CONFRONTING AN EPIDEMIC:
Response to the opioid crisis in Indian Country
Learning Objectives

- Review the history of the opioid overdose epidemic across the United States and the Obama administration’s response to this growing public health crisis.

- Understand state and local approaches to providing access to naloxone for opioid overdose prevention.

- Review information on treatment resources

- Understand the behavioral health challenges related to this crisis
New effort targets drug overdoses in Indian Country

Provision of life-saving medication will help reduce rate of opioid overdoses in American Indian and Alaska Native communities
Opioid Related Deaths: Risk Factors

- The MOST likely person to overdose is an opioid dependent person:
  - Reduced tolerance due to: detoxification, incarceration, cessation of treatment
  - IV drug use (heroin use mostly)
  - High dose prescription drug use (> 90 mg of morphine equivalent dose)
  - Concurrent use with sedatives
  - History of substance abuse
  - Heath issues: asthma, COPD, sleep apnea, dementia, renal insufficiency, elderly
Four-fold increase in opioid overdoses from 1999 to 2013 among American Indians and Alaska Natives (AI/AN)

Four-fold increase in all drug-related deaths among AI/AN as well

Twice the rate of the general U.S. population
Opioid Prescriptions Dispensed by Retail Pharmacies—United States, 1991–2011

Drug Overdose Deaths by Major Drug Type, United States, 1999–2010

- **Opioids**
- **Heroin**
- **Cocaine**
- **Benzodiazepines**

2014 Statistics

- Sharp increase in heroin related deaths
  - Incr. 28% from 2013 to 2014: 10,574 deaths in 2014
- Increase in synthetic opioid deaths
  - Increase in illicit manufacturing of fentanyl
- 16% increase, or 2,658 opioid related deaths from 2013
  - 18,893 deaths from prescription opioids in 2014
Nearly 19,000 Deaths in 2014

AIDS and HIV

Morbidity
• Number of HIV diagnoses: 44,073 (2014)

Source: Health, United States, 2015, table 34 [PDF - 9.8 MB]
• Percent of adults 18 years and over who had ever been tested for HIV

Source: Early release of selected estimates based on data from the

Mortality
• Number of deaths: 6,955
• Deaths per 100,000 population: 2.2

CDC > NCHS Home > FastStats Homepage > Infectious/Immune

Influenza

Vaccination
• Percent of children 6 months to 17 years who received an influenza vaccine
• Percent of adults 18-49 years who received an influenza vaccine
• Percent of adults 50-64 years who received an influenza vaccine
• Percent of adults 65 years and over who received an influenza vaccine

Source: Early release of selected estimates based on data from

Mortality
• Number of deaths: 3,697
• Deaths per 100,000 population: 1.2
Youth and Young Adults

Abuse of Prescription (Rx) Drugs Affects Young Adults Most

Young adults (age 18 to 25) are the biggest abusers of prescription (Rx) opioid pain relievers, ADHD stimulants, and anti-anxiety drugs. They do it for all kinds of reasons, including to get high or because they think Rx stimulants will help them study better. But Rx abuse is dangerous. In 2014, more than 1,700 young adults died from prescription drug (mainly opioid) overdoses—more than died from overdoses of any other drug, including heroin and cocaine combined—and many more needed emergency treatment.¹

More than 1,700 young adults, ages 18-24, died from Rx drug overdose in 2014—a 4-fold increase since 1999¹...

...nearly 5 persons per day
Among young adults, for every death due to Rx drug overdose, there were: 119 Emergency Room Visits\textsuperscript{6} & 22 Treatment Admissions\textsuperscript{7}

In 2014, the nonmedical use of prescription drugs was highest among young adults.\textsuperscript{2}
**MEDICINE ABUSE REPORT CARD**

<table>
<thead>
<tr>
<th>Subject</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the last conversation they had with their parents regarding</td>
<td>F−</td>
</tr>
<tr>
<td>substance abuse, only <strong>14 percent of teens</strong> indicated they had</td>
<td></td>
</tr>
<tr>
<td>discussed the misuse or abuse of any type of prescription drug.</td>
<td></td>
</tr>
<tr>
<td>In comparison, <strong>a majority of teens (81 percent)</strong> say they have</td>
<td>B</td>
</tr>
<tr>
<td>discussed the risks of marijuana use with their parents.</td>
<td></td>
</tr>
<tr>
<td><strong>80 percent</strong> have discussed alcohol.</td>
<td>B</td>
</tr>
<tr>
<td><strong>Nearly one-third of teens</strong> have discussed crack/cocaine.</td>
<td>D−</td>
</tr>
</tbody>
</table>
The 2014 White House Opioids Fact Sheet

- 2010 Inaugural National Drug Control Strategy
  - DHHS directed to assist with training HC providers and first responders to treat overdose.
  - Support for naloxone use

- 2011 Prescription Drug Abuse Action Plan released:
  - Community-based drug use prevention, improve prescribing practices, reduce overdose deaths, etc
  - Goal was 15% reduction in overdose deaths
2013: SAMHSA releases Opioid Overdose Prevention Toolkit

- Comprehensive guide for 1st responders, prescribers and caregivers
- Available at the TurntheTide.org & SAMHSA websites

2014: Administration actively endorses and supports the use of naloxone “in concert with Good Samaritan laws” to save lives and “strongly encourages” the training of local law enforcement officers (LEO’s)
White House Announces Community Forums on Opioid Epidemic

New data show opioid-related overdose deaths rose again in 2014

Today, the White House announced that National Drug Control Policy Director Michael Botticelli will host community forums across the country focused on best practices and evidence-based initiatives to prevent and treat prescription drug abuse and heroin use. These forums will serve as an opportunity to continue the conversation that President Obama began in West Virginia in October, where he announced new public and private sector efforts to address the opioid overdose epidemic. New data from the Centers for Disease Control and Prevention (CDC) show that overdose deaths associated with opioids increased significantly across the country in 2014.
The White House Press Release

- **Series of “community forums”:**
  - Focus on best practices, evidence-based initiatives including use of naloxone
  - Highlight local examples to serve as models for others

- **Public and private sector commitment**
  - 40 provider groups to train 540K HC professionals with opioid prescriber training
  - Media space for Partnership for Drug-Free Kids
    - ABC, CBS, Google, NY Times, NBA, MLB, and more will donate “millions”
2016 Surgeon General’s Tour

- “Turn the Tide” tour and website launch
- Turn the Tide RX Website
  - Take the pledge
    - http://turnthetiderx.org/#
  - Letter from the Surgeon General addressing the epidemic
- Visit from the Surgeon General to some of the worst hit areas around the country
What is Naloxone

- Opioid antagonist (“blocker”)
- Used to quickly reverse opioid overdose
- Naloxone is:
  - Most effective in the hands of the people closest to the victim
  - Available in nasal or injectable forms
  - Has no abuse potential
  - Safe for all ages
Changes in naloxone laws mainly focus on 2 areas:

1. Good faith laws:
   - prescribe and use without risk of legal action

2. Good Samaritan laws:
   - encourage bystanders to summon emergency care without risk of negative legal repercussions
Access to Naloxone

- Available by prescription only except:
  - IHS programs
  - Ever-changing state laws
- Training and access for First Responders
  - Tribal Law Enforcement
  - Other Law Enforcement
  - Emergency Medical Services
"IHS is working to ensure that tribal communities receive the fastest possible access to this life-saving medication in situations where every minute matters,"

Robert G. McSwain,
Deputy Director, IHS
The BIA/IHS/White House Initiative

- Equips Bureau of Indian Affairs (BIA) federal law enforcement officers with naloxone

- Coordinates efforts of:
  - White House Office of National Drug Control Policy
  - Department of Health and Human Services/Indian Health Service
  - Bureau of Indian Affairs

- Formal partnership between IHS & BIA to reduce opioid overdoses among AI and AN
The IHS/BIA partnership

- 340 BIA law enforcement officers (LEO’s) equipped with naloxone
- 60 reservations involved
- 95 federal IHS pharmacies will be prepared to dispense and train on use of naloxone
- IHS to cover costs of naloxone kits
MOU applicable to only federal Indian Health Service facilities

Tribal sites are encouraged to adapt the MOU with local law enforcement agencies
Naloxone Community-Based Projects Examples

- EMT’s and Law enforcement officers
- Project Lazarus, Wilkes City, NC
- NM co-prescription pilot study
- MassTAPP
- Cleveland, OH area free kits
Opioid Use Disorder Diagnostic Criteria

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following: a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect. b. A markedly diminished effect with continued use of the same amount of an opioid. Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.
11. Withdrawal, as manifested by either of the following: a. The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal). b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.
305.50 (F11.10) Mild: Presence of 2–3 symptoms.

304.00 (F11.20) Moderate: Presence of 4–5 symptoms.

304.00 (F11.20) Severe: Presence of 6 or more symptoms.

*Other specifiers based on controlled environment or variations in individual use over time.

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (Copyright 2013). American Psychiatric Association. All Rights Reserved
# Opioid Use Disorder Phoenix Area

**Opioid Dependence Use in the Phoenix Area**

(ICD-9 code: 304.0 - Opioid Dependence)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Clinic Code = 30 (Emergency Medicine)</th>
<th>PIMC Visits</th>
<th>Visits</th>
<th>Active Users</th>
<th>Visits per 1,000 Active Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>16</td>
<td>363</td>
<td>715</td>
<td>150,886</td>
<td>4.7</td>
</tr>
<tr>
<td>2007</td>
<td>62</td>
<td>649</td>
<td>1,020</td>
<td>153,607</td>
<td>6.6</td>
</tr>
<tr>
<td>2008</td>
<td>46</td>
<td>878</td>
<td>1,241</td>
<td>156,803</td>
<td>7.9</td>
</tr>
<tr>
<td>2009</td>
<td>47</td>
<td>969</td>
<td>1,545</td>
<td>159,166</td>
<td>9.7</td>
</tr>
<tr>
<td>2010</td>
<td>46</td>
<td>1,013</td>
<td>1,665</td>
<td>162,349</td>
<td>10.3</td>
</tr>
<tr>
<td>2011</td>
<td>35</td>
<td>859</td>
<td>1,527</td>
<td>164,065</td>
<td>9.3</td>
</tr>
<tr>
<td>2012</td>
<td>31</td>
<td>549</td>
<td>1,605</td>
<td>166,398</td>
<td>9.6</td>
</tr>
<tr>
<td>2013</td>
<td>28</td>
<td>197</td>
<td>1,506</td>
<td>169,048</td>
<td>8.9</td>
</tr>
<tr>
<td>2014</td>
<td>40</td>
<td>230</td>
<td>1,603</td>
<td>172,247</td>
<td>9.3</td>
</tr>
<tr>
<td>2015</td>
<td>72</td>
<td>264</td>
<td>1,543</td>
<td>174,260</td>
<td>8.9</td>
</tr>
<tr>
<td>CLINIC_CD</td>
<td>CLINIC_NM</td>
<td>CountOfENCTRSS_ID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------</td>
<td>-------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>PHARMACY</td>
<td>2459</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>FAMILY PRACTICE</td>
<td>1947</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>ALCOHOL AND SUBSTANCE</td>
<td>1821</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>TELEPHONE CALL</td>
<td>1459</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C4</td>
<td>BEHAVIORAL HEALTH</td>
<td>1374</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01</td>
<td>GENERAL</td>
<td>990</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>INTERNAL MEDICINE</td>
<td>958</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>MENTAL HEALTH</td>
<td>690</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>REHABILIATION</td>
<td>513</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>EMERGENCY MEDICINE</td>
<td>423</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>LABORATORY SERVICES</td>
<td>355</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Phoenix Area Treatment Pool

35 tribal programs have returned or utilized a buy back to keep funds in the Treatment Pool. These funds total $431,500 and are utilized to fund patient treatment stays. The following programs serve these referrals:

Whiteside Manor - Riverside, California

New Frontier - Fallon, Nevada

The Haven – Tucson, Arizona

Pasadera Behavioral Health, Tucson, Arizona

Native American Rehabilitation Association, Inc. – Portland, Oregon

Native American Connections – Phoenix, Arizona

* These are in addition to the RTCs- Desert Visions, Nevada Skies, & Healing Lodge which is an IHS/Tribal collaborative program
Challenges for Behavioral Health in addressing the Opioid Epidemic

- Lack of resources, funding and referral locations for detoxification services, patchwork of detox clinics mostly served by Community Bridges- visited by Surgeon General 2 months ago.
- Detox intensity and level of care varies by facility, insurance, AHHCCS, higher volume, factors, acuity, locations of community bridges
- TX options, stability, screening for depression and suicide
- Co-occurring clients creating needs for more education on best practices, improved prevention programs, BH integration, zero suicide, continuum of care including aftercare in the community for return, medication management on MDT basis
THANK YOU

CAPT Rebecca Reyes
Pharmacy Consultant
Phoenix Area Indian Health Service
Rebecca.reyes@ihs.gov

Derek Patton, Division Director
Integrated Behavioral Health
Phoenix Area Indian Health Service
Derek.patton@ihs.gov