



Opioid Overdose

Summary Report

BEHAVIORAL HEALTH GOALS

1. Increase community readiness to deploy evidence-based prevention programs, strategies and policies
2. Participate in community coalitions to address misuse and overdose.
3. Provide Hepatitis C and HIV education and care coordination.
4. Coordinate care for individuals/families after an overdose.
5. Collaborate with community and other partners on a local public health campaign to increase awareness of and decrease opioid misuse and opiate overdose.
6. Collaborate with community and other partners to educate community members of the usefulness of naloxone and distribute naloxone.
7. Provide training to teachers, hospitals, coalition members and the public.

Behavioral Health Goals

- Model Hep C Nursing Protocol
 - Protocol for Hep C testing and treatment of Hep C positive inmates at county jail
- Hepatitis C in Prison and Jail handout
 - Informational flyer for jail kiosk
- PowerPoint Hepatitis C Overview
 - Education for community and other partners
- SEUHD Opioid Survey
 - Survey reflecting medical providers willingness to implement evidence -based training.
- Community Coalitions
 - Partnerships and training to include prevention, naloxone training, increase awareness and overdose programs
 - Carbon & Emery Opioid & Substance Use Coalition
 - HOPE Squad
 - Intergenerational Poverty Program
 - Project Recovery
 - Utah Opioid Summit / Sen Lee
 - Mental Health 1st Aid
 - Naloxone training
- Opioid Community Resource Guide
 - Resource guide for substance use disorder
- STIGMA reduction handout
 - Community handout to increase awareness and reduce stigma for substance use disorder.
- Under development and review for implementation
 - Medication Assistance Treatment (MAT) program development for hospital and jail.

Nursing Protocol for Hepatitis

When an inmate complains of possible exposure, concern, or risk of Hepatitis, the nurse shall:

- Obtain a history of potential exposure including history of IV drug use, history of Tattoos in jail or prison, sexual history risks.
- Ask the inmate about any knowledge of a previous positive testing for Hepatitis A, B, or C.
- Ask the inmate about previous treatment
- Obtain history of any current symptoms
- Determine risk
- If positive history – review chart to see if this has been confirmed.
- Document all assessment and history data in the inmate's electronic medical record (EMR)

Low Risk:

- No current symptoms
- No history of IV Drug Use or Tattoos
- May or May not have a spouse or significant other with history of Hepatitis

Moderate Risk:

- No current symptoms
- Previous history of IV Drug Use and/or Tattoos (in jail or prison) and no history of sharing needles
- May or May not have a spouse or significant other with history of Hepatitis

High Risk:

- Current symptoms or No Symptoms
- Previous history of IV Drug Use and/or Tattoos (in jail or prison) and a history of sharing needles
- May or May not have a spouse or significant other with history of Hepatitis

Nurses shall:

- Hepatitis A Vaccine will be given according to Health Department Recommendations
- If low risk for Hepatitis B and C – ask inmate to place a HCR to be seen, if they want this issue addressed
- If Moderate or High risk for Hepatitis B and C – Obtain Blood work – Acute Hepatitis Panel, CBC, and CMP, and inform the provider.

If positive finding from testing:

- The inmate will be scheduled with a provider, the provider will inform them of results.
- The inmate will receive information about diagnosis.
- The infection control nurse will be notified of the results, the patient, and given a copy of the findings.

Follow up

- Follow up will occur as needed.
- If the Local Health Department contacts the jail, they will be referred to the infection control nurse and/or the provider.
- The infection control nurse, if changes or follow up is required will initiate, and inform the provider and other administration as needed.

If History of Positive Hepatitis History

- Inmate will be placed on Chronic Care for Hepatitis.
- Inmate will be scheduled a visit in the next 4-8 weeks for Chronic Care.
- Schedule Acute Hepatitis Panel to confirm diagnosis, verify it's correctly documented in jail records.
- Schedule blood test-CBC, CMP if no blood work has been done in the last 6 months-unless the inmate has had blood work in jail within the last 6 months that was normal- at that time schedule for a year out from the date of last blood work.

Date Approved

Date Reviewed

Contracted Physician

Health Services Administrator

Provider Chronic Care for Hepatitis

- 1) Inmate seen or reviewed on Chronic Care for Hepatitis within 4-8 weeks of arrival
- 2) Hepatitis has been confirmed through medications and/or based on response to intake questions.
- 3) New Diagnosis of Hepatitis – patient will be scheduled within 1 week of diagnosis

During Provider Visit:

- Review Records as indicated

History of illness

- Age of onset of symptoms or diagnosis:
- Past hospitalizations
- Past treatments or GI specialist visits
- History of IV drug use and/or Tattoos
- History of Hepatitis in family members and friends
- Previous Immunization when applicable
- Recent episodes of Jaundice
- History of Homeless
- Review recent lab work – Acute hep panel, LFTS, CBC, others
- Discuss concerns with new diagnosis including prognosis, treatment options, risk factors
- Discuss concerns with other medications, Alcohol, etc
- Contact Infectious Disease nurse who will contact Health Department for additional orders

Physical Exam:

- Vital Signs
- HHENT, Heart, Lungs, abdomen
- If Hepatitis A diagnosis is new – will isolate in medical
- If Hepatitis C diagnosis is new – will discuss treatment options

Current Control Level:

- 1.) Good
- 2.) Fair
- 3.) Poor

Monitoring Schedule:

- 1.) Good
 - Chronic Hep C with normal LFTs – F/U in 6 months and blood work in 6 months
 - Chronic Hep B with normal LFTs – F/U in 6 months and blood work in 6 months
 - History of Hep A – with normal LFTs – F/U in 6 months and blood work in 6 months
- 2.) Fair
 - Hep C with slightly elevated LFTs – F/U in 3 months and blood work in 3-6 months
 - Hep B with slightly elevated LFTs – F/U in 3 months and blood work in 3-6 months
 - Current diagnosis with Hep A – with slightly elevated LFTs – F/U in 3 months and blood work in 3-6 months
- 3.) Poor
 - New diagnosis of Hep C and/or with moderately to severely elevated LFTs – F/U in 1 month and blood work in 1-3 months
 - New diagnosis of Hep B and/or with moderately to severely elevated LFTs – F/U in 1 month and blood work in 1-3 months
 - New diagnosis of Hep A with moderately to severely elevated LFTs – F/U in 2-4 weeks and blood work in 1-3 months.

6 If you can't get treated for HCV while you're locked up

There may be limitations on who is eligible for treatment in prison or jail. Doctors will consider many factors, including your current liver health, the length of your sentence, and your medical history.

If you have been told that you are not eligible for HCV treatment or you have to wait:

- ✓ Ask questions so you know why it is being delayed or denied
- ✓ Follow procedures at your facility to get more answers
- ✓ Continue to see your nurses and doctors regularly to stay healthy, monitor your liver, catch any problems early, and prepare for treatment in the future
- ✓ Make sure you get copies of your medical records during release so you can follow up with your doctor
- ✓ Ask your facility to help you sign up for health insurance or Medicaid when you are released from custody
- ✓ After release, consider enrolling in patient assistance programs offered by drug companies or ask about clinical trials

While it may be frustrating to wait for treatment, know that many people live with hepatitis C for years without problems. Ask your doctor or someone you trust for more information. You may also write to the NHCN at the address below to ask questions.



BE SAFE. BE HEALTHY. LEARN AS MUCH AS YOU CAN ABOUT HEPATITIS C.

The National Hepatitis Corrections Network
911 Western Ave, Suite 302
Seattle, WA 98104
www.hcvinprison.org

HEP
HEPATITIS
EDUCATION
PROJECT

CEJ
Center for
Health Justice

Produced by:



NATIONAL HEPATITIS CORRECTIONS NETWORK

HEPATITIS C IN PRISON AND JAIL

Hepatitis C Overview



Southeastern Utah Health Department

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Liver Functions

- Chemical Factory- >500 chemical functions
- Detoxifies or Filters
- Clotting Factors
- Bile
- Hormones
- Immune System

Regenerates Itself!

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Introduction

- Self-Advocacy through Education!
- *The information in this presentation is designed to help you understand and manage HCV and is not intended as medical advice. HCV medical care is a partnership between patients and their medical providers*

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Keep the Liver Healthy!

- If you have HCV – Avoid Alcohol
- Avoid mixing drugs – prescription, over the counter, herbs/supplements and street drugs
- Eat a healthy, balanced diet based on the food www.choosemyplate.gov

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The Liver – A Chemical Factory

- Largest internal organ
- Size of a football
- Approximately 3 lbs in the average sized male

1.5 quarts of blood flow through it every minute

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Keep the liver healthy!

- Get vaccinated!
 - HAV and HBV vaccines
- Avoid toxic substances / fumes

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Hepatitis C Statistics

U.S. Population

- 3.5 Million Americans Chronically Infected

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Viral Load Tests

- Viral Load tests
 - Hepatitis C RNA by PCR - >10 IU/mL
 - HCV RNA by branched DNA Assay - > 650 IU/mL
 - TMA - > 5-10 IU/mL
- Why Is a Viral Load Test Important?
 - To confirm active infection
 - Indication that treatment is working

** Viral load does not correlate with disease progression**

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Twin Epidemics

- Baby Boomers born 1945 to 1965
- Current Epidemic
 - Highest Prevalence in Ages 20 to 29years old – but even in teens

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Genotype Test

- Genotype (1,2,3,4,5,6 and 7)
 - U.S. population
 - ~70% genotype 1
 - ~30% genotypes 2 & 3
- Why Is a Genotype Test Important?
 - Medication and treatment duration for some medications

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HCV Antibody tests

- HCV Elisa II or III
 - Most common antibody test
- A positive antibody test indicates exposure
 - It does not indicate current hepatitis C infection
 - HCV viral load (HCV RNA) test performed to indicate active HCV infection

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Measuring Liver Damage

- Liver Biopsy
- Fibroscan
- Various Blood Tests, Liver Enzymes

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Transmission- Prevention

- Direct blood-to-blood transmission route
- Not spread casually

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Prevention Tips

- Safer Sex
 - For so called "high risk groups"
 - Multiple sexual partners, people with sexually transmitted diseases, coinfection with HIV or HBV
 - Any situation where blood is present

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Transmission

Shared Needles	All Drug Paraphernalia	Blood Before 1992 - transfused, products, procedures
Sexual Transmission (1-3%)*	Healthcare Workers – needle sticks	Shared Household items – razors & toothbrushes
Mother to Child ~5%	Tattoos / Piercing	<10% of routes can not be identified

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Prevention Tips

- Mother to Child Transmission
 - Low risk – about 4-6% chance of hepatitis being transmitted to infant
 - Most recommend treatment first
- Health-Care Settings
 - Follow standard precautions

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Prevention Tips

- Injection and Non-Injection Drugs
 - Do not share needles, cookers, cottons, straws, pipes, water or any items that might come into contact with blood
- People in Stable Long-Term Monogamous Sexual Relationships
 - Most experts recommend - no need to change current sexual practices – but there is a risk

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Prevention Tips

- Tattoos & Piercing
 - Considered a low/no risk in commercial setting
 - Make sure disposable needles and separate ink pot are used and that general safety precautions are followed
 - Considered a higher risk in other settings
 - Non-commercial settings such as in prison or on the streets

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Shared Personal Items

- Household
 - Cover cuts or sores
 - Do not share personal hygiene items (toothbrushes, razors, etc.)
- Professional Personal Care Settings
 - Standard precautions
 - Disposable equipment
 - Bring own equipment

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Disease Progression

- 10-25% of HCV positive people progress on to serious disease over 10-40 years
 - Fibrosis
 - Light scarring to severe
 - Cirrhosis
 - Compensated vs. decompensated
 - Steatosis
 - Fatty deposits in the liver

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HCV CAN NOT BE SPREAD BY:

- BREASTFEEDING
- FOOD OR WATER
- SNEEZING
- SHARING EATING UTENSILS OR DRINKING GLASSES
- HUGGING
- CASUAL CONTACT
- COUGHING

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Treatment Recommendations

- AASLD / IDSA:
 - The panel continues to recommend treatment for all patients with chronic HCV infection, except those with short life expectancies that cannot be remediated by treating HCV, by transplantation, or by other directed therapy

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Chronic Symptoms

- Fatigue – mild to severe
- Liver pain
- Loss of appetite
- Flu-like symptoms (muscle/joint/fever)
- Headaches
- 'Brain Fog'
- Gastro problems
- and more.....

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Treatment

- What are direct-acting antivirals?
 - Inhibit the hepatitis C Virus – protease, polymase and NS5A inhibitors from replicating
- What is ribavirin?
 - Antiviral
 - Used only in combination with some direct-acting antivirals pills

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Approved Medications

Brand Name	Genotype(s)	Cure Rates
Mavyret	1-6	Up to 100%
Eplclusa	1-6	Up to 100%
Harvoni	1,4,5,6	Up to 100%
Zepatier	1 - 6	Up to 100%

Visit <http://hepatitismedications.hcvadvocate.org/> for more information on all of the direct-acting antiviral medications including costs

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Experimental Therapies

- There are many drugs under study to treat hepatitis C. Visit our Hepatitis C Reference Guide:

<http://hcvclinical.hcvadvocate.org/>

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Side-effects

- Direct-Acting Antivirals
 - headache
 - fatigue
 - Nausea
 - Itching
 - Insomnia
- Ribavirin
 - seems to make side effects worse – especially fatigue – Anemia

** (both men & women must use birth control)

*depends on the medication

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Complementary Medicine

- Herbs – milk thistle, licorice root, etc.
 - Always check with your doctor and herbalist – some herbs are unsafe especially with the hepatitis C drugs
- Acupuncture / Acupressure
- Traditional Chinese Medicine

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Managing Side-Effects

Always report any serious side effects to the medical provider

- Stay hydrated
- Low doses of ibuprofen or acetaminophen for aches and pains
- Light exercise
- Daily moisturizing
- Rest when tired
- Frequent small meals

Key: support from medical providers, family, friends, work – all areas of life

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Lifestyle Changes That Help!

- Alcohol – Avoid or reduce
- Exercise
- Get vaccinated – Hep A & Hep B
- Stress Reduction
- Healthy balanced diet
- Support Groups

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Advocate for Yourself!

- Educate yourself
- Ask questions
- Establish a good relationship with your doctor
- Keep copies of all medical tests
- Bring an advocate for doctor's visits
- Keep a diary
- Keep an open mind

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Resources – www.hcvadvocate.org

- HCV Advocate Newsletter
- Fact Sheets in English, Spanish,
- National Support Group Listing
- Recommended links
- Information on hepatitis C and hepatitis B, HIV/HCV Coinfection

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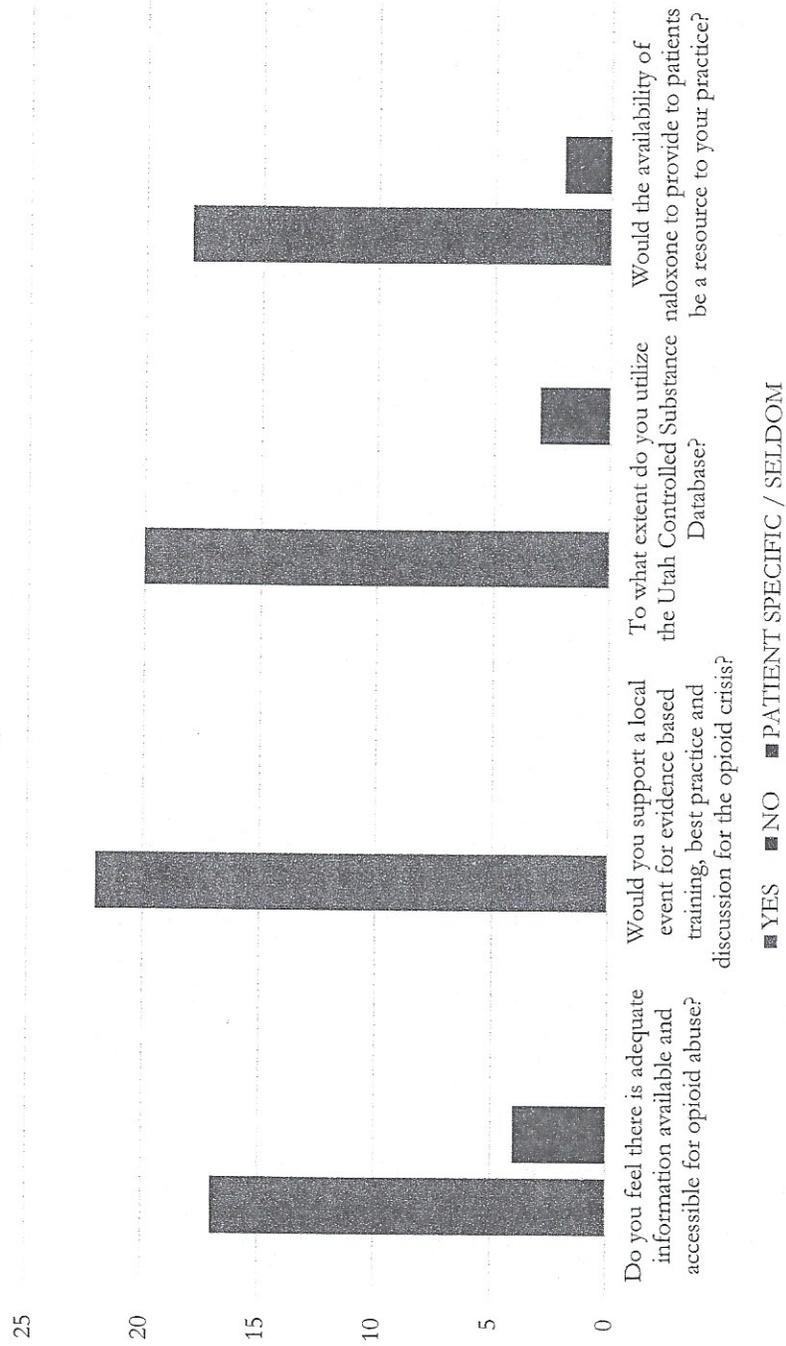


Southeast Utah Health Department

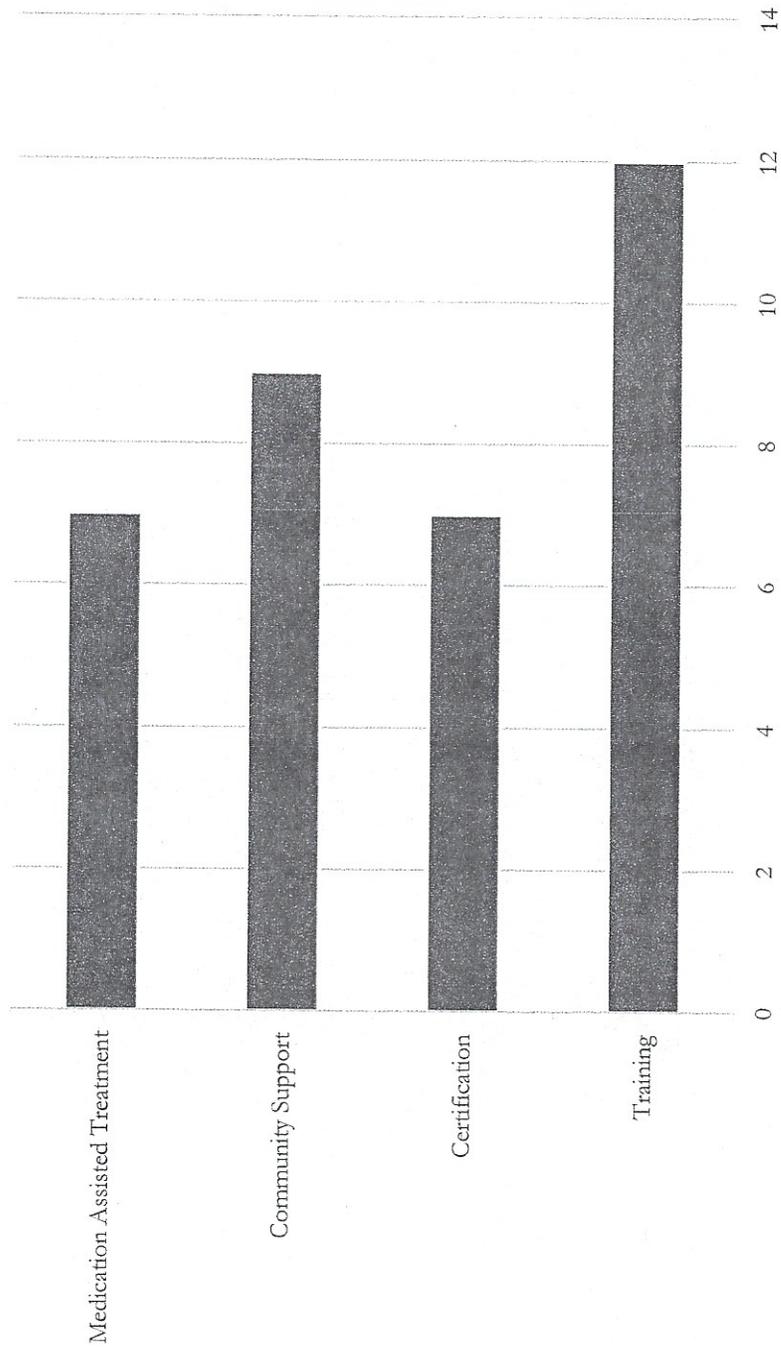
Opioid Survey Results of Medical Community Carbon, Emery
and Grand Counties

January 2019

2019 Medical Clinician Survey
 Completed 23 of 30



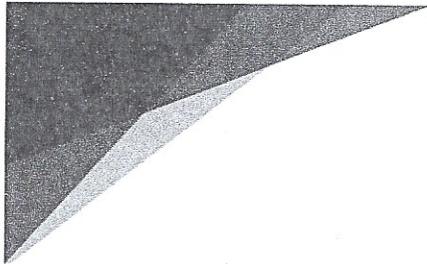
What resources are the biggest need to treat a patient with an opioid use disorder?



Survey Additional Comments

- “Until we acknowledge the true ”why” they take them we fight uphill. They don’t get “ High” but most feel they “center” except then it’s a dangerous false “baseline”. Understanding the true reason most are addicted (or “use” them) which is often the de facto antidepressant and they will tell you if asked the magic Buzzword – completely misunderstood by the healthcare community is they give them energy. They perk them up, only hardcore users/abusers “nod off”
- “I do what I can to help”
- “Drug court seems to be the only resource for us here- we need other options besides drug court and MAT”
- “Quit focusing on preventing overdose as much and focus on stopping Rx of opioids which are the wrong medication in the majority of chronic pain. Narcan without RX will increase heroin use. Less likely to be afraid to use it,”
- “I feel we lack in-patient rehabilitation resources for our patients that can be treated in our out patient setting. They can be very expensive and involve transportation, gas money, etc.”

OPIOID COMMUNITY RESOURCE GUIDE



A Reference Tool to Help
Individuals Who Are
Impacted by Opioid Use
and Addiction

Carbon & Emery Opioid & Substance Use Coalition

Vision: The Carbon and Emery Opioid and Substance Use Coalition seeks to coordinate the efforts of our communities to comprehensively address the opioid epidemic we are facing. We seek to decrease stigma; increase effective prevention, treatment, harm reduction, and other efforts; and come together to create healthier communities.

STIGMA

HANDOUT

Stigma Around Opioids

Understanding Opioid Use Disorder and the stigma that it creates is a vital step in the recovery process. According to the American Psychological Association, "stigma is the shame or disgrace attached to something regarded as socially unacceptable, a mark of disgrace associated with a particular circumstance, quality, or person."

Sometimes it's easy to believe that opioid abuse is a personal problem and someone can simply stop the addictive behavior if they truly want to. But, this resulting stigma feeds into an individual's shame and guilt, and might prevent them from seeking the tools they need for recovery.

The Center for Substance Abuse Treatment, a part of the Substance Abuse and Mental Health Services Administration, has released a few main points relating to substance abuse-related stigma:

- "Addiction-related" stigma is a powerful, shame-based mark of disgrace and reproach.
- Stigma is generated and perpetuated by prejudicial attitudes and beliefs.
- Stigma promotes discrimination among individuals at risk for, experiencing, or in recovery from addiction, as well as individuals associated with them.
- People with substance-abuse disorders and people in recovery are ostracized, discriminated against, and deprived of basic human rights.
- Individuals who are stigmatized often internalize inappropriate attitudes and practices, making them part of their self-identity.

Why stigma matters

You may be familiar with the life-saving medication, Naloxone. "One barrier to widespread access to the medication...was the stigma around the word 'overdose,' writes Chris Elkin, senior writer and researcher for DrugRehab.com. "Doctors believed patients would worry that the doctor didn't trust them or considered them an addict if they prescribed it."

Think about how many lives could have been saved.

"People with substance use disorders and people in recovery are more likely to seek treatment and maintain sobriety when they develop social connections," writes Elkin. "Isolation, discrimination and prejudice are obstacles to social inclusion."

What can I do?

Remember...

- Opioid Use Disorder is a psychiatric disease and often requires an extensive recovery process.
- Supporting a loved one is important to their recovery and helps to lessen the stigma they may feel.
- Failure to keep sobriety or continuing abuse of opioids is not a reflection on the person's character.
- Recovery looks different for everyone and everyone is deserving of treatment.
- Avoid hurtful language. Terms like "junkie" and "addict" only contribute to the stigma of OUD and other substance-use disorders.

http://www.sunad.com/opinion/letters_to_editor/letter-to-the-editor-re-jail-bookings---scott/article_383a0ab4-ad78-11e8-b4d3-a39b247ecb3e.html

Letter to the Editor, RE: Jail Bookings - Scott Young

Sep 4, 2018

RE: Jail Bookings

Dear Editor,

I am a lifelong resident of Carbon County.

I disagree with your upcoming removal of the jail bookings.

If you talk with local leaders, I'm sure they will tell you that 10 percent of the populace is using 90 percent of resources. (Police, Ambulance, fire department assistance.)

The public has a right to know who is helping our already overstretched budget continue to decline.

Not long ago, my neighbor overdosed. In short order there were four CCSO deputies, two ambulance people, and four firefighters on hand.

My neighbor is a frequent flier in court and jail. The community deserves to know who the local criminals are.

Please reconsider your decision.

Thank you.

—Scott Young,

Carbonville

Recently, news organizations and social media channels have increased exposure of devastating images of addiction, especially photos and videos of people overdosing or near-death, sometimes with their children nearby. In several cases, community leaders and first responders posted or shared these pictures and videos, believing that public exposure to these images will help address the problem.

But imagine this response to a different medical emergency: A mother who is significantly overweight falls unconscious on a train, her son crying out something about her “sugar.” While others rush to help, another watches the drama unfold and captures it on his phone. He zooms in on the stricken mother, zooms out to the terrified child. It is intense, heartbreaking and scary. A life-and-death moment captured on camera to be shared with his social media world.

Would a bystander really do this in response to a diabetic crisis? Perhaps. But, it is much harder to imagine this video or one involving a heart attack, epileptic seizure, or asthma attack being shared by others whose jobs involve helping those who are sick and improving the health of their community.

And yet, when it comes to addiction, this practice seems to be gaining momentum as an acceptable response to witnessing parents overdosing on opioids in the presence of their child. Or at least considered forgivable – a frustrated reaction to an out-of-control problem. But, if these leaders or helpers sent out videos of an inconsolable child and a critically ill parent with a respiratory, endocrine, or cardiovascular disease, wouldn't the public outcry be focused on the person releasing the video, rather than the afflicted person?

So why is it acceptable when the videos feature people with addiction?

Two long-standing problems surround addiction and impede effective responses to the opioid epidemic: **stigma and ignorance**. The fictional scenario above involves a seriously ill woman with obesity, the one medical disorder that is arguably more stigmatized than the disease of addiction. And yet, it is much harder to imagine that train video being distributed by a community leader in hopes of scaring people into eating less or shaming someone suffering from obesity into losing weight for the sake of their children.

The stigma of addiction will remain strong because some of its symptoms result in real risk or harm to others. But more of the stigma of addiction, which is also true of obesity, *comes from the public believing that these different, life-threatening medical conditions result from poor willpower and that they can be changed solely through motivation, effort and self-control*. Research has proven these prejudices to be untrue.

The truth is most young people who have unhealthy diets or use substances do not go on to develop the diseases of chronic obesity or addiction. Genetic and environmental factors influence how our bodies and brains process food and substances and more powerfully determine chronic obesity and addiction than choice or willpower. Yet, the general public still dismisses these facts and blames the victim. **The reality is that expecting sick people to change by judging, shaming, arresting, or admonishing them rarely works and sometimes worsens their condition.**

In the case of opioid addiction, **expecting people to recover without the help of medication-assistant treatment can be deadly.** People with opioid addiction not only suffer the stigma of the disease, but also the stigma of its treatment. Methadone, Suboxone, and Vivitrol are the most effective treatments, but remain highly stigmatized, underutilized and **insufficiently covered by insurance.**

The second impediment to stopping the opioid epidemic is **ignorance**, which is deeply entwined with stigma. **Community leaders and first responders have justified promotion of these horrifying images as a way to increase public awareness.** They hope they will help prevent people from using opioids or encourage others to seek treatment, including the person whose medical condition is being publicized without their consent.

Decades of research and expert opinion conclude that scare tactics do not work. Worse, these videos may lead to even greater suffering by shaming and humiliating the victims or re-traumatizing those who have lost loved ones to addiction. These videos do nothing positive to promote lasting change or improve the health of people suffering with addiction or the well-being of their families. **Opioid overdose reversal medication followed by long-term maintenance treatment and continuous care monitoring are needed for those people most seriously addicted to opioids. Not videos.** **And most definitely, not the judgment, shame, humiliation, and ignorance of those who may be trying to help, but are only adding to the stigma and suffering.**

**broken
NO MORE**

Substance Use Forum

The Power of Words: Changing the Language of Addiction

**CATEGORIES**[announcement](#)[articles](#)[drug policy](#)[editorial](#)[events](#)[harm reduction](#)[legislative](#)[news](#)[past events](#)

THE POWER OF WORDS: CHANGING THE LANGUAGE OF ADDICTION

Submission Date: February 1, 2018

Attributing Author: Sam Snodgrass, PhD

Source: Broken-No-More.org

Words matter. They determine how we understand and perceive our world. They carry power, for good and for ill. Stigma is driven by the pejorative words, the labels, that are used to describe us. This is not a matter of political correctness. Until we are seen as people, until we are provided the same respect and dignity as everyone else, we will continue to die. We have to change the cultural perception of those with an opioid disorder. To do that we have to first change the language of opioid addiction:

"The words "addict" and "clean" do not reduce stigma, they drive it. I am not an "addict." I am a person. An addict is a thing. Yes, I live with an addiction, but that addiction does not define me. And I am not in "recovery." My addiction is in remission. And as with any other chronic disease that is in remission, it can come back. And I am not "clean" when I haven't used and I'm not "dirty" when I have.

Stigma is driven by the words we use. To decrease stigma, if that's the goal, we should start with our words. Person first language. A person with an alcohol disorder; a person with an opioid disorder, a person with a substance disorder. These words take the blame off of the person and put it where it should be; on the medical disorder:

"People-first language literally puts the words referring to the individual before words describing his/her behaviors or conditions. This practice helps highlight the fact that an individual's condition, illness, or behavior is "only one aspect of who the person is, not the defining characteristic." 12 In the realm of addiction, terms such as "alcoholics," "addicts," and even the more generic "users" are terms that group, characterize, and label people by their illness, and in so doing, linguistically erase individual differences in experience. To a large extent, these terms also presume a homogeneity in experience, character, and motivation that depersonalizes the people to whom the terms are applied. 13 Instead, referring to the person first, e.g., "person with a cocaine use disorder," "adolescent with an addiction," or "individuals engaged in risky use of substances," reinforces the affected individual's identity as a person first and foremost."

<https://www.researchgate.net/.../262940305> Confronting Inadve

"Use of "abuse" and "abuser" terminology may evoke implicit punitive biases compromising the quality of medical care and also may create unintended barriers to honest self-disclosure and treatment engagement for those suffering from alcohol or drug use conditions. For individuals receiving treatment for addiction, describing urine toxicology screen results as "dirty" or "clean" instead of "positive" or "negative," in a similar way may evoke more negative and punitive implicit cognitions (Kelly et al., 2015). Such language is inconsistent with other medical language and standards. People themselves, also, can be

described as being “clean” or “dirty.” Use of such terms may also decrease patients’ own sense of hope and self-efficacy for change diminishing the effectiveness of treatment.”

“In the evolution of languages, there is a tacit goal toward enhanced utility and ever greater efficiency. Consequently, there is a definite tension between being clear and unambiguous and communicating in shorthand with more speed and efficiency. It does take longer to describe someone as “a person with, or suffering from, a substance use disorder” than describing that same person as “a substance abuser” or “addict.” However, modifying language has been important in the recognition of equity and the resolution of prior stigmatization. In this case, where the lives of a historically marginalized population are at stake, there is a need to sacrifice efficiency in favor of accuracy and the potential of minimizing the chances for further stigma and negative bias.”

<https://www.thenationalcouncil.org/.../Substance-Use-Terminology...>

“Every day in our work, we see and hear individuals described as “alcohol/substance abusers” and urine toxicology screens coming back “dirty” with drugs. Clinicians may even praise a patient for staying “clean” instead of for having “a negative test result.” We argue such language is neither professional nor culturally competent and serves only to perpetuate stigma. Use of such terms may evoke implicit punitive biases and decrease patients’ own sense of hope and self-efficacy for change.”

“Growing up, we all heard and sometimes voiced the childish refrain, “Sticks and stones may break my bones, but words will never hurt me.” But words can and do hurt, and in ways that we are not aware and cannot always anticipate. Because substance-related conditions are the number one public health concern in the United States and stigma is a major barrier to accessing treatment,¹ reducing stigma is vital for enhancing public health. One inexpensive way we could begin to do this would be to remove the terms “abuse” and “abuser,” “dirty” and “clean” from our vocabulary and commit to a medically appropriate lexicon that conveys the same dignity and respect we offer to other patients.”

[http://www.amjmed.com/article/S0002-9343\(14\)00770-0/fulltext](http://www.amjmed.com/article/S0002-9343(14)00770-0/fulltext)

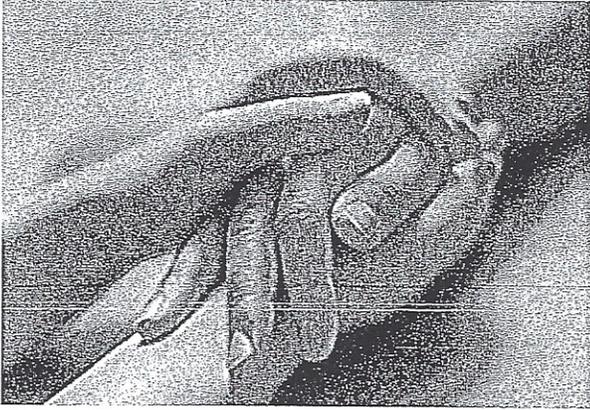
“The language we use related to addiction treatment also impacts stigma. Methadone and buprenorphine are lifesaving, effective medications for opioid use disorder. Their use reduces relapse and death far more than any other available treatment. And yet they are frequently referred to as “replacements,” worsening the mistaken notion that these

medications are simply a way to substitute a legal opioid for an illicit opioid. They are not. Addiction is a behavioral syndrome characterized by compulsive drug use despite negative consequences. Patients successfully treated with methadone no longer meet the criteria for active opioid use disorder. Taking a medication to manage an illness is the hallmark of chronic disease treatment. Individuals taking medication to successfully treat addiction are physically dependent, just as someone taking insulin for diabetes requires a daily shot to be able to function normally. Both will get sick if they stop their medication. But someone on methadone is no more “addicted” than any person who relies on a daily prescription to keep a chronic disease under good control.”

<https://www.health.harvard.edu/.../words-matter-language-addi...>

Addiction is a disease.

It's important that we use language that frames it as a health issue and shows respect to people with an addiction and to their families who are impacted. Just like we would with any other disease, like diabetes or asthma.



A person shouldn't be defined or labeled by his or her disease or illness, it is something they have. For example: Instead of calling someone a "diabetic," it's preferable to use person-first language and say "someone with diabetes." The same goes with the word "addict."

We have a choice when we communicate. We can use words that perpetuate the negative stigma around substance use – words that label people with an addiction in a negative, shameful and judgmental way. Or we can use words that are compassionate, supportive and respectful – words that helps others understand substance use disorder as the health issue that it is.

By choosing to rethink and reshape our language, we will allow people with an addiction to more easily regain their self-esteem and more comfortably seek treatment, allow lawmakers to appropriate funding, allow doctors to deliver better treatment, allow insurers to increase coverage of evidence-based treatment and help the public understand this is a medical condition and should be treated as such.

The Associated Press took an important step to stop using stigmatizing language toward people struggling with a substance use disorder, recognizing that words have power. We invite you to do the same.

Here is a list of words and phrases to avoid and words to use in their place. Together, with a unified language, we can help reshape the landscape and end the negative stereotypes and stigma of addiction. And by doing so, we can remove barriers that continue to hold back too many people from the lifesaving treatment they need.

AVOID SAYING: Abuse / Abuser

EXAMPLE: *He's a drug abuser.*

WHY? Linked with violence, anger or a lack of control. Not positioned as a health issue and places blame on the person with an addiction.

INSTEAD SAY: Misuse, risky use, harmful use, inappropriate use, unhealthy use, hazardous use, problem use, unhealthy use, non-medical use; individual struggling with misuse, individual suffering with substance use disorder, individual struggling with chemical dependency.

AVOID SAYING: Addict

EXAMPLE: *She's an addict.*

RELATED: alcoholic, crackhead, druggie, dopehead, doper, drunk, drunkard, junkie, pothead

WHY? The word addict is stigmatizing, reducing a person's identity down to their struggle with substance use and denies their dignity and humanity. In addition,

these labels imply a permanency to the condition, leaving no room for change. It's better to use words that reinforce the medical nature of the condition.

INSTEAD SAY: A person with a substance use disorder (SUD), with addiction, in active addiction, experiencing an alcohol/drug problem, with an addictive disorder; with the disease of addiction, with an addictive disease; person who suffers/suffered with addiction; patient (if receiving treatment services).

AVOID SAYING: User

EXAMPLE: *He's a drug user.*

WHY? The term is stigmatizing because it labels a person by his or her behavior (much like "addict").

INSTEAD SAY: Person who misuses alcohol/drugs; person engaged in risky use of substances.

AVOID SAYING: Clean/Sober/Staying Clean/Clean Test

EXAMPLE: *She smoked pot for many years but now she's clean; His test was clean.*

WHY? It associates illness symptoms with filth and implies a person struggling with a dependence on drugs or alcohol is inherently "dirty" or socially unacceptable. Same goes when referring to a drug test as a "clean test" (i.e. a

negative result/no evidence of use) or “dirty test” (i.e. to a positive result/evidence of use). These terms regarding tests should also be avoided.

INSTEAD SAY: In recovery, addiction-free, addiction survivor, in remission, maintaining recovery, wellness, quality of life, substance-free; positive test or negative test.

AVOID SAYING: Habit

EXAMPLE: *She has a bad drug habit.*

WHY? A habit is something that can easily be broken through persistence or willpower. Addiction is more complicated. As a disease of the brain, it requires medical treatment in addition to an emotional commitment to treatment and recovery. Calling addictive disorders a habit denies the medical nature of the condition and implies that resolution of the problem is simply a matter of willpower.

INSTEAD SAY: Substance use disorder (SUD), alcohol and drug disorder, alcohol and drug disease, active addiction, inappropriate use, hazardous use, problem use, non-medical use, unhealthy use, misuse, risky use, harmful use; person struggling with misuse, person suffering with substance use disorder, person struggling with chemical dependency, person who suffers/suffered from/with addiction.

AVOID SAYING: Replacement/Substitution Therapy

Example: *He takes Suboxone, a replacement therapy for his opioid addiction.*

WHY? The use of this term applies to discussions surrounding treatments for opioid dependence like Methadone, Suboxone and Vivitrol. By describing them as “replacements,” it minimizes the validity of these treatments and implies that the individual is still actively using drugs. Methadone, Suboxone and Vivitrol are medications prescribed to a person suffering from an illness, the disease of opioid addiction. Addiction is an uncontrollable compulsive behavior. The first goal of addiction treatment is to stop this dangerous behavior. With medication-assisted treatment as part of a comprehensive treatment plan with behavioral counseling, the dangerous addictive behavior is stopped, not replaced – and life can be extended.

A black and white photograph of three hikers standing on a grassy ridge, looking out over a valley. The hiker on the left is wearing a backpack and a hat. The hiker in the middle is also wearing a backpack. The hiker on the right is wearing a plaid shirt and a hat.

instead
**COMING TOGETHER TO
SOLVE THE OPIOID CRISIS**

A black and white photograph showing a group of people huddled together, with their hands raised in a gesture of unity or support.

5TH ANNUAL | OCTOBER 12, 2018
**SOLUTIONS
SUMMIT**

HOSTED BY

U.S. Senator Mike Lee
Utah Attorney General
Sean Reyes

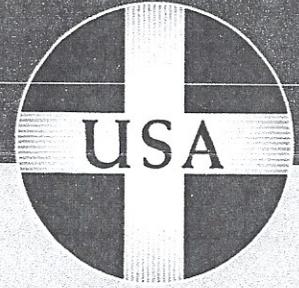
DEA 360

OCTOBER 12, 2018

Vivint Smart Home Arena
Salt Lake City, UT



Mental Health
First Aid USA



MENTAL
HEALTH
FIRST AID®

Jo Christman

Has completed the 8-hour course and is now certified in

Mental Health First Aid USA

And has been trained to provide initial help to people experiencing problems such as depression, anxiety disorders, psychosis, and substance use disorders.

This certificate became effective on: 11/29/2018

Date

This certificate expires on: 11/29/2021

Date

Cacilia Jensen

Instructor

Jonathon Fauver ~ MSW, LCSW, DE

Instructor

**NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH**
STATE ASSOCIATIONS OF ADDICTION SERVICES
Stronger Together.

National Council for Behavioral Health operates Mental Health First Aid in the USA. The National Council for Behavioral Health, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health founded Mental Health First Aid USA.

October 2018
Activity Report
Opioid Prevention Specialist

Carbon Emery Opioid Coalition
Hope Squad
Opioid Summit 2018 conference
Coffee with a Cop
One Voice Recovery
Mental Health 1st Aid
ICC meeting
UROHC
Creekview Elementary
Carbon School District Family Night
Helper Clinic
Carbon County Jail
Castlevue Hospital
Helper Fire Department
USU Eastern
Operation Recovery
Four Corners Behavioral Health
Positive Pathways

Developing community resource list, physician survey, Kiosk development at Carbon County jail,

November 2018
Activity Report
Opioid Prevention Specialist

Carbon Emery Opioid Coalition
Hope Squad
Mental Health 1st Aid
ICC meeting
Helper Clinic
Carbon County Jail
Castleview Hospital
USU Eastern
Four Corners Behavioral Health
Care Coalition
UDOH SLC Ad Campaign
Meet with Craig Povey – Grant Review
Submit 3 Goals to Gary Mower
University of Utah Cancer / Community Out reach meeting at USU Eastern
Medical Provider survey mailed
Hep C testing, MAT and jail kiosk development

Activity Report

Opioid Prevention

December 3	Carbon & Emery Opioid & Substance Use Coalition meeting
December 4	Opioid Crisis Response Training phone conference
December 6	Staff Meeting
December 6	U of U Opioid Addicted Expectant Mothers meeting
December 7	SEUTSC meeting, DUI controlled substances
December 11	Utah Opioid Overdose Crisis Response Team Training – SLC
December 12	Winter Summit for Prevention / Utah Substance Abuse Div.- Moab
December 14	HOPE Festival
December 21	Utah Rural Opioid Healthcare Consortium meeting

Prepared Opioid Crisis Response plan for Southeast Utah Health Dept. for submission to Gary Mower. Submitted 1/2//19.

Medical Professional Survey – 30 Surveys mailed and received 21 surveys back Results being tabulated for review.

MAT (Medical Assisted Training) Continuing with development for implementation at Castleview ER and Carbon County Jail. Meetings with Sheriff Wood, Chief Deputy Steele, Dr. Williams, Dr. Woolsey -HealthInsight, Carbon Medical.

Hepatitis C – Working on kiosk information for Carbon County jail, Develop of model jail policy – Discussion with Carbon Medical regarding treatment

Community Resource Guide – Submitted resource list of medical and dental along with other community resources for publication

Stigma Reduction – Prepared handout for stigma reduction for the coalition.

Narcan – Conducting needs assessment for further Narcan training

Education – Developing information / education presentation for elected officials

January 2019

Activity Report Opioid Prevention

January 2	Survey of medical professionals compiled
January 3	Hep C testing model policy, reviewed with Lex Black, RN
January 7	Carbon /Emery Opioid Coalition meeting
January 9	Grand Rounds: MAT in ER- SLC
January 10	Care Coalition meeting
January 11	Operation Recovery open house
January 14	ICC meeting
January 16	Health Insight – MAT and academic detailing
January 17	Faith Based Coalition meeting
January 25	UROHC meeting

Opioid Crisis Response completed, Dashboard input to UDOH

Medical Professional Survey completed and disseminated to partners

Narcan training scheduled for Rocky Mountain Home Health

In Progress:

Continuing efforts to implement MAT in the ER, Hep C testing in county jail, stigma reduction through community education and harm reduction efforts

Summit Schedule

Registration is free*



7:30 AM - 8:30 AM Breakfast

8:30 AM - 9:00 AM Welcome with Shara Park

9:00 AM - 10:30 AM Judge Zweig

10:30 AM - 11:15 AM Dr. Cook

11:15 AM - 11:30 AM Mindfulness Gonging

11:30 AM - 12:15 PM VaRonica Little

12:30 PM - 1:15 PM Positive Recovery language

1:15PM - 2:00 PM Client-centered TICS

2:00 PM - 2:15 PM Mindfulness Gong

2:15 PM - 3:30 PM Recovery Panel

3:30 PM - 4:00 PM Awards & Prizes

Breakfast and lunch will be provided.

*Seating is limited, please register with link below.

Tuesday, March 5
8AM - 4PM

Utah State University Eastern 414 North 300 East
Price, UT 84501

To register: <http://urohc-opioid-recovery-summit.eventbrite.com?s=90655982>

For more information visit: www.suu.edu/ahec/urohc

Utah Rural Opioid Healthcare Consortium (UROHC)

*UROHC is a HRSA funded Consortium

Every month in Utah, 24 individuals die from prescription opioid overdoses.



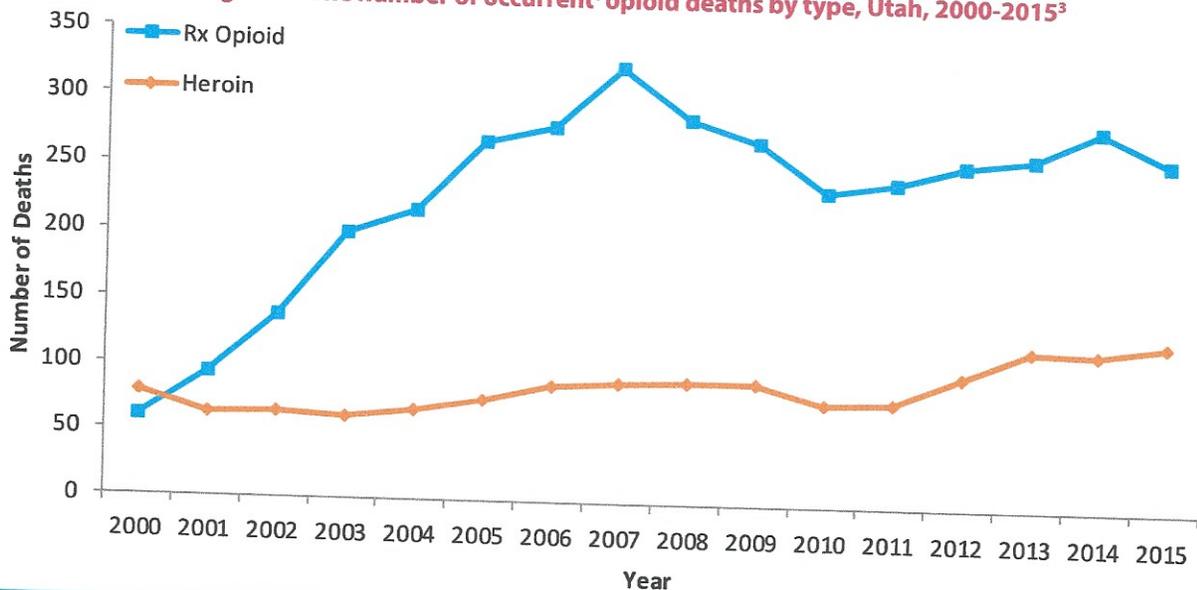
Introduction

- From 2013 to 2015, Utah ranked 7th highest in the nation for drug overdose deaths.¹
- Drug poisoning deaths are a preventable public health problem that has outpaced deaths due to firearms, falls, and motor vehicle crashes in Utah since 2002.²
- In 2015, 24 individuals (residents and non-residents) died every month from a prescription opioid overdose in Utah (Table 1).³
- 2015 was the first time in six years that there was a decrease in the rate of prescription opioid deaths ages 18 years and older in 2015 (Table 1).
- Although Utah is seeing a decrease in the number of prescription opioid deaths since 2010, the number of heroin deaths that have increased in the same time period (Figure 1).³

Table 1. Count and rate of poisoning deaths by select categories, Utah, 2006-2015³

Year	Occurrent [†] Poisoning Deaths	Occurrent [†] Rx Drug Deaths	Occurrent [†] Rx Opioid Deaths	Rx Opioid Deaths, UT Residents 18+	Rx Opioid Death Rate per 100,000 UT Residents 18+	95% Confidence Interval
2006	416	308	280	274	15.8	(14.0 - 17.8)
2007	478	371	326	313	17.6	(15.7 - 19.6)
2008	430	321	289	278	15.2	(13.5 - 17.1)
2009	420	306	272	269	14.4	(12.7 - 16.2)
2010	369	278	236	227	11.9	(10.4 - 13.6)
2011	444	306	246	233	12.0	(10.5 - 13.7)
2012	536	327	268	257	13.1	(11.5 - 14.8)
2013	531	354	274	265	13.2	(11.7 - 14.9)
2014	531	363	301	285	14.0	(12.4 - 15.7)
2015	566	357	282	262	12.6	(11.1 - 14.2)

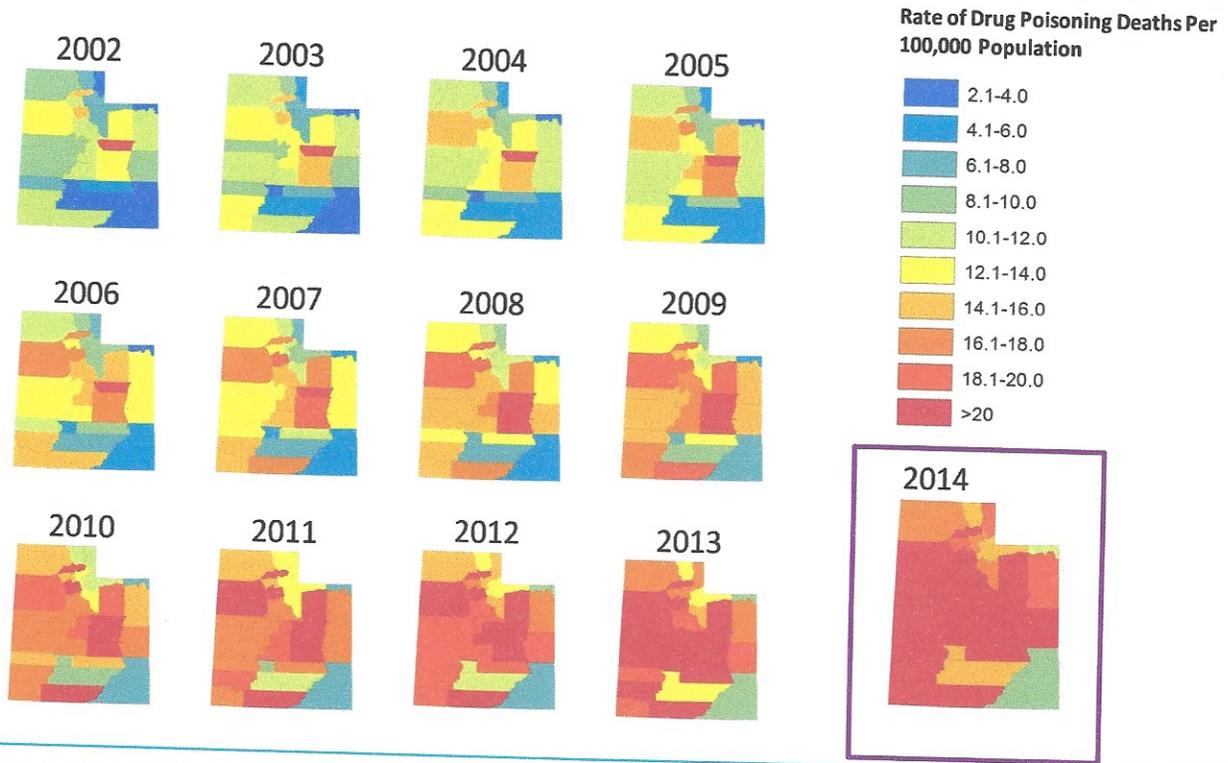
Figure 1: The number of occurrent[†] opioid deaths by type, Utah, 2000-2015³



Utah Trends

Since 2002, drug poisoning deaths per 100,000 population have increased at an alarming rate (Figure 2) and prescription opioids have been responsible for more drug deaths in Utah than all other drug categories, such as benzodiazepines, over-the-counter medications, or illicit drugs.¹

Figure 2. Rate of drug poisoning deaths per 100,000 population by county, Utah, 2002-2014 (age-adjusted)³



Age and Sex

Overall, there was not a significant difference between the adult male and female rate of prescription opioid overdose deaths (13.0 and 13.4 per 100,000 adults) (Figure 3). The highest prescription opioid overdose deaths rates were observed in Utahns aged 45-54 for both males and female (Figure 3).³ The highest prescription opioid overdose emergency department visits rates were observed among Utahns aged 25-34, closely followed by Utahns aged 45-54. However, for heroin overdose emergency department visits, the highest rates were observed for Utahns aged 18-24 (Figure 4).²

Figure 3: Rate of prescription opioid overdose deaths per 100,000 adult residents by sex, Utah, 2013-2015³

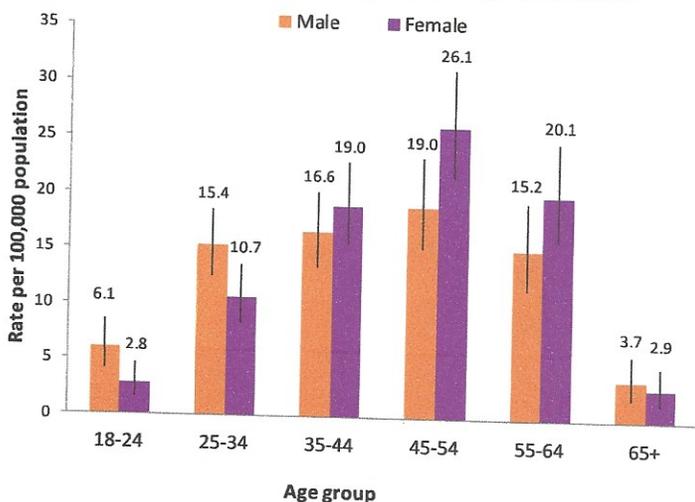
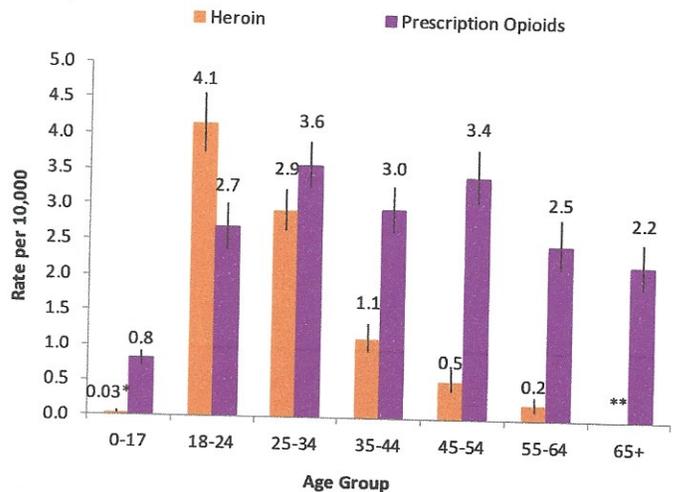


Figure 4: Rate of emergency department visits per 10,000 population by age group and opioid type, Utah, 2012-2014²



*Use caution when interpreting results, data does not meet UDOH standard for data reliability.
 **Data does not meet UDOH standard for data reliability

Figure 5: Percent of occurrent[†] prescription opioid deaths by drug type, Utah, 2015³

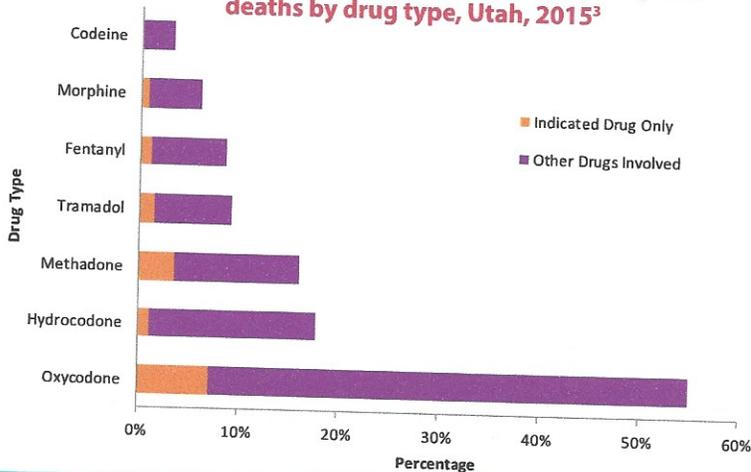


Figure 6: Rate of occurrent[†] deaths per 100,000 prescriptions by year and prescription type, Utah, 2004-2015⁵

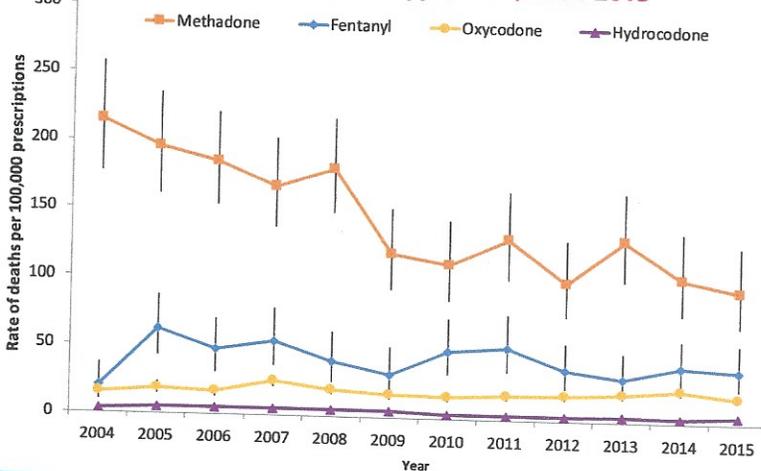
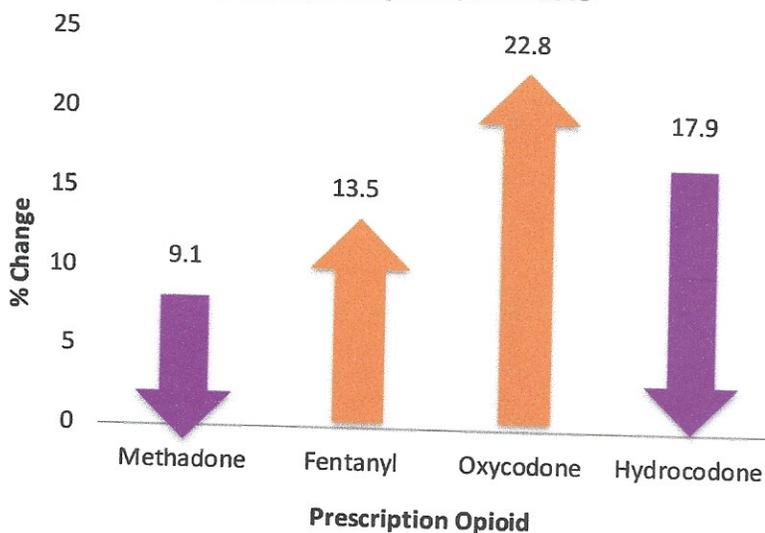


Figure 7: Percent change in number of deaths per 100,000 prescriptions, 2011-2015⁵



Prescribing Trends

Deaths from oxycodone drugs, such as oxycontin and percocet, accounted for 55.0 percent of all prescription opioid deaths in 2015. Hydrocodone was second at 17.7 percent. The majority of prescription opioid deaths involved other drugs (Figure 5).³

Although the majority of prescription opioid deaths involved oxycodone, the risk of death was significantly higher when methadone was involved compared to fentanyl, oxycodone, and hydrocodone. Fentanyl had the second highest risk of death per 100,000 prescriptions (Figure 6). Prescriptions dispensed for fentanyl and oxycodone increased 13.5 and 22.8 percent respectively from 2011 to 2015. Prescriptions for methadone and hydrocodone decreased 9.1 and 17.9 percent respectively during the same time period (Figure 7).⁵

Location of Death

The following Utah Small Areas had significantly higher prescription opioid death rates compared to the state (13.2 per 100,000 adults):³

- Carbon/Emery Counties (47.3 per 100,000 adults)
- Ogden (Downtown) (31.6 per 100,000 adults)

Circumstances of Death

In Utah, the top circumstances observed in prescription opioid deaths included:⁴

- 71.0% physical health problem
- 68.3% substance abuse problem†
- 65.7% current mental health problem
- 60.4% current mental health/substance abuse treatment
- 27.4% drug involvement (not a prescription)
- 17.1% alcohol dependence/problem
- 13.7% history of suicide attempts

Prevention

- Talk to your doctor about alternatives to prescription opioids.
- Never share your prescription opioids with anyone.
- Store prescription opioids out of reach, with the label attached, and with the child-resistant cap secured.
- Dispose of all unused and expired prescription opioids properly. If possible, take your unused prescription opioids to a permanent collection site or drop-off event. If you can't find a drop-off site, dispose of your medications by following the guidelines at www.useonlyasdirected.org.
- For other tips on safe use, safe storage, and safe disposal, visit Use Only As Directed at www.useonlyasdirected.org.
- Know what the common opioids are and know their risks – dependency, addiction, or overdose.
- Know what the signs of an opioid overdose are:
 - Small, pinpoint pupils
 - Blue/purple fingernail and lips
 - Won't wake up, limp body
 - Shallow or stopped breathing
 - Faint heartbeat
 - Gurgling or choking noise
- Carry naloxone and know how to properly administer it. Visit naloxone.utah.gov for more information.
- For more information on the risks of opioid, signs of an opioid overdose, or the use of naloxone, visit Stop the Opidemic at www.opidemic.org.

Resources

- Naloxone naloxone.utah.gov
- Stop the Opidemic opidemic.org
- Use Only As Directed: www.useonlyasdirected.org
- Utah Department of Health: www.health.utah.gov/vipp
- Utah Poison Control Center: uuhsc.utah.edu/poison 1-800-222-1222.

Last Updated: April 2017

References

1. U.S. Centers for Disease Control and Prevention, Web-based Injury and Statistics
2. Utah Department of Health Office of Public Health Assessment, Indicator Based Information System for Public Health
3. Utah Department of Health Violence and Injury Prevention Program, Prescription Pain Medication Program Database
4. Utah Department of Health Violence and Injury Prevention Program, Utah Violent Death Reporting System
5. Utah Department of Commerce Division of Occupational and Professional Licensing, Controlled Substance Database

*Occurrent deaths include individuals who died in Utah, whether or not they were a resident of Utah.

†Utah resident status not available to report counts and rates.

‡A circumstance in which the individual was noted as using illegal drugs, abusing prescription medications, or regularly using inhalants at the time of death even if the addiction or abuse is not specifically mentioned.



If your life has been affected by opioids, the Utah Department of Health wants to hear from you. Share your story with the Utah Health Story Bank at www.health.utah.gov/bhp/sb/.

Our Mission: VIPP is a trusted and comprehensive resource for data and technical assistance related to violence and injury. This information helps promote partnerships and programs to prevent injuries and improve public health.

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www.health.utah.gov/vipp