



# COMMUNITY TOOLKIT

Designed from real experience and results for communities everywhere combating prescription medication, heroin and other substance use.

**Preventing Overdose, Presenting Responsible Pain Management,  
Promoting Substance Use Treatment and Support Services.**



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# Introduction

The Project Lazarus Community Toolkit was designed from real experience and results with local communities everywhere in mind. The components included in this toolkit will provide the basis and guidance for communities everywhere to start their own coalition to fight the epidemic surrounding prescription drug misuse, abuse, diversion, and overdose. The toolkit is divided into four sections and may be read as a whole or sections may be read separately depending on the needs of the reader. The sections are as follows:

- **Section I: Project Lazarus Community Coalition Leader Manual**  
*The Project Lazarus Community Coalition Leader Manual explains in detail the various parts of the Project Lazarus Model, while also providing illustrations and testimonies to further understanding of the Model.*
  
- **Section II: Project Lazarus Sustainability Series**  
*The Project Lazarus Sustainability Series delivers the necessary training materials for sustaining efficiency once a coalition is established. Topics covered include Capacity Building, Community Assessment, Data, Reporting and Evaluation, Leadership, Strategic Planning, and Structure.*
  
- **Section III: Project Lazarus Sector Factsheets**  
*The Project Lazarus Sector Factsheets provide sectors with information relative to their specific area of work, knowledge, and/or interest.*
  
- **Section IV: Project Lazarus Appendix**  
*The Project Lazarus Appendix contains the essentials for keeping coalitions and communities engaged. The appendix is broken into four sub-sections:*
  - **Section IV.I: Naloxone**  
*The Naloxone sub-section contains informational pages about how to order naloxone for prescribers and individuals, health center naloxone programs, and prescribing naloxone. A naloxone rescue kit order form is also included.*
  
  - **Section IV.II: Resources & Samples**  
*The Resources & Samples sub-section provides a sample action plan, budget, community readiness survey, job description, logic model, request for application, and satisfaction survey. Articles on coalition sustainability and the North Carolina Good Samaritan Law are also included.*
  
  - **Section IV.III: Templates**  
*The Templates sub-section offers user-friendly documents that allow for easy input by coalitions. A county invitation, meeting agenda, minutes, membership form, organizational chart, sign-in sheet, and simple strategic plan are all included in this sub-section.*
  
  - **Section IV.IV: Handouts**  
*The Handouts sub-section is ever-growing and will continue to provide promotional materials to coalitions as developed. Currently available documents include a Project Lazarus factsheet, pharmacy stickers, medication disposal infocards (Project Pill Drop),*

*NC Good Samaritan Law infocards, with more to come. While some of these materials are generic for any Project Lazarus coalition, most can have individual coalition information input for local distribution.*

With the use of this toolkit coalitions can make a difference in their communities. It is vital for success to remember that all communities have a specific make-up that is unique and coalition activities must be tailored to fit this uniqueness. Project Lazarus has taken great strides to produce a toolkit that can be applicable in any community, while also maintaining room for coalitions to add in their own individuality. With that in mind, coalitions should also reach out to local, state, and even national resources for help in their community; the larger the amount of support and resources available, the more positive the results will be. Project Lazarus can help communities in their initial search for support and resources locally, statewide, and nationally.

# Acknowledgements

Project Lazarus would like to give special thanks to our partners for all of their help and acknowledge our gratitude for the North Carolina Project Lazarus Initiative sponsors:

*Kate B. Reynolds Charitable Trust, Office of Rural Health, Mountain Area Health Education Center (MAHEC), Purdue Pharma, L.P. Healthcare (Grant No.:NED103476), Cherokee Preservation Foundation, Community Care of North Carolina, Northwest Community Care Network, UNC Injury Prevention Research Center, Covidien, Governor's Institute, and Open Society Institute.*



# The Beginning of Project Lazarus

In 2007, Wilkes County, a large land mass county in the western mountains of North Carolina (NC), had an unintentional drug poisoning mortality rate of 28.3 deaths per 100,000 people, making it the third highest county death rate *in the country*. The problem had worsened by 2009. In 2009, the Wilkes County unintentional drug poisoning mortality rate was quadruple that of NC's (46.6 vs. 11.0 state mortality rate per 100,000 population), and was due almost exclusively to misuse of prescription opioid pain relievers. The average age of death was in the late 30s and the people who died often had other health problems such as respiratory, circulatory, and metabolic disorders. The victims of overdose in Wilkes used opioids for both medical and nonmedical reasons and exceeded their physiologic tolerance, either directly or in combination with other licit or illicit substances.

At the time, Fred Wells Brason II was serving as the Director and Chaplain of Wilkes Hospice and began to notice increased issues with prescription drugs in the homes of patients in 2004. The level of sharing, stealing, and selling escalated to such a point that prescribers would no longer write prescriptions to certain households, creating a barrier between the patient and critical medical care. Further investigation led Brason to local law enforcement personnel and the local hospital emergency department, who both readily testified to the magnitude of the problem among Wilkes County residents. Upon connecting with the Wilkes Health Department, Brason was referred to the Substance Abuse Task Force and quickly learned that they were not fully aware of the prescription drug problem. Neither NC State nor Federal authorities were able to give specific guidance on effective ways to address the issue. Brason then turned inward to his community, who designed their own responses and solutions to the problem. By obtaining real time data on unintentional drug poisoning mortality rates, emergency departments and hospitalization admissions involving overdose and withdrawal information, and data on prescribing patterns, the process of finding solutions to the monumental problem improved dramatically. The data proved to be one of the key drivers in building awareness and response in the community, leading to coalition engagement. Ultimately, these three key factors determined the project's objective and specific action plans.

The combination of compelling data and Brason's energy, hard work, and desire to make change attracted community groups, particularly practitioners, to join together in addressing the epidemic in Wilkes County. The project began with a community coalition in which there was representation from key county stakeholders, such as the health department, hospital, mental health centers, drug treatment facilities, law enforcement, and schools.

The venture was dubbed Project Lazarus and soon after a small non-profit organization with the same name was formed. The Project Lazarus mission was and is still clear:

*"Project Lazarus believes that communities are ultimately responsible for their own health and that every drug overdose is preventable. We are a non-profit organization that provides training and technical assistance to community groups and clinicians. Using experience, data, and compassion we empower communities and individuals to prevent drug overdoses, provide effective substance use treatment, and meet the needs of those living with chronic pain."*

Once the coalition was underway and began addressing the problem, the results were increasingly notable. For more information on the start of Project Lazarus, see the [North Carolina Medical Journal Vol. 74, No. 3, Spotlight on the Safety Net article: Project Lazarus: An Innovative Community Response to Prescription Drug Overdose.](#)



# Community Care of North Carolina & Project Lazarus

*A community-wide response to managing chronic pain*

## **Problem:**

Utilization of highly addictive opioid medications has risen 160% in the last 10 years. In North Carolina the death rate for unintentional poisonings is 11.4 per 100,000 citizens (22nd in the country), with 1140 such deaths occurring in 2011. In North Carolina, deaths by motor vehicle accidents and unintentional poisonings are almost equal. North Carolina Division of Public Health describes unintentional poisoning deaths as of “epidemic proportions”

## **Solution:**

The model of intervention in the chronic pain cycle is based on a successful integrated care pilot in Wilkes County called Project Lazarus (PL). Begun in 2007, PL decreased unintentional overdose deaths in the county by 69% from 2009-2011.

Community Care of North Carolina (CCNC), supported by a \$2.6 million grant from The Trust (KBR) and matching funds from the ORH, is expanding the Project Lazarus approach statewide through three interrelated initiatives:

1. **Community-based Coalitions** aim to broaden awareness of the extent and seriousness of unintentional poisonings and chronic pain issues, and to support community involvement in prevention and early intervention. Attendees include a broad range of community partners including law enforcement, public health, schools, hospitals and faith based organizations.
2. **The Clinical Process** focuses on the medical assessment and treatment of chronic pain. Toolkits have been developed to guide decisions by treating providers in Emergency Room, primary care and care management settings. The kits provide decision support and other tools for providers identifying and addressing each patient’s specific care needs. Additional training will be rolled out in 40 sites across the state for all opioid prescribers including primary care physicians, emergency room doctors, hospitalists, dentists, and local pharmacists. The focus of the education is on assessment criteria for pain, safe opioid prescribing, use of CCNC’s Provider Portal, and registration and use of the Controlled Substance Reporting System (CSRS). Information tailored to specific clinicians includes:
  - **Care managers.** Data tools have been developed to help care managers identify patients most at-risk of developing issues with opioids, (>12 narcotic scripts and >=10 ED admissions in a 12 month period of time). Tools tailored to the needs of these high-risk patients such as pain agreements are available through the CCNC Provider Portal and the CCNC website.
  - **Primary care physicians.** The PCP tool kit provides information on assessing and managing chronic pain in the primary care setting, encourages the use of pain treatment agreements and offers guidance for accessing and using the Provider Portal and the CSRS.
  - **Emergency Department physicians.** The ED toolkit describes policy issues that must be addressed at the administrative level; provides clinical tools for the assessment of acute vs. chronic pain; discusses the value of the Provider Portal and CSRS in the ED setting; shares strategies to decrease unnecessary imaging; and lists appropriate pain treatment pathways.
3. **Program outcome goals** (as measured through the Injury Prevention research Center): Decrease mortality due to unintentional poisonings; decrease inappropriate utilization of ED for pain management; decrease inappropriate ED utilization of imaging with diagnosis of chronic pain; and increase use of Provider Portal and CSRS.

*Project Lazarus Resources: Infrastructure of Community Care of North Carolina (14 CCNC Networks, 14 local Chronic Pain Coordinators, 600 care coordinators statewide, 5,000 primary care physicians participating with CCNC).*

# Section I:

## Project Lazarus Community Coalition Leader Manual

The Project Lazarus Community Coalition Leader Manual elaborates on all components of the Project Lazarus Model necessary for community leaders to establish their own working coalition. Graphs, charts, and info-boxes provide detailed statistics, as well as testimonies and samples from various Project Lazarus Community Coalitions.



# Wilkes County, NC: The Beginning

In 2009, the Wilkes County unintentional drug poisoning mortality rate was quadruple that of NC's (46.6 vs. 11.0 state mortality rate per 100,000 population) and was due almost exclusively to the misuse of prescription opioid pain relievers. The average age of death was in the late 30s and the people who died often had other health problems, such as respiratory, circulatory, and metabolic disorders. The victims of overdose in Wilkes used opioids for both medical and nonmedical reasons and exceeded their physiologic tolerance, either directly or in combination with other licit or illicit substances.

Figure 1.1 Unintentional Drug Poisoning Mortality Rate in the US, NC, and Wilkes County from 2004-2011

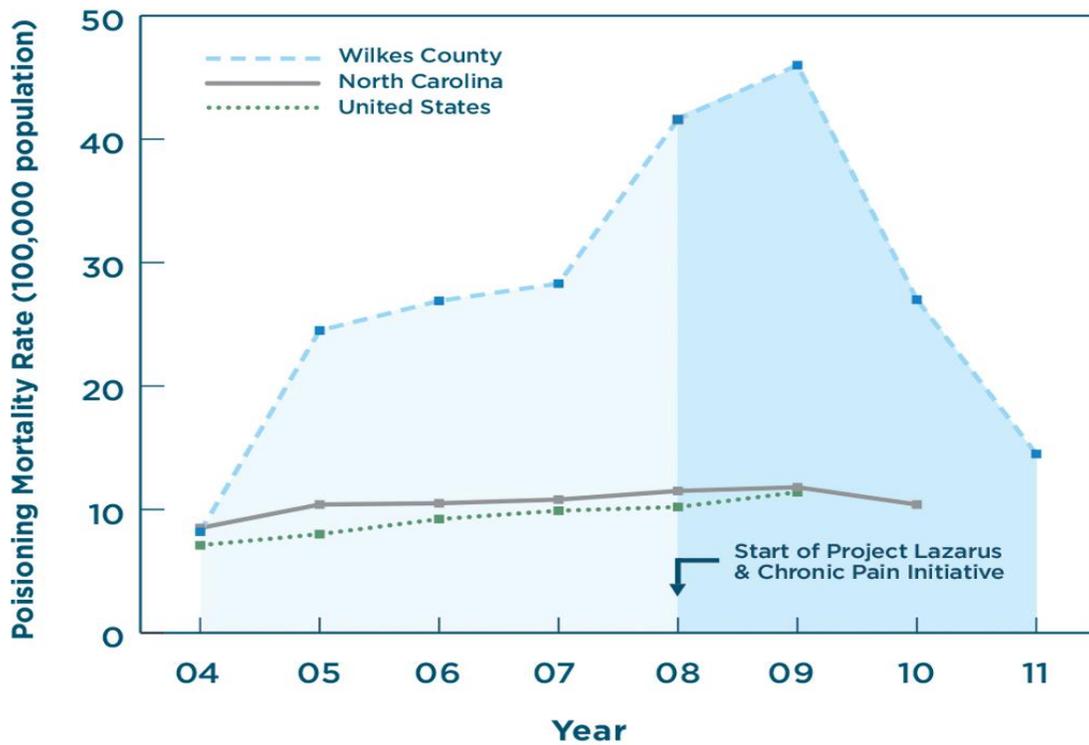


Figure 1.1 shows the steep decline in Wilkes County's unintentional drug poisoning mortality rate that occurred in the three years after Project Lazarus began. This decline occurred as the death rates in the rest of the state and country continued to climb.

## The Project Lazarus Model

The Project Lazarus Model is a public health model based on the twin premises that drug overdose deaths are preventable and that all communities are ultimately responsible for their own health. The Model can be conceptualized as a wheel, with three core components in the “Hub,” and seven components that make up the “Spokes.” The three foundational components of the Hub are: 1) **Public Awareness**, 2) **Coalition Action**, and 3) **Data and Evaluation**. **Public Awareness** is defined by shining the light on the issue and providing accurate information about prescription drug overdoses. **Coalition Action** is concerned with coordinating the community’s response to the issue and how it impacts their specific area. **Data and Evaluation** relates a community’s response to their unique and local issues, and helps to focus on where help is needed most. Each one of the seven components of the Spokes has a menu of different activities that can fall within. The seven Spokes are: 1) **Community Education**, 2) **Prescriber Education**, 3) **Hospital ED Policies**, 4) **Diversion Control**, 5) **Pain Patient Support**, 6) **Harm Reduction**, and 7) **Addiction Treatment**. This wheel is always in motion since coalitions and communities are always evolving. A coalition may start with a focus in one or two areas and then expand to other areas as the availability of resources changes, community sector engagement increases, or the nature of the problem shifts.

The flexibility of the Model should not be confused for a model which can only be partially implemented. The Project Lazarus Model was developed in response to some of the highest drug overdose death rates in the country. There are ten components of the Model altogether and communities should implement components from all ten to have an appreciable impact on overdose deaths. Focusing on only a few of these areas has been proven ineffective in reducing overdose deaths. The dramatic effects seen in Wilkes County, NC occurred after the core Hub activities were in place and at least some aspects of all seven Spoke components had been addressed in the community. The Model is shown in figure 1.2.

Figure 1.2 The Project Lazarus Model

# PROJECT LAZARUS

The Project Lazarus model can be conceptualized as a wheel, with three core components (The Hub) that must always be present, and seven components (The Spokes) which can be initiated based on the specific needs of a community.

## THE HUB

**Public Awareness** of the problem of overdose from prescription opioid analgesics.

**Coalition Action** to coordinate all sectors of the community response.

**Data and Evaluation** to ground a community's unique approach in their locally identified needs and improve interventions.

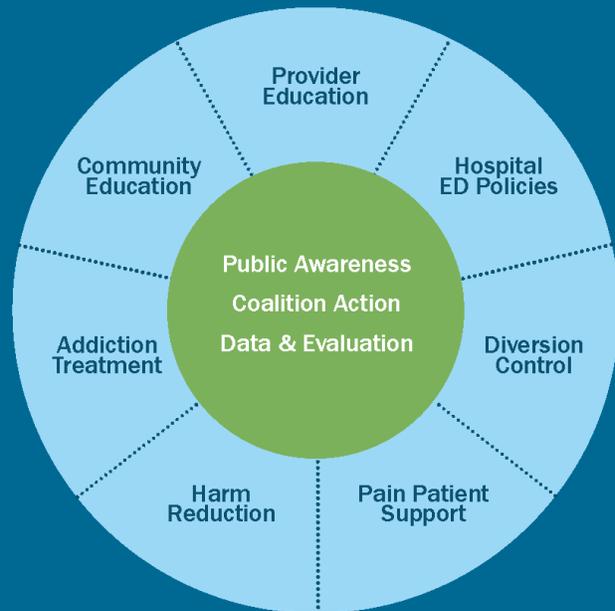
## THE SPOKES

**Community Education** to improve the public's capacity to recognize and avoid the dangers of misuse/abuse of prescription opioids.

**Provider Education** to support screening and appropriate treatment for mental illness, addiction, and pain.

**Hospital ED Policies** to encourage safe prescribing of controlled substances and provide meaningful referrals for chronic pain and addiction.

**Diversion Control** to reduce the presence of unused medicines in society.



**Pain Patient Support** to help patients and caregivers manage chronic pain.

**Harm Reduction** to help prevent opioid overdose deaths with the antidote naloxone.

**Addiction Treatment** to help find effective treatment for those ready to enter recovery.

## **The Hub**

The Hub is the foundation and center of the wheel. This is the part of the Model that defines the issue through Data and Evaluation, gets the community to identify the problem as their own through Public Awareness, and builds capacity to act through Coalition Action.

## **Public Awareness**

Public Awareness is particularly important because there are widespread misconceptions about the risks of prescription drug abuse/misuse/diversion/overdose. It is crucial to build public identification of prescription drug overdose as a community issue. Project Lazarus's message is that prescription drugs must be "taken correctly, stored securely, disposed of properly, and never shared." Project Lazarus explains to communities that while overdose is common, it is preventable. If these messages are not spread widely, the efforts developed by the coalition will have difficulty taking hold and being sustainable. Communities can develop new and creative ways to share messages and enhance awareness, as well as rely on what has been tried with success in other places. The following is a list of some of the activities and venues that can be used to improve Public Awareness:

- Town hall meetings
- Specialized task forces
- Youth prevention teams
- Inclusion of community-based leadership
- Billboards, posters, and flyers containing messages about prescription drugs and the risks of sharing medications
- Presentations at colleges, community forums, civic organizations, churches, schools, and military bases.
- Radio and newspaper advertisements
- Coalition building

## **Coalition Action**

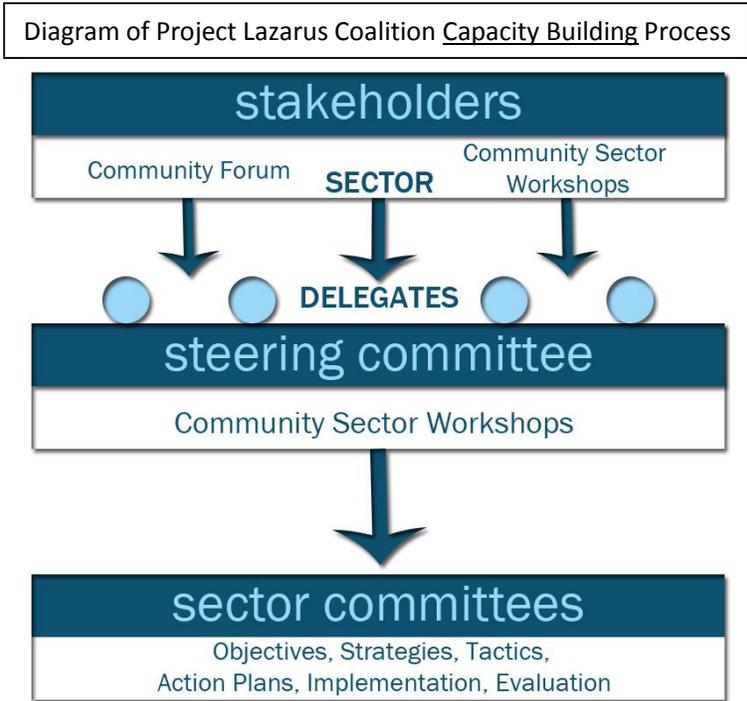
***Building the Coalition:*** Counties that have adopted the Project Lazarus Model of a community approach to prescription drug overdose have largely followed the same general steps in establishing a community coalition, which is the driving force behind most of the other work that occurs. This section describes the chronological steps that the majority of coalitions have taken. Naturally, every community is different and if there is an already existing coalition that will be adopting the model, the process will look slightly different. However, each of the following steps has a specific function that should occur in order to maintain the integrity and usefulness of the Project Lazarus Model.

***Getting High Level Stakeholders On Board:*** The stakeholders may be the individuals who identified the issue in the first place. The fundamental point is to get the decision makers from the key sectors involved at the lead table from the initial onset. These are not the "worker bees," but rather the ones who can assign resources, such as human resources, financial support, influence, and intellectual or

informational resources to the issue. Examples of the kinds of high level stakeholders who have been involved in other communities have included health directors, superintendents of schools, sheriffs and/or chiefs of police, directors of local substance abuse treatment facilities, mental health services administrators, hospital executives, and leaders in the medical field. Project Lazarus can help identify people in communities that should be involved at this stage. These stakeholders should come together and initiate action to guarantee support from county leaders in order for the efforts to be sustainable. If an already established coalition exists, but the support of the high level stakeholder does not, it is crucial to go back and engage with these key participants.

- Initial Stakeholders Presentation Example  
Surry Co. Participant List**
- Blue Ridge Medical Group
  - City Commissioners of Mount Airy
  - Cross Roads Behavioral
  - Department of Social Services
  - Dobson, Mt Airy, Pilot Mtn, and Elkin Police Depts.
  - Elkin City, Surry Co, and Mt Airy School Systems
  - Foothills Primary Care
  - Kerr Drug
  - Medical Associates of Surry
  - Mount Airy Ministerial Association
  - North Carolina State Senator
  - North West Medical Partners
  - Northern Hospital of Surry County
  - Pain Center of Mount Airy
  - Right Care Doctors Office
  - Surry County Health and Nutrition Center
  - Surry County Sheriff Office
  - Unlimited Success
  - Wal-Mart Pharmacy

**Bring Together the Larger Community:** Once the stakeholders have committed to engage the support from each of the key sectors in the community, along with a preliminary base of public awareness on the issue, the first task is to plan and hold a community forum. The community forum is designed to share information with the broader community about the issue of prescription drug abuse/misuse/diversion/overdose specific to their county. Based on Project Lazarus experience, the community forums are held approximately 45 days after the initial stakeholders’ presentation has taken place in order to build on initial community energy surrounding the issue. The forum serves two purposes: to raise awareness in the community that there is a problem, so community members are ready to engage as efforts are developed to address it, and to draw the attention of other dedicated people who want to become part of an on-going coalition that drives those efforts.



### **The Community Forum: Haywood County, NC**

The stakeholders promoted and recruited were among the organizations, colleagues, peers, families, and friends in the community. Local space was donated and a buffet lunch paid for with donations. The forum was advertised through public service announcements on the radio, notices in newspapers, email lists, church bulletins, flyers, and other material provided at diverse venues. The speaker agenda was created to include a full presentation by Project Lazarus, local law enforcement, and an addiction medicine specialist. Other programs addressing the issue within the community were invited as exhibitors to further build a strong network. The entire forum was set for 2 hours.

In this small community, 133 individuals attended. Those present included media, various law enforcement agencies, the medical community, schools, faith groups, youth, substance abuse treatment centers, those in recovery, family members who had lost loved ones to overdose, and others.

Contacts made at the forum were informed of the first meeting date for a community sector coalition workshop, where over 70 people attended and led to the formation of the Haywood Co. Coalition.

***The Steering Committee:*** The Steering Committee is a group of liaisons delegated from each sector along with the most active community representatives. This committee works closely with Project Lazarus in the establishment of the coalition and then propels and sustains the ongoing work of the coalition after Project Lazarus's role diminishes. The role of the Steering Committee cannot be emphasized enough. The high level stakeholders should designate one person from each sector to be involved and to ensure that the coalition has the organizational support to really engage members. The Steering Committee is absolutely necessary. At some point in this process, it is important that a **Community Coalition Coordinator** steps forward to work within the Steering Committee. It is important to have a designated person available for Project Lazarus to contact, as well as someone who will keep the process on track and gauge the effectiveness of their efforts.

***Establish a Working Coalition:*** This is the group of people that will accomplish tasks. The forum will have hopefully identified community members such as parents, teens, people in recovery, pain patients, or patient advocates who would like to be involved, yet were not otherwise designated by the high level stakeholders. Together with the Steering Committee and Community Coalition Coordinator, these interested parties form the coalition.

***Establish a Community Plan for Addressing Prescription Drug Overdose:*** Establishing a community plan generally happens through a series of workshops, often facilitated by Project Lazarus for the coalition. However, with the guidance of this manual, coalitions should be able to make progress without the presence of a Project Lazarus staff member at every meeting. Workshops begin by having coalition members divide into groups by sector such as clinical care, health department, public health, law enforcement, schools, faith community, general public, and local government, with at least one member of the Steering Committee in each group. Each group then works through the primary goals and objectives for their sector. Overviews for each sector are available in the **Community Toolkit Sector Factsheets**. The groups then report back to the coalition for discussion, alignment, and collaboration with other sectors. Next, each sector group identifies specific activities that would move them towards their revised goals and objectives. Again, input from the whole coalition allows for

### **Creating a Community Plan: Surry County, NC.**

At the first coalition workshop in Surry County, placards were set on each table indicating the different community sectors to be represented. Participants were directed to sit at their respective tables. After a brief synopsis of the agenda, plans, and strategy of coalition building, each sector was given a worksheet to guide discussion and planning around how to address prescription drug misuse, abuse, diversion and overdose within their sphere of influence. Upon completion of the worksheet, one person from each sector reported back to the entire coalition, inviting input by all other sectors. As is common in the early meetings, participants identified already on-going activities about which other sectors were unaware. Over time, the different sectors developed different action plans. Within 2 months of the initial meeting, the schools sector convened a student working group who created their own initiative utilizing flyers, posters, and t-shirts addressing awareness and dangers of prescription medications in the schools. They also chose a curriculum for the classroom and had it approved by the local school board. The awareness plan and curriculum were disseminated to the administration, teachers, school counselors, nurses and social workers, as well as parents. The law enforcement sector decided to seek out additional diversion training for officers, increase pill take back days (with more promotional activities) and establish permanent pill take-back locations. They worked with law enforcement, local pharmacies, the emergency department, and prescribers to direct patients to proper disposal. Within the medical sector was an emergency department physician who learned of the Project Lazarus ED policies through the coalition presentations and workshops. He set an action plan to request his hospital administration to formally adopt and implement these policies.

feedback and coordination of activities between sectors since many of them will overlap. At this point, the members of the Steering Committee work with the list of goals, objectives, and activities to figure out resources, responsible parties, and deadlines by which activities should occur. *Remember*, this is a multi-stage process that will initially occur in a series of meetings over 6-9 months.

This short video describes a Project Lazarus Workshop in Surry County:

<http://www.youtube.com/watch?v=a2FQQuzt02g>

***Coalition leaders:*** Coalition leaders should have a strong understanding of what the nature of the issue is in the community and what the priorities should be to address the problem. There will be relatively high levels of energy and enthusiasm in each group. The key will be to figure out how to maintain and sustain the engagement and activity as the issue is addressed. A coalition and Steering Committee are needed for the long haul. While change varies from community to community, it can be anticipated that the first fruits of the coalition's efforts will be seen in 1-2 years, although some changes such as ED policies may occur much more quickly. Finally, it is important to keep in mind the needs of coalition members who are not only professionally engaged with this topic, but who also may have personal connections. In building a community coalition, be prepared to support the members who are personally adversely affected, such as loved ones of people who are currently struggling or have overdosed. Specifically, resources about addiction treatment support for families of people who are currently using and grief support should be made available to coalition members. If there are no resources for these issues locally, direct individuals to internet-based resources, but know that development of local resources for support will need to be part of the action of the coalition.

**A Well-Functioning Coalition:**

Every coalition looks different; however, there are some common features in those that work well. There is consistent participation in community sectors, ranging from simply identifying the problem to actively implementing the strategies and action plans, as well as reporting to the coalition on a regular basis. Interaction between the various sectors is occurring outside of coalition meetings and more networking is taking place. Those sectors who may not have engaged at the onset are now beginning to or have become part of the coalition as word of the group's efforts and successes has filtered throughout the community, and coalition members are taking it upon themselves to reach out to the missing sector groups.

An active coalition should see the development of a change in behaviors, practices, and policies among the community sectors without accusation or blame focused on any one particular group for the issue.

Relational Diagram Among All Components of the Coalition



Venues Provided by Project Lazarus for Coalition Building



## Data and Evaluation

Several pieces of this work will help with ongoing coalition maintenance. First, collecting strong Data and Evaluation will give coalition members feedback to ensure that they have a sense of the impact and results from their work. The data also lays the groundwork for making subsequent decisions on how to move forward after an initial round of efforts. Data and Evaluation are collected and used by each community to establish priorities and identify progress, which helps sustain coalition momentum. All Project Lazarus coalitions have certain Data and Evaluation requirements, which take the form of surveys and reports. This requirement comes as part of a larger effort to measure the effectiveness of the Model on a statewide level.

Second, coalition self-evaluation should constantly be assessing who is NOT at the table. Bringing in new energy is always helpful. Even more important is making sure that all the key players in the community are engaged to make certain that there is widespread ownership of the activities and the outcomes. This also helps ensure that no single sector dominants planning or implementing strategies.

The early data that is needed includes specific health related information, such as the number of emergency department visits and hospitalizations due to overdose, the number of overdose deaths, the number of prescriptions and recipients for opioid pain medication and other controlled substances dispensed, and the number of providers in the county who actively use the state's prescription drug monitoring program (PDMP). In NC, the PDMP is called the Controlled Substances Reporting System, or CSRS. The data can be obtained by working with your local health department as well as with the state's Injury and Violence Prevention Branch.

Project Lazarus will provide training for data querying and will help connect communities with the state resources needed. Service oriented data and information such as numbers, types, and locations of drug treatment facilities, and numbers and locations of physicians who can prescribe buprenorphine for opioid addiction is also needed. Access to this data is available through each state department of Health and Human Services, as well as at [www.SAMHSA.gov](http://www.SAMHSA.gov) for buprenorphine prescribers and opioid treatment programs.

### How Will the Data Change Early On?

Data may begin to show a decline in overdoses while treatment numbers increase and emergency department drug seeking behavior issues decrease. Most communities expect to see an early decrease in prescribing and increase in arrests; however, do not anticipate this occurring. Do expect more *appropriate* prescribing, less sharing of medications, and more people with addiction who are identified by the medical community and law enforcement finding their way into treatment. This will apply pressure and possibly overtax current treatment options within a community, but with concerted effort an increased capacity of effective substance abuse treatment should become evident.

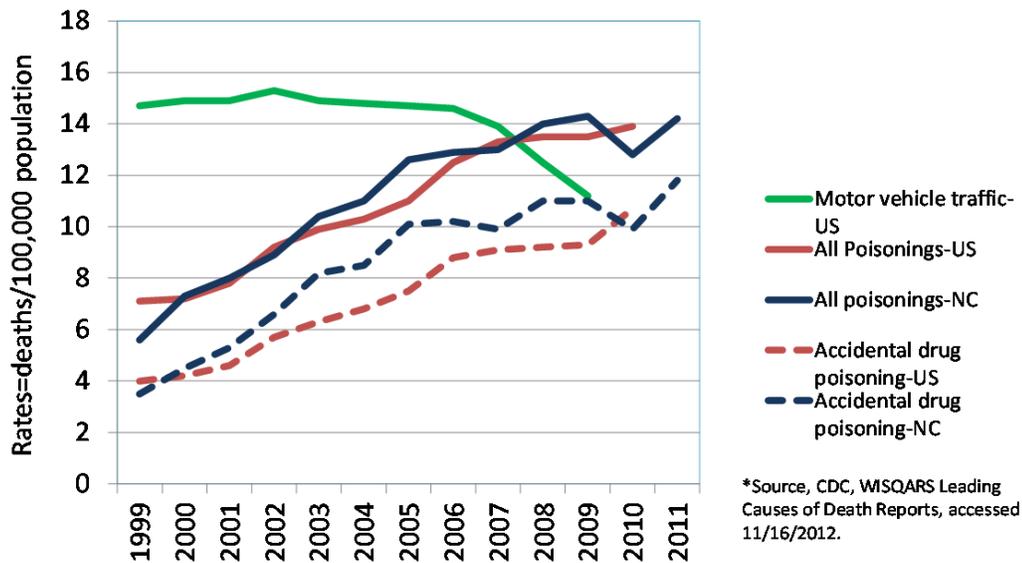
Project Lazarus will be collecting a biannual report from each coalition. These reports will serve multiple functions and be used by multiple parties. First, they will serve the coalition directly as a reminder to stay focused on the specific activities and outcomes that are unique to the Project Lazarus Model. The reports also help the coalition keep track of progress, which is crucial in being able to tell the story of the work being done as new partners and sectors are invited to participate. Second, the reports will serve Project Lazarus. The lessons learned from how the work progresses differentially in each county will help enrich and improve the training and technical assistance that Project Lazarus can offer to all counties. Third, they will serve the needs of researchers at the University of North Carolina Injury and Prevention Research Center at Chapel Hill who are conducting a formal evaluation of the

statewide Community Care of NC collaborative Project Lazarus. Being able to measure the extent to which different activities are in place in different counties is crucial to their ability to connect the work Project Lazarus is doing to health outcomes, like changes in ED admissions for overdose rates across the state. The information provided in these reports will capture the process of the work, which could then be connected to the outcomes this work is aiming to affect.

It is very important to understand that these reports are not “graded” reports on the coalition leader or the work of the coalition. There is not a standard that coalitions are being measured against. Rather, the information provided in the reports will help everyone better understand what the Model looks like when implemented in varied settings. These reports help describe the program in the real world rather than being used to measure coalitions against some theoretically perfect program. The following are some examples of how data and evaluation has been used in Wilkes County, NC to enhance coalition efforts.

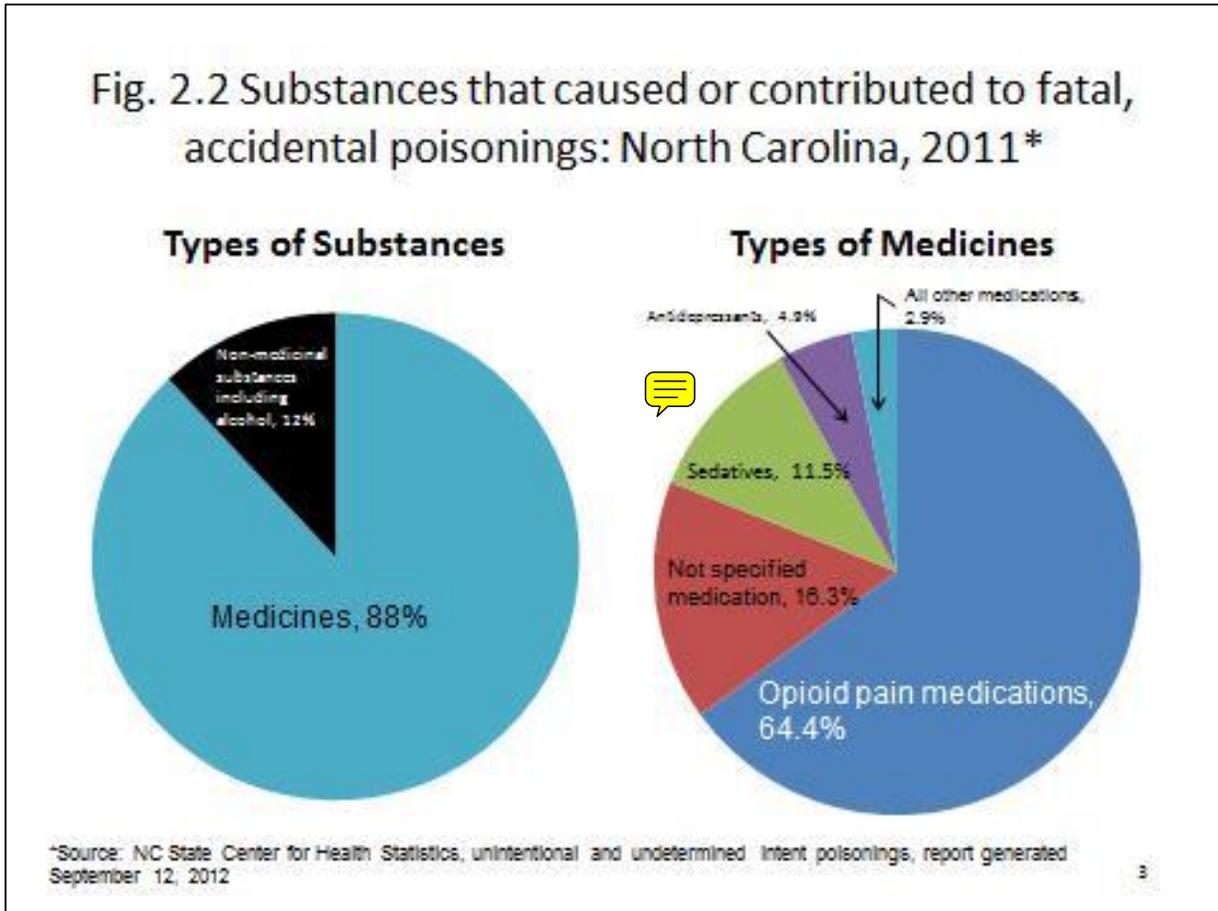
Poisoning deaths are on the rise nationally and in NC (solid red and blue lines), as seen in Figure 2.1. These death rates have even surpassed the national mortality rate from motor vehicle crashes (solid green line). Accidental drug poisonings are the main cause of this increase (dashed red and blue lines); this is evident from the similar trajectories of each dashed line when compared with its same-colored solid line. By comparing both blue lines (NC) with both red lines (USA), it is apparent that NC has consistently had a higher death rate from poisonings than the nation as a whole. Over a five year span (2007-2011), over 5,000 people died from accidental drug poisonings in NC. Nearly all of these deaths (88%) involved medicine, as opposed to illicit drugs like cocaine or heroin (Figure 2.2).

**Fig. 2.1 Fatalities from all poisonings, accidental poisonings, and motor vehicle traffic\*:  
U.S. (1999-2010) and N.C. (1999-2011)**

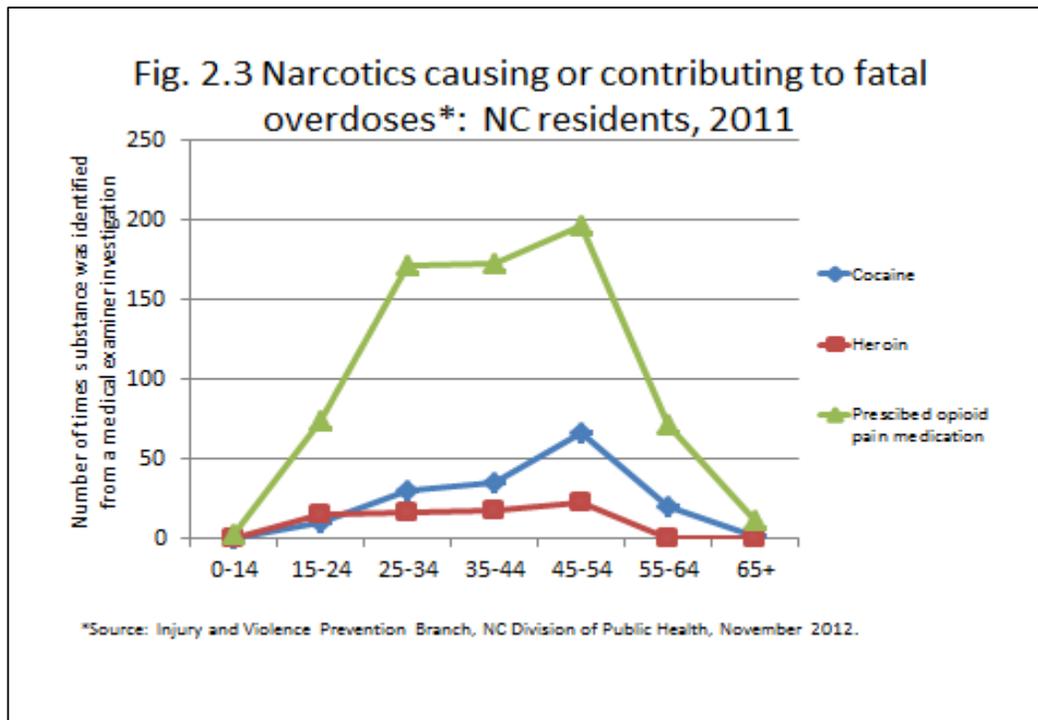


Of the deaths from medicine, over half (64%) are from one class of medication: prescription opioid pain relievers (e.g. methadone, oxycodone, fentanyl, morphine, hydrocodone).

In fact, deaths from prescription opioids *alone* outnumbered those from cocaine and heroin *combined* (Figure 2.2).



Who is dying must also be considered in order to understand this epidemic further. Figure 2.3 below shows that this is not an epidemic of the young or the old, but that the majority of these deaths are adults between the ages of 25 and 54. Moreover, men are dying from prescription drug overdose at a much higher rate than women. The information shared in this section can be used for brief conversations to describe the problem to those unaware of the accidental poisoning epidemic.



Main talking points can include:

- Poisoning deaths are on the rise nationally and in NC. Poisoning death rates have surpassed the national mortality rate from motor vehicle crashes.
- Most of the rise in deaths are due to accidental drug overdose.
- NC has a higher death rate from accidental poisonings than the nation as a whole. Over 5,000 people died from accidental poisonings in NC between 2007 and 2011.
- Nearly all of these deaths (88%) involved medications. Of the deaths from medicine, over half (64%) are from prescription opioid pain relievers.
- Prescription opioid pain relievers are involved in more deaths in NC than cocaine and heroin combined.
- Most deaths are among men between the ages of 25 and 55.

For discussions that move beyond these talking points or for community presentations on the topic, see the NC Injury and Violence Prevention Branch.

(<http://www.injuryfreenc.ncdhhs.gov/About/poisoning.htm>)

## The Seven Spokes

Transitioning from the Hub to the Spokes is moving from building the community's ability to define and identify the problem, along with gathering the resources to address it, to actually providing solutions to the problem and reversing the epidemic.

### Spoke #1 - Community Education

Education is almost always the first response in addressing public health problems. It is indeed an important strategy, but its goals and objectives need to be carefully defined. The line between Public Awareness building and Community Education is not strict, but there are differences. Whereas the Public Awareness activities can be thought of as sharing information, the Community Education activities are about changing skills, behaviors, and norms to actually address the issue. These educational activities can be understood as two broad categories: *General Community Education* and *Specific Community Education*.

**General Community Education:** These efforts are those offered to the general public and are aimed at changing the perception and behaviors around sharing prescription medications, as well as improving safety behaviors around their use, storage, and disposal. The main message in these general efforts is the same as the awareness message: "*Prescription Medication: Take Correctly, Store Securely, Dispose Properly, and Never Share.*"

Many of the same venues that are used in Public Awareness may be used in this type of Community Education, but the emphasis is different: Public Awareness teaches that "this is a problem," while Community Education teaches "this is what you should do about it." There are many activities that might serve dual purposes of Public Awareness *and* General Community Education. For example, a billboard might let people know that this is a problem (awareness) and have a list of actions to take around safe storage practices (education). A Red Ribbon campaign (warnings not to share medications attached to dispensed prescription packaging) may primarily work on changing behaviors around sharing of medications (education), but will also reinforce the basic message that prescription drugs can be dangerous (awareness). This is fine, as long as coalitions make sure that efforts don't confuse the two kinds of messages. It is important to ensure that while teaching awareness, coalitions do not forget to educate on how to resolve problems.

**Specific Community Education:** This refers to the specially tailored educational messages that must be put into place by each sector. Because communities are made of various individuals with their own biological, psychological, social, and spiritual make-up, each community also has a unique make-up; therefore, the medical and substance abuse treatment options must be

The sharing of these basic educational messages must be ongoing. Based on the University of North Carolina Injury Prevention Research Center's Health Department survey, in 2012, Wilkes Co. had received more concerted overdose prevention education than any county in the state of NC and had indeed shown dramatic reductions in overdose deaths. Still, there continued to be cases of overdoses caused by abuse of pain medications obtained illegally from outside the community and through misuse from sharing legally obtained pain medications. There are two lessons here:

1. Never stop providing the basic messages about prescription medications, and
2. General education *alone* is not enough to change behaviors.
3. Continue to evaluate to implement interventions to specific population groups that may remain adversely affected.

crafted to fit this specific make-up. Core messages for each sector include:

- School Children: Teach Wisdom, i.e. the dangers of taking medication not prescribed to them.
- Senior Citizens: Teach Safety, i.e. taking medication correctly and storing securely.
- Inmates and Jail/Prison Staff: Teach Tolerance, i.e. awareness of body tolerance changes when not using often and the danger of overdose.
- Faith Community: Teach Public Education, i.e. “Prescription Medications: take correctly, store securely, dispose properly and never share,” and perceptions about drug use and addiction.
- People Who Use Drugs or Misuse Prescription Medications: Teach Harm Reduction, i.e. overdose, tolerance, diseases from sharing drug paraphernalia, and avenues for treatment while always reducing stigma.
- Law Enforcement: Teach the properties of addiction, naloxone rescue, and provide community resources.
- Parents: Teach wisdom and safety surrounding prescription medications for themselves and children.
- Workplace/Employers: Teach properties of addiction, medication effects, workplace use, and diversion.
- Medical Community: Teach Chronic Pain Management & Appropriate Prescribing, i.e. use of PDMP, patient assessment, universal precautions, treatment referral, and expansion for access to care.

In addition to reaching out to the above groups, which are universally present in communities, each community must evaluate their various population groups that may require specific collaboration. These groups may include military families, tribal groups, particular linguistic or cultural groups, and others who may need individually customized messages. Project Lazarus has detailed information to assist with the crafting and modifying of messages for different groups.

## Spoke #2 - **Prescriber Education**

Chronic pain is recognized as a complicated medical condition requiring a substantial amount of knowledge and skill for appropriate evaluation, assessment, and management. Pain is sometimes treated in an emergency department with opioid-based medicine and often is not recognized as requiring pain-specific clinical expertise. Prescriber Education is most effective when provided by professional peers as opposed to concerned citizens. Members of the Prescriber Education sector group should include clinicians and work with other organizations offering continuing medical education (CME) to prescribers in the community to optimize their efforts. The local

Project Lazarus, working in collaboration with Community Care of North Carolina (CCNC), developed prescriber and care manager toolkits as part of the statewide Project Lazarus.

(<http://www.communitycarenc.com/population-management/chronic-pain-project/>) Each of the 14 CCNC regions in the state has a Chronic Pain Initiative (CPI) regional coordinator whose role is to focus specifically on the medical/clinical aspects of the Project Lazarus model. The Prescriber Education sector should absolutely collaborate with their regional CPI coordinator to support his or her efforts. Additional prescriber education will be accomplished by Project Lazarus, Governors Institute on Substance Abuse, NC Hospital Association, Medical Society and other educational organizations offering CMEs specific to pain prescriptions. Naloxone prescribing is also encouraged.

hospitals, statewide chronic pain organizations, local addiction treatment specialists, and local pain specialists are all examples of the kinds of resources that can support these efforts.

While much of the emphasis in these efforts is on those writing the actual prescriptions, it is important to also engage with nurses and pharmacists. Nurse practitioners should be receiving the same Prescriber Education as all other prescribers. The nurses being discussed here are those without prescriptive authority. Nurses have a vital role in caring for patients with chronic pain and/or addiction and should understand the signs of patients' risk behavior and be able to care for them effectively. Pharmacists also have an incredibly important role in this effort. Pharmacists should understand the problem and what their role is in identifying diversion, forgery, and promoting patient safety.

Communities and professional organizations are continually developing new and creative ways to optimize education for prescribers and other clinicians. The following is a list of some of the activities that have been successfully implemented:

- Promoting adoption of the CPI toolkits for primary care providers, emergency departments, and care managers.
- One-on-one Prescriber Education or "academic detailing" on pain management.
- Continuing medical education sessions on pain management, appropriate prescribing, and diversion control.
- Pharmacist continuing education on diversion, forgery and the use of the PDMP.
- Promoting prescriber and dispenser use of the PDMP.
- Information concerning the Good Samaritan Law and prescribing naloxone.

### Spoke #3 - **Hospital Emergency Department Policies**

The emergency department (ED) is a source of many prescriptions for opioid pain medications. There are several factors that could increase the risk of adverse events in patients receiving controlled substances through the ED. Since there is no ongoing physician-to-patient relationship in most cases, the ED provider may not have readily available information regarding co-morbid medical conditions, other prescription medicines the patient is taking and possible drug-to-drug adverse interactions, or other patient factors that could increase the risk for overdose. There are also patients who exhibit "drug seeking behavior" and come through the ED, sometimes even multiple EDs, to get controlled medications for a variety of reasons, including trying to address unrelieved pain and issues related to medication dependency. For these reasons, it is recommended that hospital EDs develop a system-wide standard protocol with respect to prescribing narcotic analgesics. Considerations in developing an opioid prescribing policy might include the following points:

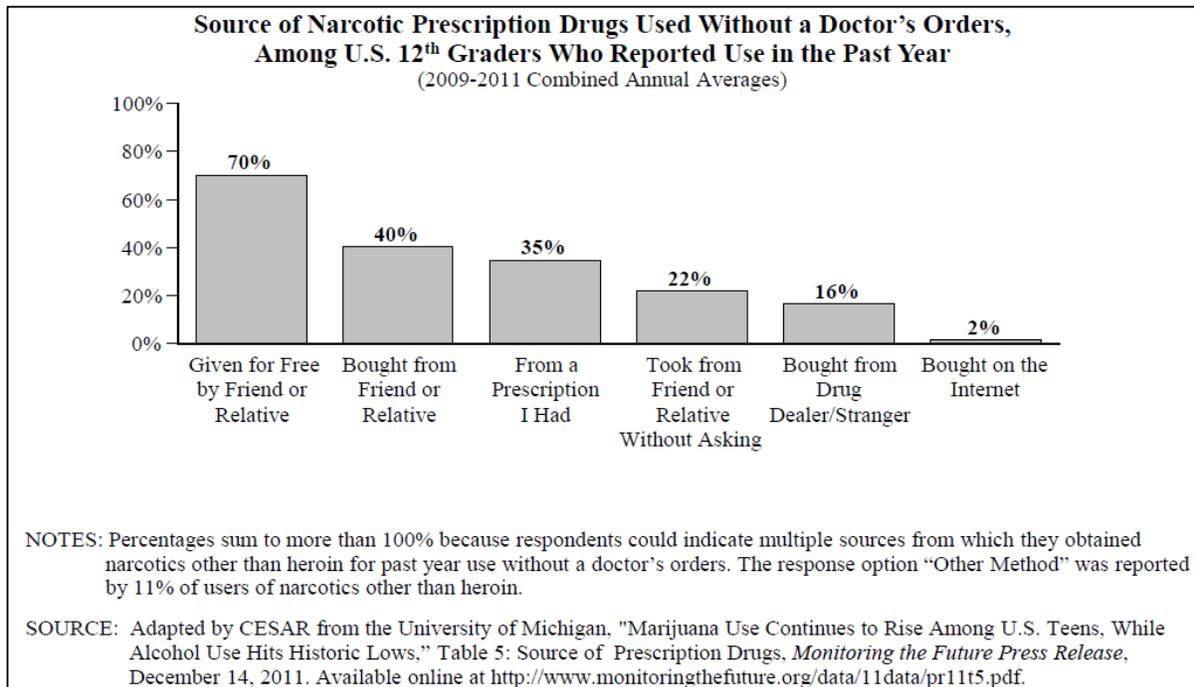
- a. ED will avoid prescribing controlled substances for pain that is chronic and, instead, prescribe a non-narcotic medication and refer to the patient's primary care provider, pain specialist, or dentist.
- b. ED will avoid providing refills for chronic pain medications due to lost prescriptions, need for after hours, or weekend refills.
- c. ED provider should check the PDMP (CSRS) before prescribing a controlled medication for pain.

- d. ED will limit the number of doses of controlled medications dispensed or prescribed. For instance, the default number for computerized prescriptions for opiates will be set at #10 or less for chronic pain.
- e. For patients who are frequently seen in the ED for pain complaints and who have no established primary care provider, the ED or other hospital staff will work to help get that patient established with a regular provider.
- f. ED will create a case manager position to work specifically with patients dealing with chronic pain and substance abuse issues, as well as coordinate appropriate care and work with patients who are under-or uninsured.

Again, in NC, the CPI regional coordinator uses the ED CPI Toolkit in reaching out to every hospital in the region and promoting the above points as part of a model ED policy. Make sure that any efforts initiated are coordinated with the broader Chronic Pain Initiative.

### Spoke #4 - Diversion Control

Supporting patients who have pain, particularly those who treat pain with opioid pain medications, is an important form of Diversion Control. However, there are additional ways to prevent diversion in communities. As seen in Figure 4.1, the majority of prescription pain medication used by teenagers without a doctor's prescription come from legitimate prescriptions written for someone known to them. Pills being imported from other countries, obtained from dealers, or over the internet are considerably less common among young people.



Because the way people get prescription drugs is different than illicit drugs, i.e. from a friend or family member vs. from a drug dealer or on the black market, the strategies for preventing access to prescription drugs must also be different. There are several main strategies, most of which require the

involvement of law enforcement. One strategy is to reduce the overall supply of unused prescription medications available in communities for potential abuse/misuse/diversion/overdose. The ED policy points described above help in this effort. In addition, many people have medicine cabinets full of expired or unused prescriptions. Helping people to dispose of these medications in ways that are not harmful to the environment, such as flushing them down the toilet and into public water supply, is a crucial piece of Diversion Control. For those controlled substances that need to remain in the home, locked storage containers can be made available and promoted. Another main strategy is to support capacity building among state and local law enforcement to identify, investigate, and prosecute illegal diversion activities. Promoting networking between law enforcement and local behavioral health and/or substance abuse treatment services is also an important strategy. The Crisis Intervention Team (CIT) model has been very well received in many communities. For more information on this, visit <http://www.nami.org/template.cfm?section=cit2>.

Communities, law enforcement agencies, and health care professionals are constantly developing new and creative ways to ensure that prescription medications are used only by the person they are prescribed for and to minimize diversion. The following is a list of some of the activities that have been successfully implemented:

- Hospital ED opioid dispensing policy modified as described above.
- Unused medication take-back events by sheriff and police departments, with support from DEA and State Bureau of Investigation.
- In NC, Operation Medicine Drop is an excellent resource for supporting local communities in sponsoring these events. For more information visit: [http://www.ncdoi.com/osfm/SafeKids/sk\\_OperationMedicineDrop.asp](http://www.ncdoi.com/osfm/SafeKids/sk_OperationMedicineDrop.asp)
- Fixed medicine disposal sites at law enforcement offices.
- Project Lazarus has initiated Project Pill Drop, supplying county law enforcement agencies with permanent pill take back “kiosks,” see [www.projectpilldrop.org](http://www.projectpilldrop.org) for more information.
- Hiring and training drug diversion specialized law enforcement officers.
- Encouraging the use of locked storage for controlled substances in the home.

#### Spoke #5 - **Pain Patient Support**

In the same way that prescribers benefit from additional education on managing chronic pain, the complexity of living with chronic pain makes supporting community members with pain vitally important.

A factor that contributes to the complexity of the overdose situation is the overlap of pain patients who have previously developed or have substance use disorders. If people who have pain and people who have substance use disorders were separate non-overlapping groups, then an effective intervention might be simpler. However, whether the use of prescription drugs is legitimate or not is irrelevant when unintentional overdose deaths can be prevented. No one deserves to die of an overdose no matter where the substance came from or why it was being used. Table 4.1 summarizes the research to date on these two groups and the overlap between substance use and chronic pain.

Table 4.1 Statistics on Substance Use and Chronic Pain in the United States

Category	Statistic	Source
Chronic pain patients who may have addictive disorders	32%	Chelminski et al., 2005
People ages 20 and older who report pain that lasted more than 3 months	56%	National Center for Health Statistics, 2006
People experiencing disabling pain in the previous year	36%	Portenoy, Ugarte, Fuller, & Haas, 2004
People ages 65 and older who experience pain that has lasted more than 12 months	57%	National Center for Health Statistics, 2006
Civilian, non-institutionalized U.S. residents ages 12 and older who report nonmedical use of pain relievers in past year	5%	Substance Abuse and Mental Health Services Administration [SAMHSA], 2007
People ages 12 and older who report that they initiated illegal drug use with pain relievers	19%	SAMHSA, 2008
People with opioid addiction who report chronic pain	29–60%	Pele et al., 2005; Potter, Shiffman, & Weiss, 2008; Sheu et al., 2008

These factors contribute to the complex relationship between pain and substance abuse. Project Lazarus and Community Care of North Carolina have developed the Chronic Pain Initiative toolkits for the needs of NC health care providers who treat pain: <https://www.communitycarenc.org/population-management/chronic-pain-project/>. There are also national resources like the American Chronic Pain Association, <http://www.theacpa.org>, which can provide useful information for provider and patient alike.

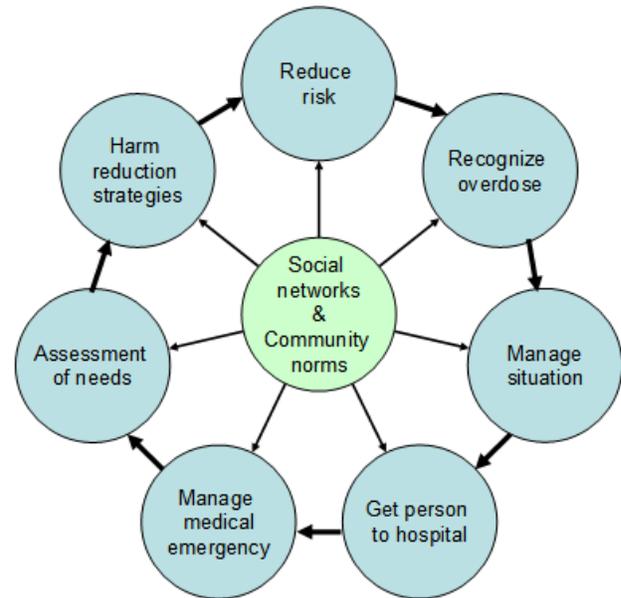
Communities and health care professionals can work in many ways to optimize pain management and support patients with pain. The following is a list of some of the activities that have been successfully implemented.

- Promoting adoption of the CPI toolkits for primary care providers, EDs, and care managers.
- Medicaid policy change: Mandatory use of patient–prescriber agreements, medical home, and pharmacy home for high risk patients which could also be adopted by private insurance companies.
- Support groups for pain patients and their families.
- ED case manager for patients with chronic pain.
- Medical practice vetting of local pain clinics and facilitation of specialized pain clinic referrals.

Many of these activities around pain patient treatment and support fall directly under the purview of the regional CPI coordinators. Be sure to align these activities with their efforts.

## Spoke #6 - Harm Reduction

For individuals who are at risk of overdose, prevention can be conceptualized as a cycle including a series of stages where different actions are appropriate or effective at different times. At each stage there are opportunities to act and save a person's life. The actions that are appropriate and available are also influenced by community norms and by social networks. An important Harm Reduction intervention is to equip people in the community with training and the medicine naloxone to reverse overdoses.



### Elements of Overdose Harm Reduction Education

Often, during an overdose another person is present. *Recognizing that an overdose is occurring* is the first step in ensuring that someone survives.

While this might seem obvious, there have been many reports of someone who thought an overdose victim was sleepy or snoring when the person was actually beginning to have the respiratory distress that comes with an overdose that leads to death. If the overdose is recognized, a bystander who has been taught how to manage the situation can save a life. Through simple training, family and friends learn that by calling 911, beginning rescue breathing, administering naloxone, and placing the victim in the rescue position, they can prevent the death of a family member or friend and save a life. Having naloxone available and knowing what to do is a key component that may not be accessible in various communities. Even if the overdose victim has had naloxone administered, he or she should still receive medical attention. *Getting the victim to the hospital* is important, but is also influenced by other factors. These factors include variables, such as if they expect to be treated with respect, if going to the hospital initiates arrest, investigation, probation violation, or a housing investigation, and if the cost is perceived to be a barrier. Once at the hospital, the medical emergency is managed. After the immediate danger has passed, this can be an excellent time to do an *assessment of needs*, including the evaluation of whether drug treatment is appropriate and desirable for the overdose victim. The overdose victim's experience, whether positive or negative at this moment, may influence the person's willingness to utilize services. Particularly for people who do not have or want access to drug treatment, *Harm Reduction strategies*, including conversations about overdose prevention, naloxone, and making an overdose plan, are very appropriate. Discussing Harm Reduction strategies like naloxone, practicing safer drug use strategies such as minimizing drug mixing, and being aware of the community norm for tolerance of drug overdose can *reduce the risk* of overdose among people who continue to use drugs.

There are many efforts all over the country to improve the availability and accessibility of Harm Reduction strategies in communities; some function at the state level. For example, changing the Good Samaritan laws to reduce fear of arrest by a witness to an overdose who might call 911 can make a huge impact. The following is a list of some of the activities that have been successfully implemented in communities in NC:

- Overdose prevention education in prisons.
- Take-home naloxone prescribing. For more supporting information about this, visit <http://prescribetoprevent.org/>.
- Overdose recognition, prevention, and response education. See the [Harm Reduction & Prescription Drugs](#) factsheets included in this Community Toolkit that can be used in educational efforts.

The NC Harm Reduction Coalition, <http://www.nchrc.org>, is North Carolina's only comprehensive Harm Reduction program that addresses many issues, including prescription drug overdose.

The North Carolina Medical Board has issued a statement supporting the use of naloxone to prevent overdoses:

***Drug Overdose Prevention Created: Sep 1, 2008 Modified: March 2013***

*"The Board is concerned about the rise in overdose deaths over the past decade in the State of North Carolina as a result of both prescription and non-prescription drugs. The Board is encouraged by programs that are attempting to reduce the number of drug overdoses by making available or prescribing an opioid antagonist such as naloxone to someone in a position to assist a person at risk of an opiate-related overdose.*

*The prevention of drug overdoses is consistent with the Board's statutory mission to protect the people of North Carolina. The Board therefore encourages its licensees to cooperate with programs in their efforts to make opioid antagonists available to persons at risk of suffering an opiate-related overdose."*

*\* Naloxone is the antidote used in emergency medical settings to reverse respiratory depression due to opioid toxicity.*

[http://www.ncmedboard.org/position\\_statements/detail/drug\\_overdose\\_prevention](http://www.ncmedboard.org/position_statements/detail/drug_overdose_prevention)

Additionally, the American Medical Association has issued a positive position statement, as has the National Association of Drug Diversion Investigators, [www.naddi.org](http://www.naddi.org).

Moreover, the White House Director of the Office of National Drug Control Policy, R. Gil Kerlikowske, often referred to as the "Drug Czar," is also supportive of efforts to promote the use of naloxone. At a symposium in Wilkes County, NC on prescription drug overdose prevention hosted by Project Lazarus in August 2012, for the first time, he voiced support for naloxone and encouraged making it widely available. He also broadly praised Project Lazarus:

*"Project Lazarus is an exceptional organization—not only because it saves lives in Wilkes County, but also because it sets a pioneering example in community-based public health for the rest of the country... This Administration understands that substance dependence is a health issue—not necessarily a criminal justice issue—and we support innovative ways to bring treatment to people who need it most... Project Lazarus is a striking example of this kind of innovation."-R. Gil Kerlikowske*

The latter statement is especially important in thinking about naloxone. Reaching out to those who are still misusing and abusing prescription drugs to help them avoid dying of overdose will never be

effectively done if the issue is framed as a criminal justice matter. For more information, download the opioid overdose toolkit recently released by SAMHSA at <http://store.samhsa.gov/product/SMA13-4742>.

The use of naloxone is the most innovative part of the Project Lazarus Model. This is because Project Lazarus was among the first communities in the country to dispense naloxone to people receiving prescription opioids. Previously, naloxone had only been provided for heroin users. This use of naloxone is very cutting edge, and, therefore, when new naloxone programs begin in a community, the coalition should be prepared for additional surveys and requests for data above and beyond the basic Project Lazarus reporting requirements discussed previously.

### **Spoke #7 - Expanding Access to Drug Treatment**

Drug treatment, especially Medication-Assisted Treatment like methadone maintenance treatment or office-based buprenorphine treatment, has been shown to dramatically reduce overdose risk; see <http://www.ncbi.nlm.nih.gov/pubmed/?term=Emmanuelli+and+Desenclos+reduction+in+overdoses> for more information. Unfortunately, access to treatment is limited by three main factors: availability, accessibility of treatment options, and negative attitudes or stigma associated with addiction and drug treatment in general.

Drug treatment options are underfunded in the US and North Carolina is not an exception. Many people who seek help for their problematic drug use are unable to access treatment, encounter insurance barriers, month-long wait lists, programs that don't meet their needs, or programs they cannot afford. Regrettably, many people are only able to access drug treatment as a result of an arrest or criminal conviction. Advocating for increased funding of drug treatment and more qualified health care providers who are willing and able to provide these services can improve drug treatment access.

In addition to the possible logistical difficulties in accessing services, people with substance use disorders may not want to access drug treatment because of shame or fear of stigma. There is an increasing trend in people becoming addicted to prescription drugs; however, the community or individual perception may be that drug treatment is only for substances like alcohol, heroin, or cocaine, but not for prescription drugs. Community members and people struggling with addiction specifically need to be aware that there is a broad range of treatment options, including treatment for people addicted to prescription drugs which can be tailored to suit the needs of each individual. Additional advocacy work can be done to broaden the definition of drug treatment to include models of care that incorporate Harm Reduction principles and prioritize health, safety, and improving quality of life over strict abstinence. Drug treatment, like other health care decisions, should be consensual and self-directed.

Expanding support services for those that have been affected by prescription drug misuse/abuse/diversion/overdose is a needed adjunct to treatment centers and community self-help groups. Providing peer-led non-abstinence based support groups for those who have experienced an overdose and for their family members can make a genuine difference in getting individuals and families back on track. The same goes for youth, for those who have lost a loved one to an overdose, or for opioid dependent individuals who are not benefitting from traditional treatment options. Peer support specialists who are trained in crisis intervention, available during an emergency such as an overdose, who advocate for the overdose victim and their families, and who are well-versed in

navigating addiction recovery services provide the glue that holds all of the Recovery-Oriented Systems of Care together. Peer support service workers help to remove the barriers of stigma that come with drug abuse and dependence because they've been there. They know the recovery ropes, they act as a partner for wellness, and they give hope to those suffering from drug abuse.

The following is a list of some of the ways that access to drug treatment has been expanded as a part of prescription drug overdose prevention efforts:

- Negotiation and support for the opening of a satellite office-based drug treatment clinic using buprenorphine.
- Encouraging doctors to get trained by [SAMHSA](#) to prescribe buprenorphine. Project Lazarus can assist in linking resources for this training.
- Advocating for drug treatment services that have been proven to work.
- Fighting misinformation on ineffective strategies of dealing with substance abuse.
- Initiating peer support specialist services
- Getting eligible people enrolled in Medicaid to access drug treatment services for free or reduced cost.
- Treatment awareness campaigns, including real life success stories from relatable community members.
- Opening a drug detox program.