Pennsylvania’s Opioid Crisis: Dispelling Myths and Taking Action

2/28/2018

Questions and Answers

1. ***What has been the biggest surprise you have seen in your Opioid work?***

   Presenter-- Dr. Williams:

   Answer—Two surprises: The age range of the addicted population 25 to 55 and above and we are seeing spikes at the edges, i.e., early users and older than 65 and the devastating impact that it has had not only on the addicted individual, but families, and communities at-large particularly in the epi-center.

2. ***What sources or resources would you point us towards for tested/effective opioid abuse prevention messaging for youth?***

   Presenter--Ellen DiDomenico

   Answer--School-based prevention programs that focus on building drug resistance skills, general self-regulation and social skills, and/or changing normative expectations regarding inaccurate beliefs about the high prevalence of substance use. Programs that are highly interactive in nature, skills-focused, and implemented over multiple years.

3. ***Is there any explanation for the spike in overdose deaths in 2006?***

   Presenter--Dr. Williams

   a. The increased prescribing of opiates and benzodiazepines drugs over the same period.
   b. The legacy of high potency, cheap and accessible heroin.
   c. The influx of Fentanyl.
   d. A younger naïve population of new users.

4. ***Do the fentanyl deaths include overdoses caused by heroin laced with fentanyl or just when fentanyl is taken by itself?***

   Presenter—Ellen DiDomenico

   Fentanyl may be included in a variety of illegal substances and be a contributing factor in overdose deaths.

   Presenter--Dr. Williams

   Both heroin laced with fentanyl as well as fentanyl taken by itself.

5. ***Were there any kickbacks from the local police or first responders, not wanting to carry the Naloxone? If so How did you handle those situations?***

Presenter--Ellen DiDomenico

Currently over 700 local police departments and an increasing number of first responders are carrying Naloxone. PCCD works with local communities to make Naloxone available at the local level and continue to encourage entities to participate. These funds to provide Naloxone were made available through the Governor's budget.

Presenter Dr. Williams

The push backs from the police primarily were around the injectables and the fear of accidental sticks. The other issue revolved around the state of mind of those coming out of the overdose in an agitated state.

6. ***Can you speak more specifically about how you implemented the "warm hand off" and what the policy change looks like?***

Presenter--Ellen DiDomenico

All the SCAs are required to have a warm hand off process in their community. In addition, DOH, DDAP and other partners are holding six regional summits in the next two months to focus on the development of local policies and protocols for warm hand offs.

Presenter---Dr. Williams

The "warm hand off" is still a work in progress in Philadelphia. Philadelphia has 19 Emergency Rooms (ER) and we are gradually phases them in. Philadelphia Single County Authority utilizes a Comprehensive Certified Recovery Model to facilitate warm hand offs for behavioral health care targeting overdose survivors in local area hospital emergency room settings. Certified Recovery Specialist (CRS) services are supplemental services available to individuals before, during, and after, and in lieu of formal clinical drug and alcohol treatment to achieve the fundamental goal of accessing and sustaining long term recovery in the community. The warm hand off is a State mandate. Philadelphia is currently using a single provider to hire the CRS's and disperse them to ER's during their peak time for overdose individuals. After stabilization, the CRS accompany the overdose survivor from the ER to the drug and alcohol assessment site should they agree to go. After the assessment, the CRS assist with linking the overdose survivor to the most appropriate level of care and for drug and alcohol treatment. All ER's can refer overdose survivors to treatment for behavioral health care by contacting our managed care entity, Community Behavioral Health (CBH) for the insured 24 hours a day, 7 days per week, and Behavioral Health Special Initiative (BHSI) for the uninsured and underinsured. The contracted provider is responsible for monitoring and tracking post overdose referrals and working collaboratively with CBH and BHSI. The policy became effective 12/4/17.

7. ***With such an extraordinary response and new services available, in places like Philadelphia and statewide, what else will it take to turn continually rising death tolls around? And what more should local communities be doing?***

   Presenter--Dr. Williams

   The resolution of this crisis will be in the community. If we are going to be in this for the long term (long term recovery), we are going to have to impact the social determinants of addiction community by community to isolate the spread of overdose, continuing to spread education and training about substance use disorders, overdose and overdose rescue. We will need to incorporate service providers with community members to familiarize one with the other and integrate providers better in the community. At the same time, we will need to reinforce routine healthcare interventions coordinated around physician led teams to encourage a wellness perspective. Lastly, we need to start chasing people and develop risk profiles that give us a certain amount of predictability about a child's, adolescent's, young adult and adult's exposure to risky behaviors and access to drugs.

8. ***Is there a website with a list of all of the county opioid coalitions and their contact information? (Anyone have an answer?)***

   Presenter--Dr. Williams

   I don't believe there is a central point for all the county coalitions outside of reaching out to all the county SCA's individually.

9. ***Where do I see if my county is already involved?***

   Presenter—Lynn Mirigian

   Please contact Lynn Mirigian at lym17@pitt.edu.

10. ***How effective is Vivatrox? I have heard that Vivatrox isn't a good idea because if a person decides to use, they will use more because they cannot get high, and this leads to an overdose. Is this true?***

    Presenter--Dr. Williams

    Are we talking about vivitrol? I am not familiar with the notion that vivitrol will make the person wishing to use want to use more. I have heard that keeping people on it, i.e., coming back after the initial injection was an issue for the person struggling with using. If they want to use they just stop the injections.

11. ***Informative presentation. But, nothing was said about what help is available for families harmed by addiction (family systems, and members, including children). Why was the family not mentioned?***

Presenter-- Lynn Mirigian

Dennis Daley would be a good person to contact.

12. ***I have known of several individuals who are on Methadone. They have been on this for 7+ years. Why aren't they being weaned? Are people ever weaned from Methadone or Suboxone?***

Presenter-- Ellen DiDomenico

Each person on medication assisted treatment is support through an individually determined plan with regard to length of treatment and other related services needed to be successful in their recovery. Individuals may be tapered from the MAT as appropriate to their individual needs.

Presenter--Dr. Williams

Methadone is a life sustaining drug and individuals should have choices as to how they want to sustain long term recovery. Would you ask the same question of someone with Type II Diabetes taking medication over their lifetime? Understanding the history of methadone and it's use for opioid dependence going back to the mid-sixties and over that time being the most successful for opioid dependence because of the long-term nature of peoples' opioid use prior to seeking treatment, many entered care with an altered brain state and needing to stay on the medication to maintain stability. Although there have been many who successfully came off the medication, many more have not for several reasons, most of all not psychologically, physically or socially ready, but they have been able to sustain their recovery, hold jobs, go to school and raise families. For those who have gotten to that point, what is the need to stop the medication? The factor that we should be concerned about are those few programs that only medicate and do not treat the person's addiction, as well as a system that has a maintenance focus and no protocols around addiction management where people are able to choose a plan to come off the medication without harmful consequences.

13. ***Are there jobs, or community service opportunities for participants in half way houses, or rehab, etc. Seems that giving them a purpose would be helpful? Concerned that being idle would not be helpful.***

Presenter-- Lynn Mirigian

Fulton County is starting this process.

Presenter --Dr. Williams

There are jobs related to community support and the role of the recovering person in giving back to the community. There is also a burgeoning need for a peer workforce providing support, outreach and navigation through systems of care.

14. Is there a limit to how many times an individual can enter a rehab program in our state?

Presenter-- Ellen DiDomenico

There is no overall limitation to the number of times an individual can access treatment. Individual programs may set limitations.

15. Once an individual is "clean" how are they re-introduced into society? How do they find work, etc? Or are they considered to be disabled for life?

Presenter--Dr. Williams

I'm not sure if "clean" is the right choice of words. Also, I question the language "reintroduce to society". Our language needs to change in the face of the conditions both environmental and social that pervade neighborhoods such as 'Kensington and Fairhill" (epicenter in Philadelphia). Regardless of the conditions, we are sending people back to the very environments they survived in their addiction, and will now have to survive in their sustained recovery. Have we provided support around networks of support, personal, familial and community empowerment? Are we supporting long term recovery and building of recovery capital? Are we addressing the stigma that impacts on one seeking treatment, and on the disparities in care, which undermines the quality of care? If this is true, how quite frankly are we introducing society to the individuals in recovery. No, they are not considered disabled for life in most cases. Yes, for the most part, they can find work. Please note that addiction is a brain disease and does not favor any one socio-economic group. To this end, individuals in long term recovery can work towards having a purposeful future.