols is a vital element in efforts to reduce overdose fatalities.

Engagement in substance use disorder treatment represents a potential paradox- while it can help individuals eliminate or reduce drug use, which can decrease overdose risk; it is also a tolerance changing event that can actually increase risk for overdose death in several important ways:

1. Cycles of opioid abstinence and use, or even a single episode of use following a period of abstinence, can put an individual at high risk due to reduced tolerance.
2. Medically supervised withdrawal procedures (detox) often include the use of comfort medications, like benzodiazepines, that are sedating and increase overdose risk.
3. The period immediately following discharge from treatment is one of high overdose risk. Opioid tolerance is decreased, at the same time level of support is decreased and access to substances may increase. One instance of use- a lapse or “slip”- can be potentially fatal when tolerance is low.
4. Opioid agonist (methadone & buprenorphine) assisted treatment has a demonstrated high rate of success in reducing illicit opioid use, criminal activity, HIV transmission, and overdose among opioid addicted clients. However, the half-life is highly variable and risk of over sedation and overdose increases during changes in dosing (such as during methadone induction or discharge) or when combining with other sedating substances e.g. benzodiazepines or alcohol.



The "EMERGENCY NARCAN KIT" found outside the Boston Public Health Commission's substance use disorder treatment services sends the message that they are aware of the risk for overdose, are prepared to help people survive them, and the BPHC wants people alive to keep coming back. Photo credit: A Walley

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

### **Enhanced patient-provider relationship: A potent ingredient for change**

Addressing overdose and incorporating OEND services can enhance the therapeutic relationship between clients and counselors in several ways. We know this relationship is critical to positive treatment outcomes. 1) Focusing on safety and risk reduction sends the message that the treatment provider's priority is the client's survival, even during a re/lapse. 2) Educating clients on overdose recognition and response regards the client as a contributing member of the community and a potential life saver in an overdose situation. This is an important and

reinforcing, yet rare, message. 3) Overdose is the number one cause of fatality among people who use opioids- far more than HIV and hepatitis C combined. Communicating understanding of the significance of this issue in the lives of clients can build rapport. 4) Acknowledging the traumatic impact of experiencing fatal or non-fatal overdose can play a powerful role in therapeutic engagement. While statements such as “jails, institutions & death” or “if you play with fire, you’re going to get burned,” can instill hopelessness and reinforce fatalism, framing overdose as avoidable, preventable and survivable encourages hope and strength. Creating openings to express feelings related to overdose events may reveal significant traumas which should be dealt with on par with any other trauma experiences.

Experience or witness of fatal and nonfatal overdoses- and trauma responses- is common among people we work with in treatment. Discussion of overdose throughout systems of care and with friends, family, and community enhances a robust trauma informed approach to SUD. Integrated discussions should address past and potential future experiences.

### Healing power of engaging: Clients are important members of our communities

When providing overdose prevention education and naloxone we emphasize not only the possibility of being an overdose *victim*, but also being an effective overdose *responder*. The message that clients have the capacity, and even the responsibility, to play a life-saving role has the power to increase sense of self-worth and determination. Clients’ lives can be chaotic, sometimes relationships have been damaged or severed, and self-worth and self-efficacy may be devastated. Developing skills and a sense of responsibility to do lifesaving work can help repair some of the damage. Passing knowledge and skills on to others in need, facilitating access to life-saving materials for their community and possibly saving someone’s life, can shape a positive sense of identity, of contributing, “giving back” and making a positive difference. These practical experiences may also prepare a person to be a Peer Recovery Support provider. Involvement in overdose prevention activities can contribute to:



Chad Sabora, here with friends in Missouri advocating for overdose prevention and recovery support legislation, says that his advocacy work strengthens his recovery. Photo credit: C Sabora

- relapse prevention
- building or broadening supportive social networks
- “working the program” (however they define this for themselves)
- establishing or rebuilding a positive reputation as an important community resource
- increased general satisfaction or sense of purpose
- relief to be able to positively contribute in a way that feels tangible, practical, action-oriented, respectful, effective and/or important.

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

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

### Trauma informed care: Acknowledging the breadth and depth of grief, regret, sorrow and/or shame

Historically, overdose has often been viewed as an unavoidable consequence of illicit opioid use, rather than a preventable trauma.



After Dr Tami Olt's 16 year old son Josh died from a heroin overdose, she established the JOLT Foundation, partnered with Broken No More (of So CA) to erect this billboard in Peoria, IL, collaborated with the Chicago Recovery Alliance to begin prescribing naloxone to the community for free out of her obstetrics practice, and initiated a dialogue between local high schools, EMS dispatch, and SUD treatment providers. Photo credit: T Olt

**Can All Minnesotans Call 911 to Save a Life?**

Please join the Steve Rummler Hope Foundation, Minnesota Recovery Connection and the Good Samaritan Coalition

**Thursday, August 1, 2013 7:00 to 8:30 PM**  
**The Recovery Church - 253 State Street, St. Paul, MN 55107**

**911 Good Samaritan + Naloxone Campaign**

**WHERE ARE WE?**

- Too many people die because those who witness the overdose are afraid to call 911!
- The CDC has declared overdose the #1 cause of unnatural death!
- In the Twin Cities alone 128 overdose deaths occurred in 2011!
- 14 other states have Good Samaritan/Naloxone laws
- In the US, one person dies every 16 minutes from an overdose.
- MINNESOTA NEEDS LEGISLATION NOW!!!

**Our Speakers:**

**Gavin Bart, MD**  
 Director of the Division of Addiction Medicine at Hennepin County Medical Center and Associate Professor of Medicine at the University of Minnesota.

**Aaron DeVries, MD, MPH, FIDSA**  
 Medical Director of the Infectious Disease Epidemiology, Prevention, and Control Division at the Minnesota Department of Health.

**Senator Chris Eaton**  
 A member of the Minnesota DFL Party, she represents District 48, which includes the cities of Brooklyn Center and Brooklyn Park in Hennepin County in the Twin Cities metropolitan area. Senator Eaton will share the story of her loss of a loved one to a heroin overdose.

**Personal Stories from Julie Hooker, Judy Rummler and Nick Selleck**

Registration is requested but not required.  
 Please go to: <https://911goodsamaritannaloxonecampaign.eventbrite.com/>

Like us on Facebook: [www.facebook.com/911GoodSamaritanNaloxoneCampaign](http://www.facebook.com/911GoodSamaritanNaloxoneCampaign)  
 Follow us on Twitter: @MNGoodSam

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Logos for Steve Rummler Hope Foundation and Minnesota Recovery Connection.

Advocating for overdose prevention legislation in MN. Organizing by advocacy organizations like the Steve Rummler Foundation to connect and collaborate with SUD treatment organizations, health departments, preventionists, harm reductionists like Lee's Rig Hub. Image credit: MN 911 Good Samaritan + Naloxone Campaign



Reverend Martha Leahy understands the interconnectedness of her community in Northeastern Massachusetts and offered the church as support for people who use drugs and loved ones. Photo credit: M Wheeler



Public art installation by Mission Minicomix and Clarion Alley Mural Project: a collaboration to raise awareness and make referrals to the DOPE (Drug Overdose Prevention and Education) Project in the Bay Area of San Francisco. Photo credit: E Wheeler



The Wauconda, IL Fire Department partnered with local prevention, treatment and advocacy organizations to make a dramatic statement about the prevalence of overdose in the area. Photo credit: C Laliberte

We need to create a safe environment where grief, regret, and trauma related to overdose can be expressed and addressed. Because there are some many different groups, organizations, and stakeholders, who may provide this support and where it is provided is expanded.

According to SAMHSA:

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

If we agree that frequent exposure to sudden, preventable, unintentional overdose deaths may constitute a traumatic experience, we see that most SUD treatment and support organizations and systems working with people who have a SUD, have historically fallen short of delivering effective trauma informed care.

To enhance the effective delivery of care, we need to acknowledge and celebrate resiliencies that can mitigate the effects of trauma. Discussing personal strengths that have helped an individual survive as part of their self-inventory of strengths and vulnerabilities can be a useful exercise in the preparation and action stages of behavior change.

A holistic treatment and recovery approach means addressing overdose prevention throughout the continuum of care, remembering those who did not survive, and recognizing the imprint of trauma for many who did survive. In the absence of an existing OEND within a community, a SUD treatment program is an excellent place to implement OEND services because entry and exit from treatment are times of particularly high risk of overdose.

<sup>1</sup>[www.samhsa.gov/traumajustice/traumadefinition/approach](http://www.samhsa.gov/traumajustice/traumadefinition/approach)

## Provider support: Collateral consequences

Can incorporating overdose prevention and response into SUD treatment increase support to staff? Most definitely, by providing the opportunity to address grief that staff members may themselves experience. A study<sup>2</sup> of SUD treatment staff found grief reactions, workplace stress, and trauma to be common among those who had a current or former client fall victim to a drug related death.

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

## Incorporating Harm Reduction-based overdose prevention services

We have three basic strategies for addressing drug related problems. These elements must work together, they are all part of the solution, but none of them in isolation is the whole solution.

### Supply Reduction

This approach involves local police, the Drug Enforcement Agency (DEA), Prescription Drug

The roots of overdose prevention, as we refer to it in this document, began among people who use drugs. This is important for two main reasons: 1) Treatment professionals implementing overdose prevention education are sometimes surprised to realize that their clients are already quite well informed and have considerable experience. It is important to begin by asking questions and acknowledging experiences, strengths and resiliencies. Don't assume that we provide completely new information. Take the opportunity to learn from clients' experience and gain insight into a person's past. 2) It highlights the view of people who use drugs as community members who can and do make decisions and take actions to keep themselves and those around them safe and alive, even during active and possibly chaotic substance use. Nearly two decades of distributing naloxone and collecting stories of lives saved gives us proof that people who use drugs can- and do- take action to save lives! Sometimes we end up learning more from our clients than they from us.



This image and caption affirm that people who use drugs tackle overdose & can address stigma: *“Change the way the world sees you. Carry [naloxone] and you could save a friend’s life if they OD.”* Image courtesy Martindale Pharma

<sup>2</sup>Mcauley, A., & Forsyth, A. J. (2011). The impact of drug-related death on staff who have experienced it as part of their caseload: An exploratory study. *Journal of Substance Use*, 16(1), 68–78.

Monitoring Programs, and other agencies designed to restrict access to drugs. A constructive example: In the Pittsburgh, PA area in early 2014, fentanyl was introduced into the heroin supply resulting in 22 deaths in a two-week period. Individuals accustomed to using heroin were exposed to a drug many times stronger. Targeted police efforts confiscated a large amount of the mixture, taking it off the market, undoubtedly saving many lives.<sup>3</sup>

On the other hand, law enforcement disruption of a steady regular supply of drugs can have unintended consequences as people scramble to find an alternative that may be less safe. While efforts to reduce the supply of prescription opioids through Prescription Drug Monitoring Programs have in some cases successfully reduced diversion of opioids and reduced the supply, people accustomed to a regular supply of oxycodone, morphine, or other prescribed pain medication have sometimes turned to heroin instead. The National Survey on Drug Use and Health (NSDUH) reports that while prescription opioid misuse declined between 2007 and 2012, heroin use almost doubled.<sup>4</sup> From 2012-2013, prescription opioid overdose deaths dropped by 5%, but heroin overdose deaths increased by 35%.

H. Westley Clark, SAMHSA's director of the Center for Substance Abuse Treatment, summarizes the paradox that supply reduction, without sufficient demand and harm reduction, presents:

*"The unintended consequence of the successes in reducing prescription drug abuse may well be an increase in heroin use.*

*If there is an increase in heroin, there will be an increase in HIV, increase in hepatitis, increase in crime.....there will also be an increase in overdoses, which is painfully ironic given that the main reason prescription opioids have had so much attention is the overdoses.*

*You can predict the dosages that will cause overdoses with prescription medication. But with heroin, you can't predict ....anything and the risks really start to climb."*<sup>5</sup>

## Demand Reduction

This involves efforts to reduce the demand for illicit drugs, typically through prevention education and substance use disorder treatment. It should also include offering appropriate treatment for any untreated medical condition that may result in "self-medication" to relieve symptoms. Research clearly shows that methadone and buprenorphine treatment have reduced overdose deaths among people who are maintained on medication-assisted opioid agonist treatment regimens. While abstinence-based programs of treatment can play an invaluable role in an individual's recovery process, we know that few people enter a program for the first time and never, ever use drugs a single time in their lives again. When people leave

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<sup>3</sup> From SAMHSA's bi-monthly EOOSG (Emerging Opioid Overdose Strategic Group) discussion

<sup>4</sup> <http://www.samhsa.gov/data/nsduh/2012summnatfinddetables/nationalfindings/nsduhresults2012>

<sup>5</sup> Alcoholism & Drug Abuse Weekly, Oct 2012 available at <http://www.alcoholismdrugabuseweekly.com/article-detail-print/nsduh-heroin-increase-correlated-with-rx-opioid-abuse-decrease.aspx>

a program, they may be at higher risk of overdose due to reduced tolerance and this risk must be addressed. In other areas of health care, the standard is to provide patient education about the risks and benefits of treatment, potential side effects, and under what circumstances care should be suspended or abandoned. People receiving SUD treatment deserve the same information about the benefits and risks involved with their health care.

In recent years we have had over 41,000 overdose deaths annually in the US, an average of over 100 deaths every day of the year. Anyone who works in the field of SUD treatment has had the experience of working with an individual and feeling great confidence in that person's future and ability to maintain sobriety, only to learn months or years later that they had been re-admitted to the same program or another treatment program. Any one of those individuals could have been one of those 41,000 dead. This is why harm reduction measures are an equally important part of the equation.

### Harm Reduction

This means providing services to reduce drug related harm for individuals who may be actively using drugs. In the case of overdose prevention and response, providing accurate education and information on risk factors, developing a realistic overdose plan, identification of overdose symptoms, and the knowledge and tools to keep an opioid overdose from becoming fatal, including access to naloxone.

We often use the Stages of Change model to describe behavior change and tailor stage-based services to an individual's situation.<sup>6</sup> Consider harm



Nicholas Tate- 3/3/84-9/20/09- is one of more than 38,000 people who died from an overdose in 2009.

*"In March, he would have turned 30. I hear others talk about their children and sometimes feel so sad and so envious that they have the rest of their lives with their children, that they will likely have grandchildren, and a lifetime of companionship...a future built around whatever happens with their children. I won't have that.*

*I went through twenty five years of struggle to raise Nick. It wasn't easy. I was Nick's mom. Now I'm nobody's mom. I put so much in to trying to teach and protect him and was ultimately a failure in the end.*

*That's not entirely true though. Nick was a stellar human being...he just had problems and eventually, his problems, not knowing his limitations, his desire for escape, resulted in the ultimate escape. I think I'll always believe I could have or should have done something differently. I think I'll always have guilt and always feel it as the ultimate unfairness."*

- Kate Duncan, Nick's mother,  
April 2014

<sup>6</sup> For example, SAMHSA's TIP #35 Center for Substance Abuse Treatment. Enhancing Motivation for Change in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 35. SAMHSA, 1999.

reduction activities, particularly overdose prevention, as part of the clinical focus when working with patients in Pre-Contemplation, Contemplation, Preparation, and Action Stages of Change. Active substance use, *by definition*, is expected in these stages. A clinician adept at providing harm reduction strategies or referrals conveys willingness and ability to work with clients across all stages of a change process, affirming that being alive and healthy is more important than substance using status.

Personalized harm reduction interventions is the third component of a comprehensive strategy to reduce drug related problems because once someone is dead, they have no more options, only grieving loved ones left behind.

## Description of OEND

Providing naloxone rescue kits to individuals who use opioids, either illicitly or prescribed, as well as to members of their social network effectively prevents fatal opioid overdose. Naloxone (sometimes also called “Narcan”) is an opioid antagonist. It has no abuse potential. It reverses respiratory depression and restores consciousness and breathing during an opioid overdose, in minutes. Naloxone can be provided by prescription during regular medical care, by pharmacist-initiated collaborative practice agreement, or by community-based overdose education with naloxone distribution (OEND) programs. These programs target people who are at risk of opioid overdose and/or those

*“It used to be, overdose, you always talked about it in past tense: ‘I HAD a friend who OD’d.’ Now, overdose is in the present tense: ‘I HAVE a friend, he OD’d last week’. Naloxone did that.”*

John G, 2001

likely to be bystanders. OEND programs educate on how to reduce the risk of overdose and to prevent an overdose from becoming fatal by calling for emergency medical assistance, performing rescue breathing and administering naloxone. Between 1996 and 2010, over 50,000 potential bystanders were trained by OEND programs in the United States. These bystanders (primarily drug users themselves) reversed over 10,000 opioid overdoses with naloxone.<sup>7</sup> An analysis of OEND programs demonstrated decreased overdose deaths in communities that implemented OEND compared with communities that did not.<sup>8</sup> This intervention has been endorsed by the United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO), US President’s Emergency Plan For AIDS Relief (PEPFAR), the American Public Health Association (APHA), the Substance Abuse and Mental Health Administration (SAMHSA), as well as state legislatures, and public health departments.

<sup>7</sup> <http://www.cdc.gov/mmwr/pdf/wk/mm6106.pdf>

<sup>8</sup> <http://www.bmj.com/content/346/bmj.f174>

Several widely used overdose prevention and naloxone educational curricula are available. (web addresses in resources section) Some examples are Skills and Knowledge on Overdose Prevention (SKOOP), developed by the Harm Reduction Coalition and the Drug Overdose Prevention and Education (DOPE) Project. The Chicago Recovery Alliance has several training videos. The Center for Prisoner Health & Human Rights developed an award-winning video targeting individuals released from prison called “Staying Alive on the Outside” and Prevention Point Pittsburgh & Project Lazarus produced a video on opioid safety for pain patients and others, “Opiate Safety: The Role of Naloxone.”

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

**Discussion topic:**

There are several models for incorporating overdose prevention and management into substance use disorder treatment services. We have observed several different ways\* that people potentially at risk for overdose might access opioid safety information and overdose management training (i.e.: rescue breathing and naloxone) if they are receiving SUD treatment services:

1. Staff of a treatment program provide all OEND components for clients on-site
2. People from an outside collaborating organization invited to provide OEND on-site at the treatment program on a regular basis
3. Treatment staff provide education on-site, and refer clients to a location to obtain naloxone off-site
4. Staff from an outside agency that provided OEND services recruits participants- with or without the treatment agency’s permission- near the treatment agency
5. No relationship between those organizations providing OEND and naloxone and those providing SUD treatment, even if in the same general geographic location

Discuss advantages and disadvantages of each model.

Which model do you think is the *best* for the environment where you work? Is that different from the model that you think is *most likely to be implemented* in the environment where you work? Why or why not?

How important do you think it is that a substance use disorder treatment agency provides safety education and training to deliver rescue breathing and naloxone?

\*Adapted from Walley et al. JSAT 2013; 44:241-7

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

## Dual roles during an opioid overdose emergency

### Overdose victim

Addressing the increased risk for overdose that clients with tolerance changes may face can be a sensitive topic in the early stages of building a relationship. Intentions can be misinterpreted (“You’re acting like I’ve *already* relapsed!”) or risk minimized (“I’m done with using and ready to be done with dope- this doesn’t apply to me.”). Be prepared to address these concerns.

Many people do not complete treatment, and many leave soon after initial contact. If the individuals resume opioid use, after even a *brief period of abstinence*, they are at high risk of overdose. It is crucial to address overdose during orientation. To avoid implication that some clients are “higher risk” or less likely to complete treatment, discussing the topic universally with emphasis on gaining skills to be able to save another’s life, can minimize misinterpretation.

Some sample language:

*If someone has stopped using opioids after daily use, they may go into treatment, go to jail, or may be taking opioids for pain and no longer have pain, their tolerance is lower.*

*If they start using opioids again, it takes less; less to get high, less to get effective pain relief, and less to overdose. So, if you stop using opioids and then start again, for whatever reason, this is a high risk time for possible overdose, so it’s important to have a plan for what to do in that situation.*

### Overdose responder

Another message to convey is that learning how to preventing and respond to overdose is a valuable skill for anyone. Overdose is a large problem, but we can all be a life saver.

Some sample language:

*This is practical information that everyone should have, just like knowing how to do CPR or the Heimlich Maneuver, everyone should know how to prevent and manage overdose.*

*Hopefully you will never find yourself in a position in the future where you would be at risk of overdose yourself, but you never know when you could be the person who could save the life of someone else.*

Part of relapse prevention strategy often involves staying away from “people, places, and things” that are part of a person’s drug using habits and life, but we know that this is not always possible, realistic, or even safe. People may have family members, spouses, children, or



Reach For Me is a media campaign dedicated to increasing access to affordable naloxone. Elizabeth, from VOCAL-NY, explains how being an overdose responder strengthens relationships. Image credit: Sawbuck Productions

community members who continue to be at risk of overdose. In some situations an informed overdose responder might be the only one who knows what to do to save a life.

These skills can be part of a new image as someone who contributes positively to the community, who can be counted on to know what to do in an emergency, who cares about others. They may want to learn to be a trainer and teach these skills to others, or become an activist by helping to disseminate information or working to adopt policy changes to address the problem.

## Opportunities to address overdose in treatment

There are a number of natural places to incorporate discussion, education and training

about overdose. Addressing overdose can be an important component of trauma informed care for people with opioid use disorders and/or anyone who may have been involved in an overdose event.

We’ve highlighted several important opportunities that can be incorporated into individual clinical practice or an entire organization’s normal operating procedures. In the references and resources section, we include links to various resources, including an overdose prevention inventory from our friends at SPHERE.

### Waitlists

We want to try to keep people alive to actually make it in to our programs! People who are seeking treatment and put on a waitlist are likely to continue to use substances. Therefore, it is essential that anyone placed on a waiting list is provided information on opioid safety and overdose prevention and response. This should include: information on factors that increase risk of overdose, symptoms of overdose, and effective response to overdose, including calling

911, rescue breathing and how to administer naloxone. Also, provide information on where to get naloxone if this is available in your area.

Many people seeking treatment engage in poly-drug use. Overdose prevention information and materials should be available to everyone on a waitlist, regardless of stated “drug of choice”.

## Screening or assessment

### Intake

Screening for potential overdose risk should be done for all clients. Treatment models, such as dialectical behavior therapy (DBT), and holistic models that work to triage needs, first address any issues that may be potentially life-threatening. This is a natural place to talk about overdose risk for anyone who uses opioids. Make a plan to keep them safe that can include overdose prevention education and naloxone.

Sample language to be added to intake forms:

*Have you ever overdosed?*

*Have you ever witnessed an overdose?*

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

The first two questions deserve further exploration after the initial flurry of intake, during counseling and once relationships begin to be established.

The last question gauges knowledge of safe methods for responding to an overdose. SUD treatment staff should receive training to identify recommended overdose recognition and response actions as well as those that are not recommended.

Regardless of level of knowledge about overdose response, be prepared to give additional information, and naloxone, if possible (or a referral). If a client doesn't return after intake, this may be the only opportunity to make sure that they have reliable information about what to do, what to tell others to do, and the materials to maximize safety.

If a person describes a response that is NOT recommended, this is an opportunity to suggest more effective alternatives. Sometimes people do minimally effective and/or potentially dangerous things. Putting ice on the person; injecting with salt water, milk, or other drugs; or electrical shock will not help a person who isn't breathing. A person experiencing an opioid overdose needs oxygen (rescue breathing) and/or naloxone. A person experiencing an overdose or adverse reactions involving stimulants, alcohol, benzodiazepines, or other substances will also need attention to breathing, but naloxone will not help and medical attention is particularly critical.

## Trauma screening

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

In the past overdose has often not been seen as a traumatic event, but rather dismissed as "common among drug users" or seen as somehow the victim's fault. This view leads to underrepresentation of overdose in regular trauma screening protocols. We recommend minor modifications of existing trauma screening tools to explicitly elicit trauma reactions related to overdose experiences.

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

*Life Events Checklist (LEC)*<sup>9</sup>:

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

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

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

Response to trauma is individual and personal. Not everyone who has been involved in an overdose will experience trauma. However, when traumatic experiences slip through cracks during screening, we fail to provide the best integrated care.

## Induction or orientation phase

Some programs talk about re/lapse from the very beginning. It can be useful and clear the air to acknowledge that few people go through a program of drug treatment and never, ever use a single time again in their lives. The process of recovery is rarely a straight line and no one knows where their road will lead them. Affirming the client's survival as paramount and stressing that they will not be judged if/when they return following resumed use expresses concern and support for clients as human beings, and can help establish a strong connection right away.

With Medication Assisted Treatment involving buprenorphine or methadone, the first few weeks are considered the induction phase when dosage is adjusted until the clinician and the

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<sup>9</sup> [http://www.ptsd.va.gov/professional/assessment/te-measures/life\\_events\\_checklist.asp](http://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp)

<sup>10</sup> <http://www.ptsd.va.gov/professional/assessment/te-measures/th.s.asp>

patient agree they have achieved a therapeutic dose. With methadone specifically, a person receives a low dose that is gradually increased.

Some poly-substance use is common during this induction period where the patient may supplement treatment with heroin, other opioids, or benzodiazepines to reduce discomfort until a therapeutic dose of medicine is achieved.

Sample language:

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

*We are committed to your safety, which is why we gradually increase your methadone dose, observe your reaction to it, and discuss overdose prevention and management with you (and, with your permission, your loved ones).*

*We hope that you are here tomorrow, and next week, and next month, but if some of you are not, our foremost concern is that you stay alive, so that we can see you again down the road.*

If your program plans to give out naloxone upon discharge, telling people in the beginning that everyone will get naloxone and training when they leave reinforces the universal concern. This is not about identifying anyone as “high risk” when they leave. No one knows who may find themselves in a position where they need it for themselves, or others.

Many agencies have an orientation group which can be a good time to show a video. Web addresses to several good and discussion-provoking videos are available in the resources section.

## **Counseling**

### **Individual counseling**

Counseling is an opportunity to tease out information about overdose experience revealed during intake. Additional experiences may also come to light as clients’ begin to feel safer. The goals should be to understand social network dynamics; establish individual strengths, assets, and resiliencies that contributed to the person’s survival, as well as identifying trauma, PTSD, anxiety, or depression. These conditions may affect treatment outcomes and warrant focused or specialized treatment.

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

address the client’s own potential risk directly, but even addressing risk indirectly can be important, therapeutically.

Sample language to identify strengths and resiliencies and explore trauma:

*Have you ever ODD? [If **yes**] How did you survive? Who was with you and helped you? How did that affect the ways you used after the overdose? How did you protect yourself from it happening again? [If **no**] More than half of people who use opioids have an overdose- what did you do to avoid being part of that group? What other ways did you keep yourself safe from the risks of drug use?*

*Have you ever witnessed an OD? [If **yes**] What did you do? What did others do? Did the person live? Do you think about that event(s) often? How do you feel about it? [If **no**] Most people say that they have seen an overdose- what is special about your experience that you have not? How do you talk with friends about preventing overdose? How do you and your friends protect each other from other dangerous or difficult situations?*

## Group counseling

### *Psychoeducational groups*

There are numerous approaches to incorporating overdose prevention into psychoeducational groups. One approach is to focus on general information about opioid safety. Any time anyone takes opioids, whether getting high or for pain, they may be at risk. Sample curricula that could guide this type of group are in the reference section. SUD treatment programs that have a longer relationship with patients can consider transitioning to a peer education model.

Another approach is to incorporate overdose risk and response into HIV counseling groups or services. A recent study showed that people living with HIV/AIDS (PLWHA) are twice as likely to die of overdose as people who are HIV

#### One counselor’s experience

“I conducted an overdose prevention group at our residential treatment facility on Thursday. ‘Julia’ participated in the group. On Friday night she left treatment, AMA [against medical advice]. In accordance with our standard protocol, I did follow up contact with her and she told me that she is willing to take numbers for detox because last night she had a big scare. She was using with two other people, one of them overdosed. She shared with me that she used what she’d learned in the Overdose Prevention Group to keep the woman alive. She called 911 and kept doing rescue breathing while waiting for the paramedics to arrive. She says her friend will ‘live to use another day’ because the group made enough of an impact to reinforce the importance of rescue breathing.”

negative.<sup>11</sup> While it is not completely clear why this is, possible reasons for this disparity may be: reduced pulmonary function; reduced hepatic (liver) function, different levels of engagement in high-risk behaviors, and/or interactions between antiretroviral medications and opioids (particularly methadone, possibly heroin) that may lead to differences in metabolizing substances or patterns of use. In this study, one of the most important protective factors for PLWHA against overdose was found to be engagement in methadone assisted treatment. On the other hand, poverty and incarceration both increased overdose risk.

Sample language:

*What are the risk factors for overdose? How does HIV medicine interact with different drugs? People living with HIV/AIDS are at higher risk for overdose- does anyone have thoughts on why this might be?*

*What do you do if you are with someone who overdoses? What are some less effective ways to respond?*

[Clients may tell stories of previous responses that are less effective strategies. This can be a good opportunity to provide accurate information.] *While putting ice on someone may wake them up, if they are able to wake up, sternal scrub is quicker (and less messy) and you can get the same result. If someone isn't breathing, they need oxygen (breathe for them) and/or naloxone.*

*Has anyone used naloxone or had it used on them? Do you know where to get naloxone? Do you now or have you ever had an "overdose plan"? What are the risks and benefits of responding to someone's overdose? You may not need this information yourself, but do you know others who do?*

### **Support groups**

Relapse prevention groups are a natural fit for the topic of overdose. Relapse prevention groups can focus on helping clients develop coping skills and support networks that may keep a single or limited instance of resumed use from becoming a full blown relapse. This can help to counter "abstinence violation effect" (where feelings of guilt and loss of control after one episode of use can lead quickly to high levels of consumption ("one is too many and a thousand is never enough".) Focusing on health and safety, rather than a goal of absolute abstinence, can minimize damage that resumed use after abstinence may impose on a person's identification as "a person in recovery". It is crucial not to underestimate the overdose risk of a lapse. Indeed, a limited instance of resumed use may very well be more dangerous for survival than a period of resumed regular use. This is because tolerance is lower and a person is more vulnerable to fluctuations in purity of illegal substances.

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<sup>11</sup> Green, T. HIV infection and risk of overdose: a systematic review and meta-analysis. AIDS. Feb 20, 2012; 26(4): 403–417.

Sample language:

*How has your experience with overdose (yours or other's) affected your use? How has it influenced your recovery?*

*How do you think your family/community will react to your interest in preventing overdose (and carrying naloxone)? How has overdose affected your friendships or family relationships?*

*How would you help a friend who has had a lapse? How would you want your recovery coach to support you if you were worried about a lapse? How would you want your sponsor (or similar) to support you if you were worried about a lapse? How would you feel about making an "overdose plan"?*

### **Psychotherapy groups**

Psychotherapy groups may be a good context to explore feelings of isolation, shame, regret, anger, betrayal, survivor guilt and/or grief related to overdose. If overdose is viewed as an inextricable part of heroin use and a common event, people may not feel entitled to have these emotions or reactions. It is important to provide the context for people to express feelings they may have.

Scripted facilitator language in psychotherapy groups is not ideal, so we describe some themes that may come up:

Many times, in discussing overdose prevention or learning about naloxone availability, people reflect back on how things may have been different for friends, family, or acquaintances. This could bring up traumatic events in the past or reframe events that a person thought they had emotionally dealt with from a new perspective. This may elicit acute negative feelings.

People who have been present at an overdose scene that resulted in death may feel they tacitly or overtly contributed to that death or have some responsibility for it. The sense of responsibility or guilt is common in relation to any type of death, but can be more pronounced with overdose deaths because of the stigma involved. It is not useful to try to talk people out of feelings of responsibility, but acknowledge that this is a common feeling when someone dies. For example, a client may focus on their responsibility for: supplying the dose that caused the overdose, delivering an injection, leaving the person, dropping the person at an emergency room, removing a body from a space after death, or removing personal items from a body. A person remembering such experiences might feel guilt or shame or responsible for sadness expressed by other group members. The feelings are real and should be acknowledged. Rather than trying to sort out the details of what "really" happened, it can be useful to frame these feelings as a common part of the grief process. People often feel they could have or should have done something different that would have changed the outcome. Highlighting the fact

that feelings of guilt are often a part of any grief process and helping clients to process these feelings can be extremely valuable.

Feelings of anger and betrayal may also be expressed. Anger may be directed at the attention that overdose is currently getting in public health and media settings. “Now that rich white folks are dying, suddenly you all give a shit!” “They [advocates/politicians/ programs] don’t really care about us, they just have to do something to look good.” or “Sure would have been nice if some of us old timers had a soccer mom or two on our side back in the day.” Statements like these often reflect underlying pain and grief at individual loss and/or at experience of racism, ageism, or other dehumanization individuals may have experienced. These feelings should be acknowledged and accepted.

### *Groups for family members*

Many programs incorporate family into the treatment process. Family members may be acutely aware of the risk of overdose that individuals face when they leave or complete treatment. Being back in the community can be a difficult transition. Parents sometimes experience great fear and report going in to check to make sure their child is breathing at night. Providing them with information about what overdose looks like and how to respond effectively can help relieve some anxiety.

Some family members may have an unrealistic idea that after treatment the individual will be “cured” and they will have no further worries. Informing them about the potential for re/lapse and overdose can be essential in making sure family members are not blind-sided if this were to happen. But, often family members have been through the process with loved ones multiple times and are well aware of the risks.

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

Sample language:

*We encourage every family to make an overdose plan. It can serve as an important way to have deeper conversations, illustrate how your loved one’s use is affecting the whole family unit, and set rules and expectations. In the event of a tragedy, it may also provide some relief from regret.*

*Elements of an overdose plan could include getting trained to use naloxone; discussing where the naloxone is kept; learning rescue breathing; learning signs and symptoms of an overdose; discussing not locking bedroom or bathroom doors; agreeing to check in if*

*a re/lapse happens; agreeing to a discussion before making major decisions if a re/lapse happens.*

SUD treatment organizations may consider establishing, hosting, or collaborating with a grief support group for family and loved ones of those lost to overdose. Families may have several members who have substance use disorders, some of whom may not have survived an overdose and grief support can enhance a family's ability to be present and supportive of a living family member's recovery. [NOTE: A support group for people who have loved ones struggling to find recovery may be painful for members whose loved ones die in the process of finding recovery. It may be better to have a separate support group to address this.]

People who have lost a family member to overdose or other drug-related harms often experience judgment, marginalization, or scolding in general bereavement groups. Access to grief groups- including on-line options- specifically for those who have lost someone to overdose is very important. Several options are mentioned in the resource section.

### **Upon positive drug screen results**

Administering drug screening can be damaging to the patient-provider relationship, unless it is agreed upon by all parties for a specific purpose. Drug screening may be an organizational or inter-organizational policy beyond individual provider decision-making. If this is part of your program, discussing concerns about overdose in the event of a positive drug screen may help to reduce tensions by framing the drug screen results in terms of concern for the client's survival and the need to implement harm reduction strategies.

Sample language:

*I care about you [even though I don't like what you do] and I do not want anything to happen to you.*

*It is my job to make sure you have access to the skills & information to help you survive, no matter what happens.*

*Please do not do it alone, make sure the people you are with know what to do.*

*Do you and your friends have an overdose plan? Let's figure out how/where to get you naloxone.*

### **At discharge**

Discharge may be the last time that we see clients and, our last chance to make sure that people have the best skills, information, tools, and materials to keep themselves safe.

Administrative discharges and discharges against medical advice (AMA) are particularly important times for providing overdose prevention education and tools. However, these

discharges are also usually comparatively abrupt and quick, so it is important that overdose prevention support be woven into orientation and the early stages of treatment and that preassembled information and material “kits” are necessary for quick discharges.

Sample language:

*I hope that you never are in this situation, but with so many people dying of overdose, it's important that everyone knows what to do if you are ever with someone and might be able to save their life.*

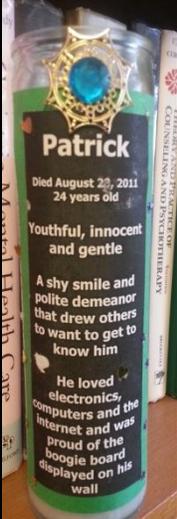
*Whether someone is getting high or taking opioids for pain, anyone who uses opioids can be at risk of overdose and people with lower tolerance are at higher risk.*

### **Other opportunities: When client overdoses & International Overdose Awareness Day**

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

International Overdose Awareness Day, recognized every August 31, originated in Melbourne, Australia in 2001. Its theme is prevention and remembrance and it provides a welcome, opportunity to mourn, celebrate and remember those who have been lost to overdose and serves as an important vehicle to advocate for hope and change.

In the US, September is Recovery Month, which makes International Overdose Awareness Day- August 31- a powerful way to kick off Recovery Month and the opportunity to continue the discussion.



**Top row:** Community candlelight vigil with family and residential treatment programs Photo credit: K Day Ongoing shrine remembering those lost to overdose at the DOPE Project Photo credit: E Wheeler **Second row:** Overdose remembrance corkboard at the Boston Public Health Commission Photo credit: N Oakes Personalized & decorated novena candles at a permanent supportive housing program in Illinois Photo credit: M Doe-Simkins Hand stitched quilt by JA2SOON with more than 200 names of those lost on travelling display Photo credit: T Dudar **Third row:** Ongoing remembrance wall in Lynn, MA where any staff or client can add writings, photos, etc. Photo credit: M Wheeler Broken No More board member Marilee Odendahl delivers a call to action at a public Overdose Awareness Day event Photo credit: M Doe-Simkins Free pins with three distinct and powerful messages address stigma and shame Photo credit: Unknown **Bottom row:** Substance use disorder treatment colleagues comfort each other following a client overdose death that occurred the day before the planned Overdose Awareness Day candlelight vigil in Gloucester, MA Photo credit: K Day

**Case study:**

Shane presented at the syringe exchange where I was working. He was a 26 year old male with a 9 year history of injection heroin use, intermittent cocaine use, mostly by injection, and considerable polysubstance use, largely benzodiazepines, clonidine, Phenergan and alcohol. During the previous 9 years, Shane had gone to a 7-day medically supervised withdrawal program (detox) 13 times, enrolled in a methadone maintenance program once, been civilly committed by his family once, been involved in an intensive outpatient program (IOP) twice, once voluntarily and once mandated by drug court. During the mandated IOP is when I met him at the syringe exchange program (though he had been a regular off and on far before my time). He had a consistent home NA group that he attended with considerable regularity at times and very little regularity at other times. When I met Shane, we had just begun the overdose education and naloxone distribution program and were offering it to everyone. He said that he was obtaining the safer injection supplies at the syringe exchange for a cousin and his girlfriend- a statement that I had no reason not to believe. Though the supplies were for his cousin, he readily acknowledged that he was very much on the verge of injecting heroin himself. He was extremely interested in obtaining naloxone and training on how to use it. His younger brother, also a person who injected heroin, recently had a single lapse to heroin use after 14 months abstinent and died in bed with Shane one night when the brother stayed with him. Shane was sleeping before the brother went to bed, awakened to use the restroom, and found his brother unresponsive. In spite of Shane calling 911 and performing rescue breathing and CPR, the brother did not survive the overdose. According to Shane, his mother believes that it is Shane's fault that the brother died. The brother's death happened 10 weeks prior. Shane has been in court mandated IOP for 6 weeks.

What do you think are Shane's current needs & how would you triage them?

What are Shane's strengths and resiliencies?

What are his vulnerabilities?

If you were his IOP counselor, in what ways would you address the death of the brother?

The mother faulting Shane for the death? How do you think these issues might influence his recovery process?

Since Shane is accessing at least two different kinds of services (IOP and syringe access), can you identify areas of overlapping priorities that the staff at the two programs might agree and possibly collaborate on?

## Clinician perspectives & supervision

### Preventing future overdose

The issue of overdose can come up in SUD treatment in the context of preventing or responding to *future overdoses* and addressing the possible trauma of *previous overdose experiences* (personal or those of a friend). Despite awareness of statistics regarding risk of overdose and injection among those leaving or completing treatment, clinicians sometimes struggle with concern that realistic prevention messages, may communicate that they are “giving up on [client]” or “don’t have faith in the strength of [client’s] recovery”. This can be reframed as “I

care about this person and want them to be alive whether or not they start using again”. Using this approach requires the support of coworkers, supervisors, and organizational commitment.

#### How one clinician discusses with colleagues:

*Have you ever had a client who you had tremendous faith and hope in for their ability to maintain sobriety and they graduate from the program only to see them back in your program or learn they are in another program in a few months or years? Any one of them could have been a statistic in between the time they left you and showed up for treatment again. Once you are dead, you never get to come back to treatment. You never get to make different choices. More than anything, they **need** to know that we want to see them again [if the situation calls for it].*

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

### Addressing past overdose experiences

A study of staff from several different models of SUD treatment programs found that between 38% and 45% had witnessed an overdose in their lifetime.<sup>12</sup> In another study nearly 90% of SUD treatment staff who had a client on their caseload die from drug related causes, reported grief

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<sup>12</sup> Walley et al. Opioid overdose prevention with intranasal naloxone among people who take methadone. J Subst Abuse Treat. 2013 Feb;44(2):241-7

reactions, such as sadness, guilt, and anger.<sup>13</sup> Staff and clients alike have a tremendous burden of overdose experiences.

A regular event that memorializes people lost to overdose can be beneficial for clients and also staff. The pervasive misconception that drug related deaths are a common “natural” consequence of a SUD can create an expectation that people working in the field should develop skills and strategies to just “deal with it”. While loss is “part of the job”, we will have a healthier, more productive staff, if we also acknowledge that grief is a part of loss, on or off the job, and build in time and space to support staff as they work to cope with loss. Establishing a regular or ongoing opportunity to remember people can provide an important opportunity to have a dialogue and express sadness, guilt, or anger responses to loss.

## Supervision

Because overdose prevention is a relatively recent addition for many professional disciplines, we are all still on a learning curve. Best practices are not yet clearly established. Pilot projects may address the topic from a variety of angles. Supervision of staff in relating to overdose is new, unexplored and not codified. We offer a few thoughts to consider based on our combined years’ experience.

- Experiencing and reacting to trauma does not reflect a lack of professional boundaries. When a staff member experiences grief and loss in their personal life, there is an assumption that supervisors and staff provide support. When the loss happens as part of one’s job, mechanisms of support must necessarily be built in to the work environment. If staff is expected to suppress their normal grief reactions, as behavioral health professionals, we know that this can end up with misdirected anger and often creates tensions among staff as well as with

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

-Shepard, Harm Reduction Journal, 2013

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<sup>13</sup> Mcauley, A., & Forsyth, A. J. (2011). The impact of drug-related death on staff who have experienced it as part of their caseload: An exploratory study. *Journal of Substance Use*, 16(1), 68–78.

clients. Staff needs to have channels to address emotional distress in ways that build the work community.

- When an organization becomes aware that a client did not survive an overdose, proactively check in with staff close to the client.
- If you learn that several employees are particularly affected by an overdose, coordinating group supervision with them may be a way to facilitate cross dialogue, support, and brainstorming.
- Create and promote venues for staff and clients to remember people who have been lost to drug related deaths.
- Provide opportunities for staff to access training on the topic- everything that an organization or a supervisor can do to help address feelings of guilt or responsibility will be individually and organizationally important.

## References and resources<sup>14</sup>

The [Chicago Recovery Alliance](#) started the first organized overdose project in the USA in 1996 and has some great resources on their Information Downloads section.

*Don't miss feature:* Some of the most realistic video training materials available, in particular [LIVE!](#) from [Sawbuck Productions](#).

[GetNaloxoneNow.org](#) is the home of the first web-based overdose recognition and management training modules- one for lay bystanders and one for uniformed first responders such as police and fire. NOTE: You cannot order naloxone directly from this site.

*Don't miss feature:* Animated & interactive trainings that include tests.

Grief and support groups specifically for those affected by opioid use and overdose are increasing in number. [Grief Recovery After a Substance Passing \(GRASP\)](#) is for those who have lost a loved one, [Learn 2 Cope](#) is for families with loved ones who have a substance use disorder. Some people prefer action-oriented groups- for example, [Moms United](#) and [Broken No More](#) are activist groups for parents of people who use drugs advocating for change. There are many groups that are appropriate for loved ones and family members. We encourage referring to those who have received explicit endorsements/referrals from the stakeholder group that will be referred.

The [Harm Reduction Coalition](#) is the USA's national harm reduction network, and has operated overdose programs in San Francisco and New York City for many years. Their site includes a great deal of information and resources on overdose in the Issues tab.

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<sup>14</sup> Resources courtesy of the Opioid Safety & Naloxone Network

*Don't miss feature:* This site has TWO- the [Guide to Developing & Managing Overdose Prevention and Take-Home Naloxone Projects](#) is the best resource of its kind and a must-have reference for anyone doing overdose work and there is [a large collection](#) of training and advocacy videos.

Health Imperative's SPHERE developed an [Overdose Prevention Inventory](#) checklist.

The OSNN members at [Law Atlas](#) are talented for so many reasons, but we particularly love the interactive maps that describe state-by-state [naloxone](#) overdose prevention and [911 Good Samaritan](#) overdose prevention laws.

*Don't miss feature:* figuring out exactly what the law says in [your](#) state!

The Overdose Prevention Alliance has a monthly curated [list of pertinent research](#), as well as a national [naloxone program locator](#).

[PrescribeToPrevent.org](#) contains resources directed toward health care providers such as doctors, nurses, and pharmacists, who are interested in prescribing naloxone to patients.

*Don't miss feature:* Tailored provider support tools, like a free [CPE course for pharmacists](#) and an education video for [patients receiving pain medicine](#) or an [animated overdose responder training video](#).

[Project Lazarus](#) is a unique effort to reduce overdose from prescribed opioids that unites health researchers, treatment providers, preventionists, activists, county officials, military, and local communities in North Carolina, USA.

*Don't miss feature:* [Toolkit](#) for implementing a community coalition-based model for addressing overdose concerns about prescription medicines.

[Reach for Me](#) documents how naloxone pricing and production shortages and a lack of public funding are impacting overdose prevention efforts in the United States. The project site also includes interviews with advocates and other resources.

*Don't miss feature:* advocacy materials, including Facebook [cover images, avatars, and downloadable, shareable posters](#).

[Staying Alive on the Outside](#) is the only overdose prevention training video we know of that is specifically targeted toward prisons, but, don't forget that the other risky time period for overdose is after being discharged from SUD treatment! This award-winning production is from the Center for Prisoner Health and Human Rights at Brown University.

*Don't miss feature:* The video!