Opioid/Overdose Epidemic: We Are All Human

David Fuller, CPRS, ADC
david@memphisprevention.org ; 901-484-2852
Regional Overdose Prevention Specialist (ROPS), Region 7

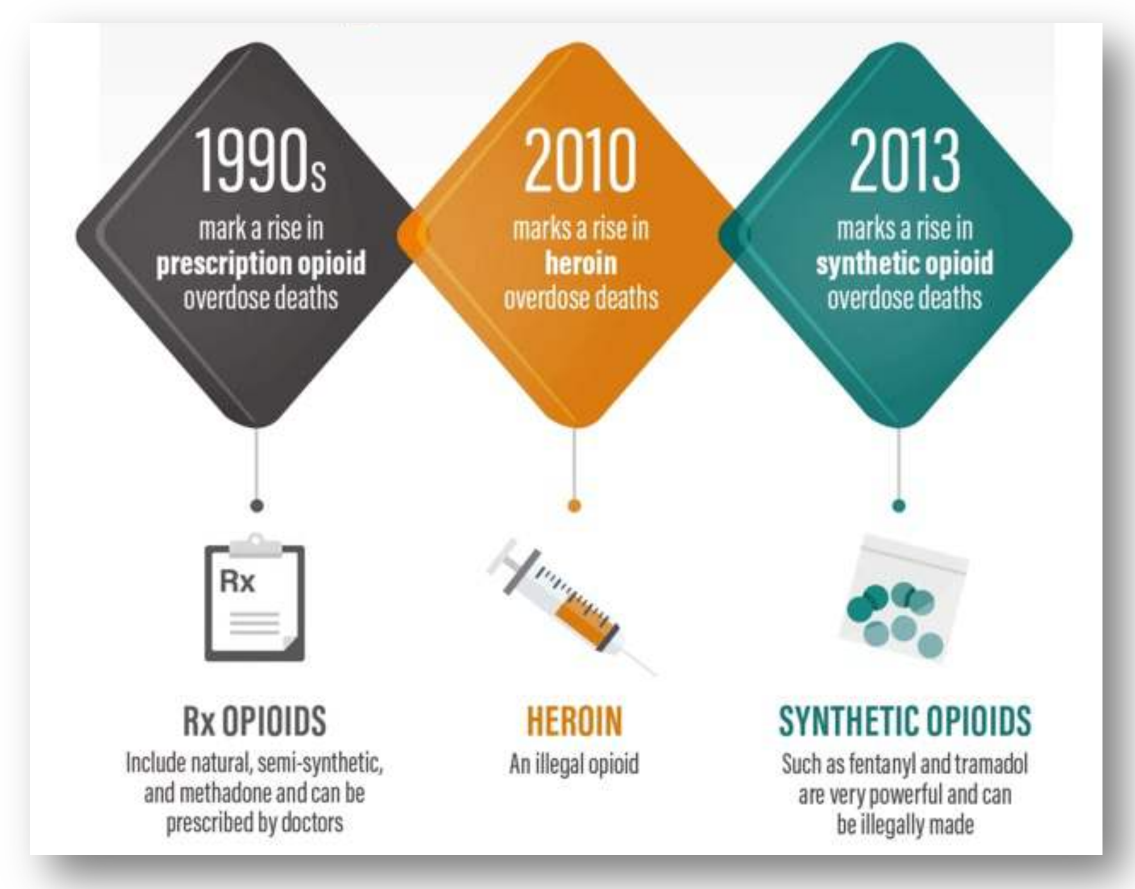
Training Agenda

1. Changing Nature of the Opioid/Overdose Epidemic
2. Overdose Statistics – These Are Not Just Numbers
3. Stigma and Relapse
4. Language and Your Experience
5. Compassion Fatigue/Burnout and Self Care
6. Basic Needs, Harm Reduction and Treatment
7. Does This Work?

Understanding the Overdose Epidemic

Tennessee continues to face an epidemic of substance use.

Similar to national trends, Tennessee has seen a shift in the primary cause of the overdose epidemic from prescription pain relievers to illicit substances.



Case Study

- 23 y/o male – opioid use disorder (pharmaceutical opiates). Almost 10 years continuous use of some type of substance(s).
- Multiple prior treatment episodes:
  - ➢ 21 days inpatient, 12 IOP sessions, and 12-step meetings
  - ➢ 3 months inpatient, halfway house & IOP, and 12 step meetings
- Living on others' couches, low functioning, and suicidal ideations
- Finally achieved stable, long-term recovery by entering long-term inpatient program (6+ months) utilizing CBT, REBT, individual therapy, group process therapy, behavior mod., and 12-steps.
- It's Me!

Understanding Overdoses in Tennessee

Fatal Overdoses in Tennessee, 2012-2021

3000
2500
2000
1500
1000
500
0

2012 2013 2014 2015 2016 2017 2018 2019 2020 2021

Prescription Opioids
Heroin
Fentanyl
Any Stimulant

- From 2012 to 2017, prescription opioids were involved in most of the overdose deaths in TN.
- Deaths due to prescription opioids declined from 2016 to 2019 while deaths due to illicit substances like heroin, fentanyl, and stimulants ***increased dramatically***.
- In 2021, **almost 3 out of 4** overdose deaths involve fentanyl.

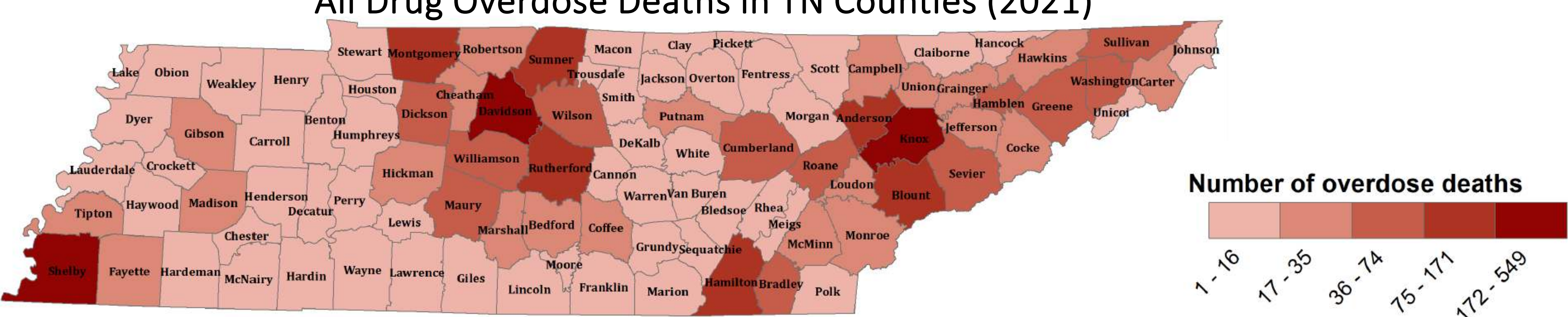
Understanding Overdoses in Tennessee

In 2021, **3,814** Tennesseans died of a drug overdose, representing a 26% increase from 2020.

- **2,734** deaths involved fentanyl, an **36%** increase from 2020
- **2,025** deaths involved a stimulant, a **54%** increase from 2020
- **167** deaths involved heroin, a **50%** decrease from 2020
- **645** deaths involved prescription pain relievers, an **8%** increase from 2020

**Please keep in mind that an overdose may involve multiple substances and that a single death may be counted in multiple drug categories.*

All Drug Overdose Deaths in TN Counties (2021)



Understanding Overdoses in Tennessee

Polysubstance Overdoses in Tennessee, 2017-2021

1800
1600
1400
1200
1000
800
600
400
200
0

2017 2018 2019 2020 2021

Opioids and Any Stimulants
Opioids & Other Stimulants
Opioids and Cocaine

- A polysubstance overdose involves multiple substances.
- In 2017, 19% of overdose deaths involved both an opioid and a stimulant.
- In 2021, 41% of overdose deaths involved an opioid and stimulant.
  - Of those, fentanyl was involved in **94%** of the deaths.

Shelby County Data: 2020/2021

Fatal Drug Overdoses in Shelby County in 2021: 549

Opioids*

- 458 Fentanyl Involved
- 15 Heroin Involved
- 90 Pain Reliever Involved

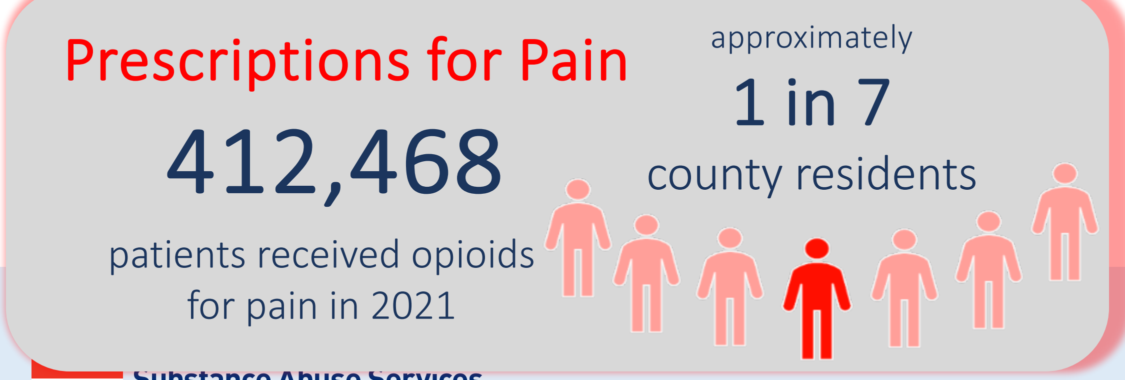
Stimulants*

- 217 Cocaine Involved
- 143 Psychostimulant Involved

Multiple Substances*

- 275 Opioid(s) and Stimulant(s) Involved
- 101 Opioid(s) and Benzodiazepine(s) Involved

*Because an overdose may involve multiple substances, individual substance categories may not add up to the total of all drug overdose deaths.



Prescriptions for Pain

412,468

patients received opioids for pain in 2021

approximately 1 in 7 county residents

Nonfatal Overdoses: Emergency Dept

2,754

nonfatal drug overdoses were treated in an outpatient setting in 2020. Outpatient visits primarily include **emergency department** visits.

Stigma & Relapse

Role of Stigma

When a person experiences stigma they are seen as *less than* because of their real or perceived health status (National Institute of Drug Abuse)

- Experiencing stigma can reduce a person's willingness to seek treatment, take other actions to reduce harm, or ask for help
- Stigma among medical and social services reduces the quality of care
- Delayed treatment can cause additional harm to an individual

Reducing Stigma

Substance use **falls on a continuum**

- Abstinence/low risk ⟷ chronic dependence
- Relapse ***does not equal*** a moral failure or a failure of treatment
  - It is a dopamine (chemical) response in the brain
- **40%-60%** will relapse ***at least*** once
  - Other chronic diseases: 50%-70% with high blood pressure experience symptoms each year that require medical attention

Beware of **unintentional personal bias**

Recognize addiction is often connected to **trauma**

Case Study - Relapse

- 27 y/o male – opioid use disorder (pharmaceutical opiates)
- Multiple prior treatment episodes
- Previous long-term recovery before relapse
- Multiple unsuccessful attempts to re-enter recovery
- Still employed (barely) and living alone in rented house.
- Able to detox w/ support of friends in recovery and re-establish stable, long-term recovery by re-engaging 12-step program.
- Is this less realistic today? Why?
- It’s Me Again!

Case Study - Relapse

- 31 y/o female – opioid use disorder – 10 years high dose methadone, alcohol use disorder – high volume daily Vodka intake, and sedative use disorder – daily alprazolam (Xanax) use.
- Multiple prior treatment episodes and 12-step involvement.
- No longer able to function or live alone.
- Admittance denied by multiple treatment facilities due to difficulty/liability of detox from methadone, alcohol and benzo.
- Finally admitted to inpatient in Memphis for methadone taper, transition to buprenorphine then taper, two months inpatient w/ Accu-detox, CBT, DBT and CPT. PHP to IOP. Sober living, individual counseling, and 12-step program.
- Over a decade of long-term recovery from the use disorders, went back to school and obtained masters degree in clinical mental health counseling, has worked in treatment over 8 years, including facility where she was a client.
- It’s Rachel!

Language Matters

Do away with labels and use "person first" language

(Person with substance use disorder **not** Addict)

- Experiencing stigma can reduce a person's willingness to seek treatment, take other actions to reduce harm, or ask for help
- Stigma among medical and social services reduces the quality of care

Your Experience

Think back.....

When you first started your career, what motivated you? What made you choose that path?

Was it…

- Wanting to help?
- Wanting to make a difference?
- Wanting to save lives?
- Wanting to serve your community?
- Feeling confident in your abilities?
- Feeling inspired to do good?

- What else?

Any of these cross your mind in the last couple of weeks?

What's wrong with these people?

Why won't they just stop?

What's it going to take for them to get to together?

Why do they make the same mistakes over and over?

How can a parent do this to their kid?

Why won't they listen to me?

When will they learn?

Don't they see how their actions are affecting other people?

And stepping back...

Do you feel satisfied and fulfilled in your work?

Or are you feeling worn down?

Do you arrive at work excited and ready to start your shift?

Or do you dread going to work?

Do you feel like you are making the difference that you thought you would?

Or do you wonder how much of a difference you are actually making?

Do you feel hopeful and optimistic about the day ahead?

Or do you feel discouraged, jaded, or even numb?

Do you see each person as a person that deserves your care?

Or are you tired of seeing the same people who do the same thing?

How did you get here?

Witnessing suffering takes a toll. No one is immune from that toll.

Often the cost of that suffering is losing compassion and empathy for the people you serve AND YOUR health and wellbeing.

Compassion Fatigue and Burnout

Compassion Fatigue	Starts quickly	Experiencing signs and symptoms of trauma that didn't happen to you
Burnout	Cumulative/ grows over time	Cumulative process of emotional exhaustion associated with workload/stress

Compassion Fatigue and Burnout

Compassion Fatigue:
starts quickly; experiencing signs and symptoms of trauma that didn't happen to you

Burnout
Cumulative/grows over time; associated with emotional exhaustion of workload/stress

<u>Mental/Emotional Symptoms</u>

- Reduced sense of accomplishment, meaning in work
- Reduced productivity
- Self isolation
- Irritability

<u>Physical Symptoms</u>

- Exhaustion
- Difficulty sleeping
- Headaches, stomachaches, digestive issues, chronic pain

Not limited to people in "helping professions"

Substance misuse affects family, friends, and loved ones

Case Study - Relapse

- 35 y/o male – opioid use disorder (heroin/fentanyl)
- Multiple prior treatment episodes
- Multiple, previous long-term recovery episodes before relapse
- Certified Alcohol & Drug Counselor & Managing MOUD outpatient program.
- Loss of career/business, loss of family trust, loss of long-term relationship and suicidal ideation w/ plan.
- 1st treatment episode unsuccessful – 28 days inpatient. Suicidal ideation, extreme anxiety and insomnia.
- 2nd treatment episode successful – 90 days inpatient.
- We (professionals) are the most difficult clients. Individualized care and therapeutic trust are always vital, maybe even more so in these cases.
- You guessed it! It’s me once again!

Compassion Fatigue and Burnout

Actions to Take

Practice healthy routines
Eat well, sleep enough, exercise

Find and use support
Find someone to talk to

Take breaks
Take time off or away

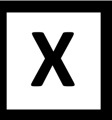
Take time to process your experiences
Journaling and meditating are good strategies

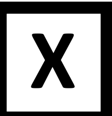
Be understanding of yourself
Know that the pain you feel is understandable

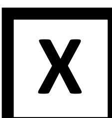
Practice healthy boundaries
Know that you are can't do it all

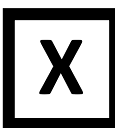
Practice mindfulness
Find a resource that works for you

Nurture your whole self
Including hobbies, relationships and spirituality


Working longer and harder


Self medicating


Neglecting your needs & interests


Fall into the habit of complaining to your coworkers

First Responder/Professional Self Care

- Use the buddy system-a person who you trust and can be a person who you can share your experiences and support one another.
- Practice breathing and relaxation techniques.
- Maintain a healthy diet and get adequate sleep and exercise.
- Take REAL breaks and nurture your own passion
  - Not ones where you are thinking about work but that refresh you!
- Avoid self medicating with alcohol and other substances.

If a colleague came to you, saying that they were struggling, would you want to help them?

What if someone was willing to do that for you?

Reminders for First Responders/Professionals

- It is not selfish to take breaks.
- The needs of the public are not more important than your own needs and well-being.
- Working all of the time does not mean you will make your best contribution.

Knowing that you have stress and coping with it as you respond will help you stay well. This will allow you to keep helping those you encounter in your work.

Basic Needs

Basic Needs

SELF-ACTUALIZA-TION
morality, creativity, spontaneity, acceptance, experience purpose, meaning and inner potential

SELF-ESTEEM
confidence, achievement, respect of others, the need to be a unique individual

LOVE AND BELONGING
friendship, family, intimacy, sense of connection

SAFETY AND SECURITY
health, employment, property, family and social abilty

PHYSIOLOGICAL NEEDS
breathing, food, water, shelter, clothing, sleep

Basic Needs

TARGETED CASE MANAGEMENT

- Housing Assistance
- Food, Clothing, & Transportation
- Substance Abuse Referral
- Parenting Classes
- Medical Needs
- Mental Health Needs/ Medication Manage.
- Crisis Support
- Children Services/ Childcare
- Educational Support/ School Advocate
- Individual Therapy
- Vocational/ Employment Opportunity

Harm Reduction & Treatment

Harm Reduction

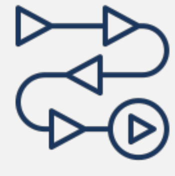
Harm Reduction is a way of **preventing disease** and **promoting health** that ***meets people where they are*.**

Not everyone is **ready or able** to **stop substance use**; therefore, **scientifically proven** ways of decreasing risks are ***essential***.

(e.g., Medication Assisted Treatment (MAT), Naloxone, Syringe Service Programs)

Harm Reduction Core Principles

Non-judgmental approach with a focus on **enhancing quality of life**



Behavior change is an **incremental process**

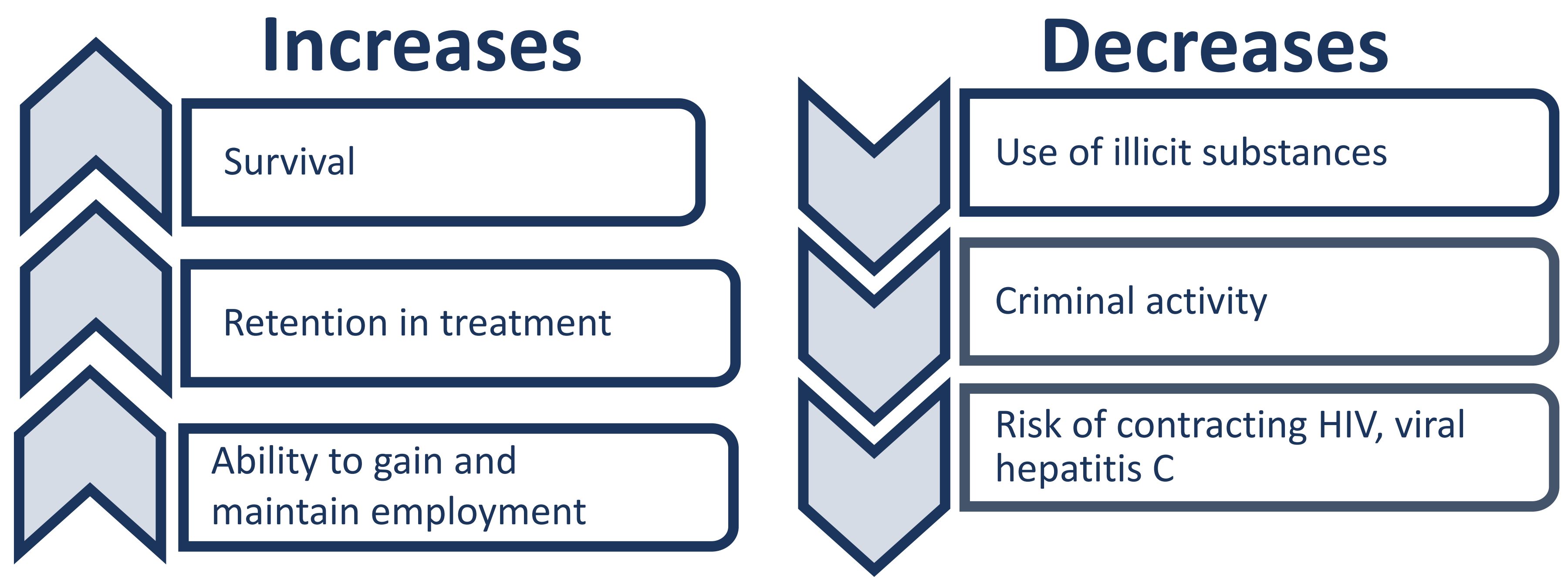
Complex social factors influence vulnerability to substance use and substance-related harm (e.g., poverty, social inequality, trauma)

Empower those who use substances to be the primary agents in reducing the harms of their substance use

Medication for Opioid Use Disorder (MOUD)/ Medication Assisted Treatment (MAT)

Using Mediation for Opioid Use Disorder (MOUD)/Medication Assisted Treatment (MAT) is a medically proven tool to **support and sustain recovery.**

Commonly Used medications: Buprenorphine, Methadone, Suboxone, Vivitrol, Sublocade



MOUD/MAT is a tool endorsed by the American Society for Addiction Medicine, American Medical Association, and the Substance Abuse and Mental Health Services Administration.

Syringe Service Programs (SSPs)

Community Health Programs

- Sterile injection equipment
- Testing for HIV, Hepatitis, STIs and linkages to services
- Referrals to treatment, medical and social services
- Education and tools for overdose prevention and safer substance use

SSPs ***reduce substance use*** over time

- *People who inject drugs are 5 times* more likely to **enter treatment for substance use disorder** when participating in an SSP

SSPs also:

- **Reduce needle stick injuries** among first responders by providing proper disposal
- Provide a place for **safe disposal of used syringes**, reducing them in public places like parks and parking lots
- **Reduce** HIV and Hepatitis C incidences and overdose deaths

Syringe Service Programs (SSPs)

- Tennessee legalized SSPs in 2017
- All SSPs must be licensed through the TN Department of Health
- 13 organizations operate in 22 locations*
  - Includes mobile and fixed locations

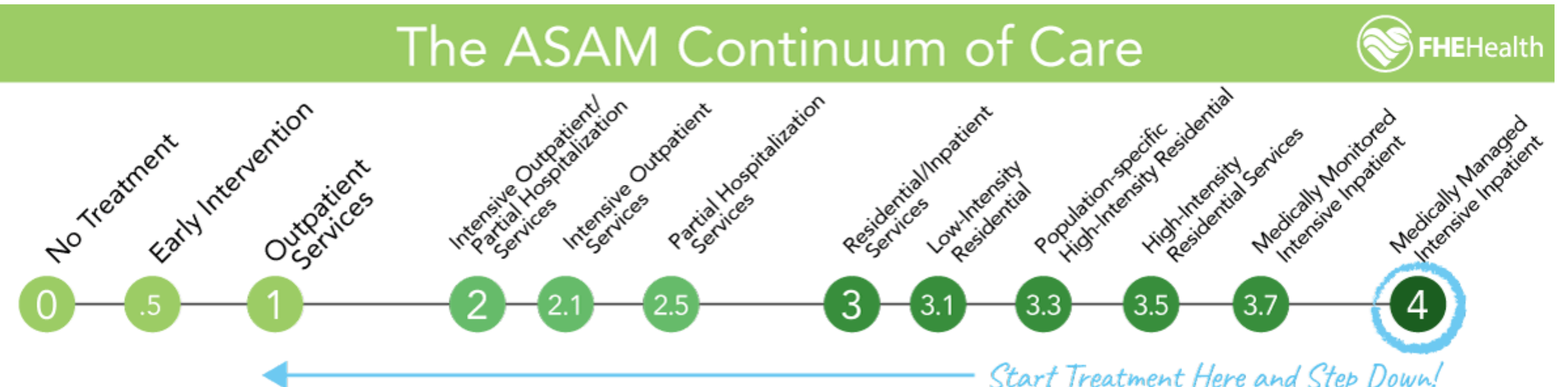
Updated locations and hours of operation can be found on the TN Department of Health website

*As of June 2023

Treatment/Levels of Care

Levels of Treatment

Crisis Services	↑	Most intensive treamt/ Highest level of support
Inpatieint Treatment		
Outpatient Treatment		
Residential Services		Least intensive treatment/ Lowest level of support
Supportive Living	↓	



Does This Work?

Case Study – Tara H.

- Female w/ opioid use disorder and stimulant use disorder
- “I had spent a long time in prison” “I was very miserable – defeated – at the end.”
- “I was assaulted, beaten, robbed and literally left in a ditch for dead.”
- Multiple unsuccessful treatment episodes. Co-occurring mental health issues.
- History of Overdoses
- “MAT/MOUD saved my life and changed my life. I could not have overcome my addiction without it.” (SOR client)
- Inpatient treatment, IOP at First Step, sober living at MSL and 12-step meetings.
- “I had counselors who believed in me. People cared about me and that meant the world.”
- Not only is she in recovery, she is a CPRS and works in treatment!
- Happy Birthday Tara!

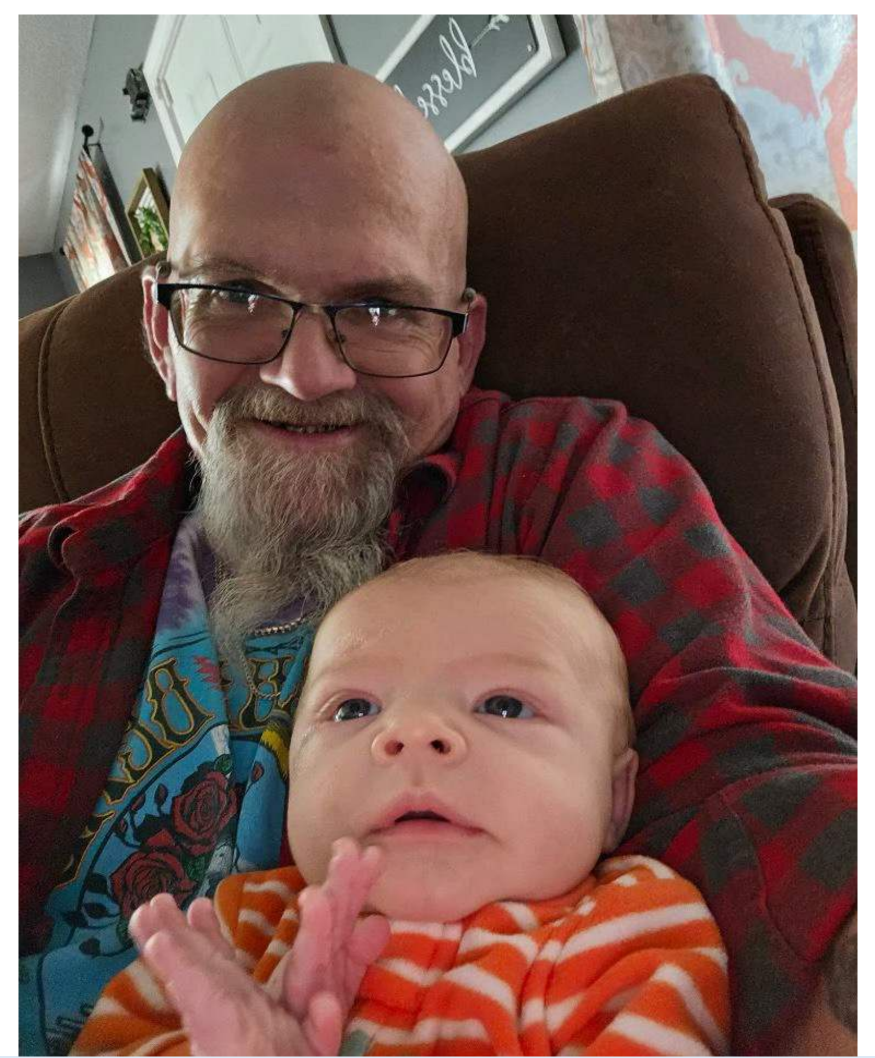
Case Study – Ashley C.

- Female w/ stimulant use disorder
- “I was homeless, hopeless and feeling isolated, but I could not be alone. I was at a dead end, everyday was like being on a hamster wheel.”
- SSP Client
- Was criminal justice involved and asked for Drug Court because “I needed accountability”.
- Went to CAAP for inpatient, First Step for outpatient and MSL and Roots Recovery for sober living.
- Utilizing trauma therapy w/ a counselor at First Step/Judicare was key.
- Not only is in long-term recovery, but is working in treatment & harm reduction.

Case Study – Robert “Chris” M.

- Male w/ opioid use disorder and stimulant use disorder
- Began using around 16 y/o – almost 40 years of active substance use
- Served 13 years in prison over three different stints.
- Was one of the first SSP clients in Memphis area (Betor Way) and “was surprised by all of the services offered (clothing, Naloxone, etc.) Received referrals for both treatment of substance abuse disorder and for Hepatitis-C.
- “SSP was key in beginning recovery.”
- Revived by Naloxone (Narcan) multiple times
- SOR client/Buprenorphine MOUD – inpatient at Serenity, IOP at First Step and sober living at MSL/Sankalpa House.
- Still lives in Sankalpa House and attends aftercare sessions and is in long-term recovery.

Chris M.



Ashley C.