



ANCOR

APPROACHES FOR NURSE-LED,
COMMUNITY-WIDE OPIOID
RESPONSES (ANCOR)



ICAP

Columbia University
Mailman School
of Public Health

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Preface

The **Approaches for Nurse-led, Community-wide Opioid Responses (ANCOR)** toolkit is rooted in an appreciation for the multifaceted role of nurses in their communities, and recognition of their unparalleled potential to lead the type of transformational change required to turn the tide on the U.S. opioid crisis.

In addition to providing care to people with substance use disorders, nurses educate patients and their families about prevention and treatment options and ways to mitigate harm. They mentor other nurses and care providers, advocate for policies and practices that reduce stigma and improve health outcomes, and convene stakeholders from different backgrounds to promote coordinated, effective action. In short, nurses are leaders and catalysts of change in their communities.

To harness their full potential towards reversing and ending the opioid crisis, nurses require up-to-date information on evidence-based tools and practices that can be immediately applied to their interactions with individual patients, their families, and the community at large.

The purpose of this toolkit is to activate nurses' unique potential to mobilize their communities towards a comprehensive response to the opioid crisis.

Acknowledgements

The ANCOR toolkit draws upon the insights and knowledge of the nurses and other public health and safety professionals who generously shared their time and perspectives with our team. It also reflects the experience, expertise, and contributions of multiple ICAP at Columbia University staff.

This toolkit and project were funded by Johnson & Johnson, in alignment with their long-term commitment to supporting nurses on the frontlines of health care. More information about ANCOR can be found at https://icap.columbia.edu/tools_resources/ancor/.

The funder had no involvement in research or content development for this toolkit. Its ideas and content are solely the product of ICAP.

Introduction

Since 1999, the U.S. has seen a dramatic and prolonged increase in drug overdoses. Overdose is now the leading cause of accidental death among adults, and two-thirds of overdose deaths involve a prescription or illicit opioid.¹ The opioid crisis demands a coordinated, comprehensive public health response that addresses the complex risk factors and co-morbidities associated with opioid misuse and addiction. At present, however, local responses to the crisis vary considerably due to differences in policies, infrastructure, resources, and leadership.

At the forefront of every local response to the opioid crisis are dynamic people who have committed themselves to overcoming barriers – including hostile laws and policies, limited resources and infrastructure, and persistent stigma – in order to prevent overdose deaths and provide a pathway to treatment and recovery for people with opioid use disorders. Often, these leaders are not executives or elected officials, but people in service professions – nurses, social workers, teachers, pharmacists, first responders – who have witnessed first-hand the harms of the opioid crisis and have chosen to act. Some have struggled personally with substance use and have resolved to use their experiential knowledge to help others.

This toolkit is written for nurses and other healthcare workers eager to engage in the opioid response, yet you do not need a nursing degree to use or benefit from this toolkit. Whether you are a seasoned health worker with experience treating substance use disorders or a community health leader eager to learn more, this toolkit is for you. Many types of public health workers, including first responders, social workers, doctors, pharmacists, and others, should find this toolkit useful.

WHY FOCUS ON NURSES?

Nurses are consistently ranked as the most trusted professionals in the U.S. In addition to providing individual care in hospital, school, and bedside settings, they interact closely with families and social support services and coordinate comprehensive care for patients. They are on the front lines of healthcare service delivery in rural, urban, and suburban areas and across a range of medical and non-medical settings. This toolkit seeks to harness the power of nurses as the largest segment of the health workforce, and to capitalize on their prominence to lead, galvanize and guide the opioid response. Together with other health workers and community partners, nurses can inspire a new norm of care that includes safer prescribing practices, stronger health education, intense patient advocacy, patient-centered care, and widespread access to prevention, early intervention, and treatment.

This toolkit has been written by a nurse-led team of physicians, social scientists and public health professionals to be user-friendly and to encourage **ACTION**. You will find a variety of resources, including introductory information on how to get started, real-world examples of promising practices and tools to improve your work, and a framework for developing a comprehensive response to the opioid crisis in your community. We encourage you to browse the toolkit content and use it in the way that best suits your needs. There is no “right” way of

using it; some may read it cover to cover, while others may search it for an answer to a specific question. The toolkit includes job aids to assist you in facilitating group exercises in your community, as well as case studies that can be used in training others. In short, the toolkit should serve as an action-oriented resource for seasoned professionals and community members interested in **learning and doing** more.

Toolkit Overview

The **ANCOR** toolkit consists of four learning modules:



Looking Back: The origins and evolution of the U.S. opioid crisis



Understanding Today's Reality: Emerging issues and promising practices in the response



Taking Action: Promoting change through collaborative assessment, planning and action



Controlling the Crisis: Measuring progress towards a comprehensive local response

Each module is organized around a set of core competencies and learning objectives, which are specified at the beginning of the module. The sections that follow – key information, patient-level and community-level case studies, small group exercises, and job aids and resources – are designed to equip nurses and other frontline workers with the essential information and skills they need to be effective caregivers to people with opioid use disorders and to mobilize their communities towards a more comprehensive response to the crisis.

Expected Outcomes

- Strengthened understanding of the history, antecedents and evolution of the opioid crisis
- Improved knowledge of and access to resource materials, program trailblazers, and emerging standards of care for prevention, treatment, and care of opioid use disorders
- Expanded capacity to educate frontline service providers and members of the community about opioid addiction prevention, emergency response, and treatment
- Increased awareness of the need for linkages between frontline service providers, public health professionals, health facility leaders, and social service providers to collectively strengthen the opioid response, and improved knowledge of linkage strategies
- Improved ability to assess and monitor your community's opioid response using a standardized assessment tool
- Increased confidence and competence to become a frontline nursing leader in an effective, data-driven opioid response

Module 1: Looking Back

Core competencies for nurses and other healthcare workers in the opioid response

1. The nurse (or other healthcare worker) can educate other healthcare professionals as well as the general public on the history and evolution of the opioid crisis
2. The nurse can educate other healthcare professionals and the general public on the interplay of pain management, addiction, and addiction prevention
3. The nurse can explain the basics of how opioids work and the role of opioid agonists and antagonists in opioid treatment and emergency management of overdose in a way that the general public can understand
4. The nurse can engage with individuals and groups to explore myths and assumptions about the opioid crisis using a non-judgmental approach that leads to greater understanding and engagement in the response
5. The nurse appreciates and can explain the interplay of addiction with an array of social and structural factors
6. The nurse recognizes the central role of nurses and the nursing profession in addressing the opioid epidemic and responds as a leader and agent of a strengthened response

Learning objectives

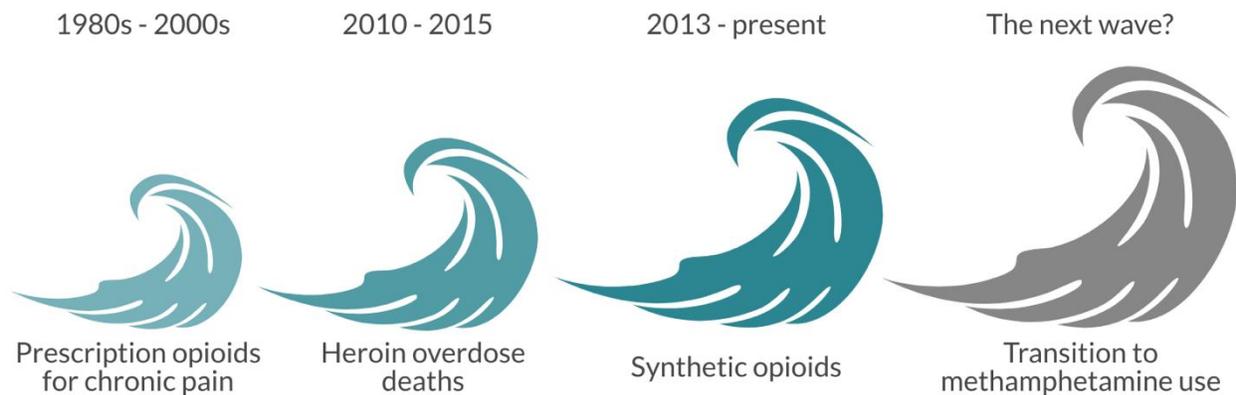
1. Summarize and explain the progression (or waves) of the U.S. opioid crisis
2. Refresh knowledge of how opioids work, their role in pain management, and the risks associated with opioid use
3. Distinguish common myths and misconceptions about the opioid crisis from reality and generate sensitive, accessible messages to educate the public about myths and misconceptions
4. Analyze the complex interplay of addiction with an array of social and structural factors and discuss nurses' experiences, challenges, and learnings as care providers for people with an opioid use disorder
5. Review, identify and discuss notable themes in the response

Key information

LO1.1: Origins of the U.S. opioid crisis: How did we get here?

The origins of the U.S. opioid crisis can be traced back to the 1980s. Since then, the crisis has grown in scope and severity as different modes of opioid misuse have emerged and overlapped. To understand how the crisis developed, it is helpful to envision a series of waves, each building on and intensifying the effects of the waves that preceded it (see Figure 1, below).

Figure 1: Waves of the U.S. Opioid Crisis



RISE IN PRESCRIPTION OPIOIDS FOR CHRONIC PAIN (1980s to 2000s)

The first wave of the opioid crisis was subtle and slow-moving. Flawed interpretations of a letter published in a medical journal in 1980 led many physicians to adopt the view that therapeutic use of opioids carried a very low risk of addiction. Despite its inaccuracy, this view soon became conventional wisdom in the medical community.

In the 1990s, a campaign by the American Pain Society touting pain as the “fifth vital sign” helped fuel a perception that physicians in the U.S. were systematically undertreating pain. Pharmaceutical companies also began to promote use of opioids in patients with non-cancer related pain. In 2001 the Joint Commission issued Pain Management Standards requiring healthcare providers to assess every patient for pain.

As attitudes towards pain management and opioid prescribing shifted, the Drug Enforcement Agency and Federation of State Medical Boards exercised less regulatory scrutiny over opioid prescribers, and pharmaceutical companies introduced new opioid formulations, including extended-release Oxycontin.

As a result of these actions, the number of opioid prescriptions per 100 persons increased by 35.2% from 2000 to 2009, and the average size of oxycodone and hydrocodone prescriptions increased by more than 69% during the same period.² Opioid diversion and misuse also began to soar, and the national opioid overdose death rate more than doubled, from 3.0 to 6.6 per 100,000 persons.³

SPIKE IN HEROIN OVERDOSE DEATHS (2010 – 2015)

The second wave of the crisis took hold around 2010. As early efforts to rein in opioid prescribing made prescription opioids harder to obtain and illicit drug trafficking and distribution grew more sophisticated, people with opioid dependencies began turning to heroin as a cheaper and more potent alternative. Heroin use increased among men and women, across the majority of age brackets, and across all socioeconomic groups, and heroin-related

overdose deaths soared. With more people injecting heroin, some communities also saw injection-related outbreaks of diseases including hepatitis C and human immunodeficiency virus (HIV).

SYNTHETIC OPIOIDS (2013 – present)

The third wave of the crisis emerged in 2013 as extremely powerful synthetic opioids like fentanyl were introduced into the illicit drug supply. Fentanyl is 50 to 100 times more potent than morphine and, because it comes in many forms – including tablets, powders, and liquids – it is often mixed with other drugs on the black market. From 2013 to 2016, the number of deaths attributed to fentanyl and related drugs nearly doubled each year.⁴ Many people who have overdosed on synthetic opioids were unaware that the drugs they consumed were laced with these substances.

A FOURTH WAVE ON THE HORIZON (2019-?)

Recent data on drug seizures and drug-related overdose deaths suggest that a fourth wave is striking as significant numbers of opioid users are also reporting methamphetamine use. Deaths related to methamphetamine use have increased sharply, and half of methamphetamine users in the U.S. suffer from an opioid use disorder.⁵ This fourth wave could prove especially harmful because, while there are highly effective medications available to treat opioid use disorders, no such treatment exists for methamphetamine addiction.

By applying the knowledge, resources, and practices in this toolkit, we can reduce the chances of experiencing yet another wave of the crisis. The remainder of this toolkit is written to empower you to take early and decisive action to address opioid-related public health challenges so that harm is minimized, and community wellbeing is maximized.

LO 1.2: How opioids work, their role in pain management, and risks associated with opioid use and misuse

WHAT OPIOIDS DO AND WHY THEY ARE ADDICTIVE

Opioids offer highly effective relief for acute pain, including pain associated with accidents, significant injuries, surgery, or even terminal cancer. They work by binding to receptors in the brain that release a natural substance called dopamine, which makes people feel relaxed, rested, happy – even blissful.

Unfortunately, opioids also have significant side effects such as nausea, vomiting, sedation, confusion, constipation, itching, dizziness, sleepiness or loss of consciousness, and decreased respiratory drive. Furthermore, people taking opioids can develop tolerance – a need to take increasing doses in order to get the same degree of pain relief – as well as withdrawal symptoms when they stop taking opioids. Withdrawal, which can occur after using opioids for as little as a few days, includes a number of complex, uncomfortable symptoms such as abdominal or muscle pain, anxiety, piloerection (goose bumps), insomnia, watery eyes, restlessness, sweating, or rapid heart rate. These symptoms occur when people decrease their dosage or stop using an opioid.

A substantial number of people who initiate use of opioids will have difficulty stopping, whether due to recurrence of pain, withdrawal symptoms, or loss of their improved sense of well-being while taking opioids. These people are at risk of developing an opioid use disorder or addiction, the continued use of a drug despite negative consequences. Opioid addiction is characterized by:

- inability to consistently abstain from using opioids,
- impairment in behavioral control,
- craving,
- diminished recognition of significant problems with one's behaviors and interpersonal relationships, and
- dysfunctional emotional response.⁶

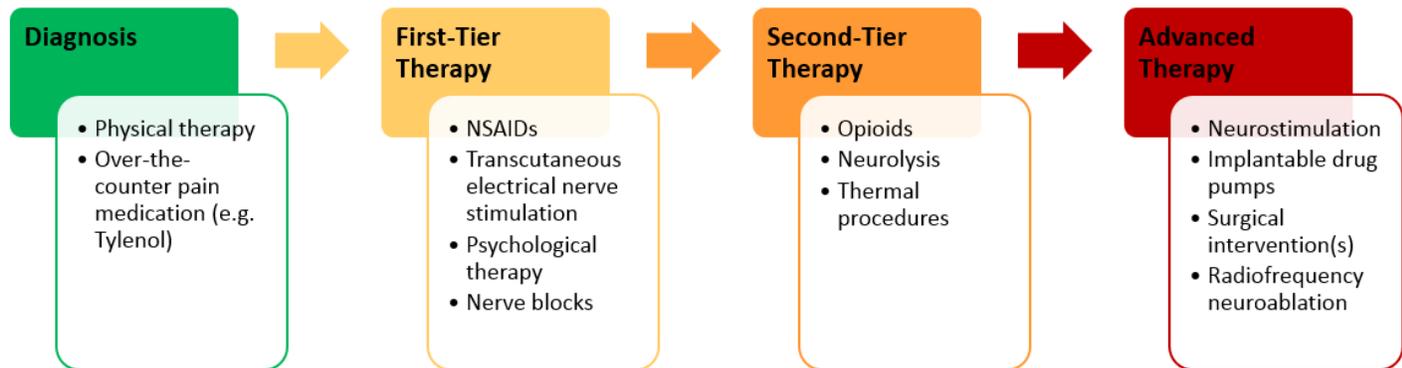
Opioid dependence arises from repeated exposure to opioids, and it can occur in individuals using prescription opioids to relieve pain as well as in nonmedical users. Observational data have shown that people who misuse or become dependent on one substance are more likely to misuse or become dependent on other substances, though the reasons for this are not fully understood. It is worth noting that use of opioids – even chronic use – is not necessarily a sign of an opioid use disorder or addiction.

OPIOIDS IN PAIN MANAGEMENT

Opioids are recognized as appropriate for the short-term treatment of severe pain. However, their unfavorable side-effect profile and addictive properties mean that they should be used in the lowest dose and for the shortest time possible, in accordance with [CDC guidelines](#), and should not be considered a first-line therapy. Generally, a patient should receive only a one- to five-day course of opioid treatment with plans to rapidly transition to acetaminophen, NSAIDs, or other modalities as their pain recedes. Local anesthetics, hot or cold packs, physical therapy, or other pain management modalities are adjunctive therapies that reduce opioid use and duration. Patients should be educated about the addictive potential of opioids, and their pain should be managed by a provider who has knowledge of all medications prescribed to the patient.

For individuals who have chronic pain conditions, opioids should be a last-resort option. Given the rapid development of tolerance and addictive potential, other modalities should be exhausted before the use of chronic opioid therapy is considered. These include the modalities discussed above, as well as orthopedic interventions, adjuvant medications such as gabapentin or antidepressants, and/or consultation with a pain specialist. Tools such as the [Nurses' Call to Action for Safer Opioid Prescribing](#) and [Opioid Risk Tool](#) are helpful in predicting and managing the risk of abuse of opioids prescribed for chronic pain. Nurses play a critical role in educating patients about their medications and advocating use of meditation, physical therapy, and other modalities of adjuvant or primary pain management. When pain relief is not adequate, nurses are an important source of information about other options or referrals. Figure 2, below, illustrates the spectrum of pain management options ranging from over-the-counter medications to advanced therapies.

Figure 2. Fundamentals of Pain Management



OPIOID OVERDOSE

The medical complications of opioid use are influenced by the drug(s) used, the amount used relative to the user's tolerance, and the method of use. All opioids can cause respiratory depression, and most overdose deaths occur because the user stops breathing. Although overdose from oral opioids is possible, it is much more likely when drugs are injected or consumed in combination with other respiratory depressants such as benzodiazepines or alcohol. Consumption of stronger synthetic opioids such as fentanyl (whether intentional or inadvertent) greatly increases the risk of overdose.

The development of naloxone, an effective opioid antagonist that can be administered easily by friends, family, or first responders in the form of a nasal spray, has dramatically improved the ability to save lives by reversing respiratory depression caused by opioids. Other strategies to reduce risk of overdose death include:

- use of drugs with friends or injection buddies who can summon assistance or administer treatment with naloxone;
- self-testing of drugs for fentanyl;
- education about slowing the injection rate; and
- use of safe injection facilities (also known as safe consumption sites or supervised injection sites) where a trained staff member is available to summon help and/or administer naloxone treatment (an approach whose legality has been contested in the U.S.).

Opioid users who temporarily abstain from use due to hospitalization, incarceration, or self-detox should be educated to understand that their tolerance will decline during abstinence and that they face a higher risk of overdosing if or when they resume use.⁷

MEDICAL COMPLICATIONS OF INJECTION OPIOID USE

Many of the medical complications of opioid use are related to unsterile injection. Bacterial infections from contaminated needles or drug paraphernalia, or contaminated drugs or water, can cause problems that range from mild irritation of the vein to large soft tissue infections

(furuncles, abscesses, cellulitis, or even necrotizing fasciitis that results in loss of limbs) to critical illness from sepsis, infection that invades joints, heart valves, the brain, or other sites. In addition, the sharing of used syringes has the potential to transmit serious bloodborne viral infections between drug users; these may also be transmitted to the sexual partners of infected drug users. These infections include HIV, hepatitis B, and hepatitis C.

Treatment of serious deep infections, most notably endocarditis (infection of the heart valves) or joint infections, often requires long courses of intravenous antibiotics. This can be problematic because injection drug users often have sclerosed veins, and maintaining intravenous access is extremely challenging. Severe endocarditis may require surgical replacement of the involved heart valve, and artificial heart valves are even more susceptible to reinfection.

The use of a harm reduction approach addresses these serious medical complications by encouraging use of clean syringes and injection supplies, instruction in careful sterile injection techniques, prompt wound care (including drainage of abscesses), and judicious use of antibiotics for the treatment of skin or soft tissue infections, potentially preventing many of these serious complications of drug use. Harm reduction also extends to vaccination against hepatitis B, rapid identification and treatment of individuals who have hepatitis C, and use of antiretrovirals (pre-exposure prophylaxis, or PrEP) to prevent HIV are interventions that may be life-saving to both the user and the community.

LO 1.3: Common myths and misconceptions about the opioid crisis

MISCONCEPTION: People with opioid use disorders are to blame for their addiction.

REALITY: Opioid use disorders do not result from a lack of principles or willpower; they develop over time and involve changes to the brain that make quitting hard. A number of factors may lead someone to misuse opioids; misuse may begin out of a desire to feel better or different or – as in most cases – with the use of a prescribed opioid in ways other than prescribed or seeking opioids on the street⁸. For example, many teenagers develop opioid use disorders after taking opioids prescribed during dental procedures.

The probability of developing an opioid use disorder is mediated by a number of biological, psychological, and social factors, including but not limited to: history of opioid or other substance use, previous mental health diagnoses, depression, age, anxiety, trauma, and employment status.⁹ Other factors, including adverse childhood experiences, lack of economic opportunity, exposure to intimate partner violence, and recent incarceration, have also been associated with higher rates of substance use.^{10,11} One, several, all, or none of these factors may influence an individual's use of opioids.

MISCONCEPTION: People with opioid use disorders only care about one thing: opioids. They do not want to improve their health, relationships, housing, or other aspects of their daily lives.

REALITY: A salient theme in the opioid response is the deep desire of people who use drugs to be healthy and accepted. Understanding the neurobiology of opioid use disorders is important to providing effective, appropriate treatment, care, and support for opioid users. While some brain abnormalities are the result of chronic opioid use, others are present before opioids are ever consumed.¹² Regardless of their cause, these abnormalities interact in complex ways with environmental variables like stress, social context, and psychological conditioning as people who use opioids go through stages of drug employment, tolerance, dependence, and addiction.

When an opioid use disorder advances to the stage of addiction, the biological need for opioids is so strong that the opioid user will seek opioids compulsively despite adverse consequences. Before a person with an addiction can focus their energies on health, relationships, or any other aspect of life, they need to fulfill this need, either through continued drug use or treatment and recovery.

People with opioid use disorders often risk social marginalization, arrest, harassment, or worse in order to access healthcare, harm reduction, and other support services. When these services are not accessible or available, it is not uncommon for people with opioid use disorders to care for one another instead of seeking care through institutional channels.

The bottom line? It's not that people with opioid use disorders don't care about their health and wellbeing. Rather, they face barriers to accessing services, or they prioritize drug use over other needs in order to avoid the suffering that accompanies withdrawal.

MISCONCEPTION: Providing anti-overdose medication, methadone and other medications for opioid use disorder, syringe exchange, and supervised injection services encourages and increases opioid use.

REALITY: Narcan (naloxone) – an anti-overdose medication with no potential for abuse – can be administered by medical professionals and untrained bystanders alike. In fact, four out of five overdose reversals with naloxone are carried out by bystanders who also use drugs.¹³ Studies have demonstrated that increasing access to naloxone does not increase opioid misuse or overdose.¹⁴ Medications for opioid use disorder (MOUD) with buprenorphine, methadone, or naltrexone is the most effective treatment for opioid use disorder (see **1.5** for additional detail).^{15, 16} When used to counter opioid use and overdose, both naloxone and MOUD are extremely successful in increasing a person's odds of recovery while reducing their opioid use.^{17, 18, 19, 20} MOUD also has been demonstrated to reduce overdose deaths following release from incarceration when initiated among prison populations²¹.

Syringe exchange programs and safe injection sites show similar success. Syringe exchanges reduce the spread of infectious disease and provide a linkage to critical treatment and support services.²² Safe injection sites provide people who inject drugs a hygienic space to use drugs

under the observation of people trained to administer naloxone and summon help. Although their legality is in question in the U.S., implementation of safe injection sites has been shown to improve individual health among people who inject drugs while reducing overdose mortality rates and illicit drug use. They are also associated with increased enrollment in drug treatment and reduce the spread of HIV, viral hepatitis and other infectious diseases^{23, 24, 25}.

Treatment and harm reduction services of all shapes and sizes have proven effective in reducing the rate of overdose death and opioid use while increasing engagement in treatment among users. Unfortunately, stigma towards people with opioid use disorders limits public support for allocating government resources to these critical services, making them more difficult to access²⁶.

MISCONCEPTION: The opioid crisis has peaked, and we've already seen the worst of its effects.

REALITY: Although the opioid crisis is gaining increased attention in the U.S., a comprehensive response to its root causes is lacking. Given the number of people already suffering from opioid use disorders, the rate of overdose and related deaths is likely to rise²⁷.

As regulations on prescription opioids grow stricter, people with opioid use disorders are likely to turn to other drugs, including illicit opioids. Heroin is several times more potent than prescription opioids and may be laced with fentanyl or other illicit synthetic opioids that can be fatal even in minute doses. The presence of fentanyl-laced cocaine is also on the rise in some areas.

Methamphetamines also pose a growing threat. Half of all methamphetamine users in the U.S. suffer from an opioid use disorder²⁸. The trend towards methamphetamine use and fentanyl-laced methamphetamine is particularly harmful because, while there are highly effective medications to treat opioid use disorders, no such treatment exists for methamphetamine addiction.

We can't predict the future, but the crisis is likely to worsen before it improves.

MISCONCEPTION: It's not my responsibility to address the opioid crisis, and I'm sure someone else is already doing it.

REALITY: The opioid crisis affects everyone, not just those with opioid use disorders. We all have a role to play, and collaboration among healthcare workers, frontline staff, policy makers, law enforcement, community members, family and friends is critical to success.

As the crisis continues to gain attention across the U.S., it is clear that the status quo is not adequate to address the problem at hand. Reducing opioid-related morbidity and mortality will require continued, focused, collaborative action from all of us.

LO 1.4: Interaction of opioid use disorder with social determinants of health

SOCIAL DETERMINANTS OF HEALTH

Like other forms of addiction, opioid use disorder is a chronic disease that influences and is influenced by an array of factors, some of which are specific to an individual and others of which are structural in nature. Individual factors known to strongly interact with addiction include depression, post-traumatic stress disorder, and learned behaviors. Structural factors relate to the broader conditions under which people are born, grow, live, work, and age. The subset of structural factors that influence an individual's health outcomes – such as household resources, access to healthcare, exposure to racism or violence, familial and social support, and housing and transportation resources – are known as *social determinants of health*.

Opioid dependency can cause deterioration in an individual's social determinants of health by weakening family and social bonds, causing isolation, and increasing exposure and vulnerability to violence. The stigma that accompanies dependency – whether anticipated or experienced – can compound an individual's social stressors and sense of isolation, leading to a gradual decline in many of the conditions that influence health. This decline has a negative impact on mental health and well being and can intensify addictive behaviors, creating a vicious cycle.

Social Determinants of Health

- Access to healthcare and nutrition
- Early childhood social and physical environment
- Education and health literacy
- Familial and social support
- Housing and transportation resources
- Neighborhood safety and recreation facilities
- Occupation and job security
- Social exclusion
- Structural racism

Through its disproportionate impact on Black, Latinx, and Native American populations, the COVID-19 pandemic has illuminated the tremendous influence that social determinants of health have in creating disparate health outcomes. COVID-19 also exacerbated structural factors that increase risk of opioid overdose and death – housing insecurity, job insecurity, social exclusion – while reducing access to treatment for opioid use disorders, harm reduction programs, recreation and family support networks. The dual threat posed by COVID-19 and the opioid crisis demands sustained, responsive action at both the policy level and the provider level.

INTEGRATED, HOLISTIC SERVICES FOR PEOPLE WITH OPIOID USE DISORDERS

Because of the intensity of interaction between opioid dependency and social determinants of health, it is essential that nurses and other caregivers are equipped with the competency and resources to address patients' needs holistically. Integrated care delivery models, many of which have been tested and refined in the context of the HIV response, can help assure that patients access the critical psychological and social support they need when they need it.

Multidisciplinary provider teams, peer support, and active referral systems between hospitals, clinics, and social service agencies are examples of service integration techniques that can be utilized at every stage of the care continuum, from prevention to sustained recovery.

Many people with opioid use disorders struggle with homelessness or housing instability, and access to safe, stable housing is a critical need as they initiate treatment for or recover from an addiction. Communities have started to recognize and respond to this need using *housing first*, *recovery housing*, and *permanent supportive housing* models that focus on meeting people's basic needs with no prerequisites, so that they have a stable foundation from which to seek treatment for substance use disorders and find employment. Forging partnerships and collaborations between healthcare providers and local housing agencies can help increase uptake of and adherence to treatment among people with opioid use disorders.

Another evidence-based approach that considers social determinants of health is *critical time intervention (CTI)*, which mobilizes community and social support for individuals during periods of transition, such as when they are completing recovery or being released from jail or prison. Data show that individuals with opioid use disorders face the highest risk of overdose when they have been abstinent for a period and their tolerance has waned. CTI ensures that people have access to medications for opioid use disorder (MOUD) and the other supports they need (e.g. housing, mental health services, job placement services) during the transition period, and that these other supports are gradually scaled back as they rebuild and strengthen their local support networks.

IMPORTANCE OF SELF-CARE

Degradation in an individual's social determinants of health affects not only the individual and those close to them, but the providers (doctors, nurses, social workers) responsible for treating and supporting them. Caring for patients with an opioid use disorder (or any addiction) can be chaotic, stressful, and frustrating due to the overwhelming range and severity of patient needs. It is vital that caregivers prioritize their own health and well-being through a combination of self-reflection, self-care, and support from fellow caregivers. Daily habits, like monitoring inner dialogues and attitudes, are an important part of sustaining a healthy state of mind and a positive work environment.

LO 1.5: Key themes in the response

Federal, state, and local responses to the opioid crisis are evolving rapidly as evidence on the effectiveness of different policy and programmatic interventions grows. While no two local responses are the same, conversations with stakeholders in communities across the U.S. reveal several common themes. Understanding these themes provides important context about how local responses take shape, the obstacles they face, and the importance of adapting interventions and services to the whole person – not just their opioid use disorder.

LOCAL TRAILBLAZERS AND CHAMPIONS

The current opioid response is being led by concerned individuals and groups who are compelled to take action in their communities for a variety of reasons, including personal experience with addiction. Many programs and services that have emerged at the local level embrace harm reduction strategies that aim to reduce the negative consequences of drug use while respecting the rights of people who use drugs.²⁹

In some communities, harm reduction services have been widely available since the early years of the HIV/AIDS crisis. In other places, they have emerged in the last five years in response to the proximity and magnitude of the opioid crisis. When school officials, first responders, care givers and friends have come together to confront the enormity of the crisis, change has occurred. These “trailblazers” have led the innovation and development of innovative, community-based models of care.

There is no single profession or group of individuals leading the opioid response. This contrasts starkly with the organized nature of the HIV/AIDS response in the late 1980s and 1990s, when the grassroots political group AIDS Coalition to Unleash Power (ACT UP) galvanized the gay community to demand funding for and access to HIV care and treatment and research.

Whereas ACT UP built a highly visible national campaign to demand action from government and the medical profession, advocacy for the opioid response has not yet achieved a similar level of coordination and impact. Given the intense stigma and legal ramifications of injection drug use, many providers of harm reduction services have kept a low profile, relying on informal networks and word of mouth to increase access to services. Many services have been developed through grassroots efforts by opioid users now in recovery, who have invested themselves in helping others despite numerous structural, legal and funding barriers.

MISSED OPPORTUNITIES AND GAPS

Within the health professions (e.g. nurses, doctors, social workers, community health workers, etc.) there are many unsung heroes working tirelessly in the opioid response at the individual, family, and community levels. Many health workers are deeply invested in improving care and access to services for people with an opioid use disorder, promoting policy change, and advancing research on addiction and addiction medicine. Their work spans many settings, including clinics, hospitals, academic institutions, and prisons.

Yet there are significant gaps and challenges that require urgent attention. The response of health professions and health systems as a whole has been fragmented and uncoordinated. Comprehensive care programs are largely absent, and stigma pervades the health system at all levels, from emergency departments to prenatal consultation rooms to commercial pharmacies.

One enormous challenge in the response is the number of barriers individuals face when trying to access addiction recovery healthcare. Barriers include the cost of care, the cumbersome process of accessing services (insurance pre-approval, multiple appointments, paperwork,

incomplete episodic care), and agonizing wait times to enter recovery programs. Each barrier to care is a missed opportunity to initiate a person on the road to recovery and wellness.

A common theme heard among people who use opioids is that stigma is prevalent in the healthcare system, in communities, and among law enforcement. When stigma is perceived or experienced, trust is lost. Stigma can also lead to erratic engagement with the health system and delays in seeking care. With opioid use disorders, delays in seeking care can have severe and irreversible consequences including death. Stigma can take many forms and leads to a person or group of people feeling diminished, devalued and fearful.³⁰ Stigma can also be internalized as self-stigma. We discuss stigma in greater detail in **2.3**.

THE DESIRE FOR WELLNESS

A third salient theme in the response is the deep desire of people who use drugs to be healthy. People who inject drugs typically overcome significant barriers to access harm reduction services. They risk arrest, harassment and stigma to obtain clean syringes, dispose of supplies safely, and test drugs for adulteration in order to protect their health and the health of others. Engagement in harm reduction is a critical point of entry into treatment and recovery, yet in many places harm reduction services remain unavailable or heavily stigmatized.

A patient-centered response leverages individuals' desire for wellness to engage them in the health system so that they receive appropriate care and treatment, timely management of co-morbidities such as HIV and hepatitis, ongoing support for recovery, and linkage to services that address social determinants of health. Without a patient-centered approach, the vicious cycle of addiction-recovery-relapse is more likely to continue, with costly and damaging consequences for individuals and society. Complications like endocarditis and co-morbidities like HIV are preventable, yet individuals and society continue to incur extreme costs for not preventing these. A focus on wellness amidst addiction is both cost-effective and potentially lifesaving. It can help communities move from counterproductive blaming and shaming to a holistic response grounded in cost effective, evidence-based, pro-health strategies.

INADEQUATE TREATMENT ACCESS AND RETENTION

Abstinence-based approaches to treating opioid use disorders have very limited success. Relapses are exceedingly common, even after years of abstinence. Medications for opioid use disorder (MOUD) demonstrate better outcomes including improved social functioning, lower rates of overdose and death, lower rates of infectious complications, and reduced criminal activity. FDA-approved MOUD include methadone, naltrexone, and buprenorphine (see the call-out box below for an overview of each one).

Buprenorphine is a powerful tool in the opioid response. Because it is minimally sedating, does not usually cause feelings of sedation or euphoria, and is very unlikely to result in respiratory depression, buprenorphine can be prescribed to people with an opioid use disorder for self-administration at home. And eligible patients can initiate buprenorphine at any time – even in the emergency department following an overdose event.

Despite the tremendous efficacy of MOUD, fewer than 50% of those who need it receive it, and the treatment gap is wider among adolescents and youth.³¹ It is not uncommon for rural counties with high rates of opioid overdose to have only a single authorized provider of MOUD, and in places where MOUD is widely available, stigma, insurance pre-approvals, and logistical barriers can prevent people from accessing it. In addition, rates of treatment retention are poor. Improving MOUD access and retention is a priority for most communities confronting the opioid crisis.

Medications for treatment of opioid use disorders

Methadone is an opioid agonist, meaning it binds to the opioid receptors in the brain, relieves pain, prevents withdrawal symptoms, and promotes a sense of wellbeing. However, users experience little sense of euphoria (being “high”) and less sedation than they would with other opioids. Federal regulations currently restrict methadone treatment to designated treatment centers and generally require daily directly observed therapy, though the latter requirement has been relaxed to extend take-home medications to **existing patients** during the COVID-19 emergency. The need for daily clinic visits often interferes with other life activities, and many individuals receiving methadone report feelings of sedation or mental fogginess, as well as constipation.

Naltrexone is an opioid antagonist that has efficacy in decreasing alcohol and opioid cravings; it blocks both the sedative and euphoric effects of opioids. However, people have to be completely off all narcotics for seven to 10 days before initiating Naltrexone. This period of abstinence is difficult for many opioid users. Furthermore, use of illicit opioids while on naltrexone can result in an overdose. Naltrexone is available as a daily pill but is usually given as a monthly intramuscular (IM) injection.

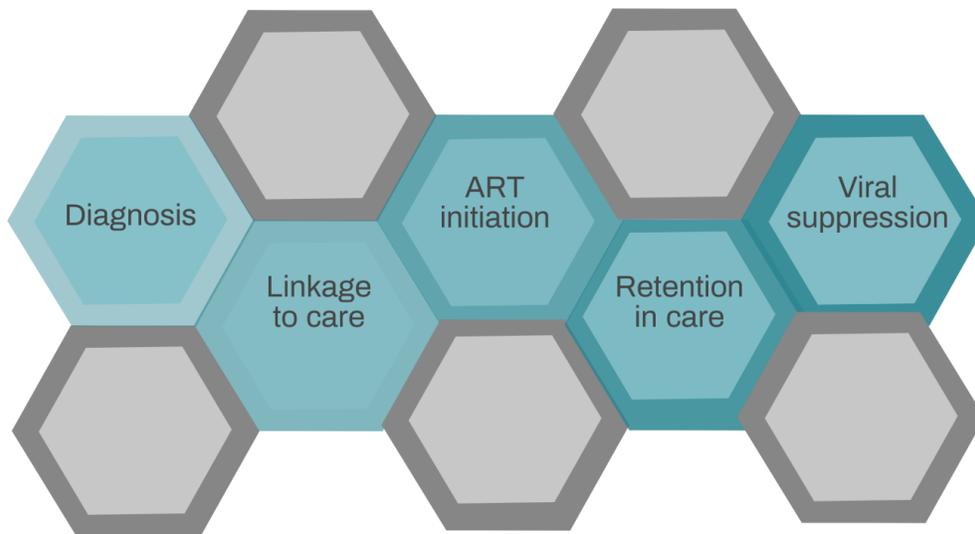
Buprenorphine is a newer medication that has both agonist and complex antagonist properties. Inconsistent or intermittent dosing of buprenorphine risks causing withdrawal, while daily regular dosing prevents withdrawal symptoms with efficacy similar to methadone. Buprenorphine is minimally sedating, does not usually cause the feeling of being sedated or euphoria (“high”), and is very unlikely to result in respiratory depression. Because of these advantages, it can be dispensed to patients as a take-home medication. In the context of the COVID-19 pandemic, federal agencies have waived the in person evaluation requirement for buprenorphine and have authorized take-home prescriptions of up to 28 days for stable patients.

TOWARD A CONTINUUM OF CARE

One of the major learnings from the public health response to the HIV epidemic in the U.S. is the critical importance of comprehensive, patient-centered care that addresses individual and structural risk factors at each stage of the HIV care continuum (see Figure 3³², below), from initial diagnosis to sustained viral suppression. Positive movement along the care continuum is not assured; some individuals who achieve viral suppression may return to earlier stages of the continuum at some point in their lives. However, by aligning services and resources to meet patient needs at each stage, healthcare professionals and systems increase rates of viral suppression, a key driver of epidemic control.

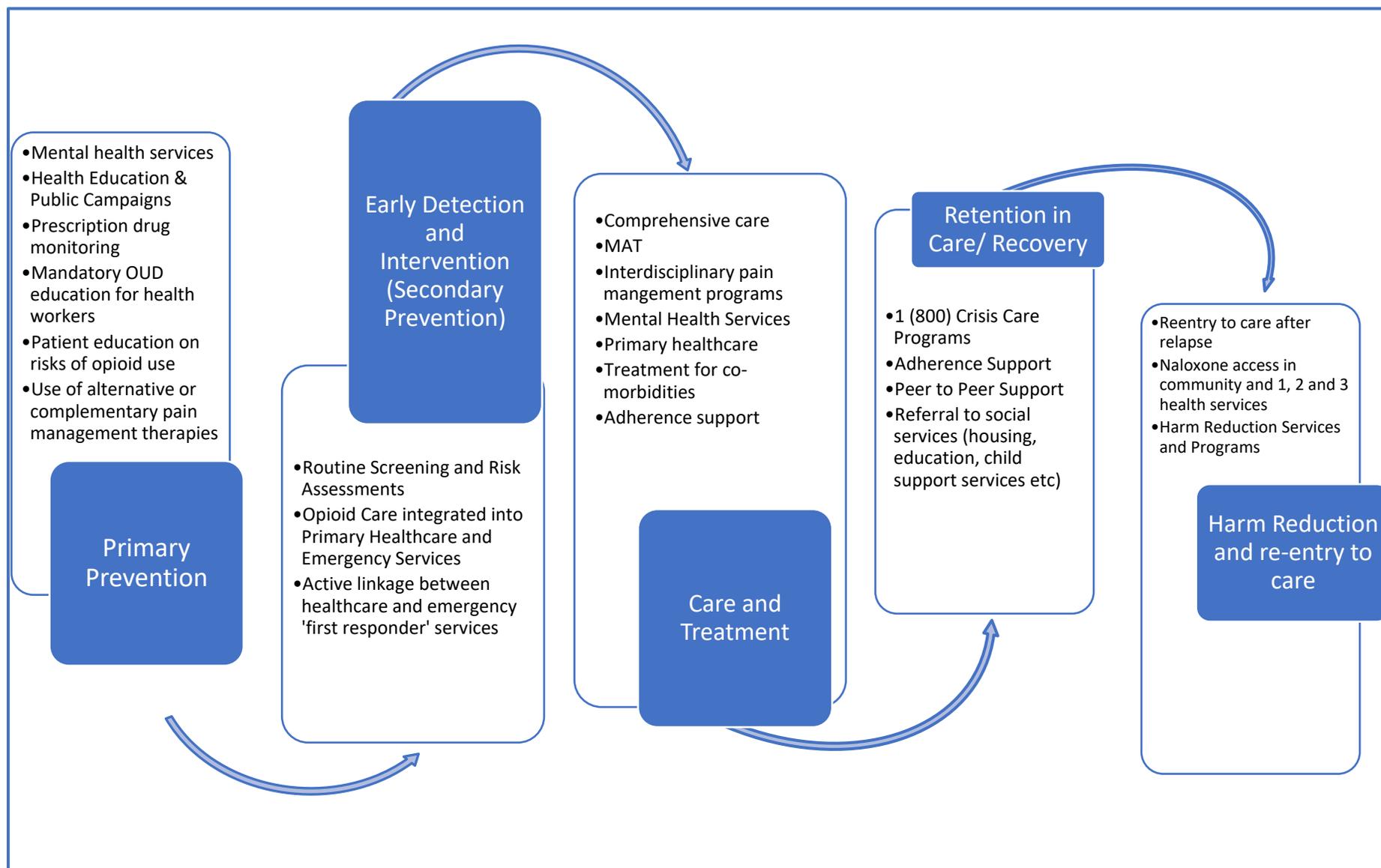
Figure 3: HIV Care Continuum

HIV Care Continuum: The steps a person takes to achieve successful treatment with ARV drugs



The care continuum concept is a useful point of reference for envisioning what a comprehensive response to the opioid crisis could and should look like. Individuals with an opioid use disorder – as well as those at risk of developing one – require holistic, evidence-based services and support at multiple stages, from education and primary prevention through MOUD and recovery. Figure 4 (below) depicts the key stages of an opioid use disorder care continuum, along with illustrative services required at each stage.

Figure 4: Care Continuum for People with an Opioid use Disorder



Exercise #1: Think Globally, Act Locally

There is no one cause or solution for addressing the opioid crisis in the U.S. It is a complex and multifaceted social problem which took many years to develop. While stronger regulation, improved health worker training, and patient awareness are critical to addressing the crisis, it will take people at all levels of the health system, from the family to state and federal policies, to achieve long-lasting results.

- The opioid crisis can be described as a multifaceted problem because personal, social, economic, environmental and cultural factors are involved.

From what you have read, heard on the news or seen in your job, list out as many problems as you can for each category using the handout to record the group's responses.

Category	Examples	Brainstorm List
Personal	e.g. depression	
Social	e.g. change in prescribing practices	
Economic	e.g. loss of jobs and social services	
Environmental	e.g. change in drugs circulating on the black market	
Cultural	e.g. emphasis on personal responsibility and autonomy	

- Given the many categories or dimensions of the opioid response, discuss why broad stakeholder engagement is needed to comprehensively address the opioid epidemic.

Record the group's feedback here.

Exercise #2: We're in this together

This exercise is a facilitated discussion based on anonymous input from participants.

Step 1- Introduce this exercise as an opportunity for participants to share stories in a safe and anonymous way. Its purpose is to explore shared experiences of the opioid crisis.

Step 2- Pass out one note card to each participant and ask them to write down one experience, challenge or lesson learned from their work or engagement in the opioid crisis. Instruct participants that no names of people or places should be written down.

Step 3- Collect and read through the cards. If you are working with a large group, read out multiple cards at a time.

Step 4 – Give time for people to think about what was shared. Ask participants the following reflection questions.

REFLECTION QUESTIONS

1. As the cards were read did you notice any common themes or issues in what was shared?
2. Is there anything that surprised you? If yes, why? If not, why not?

Case studies

John, the star football player

John, the star wide receiver for his college football team, was looking forward to a successful future in the NFL. During a game his sophomore year, he sustained a serious injury involving both a broken femur and a torn anterior cruciate ligament (ACL). He spent three months recovering at home with his family. Following surgery to repair the torn ligament, he received a prescription of Vicodin to alleviate severe pain from the surgery and leg fracture. After adhering to the prescribed dosage for two weeks, he tapered (reduced) the amount of Vicodin he was taking in week three.

John immersed himself in his studies to catch up on missed classes. When his sports medicine doctor told John it was time to start physical therapy, he was excited to get moving again and hoped he could be strong enough to join his teammates for summer training.

Being a high-performance athlete, John's physical therapy was intense. The pain in his knee persisted after therapy and was quite severe at times. While visiting his girlfriend in another state, his pain was aggravated when he slipped and fell at the pool. His girlfriend took him to an urgent care center where John was prescribed Percocet. He wasn't familiar with this drug, but the doctor reassured him it was safe and would help with the pain. Soon after, John returned to college for two months of intense summer training with his team. Through the summer, he continued to use Percocet to manage the pain.

- Discuss and debate the points in time when John was most vulnerable to developing a drug addiction.

When John's Percocet prescription ran out, he started experiencing severe withdrawal symptoms. His college doctor told him ice and a NSAID would help. He would not prescribe any drugs. John's friend told him he could get him some.

- List actions that could have been taken to avoid the development of John's drug addiction.

Is John's situation a symptom of a larger problem?

John's teammate Mark is in a similar situation, having sustained injuries on the football field that still cause him pain. Instead of reaching out to a friend, though, he recalls seeing a sign for a pain management clinic where no appointment is needed. After experiencing a lot of pain during today's practice, he decides to stop at the clinic on his way home. Mark is surprised by how busy the waiting room at this clinic is, but after an hour he receives the following prescription:



*Oxycontin 80 mg
1 tablet per day once a day.
Dispense 60 tablets 8 refills*

- Based on Mark's experience, discuss at least 3 reasons why this community has a significant opioid problem on its hands.

Job aids/Resources

- [Nurses' Call to Action for Safer Opioid Prescribing](#)
- [Opioid Risk Tool](#)
- [CDC Guideline for Prescribing Opioids for Chronic Pain](#)
- Social Determinants of Health, the Opioid Epidemic and COVID-19: [Opioid Response Network](#)
- NYTimes [feature](#) on nun, doctor, lawyer
- How opioids work: [National Geographic/HarvardX "Susan's Brain" video animation](#)
- How MOUD works: [PBS/MPT Digital Studios "Medication Assisted Treatment" video](#)
- How naloxone works: [NIDA/NIH "How Naloxone Saves Lives in Opioid Overdose" video](#)

Module 2: Understanding Today's Reality

Core competencies:

1. The nurse (or other healthcare worker) has a global understanding of the current crisis, including its geographic and demographic characteristics, and knows about key policies and promising practices in the response
2. The nurse can engage other health workers and community members in a learning session that presents and encourages nonjudgmental language and dialog to explore the reality of today's opioid crisis
3. The nurse can lead group exercises and case studies that encourage deeper understanding of the strengths and weaknesses of federal, regional and local responses
4. The nurse can motivate public health workers and community members to become part of the local response using action-oriented job aids and other response-focused resource materials

Learning objectives

- Understand the current crisis in the U.S., including its geographic and demographic distribution, and identify and describe key policies and promising practices in the response
- Explore and practice how to effectively engage health workers and community members in learning about today's crisis
- Practice techniques for addressing stigma by creating a trusting atmosphere where people can openly discuss their questions, concerns, and feelings
- Discuss key strengths and weaknesses in federal, regional and local responses with an audience including public health workers and community members

Key information

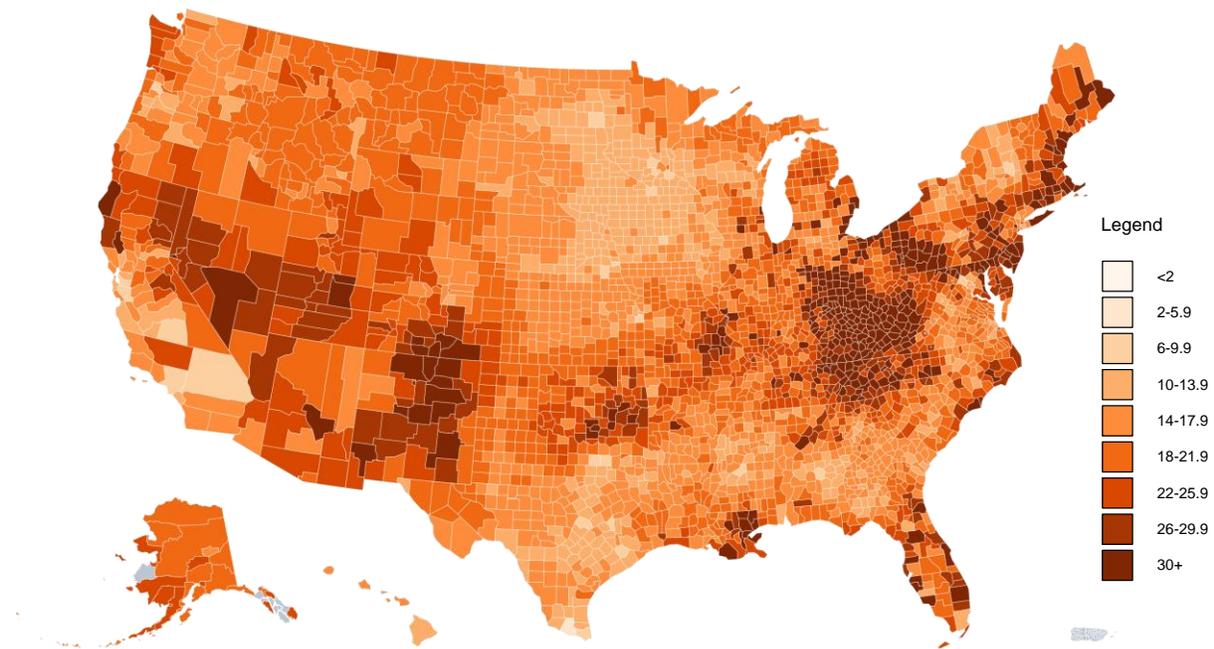
LO2.1: Data and trends in the opioid crisis

GEOGRAPHIC CONCENTRATION

Although the contemporary opioid crisis first took hold in predominantly white, rural communities, its impact now extends across racial, socio-economic and urban-rural lines. Approximately 41% of drug overdose deaths occur in urban counties, 26% in the suburbs, 18% in small metropolitan areas, and 15% in rural communities.³³ Geographically, opioid overdose deaths are concentrated in Appalachia, New England, pockets of the Southwest, and major population centers, as illustrated in the heat map³⁴ in Figure 5, below.³⁵

Figure 5: Drug Overdose Death Rate per 100,000 people in 2017 (modeled)

Age-adjusted Drug Poisoning Deaths per 100,000 (Modeled) (2017)



Source: amfAR Opioid & Health Indicators Database (opioid.amfar.org)
Accessed October 14, 2019

As of 2019, drug overdose deaths involving prescription opioids have started to decline in most states amid growing prescriber awareness and tighter controls over prescribing practices. However, overdose deaths involving heroin have increased or remained stable in several states, while overdose deaths involving synthetic opioids like fentanyl or carfentanil are still rising in most states and across all settings (urban, rural, suburban).

DEMOGRAPHICS

People dying of opioid overdose in recent years have been disproportionately white, male, middle-aged adults,³⁶ yet other groups – including African Americans in midwestern states and Native Americans – are at heightened or increasing risk of overdose death. In Chicago, the rate of opioid-related deaths is higher for non-Hispanic blacks than for any other race, and inter-group disparity has widened sharply since 2015³⁷. Nationwide, overdose mortality is rising faster among African Americans than among other racial or ethnic groups,³⁸ and opioid use disorders among pregnant women are rapidly increasing.³⁹ So while modalities of opioid misuse (prescription opioids vs. heroin vs. illicit synthetic opioids) may vary by region and urbanicity, the opioid crisis affects all groups of people in the U.S.

RISK FACTORS AND CO-MORBIDITIES

Risk factors for opioid misuse and addiction include past or current substance abuse, untreated psychiatric disorders, and social or family environments that encourage misuse.⁴⁰ A recent study found that survivors of intimate partner violence (IPV) were at 24 times the risk for an

opioid use disorder as those with no IPV history and that female survivors of IPV were at three times the risk for OUD as compared with male IPV survivors. Individual-level homelessness is also associated with higher risk of overdose as well as poor retention in substance abuse treatment.⁴¹ Co-morbidities of opioid use disorders include infectious disease (including HIV and HCV), vascular injury, post-traumatic stress disorder, IPV, depression, and anxiety.⁴²

FAMILY AND COMMUNITY IMPACT

In addition to their individual impact, opioid-related morbidity and mortality have devastated families, imposed an enormous burden on healthcare and social service providers, and left communities scrambling to respond. Some 8 million children in the U.S. – the majority of whom are under the age of five – live with an adult who has a substance use disorder and face a heightened risk of physical and sexual. And because of opioid addiction’s propensity to consume entire families and households, more children are now moving in with grandparents or entering foster care. Substance use is currently a factor in more than one third of foster care placements in the U.S., and child welfare systems in many of the hardest-hit counties are strained beyond capacity.

IMPACT ON CAREGIVERS

The demands of caring for people with an opioid use disorder have taken a toll on caregivers, including nurses, social workers, and others who work on the frontlines. From newborns exposed to opioids in the womb to repeat overdose patients to long-term injection drug users experiencing cardiac infections, many caregivers are exposed to multiple forms of opioid-related suffering on a daily basis. They can experience compassion fatigue and can grow frustrated when available resources are inadequate to meet their patients’ needs. “Care for the caregiver” – equipping caregivers with the tools and support they need to manage these stresses – is an underrecognized but very important dimension of the opioid response.

COVID-19 AND THE OPIOID CRISIS

The COVID-19 pandemic has heightened the risk of opioid-related overdose and death, both directly and indirectly. People with opioid use disorders – a high percentage of whom are housing insecure, homeless, or incarcerated relative to the general population – face an increased risk of exposure to COVID-19. If people who use opioids (whether illicitly or therapeutically) do contract COVID-19, they are at a higher risk for fatal overdose due to compromised lung function.⁴³ COVID-19 has also made access to recovery care and support services more challenging at a time when environmental risk factors for opioid use disorders, such as social isolation and economic distress, are extremely prevalent. These factors have produced a surge in opioid overdoses and deaths since the onset of the pandemic. More than 35 states have reported increases in opioid-related mortality, while suspected overdose events recorded via a federal mapping tool suggest a year-over-year increase of as much as 42%.⁴⁴ This resurgence underscores the need for a holistic approach to the opioid crisis that addresses its intersection with other pressing public health issues.

LO 2.2: Building a public health understanding of the crisis

Like opioid use disorders, the opioid crisis is heterogenous; it has manifested and evolved differently in different settings. However, the forces and factors behind its emergence – including lax regulation and overprescribing of prescription opioids and rising levels of unemployment, poverty, and inequality – are systemic. As people observe and experience the far-reaching effects of the opioid crisis on their families and communities, they can develop disparate feelings, opinions, and ideas about its causes and about what types of action are warranted to address it.

Approaching the opioid crisis from a public health perspective means acknowledging the role of multiple interacting factors, including unemployment, poverty, racism, inadequate management of pain, and poor access to addiction treatment and harm reduction services, in the creating the crisis.⁴⁵ It also means selecting interventions that provide the maximum benefit to the greatest number of people by allowing data, evidence and the fundamental value of human beings to guide decision-making. A non-judgmental attitude and acceptance of opioid use disorder as a disease are central to the design and implementation of public health interventions.

To build understanding of and support for a public health approach among frontline health workers and other stakeholders at the community level, it is helpful to examine several public health principles and how they apply to the opioid response.

- **A social orientation:** Public health acknowledges that humans are inherently social, and that social relations are an important dimension of human health. In the context of the opioid crisis, this means that interventions must target not only individuals, but families and communities, since these are critical support systems for people with an opioid use disorder.
- **Voice and representation:** Each person in a community should have the opportunity to contribute to the development and evaluation of public health policy. People with an opioid use disorder and those in recovery should be consulted and involved in the design, implementation, and evaluation of the opioid response in their communities.
- **Partnership and collaboration:** Collaboration among a wide variety of institutions, sectors, and professional disciplines is fundamental to public health. Forming unconventional partnerships – for example with the business community, emergency response personnel, schools and public libraries -- will strengthen the scope and impact of local responses to the opioid crisis.
- **Data-driven, evidence-based action:** Public health should generate knowledge through quantitative and qualitative means, and should translate that knowledge into timely action. The most impactful community opioid responses are those that prioritize and allocate resources to interventions whose effectiveness in reducing opioid-related morbidity and mortality is well documented, such as expansion of MOUD, naloxone

distribution and training, and integrated care delivery models that are tailored to patient needs and logistical constraints.

- **Values-driven action:** In the absence of available information, public health action should be guided by values, namely the fundamental value and dignity of human beings. Harm reduction approaches are an essential part of a comprehensive and humane response to the opioid crisis.

LO 2.3: Addressing stigma to strengthen therapeutic relationships and foster supportive care settings

THE ROLE OF STIGMA IN ADDICTION AND SUBSTANCE USE DISORDER

The wide-ranging impacts of opioid use disorder on socio-economic status and mental health are compounded by persistent, pervasive stigma associated with addiction.

Stigma manifests as strong negative feelings towards individuals with a stigmatized condition, and results in behaviors and attitudes that exclude them from participating in many settings, including healthcare.

Because it draws on widely shared cultural values and norms, stigma has various sources. In the context of addiction, stigma can come **from within**, as people with addiction are often acutely aware of the negative impact of their addiction on loved ones, colleagues, and their communities, and may

endorse norms and values that devalue people with addiction. Self-stigmatization produces feelings of guilt and shame, impeding people's motivation and determination to seek needed services. Because stigmatizing attitudes are widely held, stigma can also come **from within networks** of people who are substance-dependent, impacting the quality of relationships that develop among substance users, even those who are undertaking recovery together. The anticipation or experience of stigma **from service providers**, including healthcare and substance abuse treatment providers, is a powerful barrier to accessing services, even for people who are searching for help with dependence. Because stigma is pervasive and deeply internalized, it requires deliberate work to eliminate it from therapeutic settings and to provide people with opioid use disorders with tools to mitigate its impact on their lives and their recovery.

What is Stigma?

“An attribute that links a person to an undesirable stereotype leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one.”

Erving Goffman, Notes on the Management of Spoiled Identity (1963)

Stigmatizing attributes may be publicly visible (like race or obesity), or revealed in specific settings, as is true for addiction or same-sex attraction. Stigma is considered a ‘spoiling’ identity, such that stigmatized individuals cannot successfully assume important social roles, from political or religious leader to head of family or even social service recipient.

STEPS TO RECOGNIZE AND ELIMINATE STIGMA IN HEALTHCARE SETTINGS

There is mounting evidence that education and training can reduce healthcare providers' stigmatizing beliefs and attitudes towards people with substance use and mental health disorders. This is a crucial step towards improving the quality of services for people with substance use disorders.⁴⁶ The key components of stigma reduction training are: **accurate education and myth-busting data**, e.g. scientific evidence on physiological and biochemical aspects of addiction that dispel notions of addiction as a moral weakness; facilitated social and professional **contact** with people from stigmatized groups to reduce fear and stereotypes (e.g. that people with opioid addiction are dangerous, violent, and dirty); and **peer services** through which members of a stigmatized group coach and support others with the same condition to achieve health goals and overcome internalized self-stigma.⁴⁷ Peer role models can facilitate mastery of health behaviors that support recovery from addiction, and seeing recovered and recovering peers as part of a multidisciplinary healthcare team sends people with opioid use disorder a powerful message about the important role of people with experiences like their own. This messaging can create a counter-narrative to challenge internalized stigma and shame related to substance use.

STIGMA BY ASSOCIATION AND ITS IMPACT ON HEALTHCARE PROVIDERS

Professionals who provide substance use-related services can also be impacted by stigmatizing attitudes. In multiple settings where stigma is prevalent, including HIV and tuberculosis care settings, "stigma by association" takes a measurable toll on healthcare providers. While simply acknowledging the commonality of this experience can be helpful, support for providers – in the form of clinical supervision and self-care measures – may help to reduce demoralization and burnout.

THE POWER OF WORDS: TOWARDS A DESTIGMATIZING VOCABULARY

Language and terminology are a primary way in which stigma is exercised. Making a deliberate effort to change the language surrounding substance use is a powerful tool to combat stigma in therapeutic contexts.

A recent study randomly assigned students pursuing post-graduate degrees in mental health and addiction treatment to describe how they would approach a patient in one of two vignettes. In one vignette the subject was described as having a substance use disorder; in the other vignette the subject was simply a substance abuser. The wording of the vignettes was otherwise identical. Students assessing the "substance abuser" were significantly more likely to assign blame and endorse punishment for the subject than were students assessing the individual with a substance use disorder. These findings were repeated when the same scenarios were presented to study participants from the general population. The results highlight how a simple shift in terminology influences the way that providers as well as society in general approach people with substance dependency and addictive disorders.⁴⁸ Table 1 (below) explains why commonly used stigmatizing terms are harmful and presents alternatives that can be used in their place.⁴⁹

Table 1: Stigmatizing words and terms to avoid

Words and terms to avoid	The problem	Better alternatives
Addict, abuser, junkie	By failing to differentiate between a person and their disease, these terms infringe on the dignity of the individual and create the impression that their condition is permanent.	<ul style="list-style-type: none"> Person with a substance use (or opioid use) disorder Patient or client (if receiving services)
Abuse	This term ignores the fact that addictive disorders are a medical condition and places blame on the individual.	<ul style="list-style-type: none"> Use, harmful use, problem use
Clean or dirty (drug test results)	These terms associate symptoms of drug use with filth.	<ul style="list-style-type: none"> Negative, positive, substance-free
Drug habit	Referring to a disorder as a “habit” dismisses the fact that it is a disease and makes it seem like a choice.	<ul style="list-style-type: none"> Substance use (or opioid use) disorder, active addiction
Replacement therapy, substitution therapy	These terms insinuate that medications for opioid use disorder are equivalent to other drugs to which a person has an addiction, ignoring their vital role in stopping dangerous addictive behavior.	<ul style="list-style-type: none"> Treatment, medications for opioid use disorder (MOUD), medication

LO 2.4: What’s working (or showing promise) in community opioid responses

Communities across the U.S. are bringing diverse approaches to the opioid crisis, in many cases combining established public health practices with experimentation involving non-traditional partners like fire stations and public libraries. The evidence base on what works in community opioid responses is evolving rapidly, and in three years we will know far more than we do today. Already, though, several approaches have demonstrated promise and are worth replicating. These include:

- Expanding access to MOUD** by increasing the number of physicians and advanced practice nurses obtaining waivers and by integrating MOUD in a variety of care settings: hospital emergency departments, pre-natal care services, doctor’s offices, and prisons. Vermont has employed a statewide *hub-and-spoke model* to mainstream MOUD into primary care. Each “spoke” – a provider with a waiver to prescribe buprenorphine – is linked to a federally certified opioid treatment program, or “hub” that provides a full range of MOUD services, so patients can move back and forth between the spoke and hub in accordance with their treatment needs. In addition, Vermont has integrated MOUD into its prison health system, providing ongoing treatment with buprenorphine or methadone to more than a quarter of inmates. Collectively, these efforts have vastly expanded treatment access in the state. The Kentucky Opioid Response Effort (KORE) is removing barriers to same-day MOUD initiation through a statewide treatment locator website featuring real-time information on bed availability at residential and outpatient treatment programs, a live call number, and bridge funding that pays for residential care while insurance authorizations are underway.
- Increasing reach and coverage of harm reduction services**, including naloxone distribution and training (to people with an opioid use disorder and family members), syringe exchange and safe disposal, safe injection sites, provision of harm reduction kits containing syringes,

wound care and first aid supplies, hygiene products, naloxone, condoms, pregnancy tests, and HIV test kits, and supervised injection, in areas with high rates of opioid use and overdose. Naloxone distribution and training for people with an opioid use disorder, their friends and family, first responders, and other community members, saves lives and is an essential component of the community response. Syringe exchange programs and harm reduction kits can decrease transmission of infectious disease and help prevent injection-related infections and injuries. Harm reduction services are also a highly effective entry point to treatment, especially when they are integrated with healthcare through co-location or in-person referrals. Harm reduction kits can be distributed in Emergency Departments or at discharge from an inpatient hospital unit.

- **Scaling up integrated models of care**, including nurse-managed care, one-stop services, and group prenatal care services for women with an opioid use disorder. The nurse-managed care model facilitates holistic, patient-centered care, including through coordination of MOUD with care for other conditions (including HCV, HIV, and behavioral and psychosocial health issues), and linkage of patients to mental health and social services and supportive housing resources. In Massachusetts, nurse care managers are assigned to clinics to manage patients with an opioid use disorder and expedite the MOUD prescription process. They follow up with patients, daily at first and then less frequently as patients adjust to their medication. The one-stop services approach reduces missed opportunities to provide optimal care, especially to vulnerable patients for whom scheduling and keeping multiple appointments in different locations presents a logistical challenge. Data from recent studies also suggest that integrating MOUD with prenatal care and other women-centered services can decrease illicit drug use during pregnancy and increase attendance at postpartum care visits.⁵⁰⁵¹
- **Strong recovery communities and peer-led interventions.** Communities with active recovery communities may benefit from greater accountability in their opioid responses thanks to the advocacy efforts of their membership. Oregon Recovers, a statewide recovery network, is seeking to make Oregon a national leader in access to treatment and recovery services by demanding and advocating for a holistic, evidence-based, public health approach to addiction. There is mounting evidence that peer-led interventions and support services are effective in decreasing substance use and improving social determinants of health like housing stability and self-care.⁵² In addition, studies on recovery coaching for ex-offenders with an opioid use order have shown that those who work closely with a peer support worker are less likely to become repeat offenders.

The approaches described above are a small subset of the approaches that are being tried and tested on a daily basis in communities impacted by the opioid crisis. As the evidence base expands and we learn more about what works, sharing and diffusing that information rapidly and broadly will allow communities to enhance and refine their responses for greater impact.

Exercise #1: Convening a Local Community of Practice

While this toolkit is focused on the role of nurses, and is oriented broadly on the opioid crisis, in practice, an effective response will likely involve in-depth work by multiple types of individuals who might focus on particular aspects of the crisis, or interrelated social, mental health,

housing, safety, or other health-related issues. Approaches taken within these areas may need to be tailored closely to the local setting and resources available. One strategy for developing local knowledge and practice is through convening communities of practice (CoPs). CoPs have been described as “groups of people who share a concern, a set of problems, and a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis”.⁵³ This model of collaboration has been adopted widely across diverse settings and has been shown to generate valuable insights and build the capacity of attendees. The CDC has developed a resource kit containing basic information and tools to help launch CoPs, available [here](#).

As an exercise, one or more nurses involved in responding to the opioid crisis may convene and draw a blueprint for one or more CoPs that could be established within the community. The process of planning a CoP would include:

- Identifying potential CoPs by domain of interest—e.g. population, aspect of crisis or response
 - Examples of potential CoPs might include: pharmacists; public health and law enforcement; pregnant women and their infants; use of data across agencies; or strengthening responses to mental health needs
- Identifying potential members for each CoP
- Defining roles and responsibilities
 - These will depend on how large and how formal the CoP is intended to be
 - Who will provide infrastructure (technology, sponsorship, links to members’ day jobs)
 - Roles within meetings should also be defined (e.g. facilitator, faculty/knowledge broker, participant/member)
- Outlining and prioritizing goals for each CoP
- Linking knowledge to action – what opportunities for this would exist within the CoPs?
- Planning approaches to evaluate the CoP and incorporate a cycle of learning – is there a need for this, and is there adequate capacity to achieve continuous learning?
- Diffusing learnings – how might this group disseminate new knowledge generated within the CoP? How should its findings impact policy or practice?

After reflecting on and working through the considerations above, you should be prepared to make a decision about which of the CoPs seem most feasible and most likely to have an impact. Now is the time to move forward by identifying resource needs and next steps to establish and convene the CoP.

[Exercise #2: Reducing stigma through nonjudgmental messages](#)

From the outside looking in, the lives of many people who have opioid use disorders may appear fragmented, chaotic, and dysfunctional. It can be tempting to judge, but this stance effectively destroys a deeper understanding of the issues faced by people struggling with

addiction. It also interrupts the ability of care providers, family members, and friends to develop effective therapeutic alliances with and for the person experiencing an opioid use disorder. Drug users face stigma every day and are often extremely sensitive to subtle negative messages in the way that others interact with them.

To combat stigma in interactions with people with opioid use disorders, it is important to avoid judgment. Three techniques that can help to create a non-judgmental atmosphere are (1) choosing words with care, (2) using engaging body language, and (3) listening closely and patiently.

- Verbal messaging: The questions below are embedded with stigmatizing messages or words. Examine them and consider alternative, less stigmatizing ways of asking the same questions.

Do you use clean needles?
Do you still have custody of your children?
How has drug use damaged your life?

- Body Language: Nonverbal communication can convey stigma or create alliance. Lean toward the person and maintain eye contact. Respond appropriately to the emotional content of the discussion with a nod, a smile, or a tissue handed in response to tears. Body position, eye contact, and even a light touch on the arm can reduce fear and stigma while building a therapeutic alliance.
- Listening: Frame questions in a nonjudgmental manner and listen carefully to the response. Provide affirmation. Use reflective summary statements to assure that you are listening and to offer opportunities to correct the narrative. You may discover goals and internal motivations that can be used to move toward behavior change.

If I understand you correctly...
What I hear you saying....
Please tell me if I understood...
It sounds as though it was really distressing when....
Your most pressing needs seem to include...

Consider practicing a hypothetical conversation with an opioid user while an observer critiques your language and communication skills for evidence of subtle stigmatizing messages.

Case study

Jerry's journey

This case study describes a day in the life of Jerry, a 39-year-old man. Jerry came out to his family as gay when he was 19. Since then he has been homeless or living on friends' couches. His family did not accept him, and before he got the courage to leave, Jerry faced unrelenting mental and physical abuse from his father. When Jerry's nose was broken, he knew he had to leave. By the time Jerry turned 20, he moved from his family's affluent suburban home in Charleston to Greenbrier County. He had happy memories of vacations near the Greenbrier River and thought it would be a good place to go. He had a few friends there who he kept in touch with from his years at summer camp there.

Today Jerry wakes early. He has a two-hour bus ride to get to the nearest harm reduction center. He has been going there for about a year and is always treated well so the long drive and expense is worth it. With access to a syringe exchange program he has managed to prevent HIV and Hepatitis- something he was really worried about as one of his friends had just been diagnosed as HIV positive.

Jerry has a good visit at the center and is always happy to chat with the team there. Jerry heard that a new MAT program had opened nearby, and he asks them about this. Although Jerry was reluctant in the past, he is now ready to start MAT. He is told that there is a waiting list and they will put him on it right away. The wait right now is about 2-3 weeks. On the bus ride back home, he thinks about what it might be like to start MAT. He has lots of questions.

A week after Jerry visits the harm reduction center, the friend he was living with is arrested. The landlord sees Jerry and tells him he can no longer stay here. His friend is past due on his lease and the contract is no longer valid. Jerry packs up his few possessions and spends the rest of the day finding a homeless shelter. Days go by at the shelter, and Jerry's drug use increases. He is afraid the shelter staff will find out and kick him out. The harm reduction center calls Jerry to tell him he has been given an appointment for MAT, but the only contact number they have for Jerry is now disconnected.

Reflection Questions

- What role do you think stigma played in Jerry's substance abuse?
- Jerry became homeless and his substance use increased. Beside the loss of stable housing, what else could be driving increased use?
- Since Jerry's substance use has increased, besides risk of overdose, how might his health be affected?
- Develop a list of barriers to care that Jerry has experienced.

Promising practices

Safe Stations: Fire departments in communities across the U.S. have converted fire stations into entry points to treatment for people with opioid use disorders. The “safe stations” model, first launched in Manchester, New Hampshire (and later adapted and replicated in multiple states) creates a safe, non-punitive environment for people seeking assistance to initiate treatment and recovery. Fire station employees are trained to complete vital signs and conduct rapid triage assessments of people seeking drug treatment. Those requiring immediate medical attention are transported to an appropriate medical facility, and those without immediate medical needs meet with a counselor and receive a warm transfer to local treatment services. Safe station services are available around the clock, ensuring that individuals can access the services they need at any time of day or night. Some communities supporting Safe Stations have elected to provide supplemental services, including naloxone distribution and direct linkage to supportive housing and social services.

Real-world examples:

- [Safe Stations program in Anne Arundel County, Maryland](#) (News article)
- [Safe Stations program in Tacoma, Washington](#) (News article)

Family-centered treatment: Current treatment approaches for opioid use disorder typically focus on the person experiencing the disorder. However, because opioid addiction affects not only users but their parents, children and families, we need family-focused treatment models that attend to the needs and priorities of the entire family.

While problematic use and addiction to other substances, such as alcohol, take a long time to develop – thus providing those affected time to cultivate coping strategies and treatment plans – the time between a person’s first opioid use and dependency is much shorter. Further, once problematic opioid use becomes ‘the norm’, users commit crimes to maintain their habit, often at the detriment of their families: Children of people with opioid use disorder are often neglected by their parents while grandparents and other family members are then forced to raise children ‘orphaned’ by opioids.

Family-centered treatment is an approach to planning, providing and monitoring care for opioid use disorder that is grounded in cooperation among healthcare providers, patients and families. It redefines traditional treatment relationships by placing an emphasis on collaboration with people of all ages, at all levels of care, in all healthcare settings to ensure care is responsive to the priorities, preferences and values of both patients and their families. Recognizing that patients and their families are essential allies for healthcare quality, safety and efficacy, family-centered treatment allows them to determine how they will participate in care and decision-making.

Current treatment approaches fall short in meeting the needs and priorities of families, yet evidence suggests that numerous family-centered models have been proven effective, particularly those that promote effective parenting. These promising approaches to opioid use

disorder provide a platform to address critical family issues to improve healthcare for all while reducing stigma and misinformation.

Real-world examples of the family-centered treatment approach include:

- [Project Vision](#)
- [Prevention and Family Recovery Grantee Lessons Learned](#)
- [Minnesota Family Home Visiting Program](#)
- [SMART Recovery](#)

Peer recovery coaches: Hospitals and their emergency departments (EDs) are important entry points to MOUD for people who have been revived from an opioid overdose and people who present with symptoms of an opioid use disorder. However, many hospitals and EDs lack staff with the appropriate expertise and experience to engage effectively with overdose survivors, especially following overdose reversal.

Peer recovery coaches are trained behavioral health providers who have personal experience with substance use and recovery. In contrast with other behavioral health providers who may rely on clinical terminology and explanations, peer recovery coaches use language grounded in lived experience to build trust and credibility with clients. A growing body of evidence demonstrates that interaction with peer recovery coaches improves a range of health and wellbeing outcomes for people with substance use disorders. These outcomes include decreased substance use; improved housing stability, self-care, independence, and health management; and decreased rates of recidivism among ex-offenders.⁵⁴⁵⁵

To increase uptake of MOUD and recovery support services by people recently revived from opioid overdoses, hospitals and community-based recovery organizations in several states have established peer recovery programs in ED settings. These programs generally work as follows: once a patient has been physically stabilized in the ED following an overdose reversal, they are offered a meeting with a peer recovery coach. The peer recovery coach comes to the hospital to share information on MOUD as well as alternative options including continued engagement with the community-based recovery organization. If the patient opts for MOUD, they are either initiated immediately at the hospital, or in a timely manner through a referral to a collaborating community organization. The peer recovery coach follows up with the patient by phone to remind them of their treatment or recovery support appointment and to provide encouragement. Peer recovery coaches may also serve patients who have not overdosed but who present in the ED with opioid withdrawal symptoms or are otherwise flagged as having an opioid use disorder.

Real-world examples:

- [Recovery Coaches Save Lives in the Emergency Department](#) (Video feature, Greater Baltimore Medical Center)
- [Every hospital needs ‘recovery coaches’ for patients with substance use problems](#) (News feature on recovery coach model in New Jersey, Stat News)

Mobile Harm Reduction: Mobile harm reduction units can move vital harm reduction activities, drug treatment referrals, and MOUD into the community. This allows programs to have a presence in underserved neighborhoods and can be used to overcome barriers to access (such as transportation routes or costs incurred in accessing services). Mobile services offer an approach that is nimbler than brick-and-mortar buildings; such programs can utilize data (such as overdose rates, drug arrests, or other endpoints) to rapidly mobilize services and target specific geographic neighborhoods. Services often include provision of harm reduction kits with clean syringes and injection supplies, naloxone, and a spectrometer or fentanyl test strips.

Real-world example:

- [Chicago Recovery Alliance Van Service Timetable](#) (public-facing online resource)

Supervised injection sites: Supervised injection sites (SIS) may be considered the most comprehensive embodiment of harm reduction, offering legal, hygienic spaces for clients to use their own substances in the presence of trained staff who are able to intervene to avoid overdoses, ensure safe disposal of used injection equipment, and offer co-located health and supportive services. Nearly 100 SIS have been established around the world, and research shows that they are correlated with positive individual-level outcomes such as reduced overdose fatalities, reduced HIV- and viral hepatitis-related risk behaviors, and increased uptake of health and social services, including drug treatment programs. At the community-societal level, SIS benefits include reduced transmission of bloodborne diseases, reduced injection activity and disposal of used supplies in public spaces, and decreased overdose deaths.⁵⁶

SIS provide secure, clean, booths or semi-private space for clients to use drugs that they bring with them. Mirrors are generally positioned to facilitate unobtrusive monitoring by the staff. Use of the space is controlled through a combination of referral, invitation, and appointment to avoid crowding and excessive wait time. The security of the space is itself a significant harm reduction step, as clients can take time needed to inject safely, without having to rush for fear of detection or apprehension in a public space. Clients without injection equipment can access sterile supplies at the site, eliminating the risk of infection through shared or reused equipment. Staff trained in harm reduction principles and overdose prevention are present to provide equipment, dispose of used equipment safely, and intervene in overdoses. After consuming their drugs, SIS clients are able to rest and can access harm reduction and other services and referrals offered at the site.

To date, no federally authorized SIS exist in the U.S., due to legal challenges as well as debates over their social and economic impact. However, in October 2019, a federal judge ruled that a proposed SIS in Philadelphia would not violate federal drug law, opening the door to the possibility of establishing SISs in the U.S.

Real-world examples:

- [Supervised injection sites are coming to the US. Here's what you should know](#) (USC Nursing Special Feature)

Syringe exchange vending machines: Syringe exchange programs provide free sterile syringes and collect used syringes to reduce the spread of infectious disease and prevent injection-related infections and injury. Some also provide related harm reduction services, including testing for HIV and hepatitis C; counseling on how to use drugs more safely, have safer sex and reduce overall risk for infection and overdose; referral to additional support services; and provision of safer sex and drug use kits, snacks and/or hygiene products.

However, there is considerable variability throughout the US in the way syringe exchange programs are delivered through fixed, mobile and outreach programs. In addition, some countries including Denmark, Norway, Germany and Italy, use syringe exchange vending machines to supplement other programs. Syringe exchange vending machines accept coins (and sometimes tokens distributed by outreach workers) in return for sterile syringes, wound care/first aid kits, hygiene products, naloxone kits, condoms, pregnancy tests and/or HIV test kits.

Vending machines are typically installed in places where clean syringes are difficult to access and provide supplies 24 hours a day, seven days a week. Unlike fixed, mobile and outreach syringe exchange programs, vending machines provide critical supplies and information without straining the already burdened health system. Evidence suggests that syringe exchange vending machines are valuable in increasing access to services, particularly among the most marginalized.

Real-world examples:

- [Trac-B Exchange, Las Vegas](#)

Data integration: Integrating available data and expanding data sources used to analyze opioid-related trends can encourage a richer and more comprehensive understanding of a community's opioid epidemic and provide valuable insight into the areas that may be most effective for immediate, and lasting, intervention. A main goal of a comprehensive, data-driven response to the opioid crisis is to explore new ways to collaborate with agencies, authorities, and stakeholders, and developing and deploying a strategy to share and integrate agency data can be a great place to start.

The City, County, or State Department of Health (or similar body) collects health vital statistics and other government-mandated health metrics. And more frequently than ever before, Department of (Public) Health bodies around the country are being asked to collect opioid-focused response data, such as opioid-related overdoses and fatalities. In many jurisdictions, public and private hospitals and ambulatory centers must report on drug-related hospitalizations and discharge to state licensing authorities. However, there are many other public service entities that are simultaneously collecting data that may be leveraged in the

greater fight against opioids. Emergency Medical Service (EMS) agencies responsible for oversight of EMS services collect information from emergency response calls, including zip codes and clinical indicators. Fire departments and law enforcement agencies also frequently collect and report data useful for understanding the epidemic, such as arrests for narcotics-related offenses, accidental overdose incidents, and distribution of naloxone. Regional and state Poison Control Centers collect data regarding controlled-substance related calls. A successful data-driven response to the opioid epidemic seeks to access, analyze, and utilize all available data resources in an integrated manner.

Real-world examples:

- New York's [RxStat Program](#) was developed in 2012 to leverage existing datasets to generate information which can be used to tailor targeted interventions and policy responses. The RxStat Program brings together public health and public safety agencies and applies a public health analysis for comparing and triangulating findings across datasets
- [Building Successful Partnerships between Law Enforcement and Public Health Agencies to Address Opioid Use](#) describes the many different ways that public health agencies (and practitioners) can partner with law enforcement with a focus on the improving and expanding the practice of data sharing and integration.

Geospatial mapping: Geospatial information system (GIS) maps can serve as a useful tool for visualizing the impacts of opioid crisis within communities. These can be used for both ongoing monitoring to guide elements of a response, and as an opportunity for caregiver education. As the opioid crisis can affect locations within communities in different ways and at different rates, GIS maps can be helpful in understanding where, for example, overdoses vary at the region and neighborhood levels. With the involvement of community stakeholders, these maps can offer up-to-date information of opioid crises-related information that the community can use to strategize and plan interventions, such as strengthened harm reduction services, availability of naloxone, and improved linkage to substance use treatment, and monitor the effects of these interventions.

Data for community GIS maps may be provided by fire departments, emergency medical services, and/or other front-line stakeholders. This gives nurses the opportunity to potentially partner with nontraditional healthcare professionals to gain this information, identify potential community hot spots, and plan a collaborative and comprehensive response. If data is updated continuously or at relatively narrow intervals, GIS maps can be a critical tool to allow for interventions to be adjusted in nearly real-time to respond to community needs. For purposes of education, GIS maps can also be made available to nursing students to better allow them to understand the communities they serve, and tailor their treatments and screening practices accordingly.

Real-world examples:

- [Nurses use FDNY geospatial mapping of opioid overdoses to inform clinical practice in real time](#)

- [Traditional and Nontraditional Collaborations to Improve Population Health Using Geospatial Information System Maps: Analysis of the Opioid Crisis](#)
- [Vermont Health Dashboard](#)

Prescription monitoring: State-led prescription drug monitoring programs (PDMPs) aim to reduce overuse, abuse, and diversion of prescription drugs. These statewide databases collect prescription data on controlled dangerous substances – including prescription opioids like OxyContin – dispensed in outpatient settings. In states with PDMP registration mandates, both prescribers and pharmacists are required to register with their respective PDMP; in states with PDMP use mandates, registrants are also required to access the PDMP for a patient’s prescription history before prescribing or dispensing controlled substances. In New Jersey, for instance, pharmacies are required to report data within one business day of dispensing a prescription.

Information available in the database helps providers gauge whether a patient is seeking medication for misuse, abuse or diversion. It can also help health departments to assess whether physicians are overprescribing opioids. Checking the histories of both patients and providers allows for more informed decisions about whether to dispense medication, and has been shown to reduce prescription drug misuse and diversion.

Real-world examples:

- [Database of US state prescription monitoring programs](#)

Rapid assessment and response: Local trends in opioid use often require a faster response than traditional methods allow. Daily data collection and analysis can help communities identify new patterns in opioid use and misuse that can be quickly leveraged into action. For example, some state and local health departments in some cities are conducting daily reviews of emergency department (ED) data on opioid-related overdoses and deaths. By combining ED data with opioid-related data from other sources, including detailed toxicology reports linked to medical examiner death certificates, health departments can obtain a fuller picture of emerging opioid use patterns. When linked geographically, data can be used to track the location of fentanyl and other synthetic opioids, so that health departments can quickly identify specific neighborhoods or blocks at high risk for additional overdose events. This allows departments – and their partnering agencies – to dispatch rapid response teams to overdose hotspots to assess available services and gaps, engage with local residents, business owners, churches, and opioid users, and ensure that naloxone and linkage to treatment are readily available.

Real-world examples:

- [New York City’s Rapid Assessment Response Teams](#) use timely data to track emerging drug issues and associated health consequences and are deployed directly to communities in need to engage at ground-level with residents, community business owners, and other key stakeholders.

Public-facing opioid data and dashboards: Several state and local governments have designed custom surveillance systems and public-facing dashboards to collect, analyze, and share key data on the status of the opioid crisis and response. For instance, as part of an emergency declaration in 2017, Arizona established an enhanced surveillance program to monitor the state's opioid overdose crisis. This program aimed to provide more complete and timely data to assess the opioid burden and allow for better targeting of prevention services and other interventions to reduce opioid-related harm. Healthcare providers, EMS, law enforcement, medical examiners, and pharmacies statewide are required to report data on suspected opioid overdoses, suspected opioid-related deaths, cases of Neonatal Abstinence Syndrome, naloxone administration, and naloxone dispensing.

Data are aggregated and made available in near-real time on the state's web site, including via a set of interactive dashboards that display data by county. Provided alongside the data are links to a range of resources for community stakeholders.

Real-world example:

- [Real-time opioid data](#) (Arizona Department of Health Services)
- [Opioid interactive dashboard](#) (Arizona Department of Health Services)

Multi-agency coordination: At its core, multi-agency coordination (MAC) describes the activities of representatives of involved and identified agencies and/or jurisdictions who come together to make decisions regarding prioritization of incidents and the distribution and use of critical resources. This group can provide key leadership, and resources, to the fight against the opioid epidemic in a community.

The utilization of MAC groups is well-established in emergency/disaster response practice. Across the U.S., MAC groups engaged in emergency response and disaster preparedness activities have utilized the National Incident Management System (NIMS), administered by the Federal Emergency Management Agency (FEMA). Initially developed in 2005 by FEMA, NIMS defines the comprehensive approach guiding the whole community - all levels of government, nongovernmental organizations (NGO), and the private sector - to work together seamlessly to prevent, protect against, mitigate, respond to, and recover from the effects of incidents. Recognizing that the opioid crisis is one such large scale public health disaster, local government agencies have been responding to the opioid crisis in their communities using MACs and other NIMS frameworks, including resource inventorying, creating and implementing operating plans, information and incident command. In addition to providing a framework for action, NIMS also provides a common system of data collection, with tools and web-based forms that are utilized by participating agencies to report progress to government agencies. In addition to providing a framework for response, NIMS compliance is a requirement for many jurisdictions receiving emergency response/disaster preparedness funding from the federal government.

Real-world examples:

- [Snohomish County, WA MAC Group](#) (County health department website)

- [Online course on NIMS](#) (FEMA website)

Supportive policies

Public policy – including lax regulation and enforcement on the part of the Food and Drug Administration (FDA) and Drug Enforcement Agency (DEA) – had a role in creating the conditions for the opioid crisis. Today, a range of statutes, regulations, and programs have been put in place at the federal, state, and local levels to address the harmful effects of the crisis. These include more rigorous prescribing controls, expanded Medicaid coverage and treatment options, and Good Samaritan and naloxone access laws. A supportive policy environment can enhance the reach and effectiveness of community opioid responses. Table 2, below, highlights some of the supportive policies that have been enacted, including in response to the COVID-19 emergency, and summarizes their relevance to community opioid responses.

Table 2: Select supportive policies at the federal, state, and local levels

Federal policy	Relevance to community opioid responses
SAMHSA and DEA exemptions allowing expanded use of telehealth services for opioid treatment during the COVID-19 emergency (2020)	<ul style="list-style-type: none"> • Allows opioid treatment programs to temporarily conduct new patient evaluations via telehealth (Note: this applies only to patients who will be prescribed buprenorphine; an in-person physical examination is still required before prescribing methadone) • Encourages expanded use of telehealth for individual and group therapies for substance use disorders
SAMHSA blanket exceptions for take-home MOUD during the COVID-19 emergency (2020)	<ul style="list-style-type: none"> • Grants statewide blanket exceptions permitting all existing, stable patients in opioid treatment programs to receive 28 days of take-home medication for opioid use disorders (Note: this applies to both buprenorphine and methadone) • Authorizes provision of up to 14 days of take-home medication to existing, less stable patients at the discretion of their opioid treatment program (Note: this applies to both buprenorphine and methadone)
SUPPORT for Patients and Communities Act (2018)	<ul style="list-style-type: none"> • Establishes a loan repayment program for substance use disorder treatment providers practicing in high-need areas • Permanently authorizes Nurse Practitioners and Physician Assistants to prescribe buprenorphine after obtaining a waiver • Temporarily authorizes clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives to prescribe buprenorphine after obtaining a waiver
Comprehensive Addiction and Recovery Act (2016)	<ul style="list-style-type: none"> • Strengthens prescription drug monitoring programs (PDMPs) to help states monitor and track prescription drug diversion • Expands awareness and education to prevent substance abuse and promote treatment and recovery • Expands availability of naloxone to law enforcement agencies and other first responders • Expands resources to identify and treat incarcerated individuals suffering from substance use disorders • Expands disposal sites for unwanted prescription medications
State policy	Relevance to community opioid responses
New York: Methadone delivery program during the COVID-19 emergency (2020)	Delivers methadone directly to patients with COVID-19, COVID-like illness, or at high risk of contracting COVID-19, so that they do not need to risk infection or infecting others in order to access treatment
Indiana: Lock box-based overdose prevention during the COVID-19 emergency (2020)	Provides a secure method of take-home access to methadone and/or naloxone for people with opioid use disorders

	Reduces risk of COVID-19 transmission by reducing in-person visits to opioid treatment programs
Kentucky All Schedule Prescription Electronic Reporting System , a state PDMP with mandatory registration and use requirements	<ul style="list-style-type: none"> Requires prescribers of opioid analgesics and pharmacists dispensing controlled substances to register with and use the state PDMP (KASPER), which tracks information on all outpatient prescriptions for controlled substances Allows prescribers and pharmacists to delegate another healthcare professional to access and use the registry with their account; this has increased overall use of the registry
West Virginia Opioid Reduction Act	<ul style="list-style-type: none"> Sets a four-day limit on opioid prescriptions in urgent care and emergency settings Requires prescribers to discuss risks associated with opioid use and to present alternatives for pain management Requires insurance providers in the state to cover 20 alternative therapy visits per chronic pain event Authorizes patients to put a non-opioid directive in their medical files
Expansion and maximization of Medicaid coverage to treat opioid use disorders (multiple states)	<ul style="list-style-type: none"> Expands Medicaid to cover more low-income adults (36 states plus D.C.) Assures Medicaid coverage of buprenorphine, methadone, AND naltrexone (41 states) Assures Medicaid coverage of intensive outpatient treatment services (38 states)
California Substance Abuse and Crime Prevention Act	<ul style="list-style-type: none"> Mandates probation with treatment for all nonviolent drug offenders until their third conviction, then limits incarceration to a maximum of 30 days
Vermont Act 176 on provision of medication-assisted treatment for inmates	<ul style="list-style-type: none"> Authorizes state correctional facilities to continue medication-assisted treatment to inmates entering a facility while on treatment Authorized state correctional facilities to commence MOUD using buprenorphine where medically necessary
Local policy	Relevance to community opioid responses
San Francisco, CA Guidance for providers caring for people who use drugs during the COVID-19 emergency	<ul style="list-style-type: none"> Encourages scale-up of harm reduction measures including provision of naloxone, syringes and other safer consumption supplies and promotion of alternatives to drugs Recommends provision of fentanyl test strips to all patients using non-prescribed drugs Presents options for providing up to 30-day MOUD prescriptions and facilitating medication pick-up/delivery
King County, WA Law enforcement assisted diversion (LEAD)	<ul style="list-style-type: none"> Diverts low-level drug crimes from the criminal justice system to community-based treatment services
Gloucester, MA Police Policy	<ul style="list-style-type: none"> Allows people seeking help with opioid addiction to present at the police station without facing charges for possession of drugs or drug supplies Connects individuals seeking help with volunteers who ensure they access the services they need in partnership with local treatment centers In partnership with local pharmacies, gives community members access to naloxone at no cost, regardless of insurance

Job aids/Resources

- How to engage the community: [CDC Crisis + Risk Emergency Communication \(CERC\) manual](#)
- Infection prevention and control for healthcare personnel during the COVID-19 pandemic: [CDC Interim Recommendations](#)
- Interim guidance for MOUD providers during COVID-19: [San Francisco Department of Public Health](#)
- Patient-facing resources:
 - [Safer drug use during the COVID-19 emergency](#)
 - [COVID-19 and medications for opioid use disorder](#)

Module 3: Taking Action

Core competencies

1. The nurse (or other healthcare worker) can identify and help others to identify local barriers to effective action
2. The nurse can engage others to use a priority setting table to explore strengths, champions of change and identify key issues given the local context and needs
3. The nurse understands the key elements of an action plan and can help others to draft an action plan for a priority issue
4. The nurse can lead others to overcome resistance and effect change in beliefs and practices
5. The nurse is an effective communicator who can effectively convey the problem and the “ask” to media, policy makers, legislators, and other community stakeholders

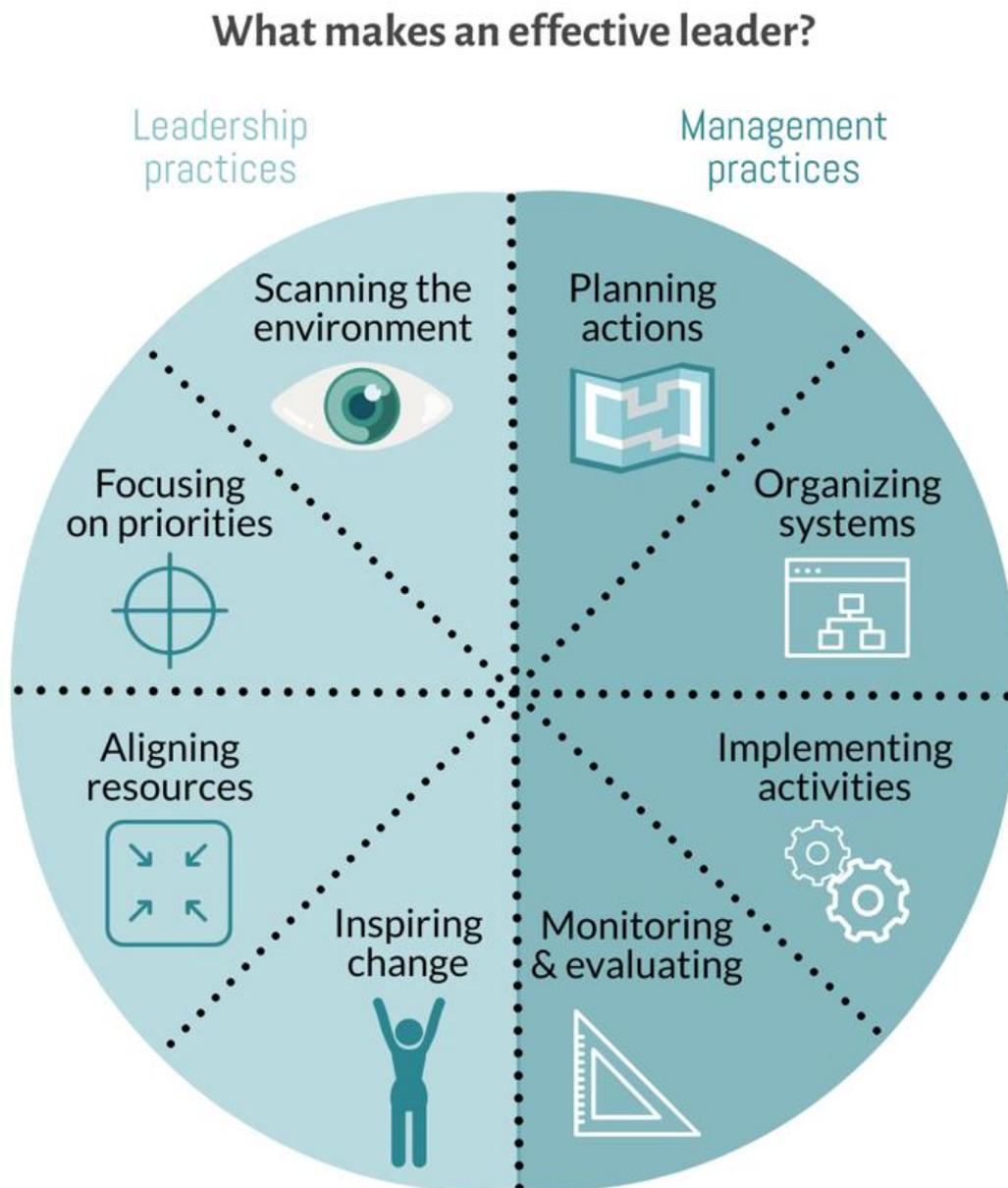
Learning objectives

1. Practice guiding groups through the process of identifying and analyzing the local opioid crisis and barriers to effective action
2. Practice facilitating a structured, collaborative approach to creating a shared vision and identifying priority areas for action
3. Identify the key elements of an action plan and practice assisting others to draft an action plan for a priority issue
4. Memorize and adapt messages to motivate others to overcome resistance and effect change in beliefs, policies, and practices
5. Practice communicating/expressing the problem and the “ask” to media, policy makers, legislators, and other community stakeholders

Key information

You don't need organizational leadership experience to lead meaningful change in your community. Leadership is often regarded as an inherent ability, but – much like management – it is actually a set of practices that can be learned, honed, and perfected over time (see Figure 6, below, and the Managers Who Lead resource at the end of this module). This module is designed to equip you with the essential tools and knowledge you need to guide local stakeholders through a collaborative process of analysis, visioning, and planning that leads to an effective and coordinated response to the opioid crisis.

Figure 6: Practices of an effective leader-manager



LO3.1: Analyzing the problem and its complex causes

The opioid crisis looks different in every community, and its underlying dynamics and causes are complex. In order to design and mount an effective response, it is important for community stakeholders to form a shared understanding about the nature of the problem and the factors contributing to it. This requires openness to examining one's own assumptions/judgments, listening to other people's experiences and observations, and engaging in respectful dialogue to identify areas of agreement and disagreement. Through this process, a group of people who hold disparate views or understandings can start to build a framework for action that reflects the different experiences and perspectives that exist within every community.

FORMULATING A PROBLEM STATEMENT

Before determining solutions, community stakeholders must agree on the problem at hand. A Problem Statement is a clear and concise statement that describes the scope and impact of the problem. It includes: (1) a brief description of the problem, and (2) data or information about the location, time frame, and size of the problem. A Problem Statement should **not** focus on causes or solutions or assign blame.

A well-constructed Problem Statement can:

- Communicate the symptoms of the problem in concrete terms;
- Create a sense of shared ownership among stakeholders; and
- Serve as an internal and external communication tool.

Examples of Problem Statements:

"In the last two years, the number of opioid overdoses in Greenhaven Township has doubled. Despite regular administration of Naloxone by local EMT teams, the increase in overdoses has caused a surge in opioid-related deaths. Repeat overdoses are common; last year, one in every six patients brought to the ED for an opioid-related overdose had been previously admitted for overdose."

"Over the past year, the number of babies born with neonatal abstinence syndrome (NAS) in Kaneville County has increased by 25%. Many of the women giving birth to babies with NAS missed multiple prenatal care appointments, leading to missed opportunities to initiate them on MOUD to reduce the risk and severity of NAS."

CONDUCTING A ROOT CAUSE ANALYSIS

Once a community has reached agreement about the nature of the problem, it can proceed to the identification of the problem's causes. A **root cause** is the most basic cause of a problem that can be identified and addressed. Addressing root causes will prevent (or significantly reduce the likelihood of) the problem's recurrence.⁵⁷

A **root cause analysis** is a problem-solving approach that minimizes individual biases while building consensus around the causes of the problem at hand. Traditionally, root cause analyses are conducted after an adverse event such as a medication error; they are also useful for addressing complex problems like the opioid crisis.

A common hurdle to problem solving is that individuals tend to believe their own perceptions of the problem are correct. While everyone involved may want to jump in and make improvements, there is often disagreement about where to focus efforts.

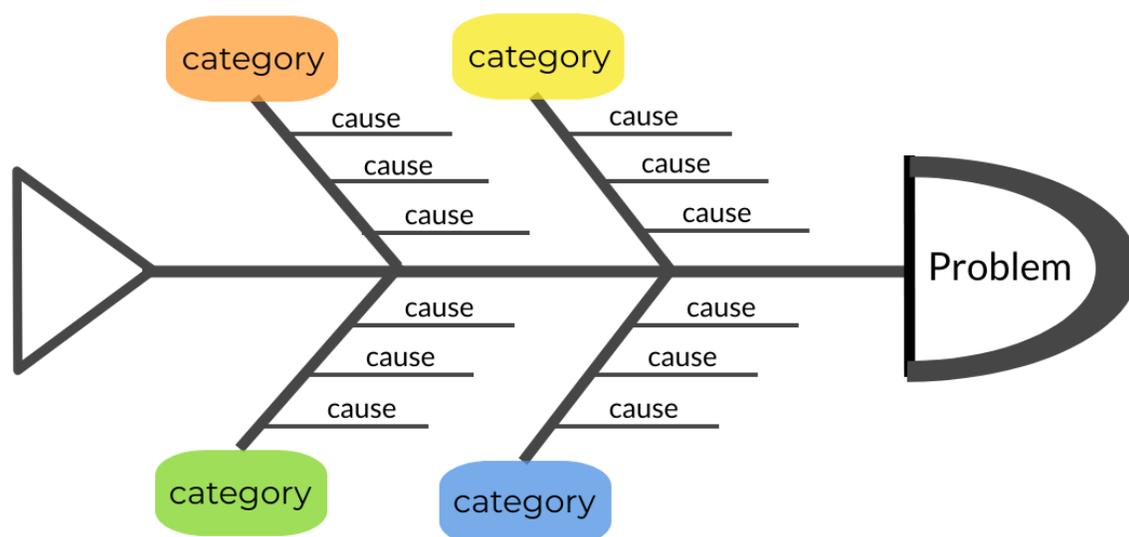
This increases the risk of a mismatch between the intervention or response and the true cause or causes of the problem. A root cause analysis can help reduce this risk by establishing a sound understanding of the problem before devising solutions.

A root cause is the most basic cause of a problem that we can both identify and fix and that, once fixed, will prevent the problem's recurrence.

TECHNIQUES FOR ROOT CAUSE ANALYSIS

Two common techniques that can be used to conduct root cause analysis are the Fishbone Diagram and the Five Whys.

The **Fishbone Diagram** – also called a “cause-and-effect” diagram – can help a group of stakeholders identify root causes of a problem by brainstorming individual causes, sorting them into categories, and uncovering commonalities between them. As represented in the figure below, the problem at the “head” of the fish is supported by a skeleton of cause categories that can range in number from four to eight, depending on the complexity of the problem. Individual causes in each category form the smaller bones of the fish.



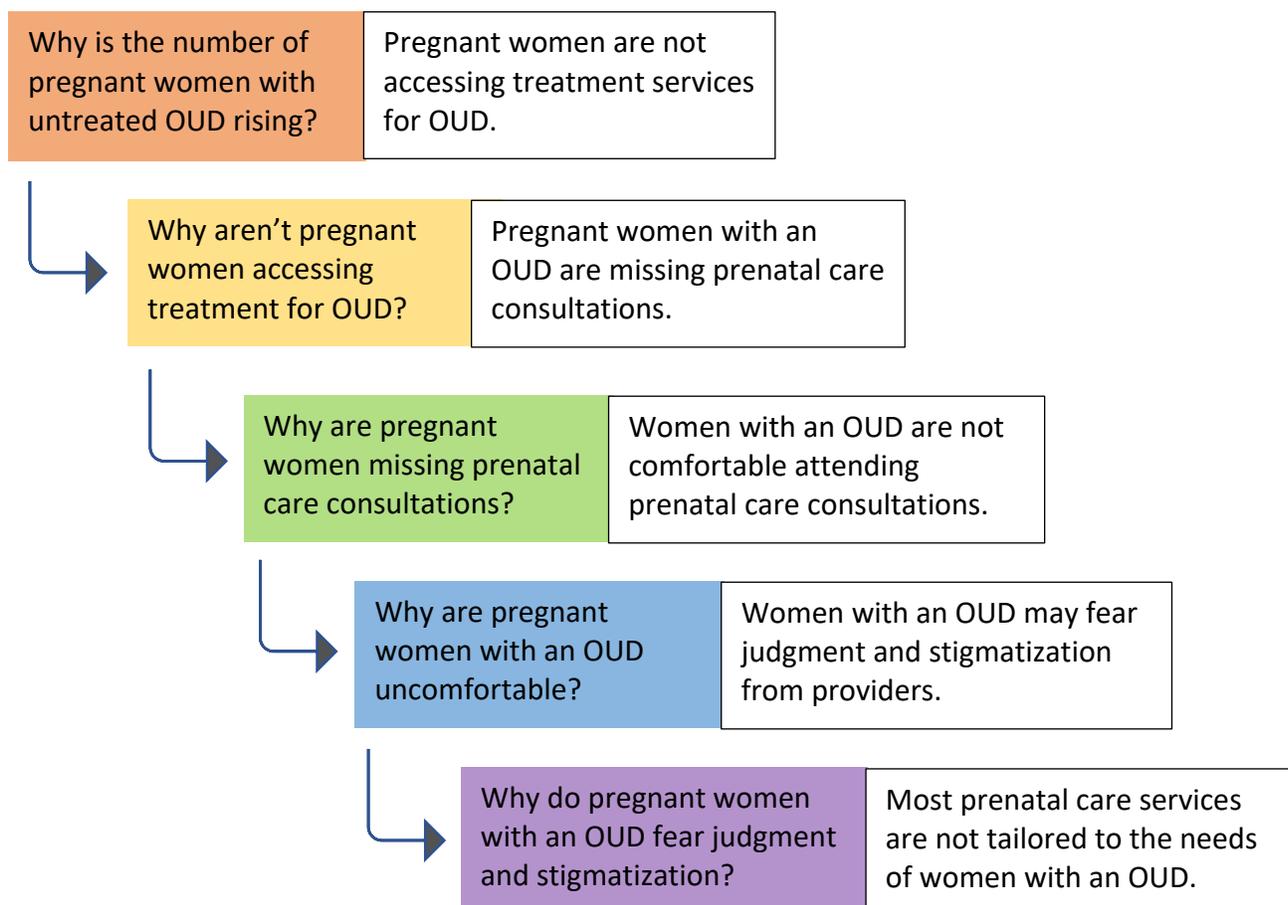
Some commonly used cause categories include: People, Policies, Equipment and Procedures. However, you and your community can use whichever categories best fit the problem as you

have described it. In the case of the opioid crisis, some useful root cause categories might include:

- **Policies and practices** (e.g. opioid prescribing guidelines, Naloxone policies, Medicaid plan coverage of MOUD, and coordination between law enforcement)
- **Infrastructure** (e.g. availability/proximity of office-based MOUD, alternative pain management centers, harm reduction services)
- **Attitudes and beliefs** (e.g. negative media representations, stigma, punitive attitudes towards substance use and addiction)
- **Information** (e.g. awareness of the problem, data systems, data sharing and use)
- **Capacity** (e.g. human resources, financial resources)

The **Five Whys** is an iterative question-asking technique that encourages deeper analysis of a situation by simply asking and answering the question “why?” until an actionable root cause is identified. Experience has shown that it commonly takes five “whys?” to uncover an actionable root cause, but it can take more or less than five, depending on the situation.

The Five Whys can be used in combination with the Fishbone Diagram, especially if team members are having trouble brainstorming additional causes of a problem. For example, if one identified cause of a spike in cases of NAS is “an increase in the number of pregnant women with untreated opioid use disorders (OUD),” the Five Whys might unfold as follows:



LO3.2: Creating a shared vision and defining goals and strategies

CREATING A SHARED VISION

Creating a shared vision can reduce the chances of problem-solving errors by integrating multiple perspectives, bringing assumptions to the surface, and providing insight into complex systems and situations. It also helps your team focus its energies and engage in collaborative work, which will be critical down the road as you seek to implement your collective vision.

A shared vision requires imagination: the ability to see things not just as they are today, but as we want them to be in the future. And because each person will have a slightly different vision for the future, it also requires patience (to listen to different ideas) and a spirit of cooperation (to highlight commonalities rather than differences).

It is helpful to start with an independent activity that allows each team member to describe in concrete terms their vision for the future. Some members may feel comfortable writing down a vision statement with little guidance, while others may need more guidance. Two techniques for eliciting creative input from team members are described below.

TECHNIQUES FOR CREATING A SHARED VISION

The **Proud Future** technique focuses team members on the aspects of the problem that are most important and asks them to visualize meaningful indications that the problem has been fixed (or that the situation has vastly improved). It then uses iterative small group work to refine and integrate individual visions into a single collective vision.

The **Letter to a Friend** technique takes a personal approach to the creation of a shared vision by asking each team member to draft a letter to a friend who has since moved away, updating them on progress and changes that have occurred in the past two years. Unlike the Proud Future technique, which starts with a visualization exercise, the Letter to a Friend technique starts with a narrative exercise. From that point on, however, both techniques follow a similar pattern for building individual visions into a single vision.

GUIDANCE FOR WRITING A VISION STATEMENT

When writing your shared vision statement, keep in mind that it will be used both internally, as a motivational guidepost, and externally, as a communication and resource mobilization tool. The best vision statements are inspirational, clear, and memorable. They also should resonate and capture the voice of those most affected by the problem or challenge you seek to address: in this case, the many individuals and families who struggle with opioid misuse or addiction. Ensuring that your community stakeholder group includes people in recovery is a good practice that will enhance the relevance of your vision and benefit the work you undertake in its pursuit.

The checklist below can be useful in assessing how a vision statement measures up on key parameters.

Is your vision statement:

- Y Future-oriented?
- People-focused?
- Ambitious and inspiring?
- Y Broad enough to capture the interest of diverse stakeholders?
- Y Enduring in the face of short-term changes or trends?
- Y Memorable?

Working from this checklist, two illustrative vision statements for communities seeking to reverse the trend of increasing opioid-related overdose deaths might be:

“A Halverson County that has minimized harm from opioids and affirmed the value of every life by extending comprehensive care, treatment, and recovery services to all residents in need, regardless of income or life situation.”

“To turn the tide on the opioid crisis in Kemper through collaborative, evidence-based action that meets people where they are and reduces their vulnerability to overdose and other harms.”

DEFINING GOALS AND STRATEGIES

One of the most productive things a community can do to ensure a successful response to the opioid crisis is to make its intentions and methods clear to internal and external stakeholders alike. Well-crafted goals and strategies help to provide a concrete sense of direction and focus, communicating what will be achieved and how (in broad terms) it will be achieved.

Your team should start by defining **goal areas**, which will serve as a high-level framework for your community response. Goal areas may vary in accordance with local challenges and priorities, but collectively, they should respond to the key challenges, gaps, or needs that you named in your problem statement. See **4.1** for guidance on the elements of a comprehensive response.

You should then formulate a **goal statement** for each goal area. To the extent possible, each of your goal statements should be Specific, Measurable, Attainable, Relevant, and Time-based (SMART). Establishing SMART goals can increase motivation and accountability during the implementation period.

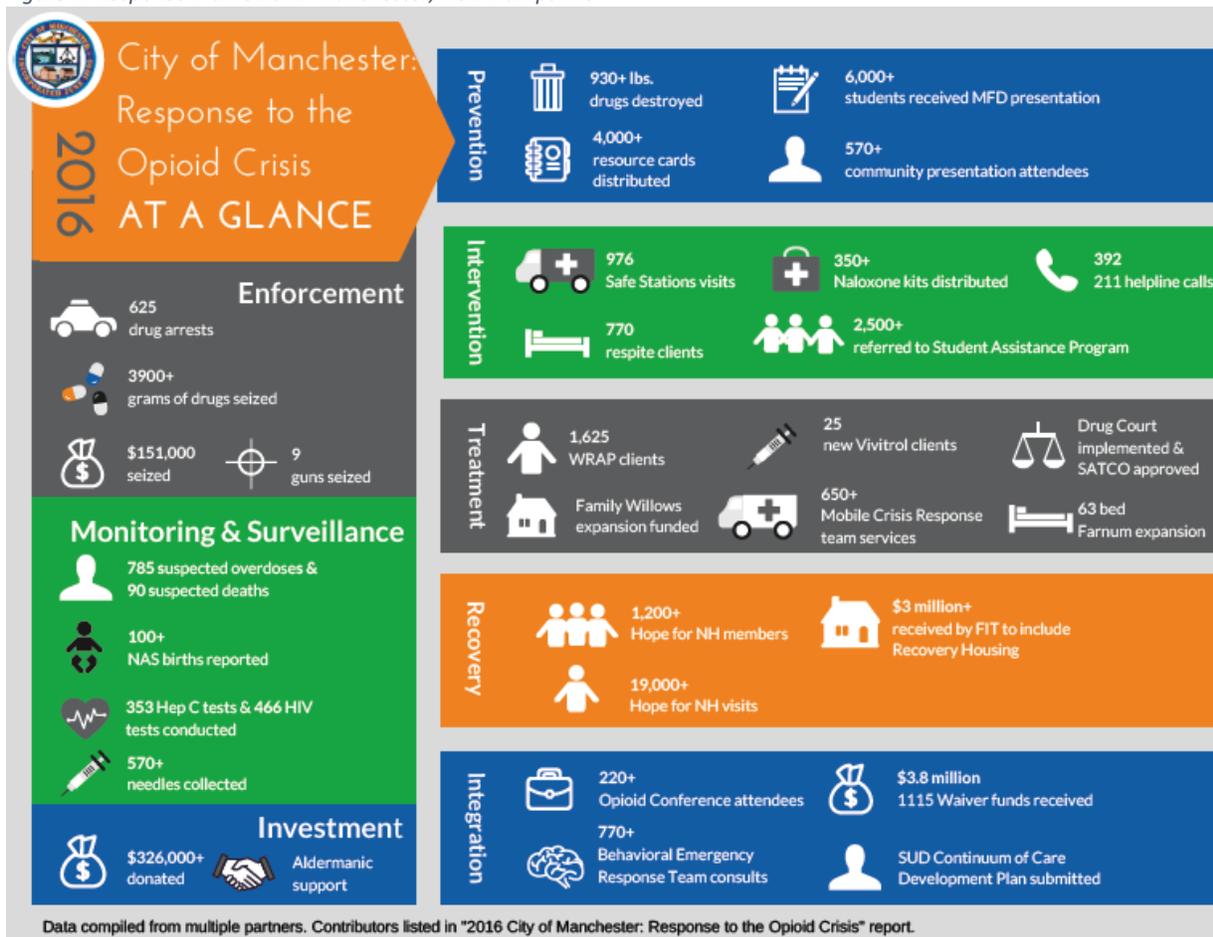
Example: By December 2022 (time-based), there will be a 25% decrease (measurable, attainable) in cases of neonatal abstinence syndrome (specific), among babies born in Vernon County (specific).



Next, your team must determine which strategies the community should pursue to achieve each goal. This requires a combination of creative thinking, knowledge of local assets, and up-to-date scientific evidence about what works in the opioid response (for a refresher on select promising practices, see 2.4). Your team’s idea generation should not be constrained by financial resources considerations; instead, you should assume that with a compelling vision and strategy, you will be able to mobilize funding for your plan.

Figure 7, below, is an example of a community opioid response framework from Manchester, New Hampshire depicting goal areas and corresponding strategies/actions.

Figure 7: Response Framework: Manchester, New Hampshire⁵⁸



LO3.3: Developing an action plan

When your community has completed the steps described in sections 1 and 2 of this module, you will have the building blocks of an action plan: you will know where you are (problem statement), what you want to achieve (vision and goals), and the strategies you will employ. The next step is to fill in the details by plotting out, in methodical detail, how your community will advance toward the realization of its vision.

whether change is appropriate and warranted, or which course of action is best. Asking clarifying questions and examining assumptions can be a helpful practice in this scenario.

There are several steps you can take to preempt or reduce resistance before it solidifies. These include:

- Consulting all interested stakeholders in the early stages of your planning process, and asking them for their suggestions and ideas.
- Clearly defining and communicating the need for and importance of the proposed changes to policies, practices and attitudes, both face to face and in writing.
- Anticipating how changes will impact different stakeholders (both individuals and organizations).
- Maintaining a positive outlook and focusing on what stands to be gained.
- Limiting unwanted disruptions to people's occupational/workplace routines.

When it does occur, resistance can prompt you and your team to do a better job of communicating the reasons that a public health approach is needed, while also illuminating potential themes or obstacles that might re-emerge at a later stage of your response. By seeing resistance as part of the process, rather than an unexpected hindrance, you can use it to your benefit and convert it into a source of strength.

Finally, if you encounter persistent resistance from one person or organization as you move ahead, don't grow discouraged. Meaningful change is rarely easy. Instead, invest your energies in identifying ways that you and your team can move ahead and be impactful in the absence of full consensus, while holding out hope that in time, critics will see change their minds.

LO 3.5: Conveying key messages to the media, policy makers, and other stakeholders

One way to garner popular support (and mobilize resources) for your community's response to the opioid crisis is to get the word out to decision-makers, influencers, and the media. Packaging your message strategically and communicating it effectively will increase the chances that it is widely circulated, especially in the age of social media. Developing a communications checklist can help you and other members of your team stay on message as you engage with a variety of people and audiences to promote different components of your response (e.g. education and primary prevention, treatment and recovery, harm reduction).

Before releasing a new communication, make sure you carefully consider the following:

- **The target audience(s)** for your communications (e.g. populations at higher risk of developing an opioid use disorder, local decision-makers, local foundations), and what action(s) you want them to take as a result of the information you share
- **Your message(s):** Journalists, reporters, and policymakers all work on tight schedules in high-pressure situations, so you should make the key messages in your communications and

press releases as relatable and easy to digest as possible. This will increase the chances that your message is published and widely read, and it will help you build stronger relationships with the media and policymakers over time.

- **Language:** Make sure that the language you use is humanizing, compassionate, and inclusive. Avoid stereotypes of any kind, and minimize use of jargon, since it can limit your audience or cause people to tune out. For a refresher on words to avoid, see **2.3**.
- **The tone** of communications should engage audiences without lecturing. Remember that the subject matter you are dealing with is heavy, so your communications should avoid long, complex sentences. Using personal narratives or anecdotes – especially positive ones – can facilitate engagement by readers, listeners, and viewers.
- **Human interest:** Wherever possible, aim to feature positive human interest stories about people on the path to recovery who are improving their own lives and the lives of others. Focus on stories that challenge negative stereotypes and combat stigma.

If your team expects to release communications to the public on a regular basis, you may want to develop a social media communications strategy that identifies a hierarchy of key messages and assigns responsibility for delivering messages to specific partner agencies and organizations. A brief guide to developing a social media strategy is included in the exercises at the end of this module.

Exercises

Exercise #1: Facilitating a Root Cause Analysis Using a Fishbone Diagram

Step 1: Setting the stage

- Explain the purpose of a fishbone diagram: to organize thoughts about which factors are contributing to the problem or problematic outcome
- Remind everyone that the purpose of the activity is *not* to place blame, but to consider root causes within the system, process and context of the problem
- Remember that the process of developing a fishbone diagram that everyone agrees is final can require several sessions

Step 2: Drawing the fish

1. Using a white board, flipchart paper or a computer program, draw the head and skeleton of the fish
2. Write the problem or undesired effect at the head of the fish
3. Agree on four to eight categories and write them on the outer bones of the skeleton
4. For each major cause category, brainstorm individual causes. Try not to overthink which cause fits into which category; categorization can be revised later. If your team is having trouble identifying specific causes, employ the Five Whys Technique (described below).

Step 3: Identifying root causes through analysis

After developing a fishbone diagram, work as a team to highlight causes over which the team (or the community at large) has power or influence. Employ the Five Whys Technique (described below) to uncover root causes.

Exercise #2: Facilitating Root Cause Analysis Using the Five Whys Technique

1. After observing a phenomenon (or identifying specific causes on a fishbone diagram) related to the problem at hand, simply ask the team “why?”
2. Upon answering the first question, then ask “why?” of the answer generated
3. Continue to ask “why?” until your team reaches an answer that is actionable and likely a root cause contributing to the problem. Actionable answers are typically related to:
 - Nonexistent or broken processes
 - Knowledge gaps and adjustable behaviors
 - Lack of standards, guidelines and operating procedures
4. When your team begins to uncover non-actionable answers, it’s best to stop there. Non-actionable answers include environmental, social and cultural issues that you do not have the control to address, such as poverty or lack of funding

Exercise #3: Creating a Shared Vision with the Proud Future Technique

Step 1: Imagine the Future

1. In a group setting, ask all participants to think about a time two years or more in the future.
2. Say, “Imagine it’s two (or more) years from now and we are looking back. We have accomplished what is important to us in confronting the opioid crisis. What do you see in your mind as the evidence of these accomplishments?”
3. Have each participant write down on a piece of paper the accomplishments they are most proud of, being as concrete as possible.

Step 2: Integrate individual visions

1. Have participants share their vision of the future with each other in pairs.
2. Ask each pair of participants to create a single vision by combining the best aspects of both individual visions.
3. Have groups of four discuss their combined visions.
4. Hand out index cards and instruct groups of four to record each key element or phrase of their visions on an index card.

Step 3: Organize key elements and phrases

1. Instruct participants to tape index cards to the wall.
2. Once all of the cards are posted, ask participants to come to the wall and move cards around, grouping similar messages and phrases together until they are arranged into categories. If a key phrase or element doesn’t fit with any others, it stands alone. It’s

okay to have many people moving cards around, as this process generates a good group discussion.

3. As a group, decide on a name for each category, and read the category and each of its elements or phrases aloud to the full group.

Step 4: Draft a shared vision

1. Have small groups synthesize the messages in each category and develop a single statement that reflects the shared vision for that category. Remind the team to retain the feeling of pride that the vision expresses.
2. Have each small group write their shared vision statement on flipchart paper and present it to the larger group for feedback.
3. As a full group, discuss each small group's shared vision and combine the small-group visions into one shared vision statement. This initial statement will likely need to be fine-tuned later on.

Step 5: Wrap-up and next steps

1. Decide on a deadline to finalize the shared vision statement. Consider who needs to be involved in finalization that may not be present in the room.
2. Discuss with the group how to use the vision as an alignment tool:
 - Discuss the final vision statement with individuals and stakeholders outside the immediate group who need to know your vision or could help you move closer to realizing it.
 - Make the vision statement accessible and visible to everyone who will be involved in working to achieve it.
3. Remember that the process of creating a shared vision together is what makes it powerful. Giving the statement to others who were not involved in creating it will not have the same power.⁵⁹

[Exercise #4: Creating a Shared Vision with the Letter to a Friend Technique](#)

Step 1: Draft individual visions

Ask each team member to imagine that a friend who today is deeply involved in the community moves away from the area and does not keep in touch. **Two years from now**, this friend writes to the member and asks how the community is doing – especially in responding to the challenges of opioid addiction and overdose.

Now ask each team member to imagine that the community has mounted a very successful response to the opioid crisis – one that is a shining example to other communities in the area. Have each team member write a letter in response to their friend, describing in great detail the specific measures the community has taken to confront the opioid crisis. The letter should describe activities and programs, clients and beneficiaries, the funding situation, and – most important – how the situation has improved. Team members should be as detailed as possible in their letters, but at this stage they should not share their letters with one another. This step should take about 10 to 15 minutes.

Step Two: Integrate individual visions

Divide team members into small groups or pairs and have each small group gather around a flipchart with the letters they have written. Have each member read their letter to the small group, then use the flipchart to record key statements about what the response – and the community – look like two years from now. After each team member has shared, have small groups discuss among themselves. Each group should aim to identify four to eight common ideas as well as ideas they found unique or worthy of further discussion. Spend about 10 to 15 minutes in small groups.

Step Three: Identify and group common ideas

Next, using a master sheet at the front of the room, ask the first group to read off its first idea. Have the other groups with similar idea(s) cross them off their lists. Have the leader then put it on the "master" list of common ideas. Keep going around the room in the same manner. By the end, there should be a list of ideas that are common to two or more of the groups. Sort these ideas into categories (it is fine if the categories are not perfect; there will be opportunities to regroup ideas during the planning process).

Step Four: Prioritize/rank ideas

Finally, hand out five to eight sticky dots to each team member in the room. Have team members vote on the ideas they like best by placing dots on the master sheet. The ideas receiving the most votes become higher priority items for the group to consider when planning.

Step Five: Compose a shared vision statement

Synthesize the messages in each category and draft a single statement that reflects the shared vision for that category. (You can do this during a coffee or lunch break.) Then present the shared vision statements to the full group and discuss how to integrate them into a single shared vision statement. Your vision statement should convey the “big picture” in language that is accessible and inspirational. Don’t worry if your vision statement is not perfect; you can always refine it later on.

*Exercise #5: Defining Shared Goals and Strategies**Step 1: Identify goals linked to the shared vision*

1. In a large group, ask individuals to pinpoint the key aspects of their shared vision that can be put into action (these are **goal areas**)
2. Ask them to brainstorm a compelling, measurable goal for each goal area that would indicate that the community is moving the right direction, and have them document each goal on a flipchart paper
3. Provide enough time for participants to come up with a collection of goals that they believe will get them to their vision

Step 2: Document goal statements that meet SMART criteria

1. Divide participants into smaller groups and ask them to discuss whether each of the written goals meet SMART criteria

2. Ask them to make each goal SMART-er and/or brainstorm additional goals
3. Review small group answers with the larger group for consensus

Step 3: Define strategies

1. Ask each smaller group to brainstorm evidence-based, locally tailored strategies for 1 to 2 goal statements
2. Have each group record its proposed strategies on a flipchart paper
3. As a large group, discuss the strategies for all goal statements and refine them based on feedback shared

[Exercise #6: Developing a social media communications strategy⁶⁰](#)

Use this guide to help your team strategize about your audience, and the potential social media tools and channels you may want to use to communicate with your audience as you introduce and implement a community response.

1. Determine your target audience.

- Describe the people you want to reach with your communication, being as specific as possible. More than one audience may be listed. Include a primary and secondary (influencers) audience if appropriate. (Examples: mothers of children younger than two years old living in Atlanta, pediatricians practicing in Nevada)
- Determine your objective(s). What do you want to achieve through your social media outreach and communication? This could include something you want your target audience to do as a direct result of experiencing the communication. Objectives may include (but are not limited to) the following:
 1. To provide information or increase awareness
 2. To highlight a campaign
 3. To encourage a health behavior
 4. To reinforce health messages
 5. To encourage interaction
 6. To obtain feedback or exchange ideas
- Define audience communication needs. People access information in various ways, at different times of the day, and for different reasons. If possible, define your audience communication needs by using data.
- Integrate your communication goals with your overall objectives. Describe how your social media objectives support your organization's mission and overall communication plan. How does it support other online or offline components? What events, either national, state, or local, present communication opportunities?
- Develop key messages. Develop the key messages based on the target audience and objectives identified.

- Determine resources and capacity. Determine who in your organization will be responsible for implementation and the number of hours they can allocate for content creation and maintenance.
- Identify social media tools. Determine what tools will effectively reach your target audience. Match the needs of the target audience with the tools that best support your objectives and resources.
- Define Activities. Based on all of the elements above, list the specific activities you will undertake to reach your communication goals and objectives.
- Identify your key partners and their roles and responsibilities.

Case studies:

Jenna, mother of two

Jenna, a mother of two, recently was treated for an overdose. Her sister found her at home unconscious. Following her release from the hospital, a social worker is scheduled to visit her to assess the safety of the home environment for the children. Jenna wants to stop using. Scared of losing her children, she finally tells her mother and sister about her addiction and they are there with her when the social worker arrives. To Jenna's surprise, the social worker does not start with questions about the children. Instead, she asks Jenna if she is ready to enter a treatment program.

- Why do you think Jenna is surprised by this question?

Jenna says she is ready to enter treatment but is told that it will take two to three weeks for a bed to become available in their city.

- Jenna has a supportive family and is eager to get help. What else might the social worker suggest/offer?
- If Jenna is a new mom breastfeeding her baby, what do you think should be done?

The social worker has brought two naloxone emergency kits and says she would like to teach them how to use this in case of an emergency.

- Do you think a social worker should be involved in the distribution of naloxone? Why or why not?

A rural community turns the tide

Last year, a small rural town in West Virginia was in crisis. IT had more 911 overdose calls than ambulances. Two people died because no emergency responder could get to them in time. Many people in the town were fed up and angry. One of the people who died was a much-loved teacher at the local middle school.

In recent months, though, there have been few 911 calls for overdose.

- What interventions might the town have started to achieve this?

You learn that last year the mayor mandated that a task force be created. The task force meets weekly and is led by the mayor, a public health nurse, and the fire department chief.

- Why do you think this task force is succeeding in addressing the opioid crisis in its community?

You later learn that the nearest addiction treatment facility is 1 ½ hours away. Despite this, the number of overdose deaths continues to decline. In the last 6 months, there were only two 911 calls related to drug overdose and both people are now doing well and back at work.

- How could this town achieve these results with such limited access to an addiction treatment facility?

You later learn that there are only two doctors in this town and one of them refuses to deal with opioid use disorders.

- With only one doctor addressing this epidemic, do you think this is possible? If you answered yes, you are correct. But how is this possible?

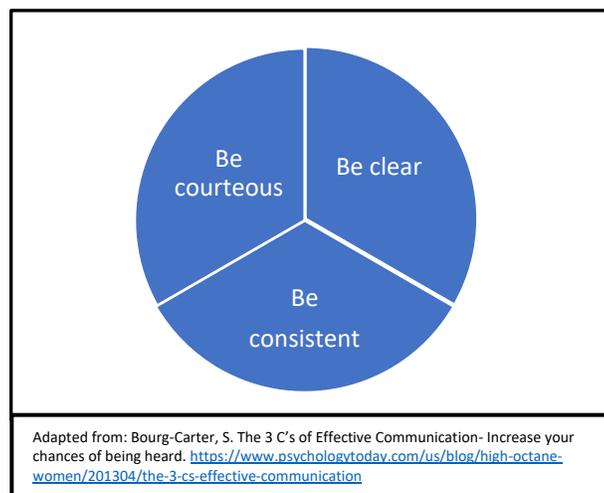
Job aids/Resources

- Leadership curriculum for frontline health workers: [MSH Managers Who Lead handbook](#)
- How to talk to the media: [CDC CERC Working with the Media manual](#)
- How to use social media effectively: [CDC CERC Social Media and Mobile Media Devices manual](#)

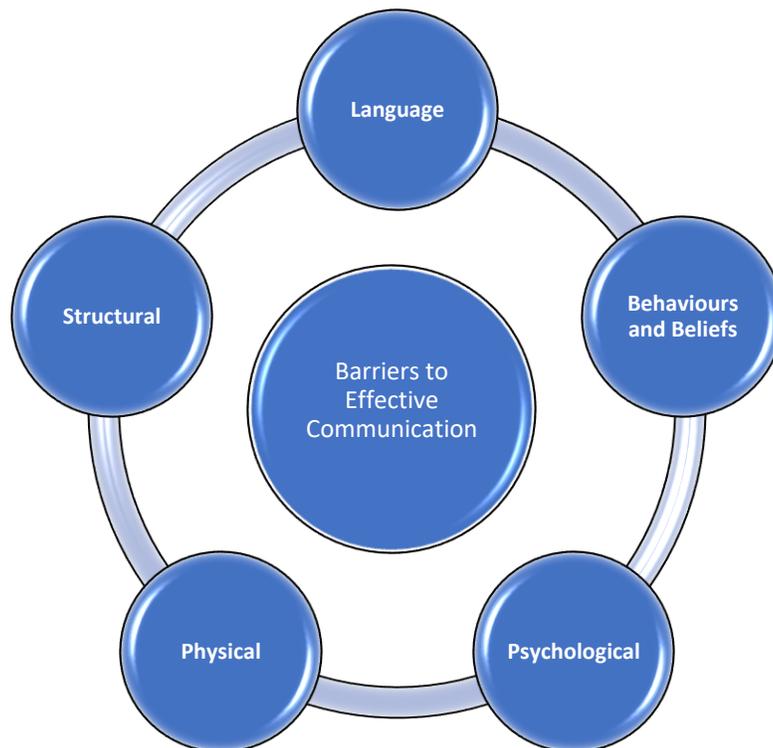
Illustrations

The 3 Cs of effective communication

- Be clear**- It is more important to be heard and understood than to be impressive. Avoid medical terminology and speak in a straightforward, logical manner.
- Be consistent**- A consistent message does not change; it builds trust and credibility in what you are saying.
- Be courteous**-if you want to be heard, show respect through what you say and how you say it. Even if you disagree with others, showing respect increases the likelihood that your view will be heard.



Common barriers to effective communication⁶¹



BARRIER

Language

Behaviors and Beliefs

Psychological

Physical

Structural

EXAMPLES

Use of slang, jargon, abbreviations, etc.

Desire to change, listen, motivation level, cultural beliefs

Anxiety, fear, anger

Using cell or video vs. face to face, distance, obstructed view

Poorly defined roles and responsibilities, unclear communication channels, norm, culture of secrecy, competitive environment, judgmental institution or leadership

Reflection

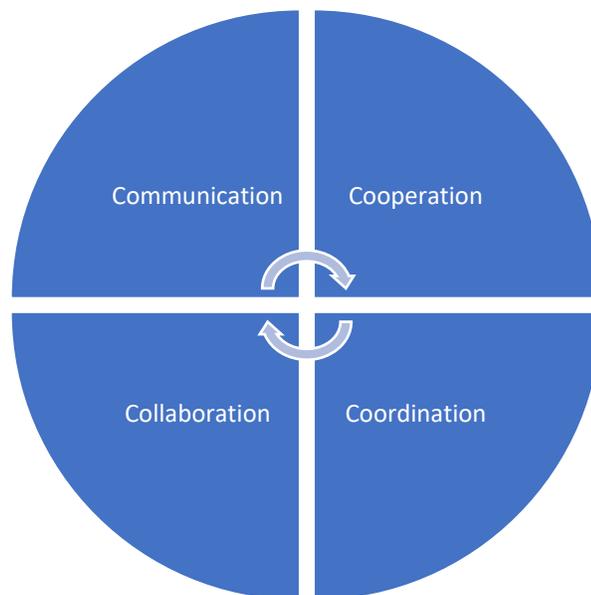
What barriers stand in the way of an effective opioid epidemic response:

- In your workplace?
- In your community?
- In your state?
- In our nation?

The 4 C's of Success⁶²

Although some sports teams have two- or three-star players, they are not always the team that wins. Why? Because a team's success depends on a team. A team that is not only on the field of play together but a team that is together in every sense towards a common well understood goal (no pun intended!).

What does it take to create a successful and thriving team? A few star players can make some amazing plays but over time, much more is needed. The 4 C's is a simple yet effective way to remember the components of a successful team. When a "C" is missing, the goal becomes harder to attain. Focus on the 4 C's for the best chance of success.



Module 4: Controlling the Epidemic

Core competencies

1. The nurse (or other healthcare worker) has a deep understanding of the key elements of a comprehensive response to the opioid crisis
2. The nurse can assess their own community/context using the **ANCOR** dashboard
3. The nurse can assist others to use the dashboard to inform community-led action
4. The nurse can use the dashboard as an advocacy tool and measure of success
5. The nurse can use the dashboard to develop measures of success towards epidemic control

Learning objectives

1. Identify and explain key domains of a comprehensive response to the opioid crisis
2. Explain the evolution and maturation of a comprehensive response
3. Present and use the dashboard to inform community-led action
4. Explore how the dashboard can be used both as an advocacy tool and evaluation tool

Key information

LO4.1 Domains of a comprehensive response

Development of response frameworks and action plans, as described in the previous section, are essential steps towards implementation of comprehensive strategies to address the opioid crisis within communities. Another important tool for guiding strategies and initiatives is the **ANCOR** Dashboard (see Figure 8, below), which tracks the maturity of local community responses. The dashboard is designed to help communities assess their response to the opioid crisis in relation to both their own baseline and an exemplar or “model” response. It is comprised of several domains, each of which is critical to a comprehensive response: Stakeholder Coordination, Community Engagement, Pain Management Approach, Training, and Leadership Development. The dashboard is intended to look across individual and organizational efforts to the community level, and to measure incremental progress over time at appropriate intervals.

The **ANCOR** Dashboard is based on a maturity staging model, ranging from least mature (red) to most mature (green), with most mature reflecting the ideal response status. While each community should have only one dashboard, nurses and other stakeholders in the response are encouraged to work collaboratively to assess their community’s maturity stage in each domain. Communities will likely find that they are at different stages in different domains— and this information will help them determine where to focus their efforts.

Figure 8: ANCOR Dashboard for Tracking Maturity of Local Community Response

Domain	Least Mature				Most Mature
Stakeholder Coordination*	No coordination of local efforts to respond to the opioid epidemic	Plans to identify appropriate stakeholders and bring them together are underway	There have been one or more meetings of stakeholders, but one or more important stakeholder(s) are not represented and/or insufficient data is available to guide actions	Stakeholders meet and implement appropriate actions, but the community response is still missing important stakeholders and/or key prescribing, health indicator, or law enforcement data	All key stakeholders are represented, and meet regularly to plan and monitor progress of appropriate responses in a comprehensively data-driven manner
Community Engagement**	Community is not engaged or interested in addressing the opioid epidemic, and no formal effort to engage the community is in place	Some community engagement has been established and a formal effort to expand community engagement has been launched	Substantial engagement with community partners exists, but community partners are not coordinated in the response to the opiate epidemic	Substantial engagement with community partners exists and community partners are coordinated in the response to the opiate epidemic	Community partners are coordinated and actively engaged with other key stakeholder in the response to the opiate epidemic
Pain Management Approach	No systems in place to educate prescribers, pharmacists, and patients on opioid risks, benefits, and best practices; and/or limited or no availability of non-medication pain management resources (PT, chiropractic, meditation, etc.)	Routine access to current education on opioids and non-medication options is available to some prescribers, pharmacists, and patients; and some non-medication pain management resources are available, though access is not well coordinated	Routine access to current education on opioids and non-medication options is available to some prescribers, pharmacists, and patients; and some non-medication pain management resources are available and care is coordinated	Routine access to current education on opioids and non-medication options is available to some prescribers, pharmacists, and patients; and sufficient non-medication pain management resources are available and care is coordinated	The community provides a well-coordinated response that includes: patient, pharmacist, and prescriber education, non-medication pain management resources, and pain experts for the referral of complex cases
Harm Reduction Approach	Community has few to no programs to reduce the harms associated with opiate use, including naloxone, clean needles, and facilitated referrals for individuals interested in drug treatment	Limited harm reduction services are available, which do not reach the majority of individuals who need them	Harm reduction services are available, however they are not fully comprehensive or accessible to many individuals who need them	Harm reduction services including naloxone, clean needles, and facilitated referrals for individuals interested in drug treatment are available for most who need them, though not in a well-coordinated or integrated way	The community provides a well-coordinated response that includes harm reduction services including naloxone and clean needles, facilitated referrals for individuals interested in drug treatment
Opioid Use Disorder Treatment	Community has no medications for opioid use disorder (MOUD) clinics or services	Some limited MOUD is available; most individuals in need of MOUD cannot access it	A substantial proportion of individuals in need to MOUD can access it, however important barriers such as distance/transportation or wait times exist for many individuals	MOUD is generally accessible to individuals in the community who need it	Treatment includes ready access to MOUD and other treatment modalities, comprehensive mental health services, psychosocial support
Data Use for Program Response	No active compilation or use of key data, e.g., overdose, drug use, criminal justice data, treatment enrollment and availability, other health metrics	Some relevant data collected but not coordinated or systematically reviewed for program improvement by community stakeholders	Some data is systematically reviewed for program improvement by limited stakeholder groups	An integrated approach to reviewing a range of key data is in development; some data is reviewed systematically by community stakeholders	Community stakeholders have access to a sufficient range of key data in a timely fashion, and use these data to guide programmatic response
Training	Community has no training program(s) for patients, law enforcement, medical providers, nurses, harm reduction staff, drug treatment staff, emergency services, pharmacists	Some limited training programs exist; little is understood about the reach or appropriateness of these programs	Appropriate trainings are in place for certain groups, though gaps in understanding about training for other groups exist	Appropriate trainings are in place for certain groups; plans to introduce appropriate trainings for other groups have been developed	Appropriate curriculums have been implemented for patient education, law enforcement, medical providers, nurses, harm reduction staff, drug treatment staff, emergency services, and pharmacists
Leadership Development	No leadership experience in addressing the opioid crisis and no leadership opportunities currently exist	Stakeholders have begun to discuss establishment of a community leadership development program	A leadership development program is planned for the community by key stakeholders	An active leadership program identifies community members and engages them with critical mentorship, capacity building, and opportunities for hands-on experience to foster leadership development	Community members have taken on relevant leadership positions following involvement in leadership development program

*Stakeholders may include community representatives (see below), government agencies, community-based services organizations, healthcare providers, drug treatment providers, law enforcement and correctional institutions, and emergency/first responders

**Community representatives may include persons with OUD, families, faith communities, advocates for persons with OUD, and others affected by OUD in communities

Communities may also face issues that overlap with opioid misuse, such as infectious disease or maternal-child health problems. If a community has identified one of these *syndemics* as an area of particular concern or consideration, the ANCOR Dashboard can be modified to incorporate additional relevant domains and/or maturity levels that can be tracked over time.

LO4.2: Stage-based measures of success

A community's dashboard staging should be conducted by a diverse group of local stakeholders that collectively possess relevant, current knowledge on each of the dashboard domains. Nurses are advised to work with other professionals – social workers, peer recovery specialists, department of health staff – to establish a representative community stakeholder working group. The stakeholder working group should complete a baseline assessment of their community and determine which stage of each domain best describes the community's current response. To guide this determination, stakeholders should compile and review relevant data, as well as other available information, from their community. They should also discuss their approach to monitoring the community response over time and assign primary responsibility for each domain to an individual or organization. The stakeholder working group should plan to re-assess and update the dashboard at least every six months.

As communities begin to better understand their needs, stakeholder working groups may find that certain domains become less mature until additional progress is made. For example, a community may initially stage themselves as yellow for the Opioid Use Disorder Treatment domain, which states that a substantial proportion of individuals in need of medications for opioid use disorder (MOUD) can access it, but significant barriers exist. Through community outreach and data collection, it may be discovered over time that the majority of individuals who need MOUD are not able to access it, which would then stage the community as orange. The maturity staging model of the ANCOR Dashboard allows communities to understand the reality of their situations and have a vision for their ideal system moving forward.

LO4.3: Activating the dashboard to drive community-level change

By staging community progress over time in specified domains, the ANCOR Dashboard provides an opportunity to create goals and establish expectations for stakeholder accountability. To best ensure that steps towards progress within a given domain are understood, stakeholder working groups should operationalize—that is, agree upon specific criteria for—what needs to be done to reach the target stage of maturity for their community. These criteria should be incorporated into the community action plan described in **3.3**.

After goals and action plans have been created, nurses will meet periodically with the stakeholder working group, and each stakeholder will be responsible for reporting progress on assigned activities within the community's action plan. Concrete progress on action plan items, along with recent data and other up-to-date information, can allow the group to confidently assess higher levels of maturity for dashboard domains over time.

LO4.4: Using the dashboard to identify bottlenecks and prioritize community investments

As a community's dashboard staging evolves over time, the stakeholder working group may notice greater progress in some domains compared to others. It is not uncommon for a community to stall or plateau in a given domain, despite having defined and implemented strategies and activities. The ANCOR Dashboard can be used not only to identify domains where progress has stagnated, but also as a communication and tool to increase attention to and mobilize investment for key domains that require additional inputs and resources.

The ANCOR Dashboard can be presented to local policy-makers or other decision-makers who determine resource allocation to demonstrate that a need exists in a particular domain and to advocate for greater investment in that area. Similarly, the dashboard can serve as a launchpad for developing proposals for grants or other sources of funding for a community. As thorough documentation will have already been completed as part of the staging process, the dashboard can help stakeholders to articulate gaps and challenges facing their community, and to focus stakeholders on the need for concrete measures to address these.

Case study

Different perspectives on progress

Your community has been monitoring the progress of its opioid response using the **ANCOR** dashboard for the past 18 months. You believe you have been making slow, but steady, progress in three domains: Community Engagement, Pain Management Approach, and Harm Reduction Approach. You most recently staged your community as light green for the Harm Reduction Approach domain, an improvement from your baseline of yellow.

At your periodic stakeholder working group meeting, a new stakeholder is in attendance: she is Program Director of a local harm reduction organization. The Program Director provides information to the rest of the group suggesting that harm reduction services *are not* reaching the majority of individuals who need them. The working group is faced with the difficult decision of whether or not to decrease the maturity staging for the Harm Reduction Approach domain from light green to orange.

- What action(s) should the working group take based on the new perspective/information?
- What, if anything, could have been done to prevent this scenario?
- What opportunities for process improvements does this scenario present?

Exercise

Exercise #1: Preliminary community dashboard assessment

For this exercise, a nurse or group of nurses will convene a diverse group of local stakeholders to review and adapt the ANCOR Dashboard provided here, and in this process will assess aspects of their community's response to the opioid crisis.

Step 1: Review the domains of the dashboard provided in this toolkit

- Does each domain capture an important dimension of the local response to the opioid crisis? Are adaptations needed to clarify any domains, or better align them with local needs?
- Do the domains capture all of the critical components of addressing the local crisis? If not, have the group propose additional domains or modified versions of the existing domains.

Step 2: Preliminary staging

- Attempt to stage your local community across the domains. Note areas that were staged as relatively mature and less mature. Do these staging results seem reasonable? If not – can the criteria be adapted to better reflect the needs of the community towards a fully mature response?
- Does the group feel that it had sufficient knowledge to stage adequately across each of the domains?
 - If additional knowledge is needed, try to identify individuals who could join the group to provide relevant insights to stage these domains.

Step 3: Strengthening the local response

- Pick one or two domains and have the group suggest actions that could substantially improve staging in these domains.
- Explore the feasibility of implementing these actions.

Step 4: Formalizing use of dashboard to assess local response

- Assess stakeholders' level of interest, availability, and buy-in regarding use of the dashboard to monitor the opioid response in the local community.
- Ideally, a broad range of stakeholders is committed to monitoring progress and identifying needs. However, if only a subgroup of stakeholders are available, activities may be focused around domains relevant to those participating stakeholders.
- If desired, make plans to meet at routine intervals—for example, every 6 months—to revisit dashboard staging.
- Plan for any follow-up that may be needed among the group and monitor implementation of priority actions (defined in Step 3) and progress, as applicable.

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