Responding to Opioid Overdoses and Treating Opioid Use Disorder

A Landscape Analysis Summary of Chicago's West and South Sides

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The opioid overdose crisis has been steadily rising both nationally and in Chicago, Illinois, exceeding deaths from vehicle accidents and gun violence.[1] Data shows that the 573 opioid-related deaths in Chicago between January and June 2020 are more than double the rate for the same period in 2019.[2] The burden of those overdoses has disproportionately been experienced by Chicago's West and South Side communities.

This landscape analysis found that overdose prevention, treatment, and response services in the communities hardest hit by the overdose crisis (the West and South Sides) are insufficient and that critical gaps in the city's overdose response system remain. The same communities hit hardest by the overdose crisis are also facing social and structural harms such as poverty, lack of affordable housing, food, and healthcare deserts. The added burden of the COVID-19 pandemic and the constantly changing illicit drug market that has been adulterated by fentanyl and novel synthetic opioids drives the disparities further.

"We are failing in so many ways in understanding where people are and what they need in order to make a decision to go to treatment."

—HARM REDUCTION PROVIDER

"...they make them [patients] jump through so many hoops like they need to do an initiation visit and then they need to do a drug screen and then they are required to go to counseling and then once they go they can follow up in two weeks and then get their medication. We don't do that with a patient with diabetes right? Like that would be medical malpractice. If they came in with an A1C of 12 and then we said, 'Oh you have to go to a nutritionist first and then you have to get labs done and then follow up in two weeks and then I'll give you medicine.' I would've lost my license."

—FQHC/CHC PROVIDER

Landscape Analysis Overview

In 2019, the Chicago Department of Public Health and the Cook County Department of Public Health conducted a survey to assess hospital emergency department (ED) capacity for responding to opioid-related overdoses and treating opioid use disorder (OUD).[3] The survey found significant gaps in ED-based care for people with OUD and individuals at risk of overdose. Supplementary data from the Illinois Department of Public Health found that the hospitals in Chicago with the highest volume of opioid-related overdoses were almost exclusively located on Chicago's West and South Sides.[4]

Building on the data gathered by city and state departments, the Illinois Public Health Institute (IPHI) conducted 25 key informant interviews with hospital providers/administrators, Opioid Treatment Program (OTPs) and Federally Qualified Health Center (FQHCs) personnel, harm reduction service providers, and people who use drugs (PWUD). The interviews identified barriers to care for people at risk of overdose and people with OUD, focusing on naloxone access, medication for opioid use disorder (MOUD), and continuity of care across Chicago's South and West Sides.

Findings: Hospital Capacity Assessment

Naloxone

- Only 28.2% of hospitals reported they had a protocol for either providing overdose prevention education to patients in-house or by referral.
- 56.4% of respondents said they did not have a protocol in place to prescribe naloxone.
- Only 7.7% of hospital respondents reported having a protocol in place for naloxone dispensing to patients in the ED.

MOUD

- Just under 72% of respondents either left their response blank or reported zero waivered providers who could prescribe buprenorphine in the ED.
- Only 5.1% of respondents reported that they had a protocol for prescribing buprenorphine.
- 92% of respondents either reported zero, left their response blank, or responded that they did not know when asked about the number of buprenorphine prescriptions provided in the ED in 2018.

Recommendations

1. **Increased resource allocation** for new services and existing services as well as the adoption of low-threshold service models and sustained policy change.
2. **Capacity development** by way of training, peer workforce development, and stigma reduction.
3. **Structural advancements** to decrease social inequity particularly around housing and criminalization.
4. **Increased system integration** that strengthen transitions of care.
5. **Upstream regulatory changes** to increase MOUD and naloxone access.

I have had a lot of bad experiences with doctors especially once they know that I'm a user, you know, and how they treat you especially if you're coming through the emergency room on an overdose.... And I look at it this way. If you're a healthcare worker, you've given up a certain part of your life to helping people.

—SERVICE USER

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"The need to be abstinent. It's complicated for people. So you're struggling with something that's a habit-based behavior like any of us might struggle with exercise or eating habits or things like that and most people don't change in absolutes and yet in most of our treatment system that's exactly what we expect, is that people walk in the first day and that they change in absolutes. And worse, we punish folks for having slips in that absoluteness. Right, we kick people out of treatment for exhibiting symptoms of their disease, and I can't think of any other health condition where we do that."

—HARM REDUCTION PROVIDER

Access Barriers

An overall lack of access to services was widely expressed and can be better understood through a series of subthemes including barriers to MOUD availability, high-threshold service model barriers, stigma, and limited naloxone access. Regarding MOUD treatment, examples of barriers included things like limited prescriber availability, access for uninsured individuals, and waitlists for treatment programs. High-threshold service model barriers influenced treatment initiation and continuation and included things like access to technology, proof of identification, travel and counseling requirements. Stigma was also a major subtheme of access barriers. Finally, barriers to naloxone access due to cost and regulatory challenges were discussed.

Continuity of Care Barriers

Barriers related to formalized linkage systems that seek to ensure continuity of care was another salient theme highlighted by stakeholders. An overall lack of discharge planning and follow up, an overreliance on referrals rather than warm hand-offs, and informal partnerships were identified. Some providers talked about the challenges of receiving a patient with complicated and/or multiple needs without any coordination or basic information about the patient, such as medical records, specialty service needs, ID, or insurance information.

"...If more hospitals and community-based programs had care coordinators to assist with the counselors and things like that, I think we could help these patients to really navigate this system a whole lot better. Because that takes a lot of dedicated time to make sure that someone is, you know, able to get to their appointments and that they made it there, that they have the transportation that they need, they have the things set up for them at home. You know, it would help a lot with someone who is trying to do the counseling. It would help all of us work together as a team if we had those additional persons or people in these different facilities that can help everyone when navigating the system a little bit better."

—HOSPITAL PROVIDER

"You know we've got a housing crisis. I think that's so big and that really affects people's ability to be retained in care and show up for appointments. There's a lot of barriers based off of broader social concerns that really have nothing to do with someone's motivation for treatment but really impact their ability to access it. And that's especially disheartening for me as I watch folks go through a 28 day and then a 3-5 month recovery home and then be discharged back to the streets. That story is way too common. And the supports that are in place in these programs to secure discharge plans that will support their path to health are very limited."

—FQHC/CHC PROVIDER

Structural Barriers

Structural barriers were often identified and included a variety of social equity issues such as housing access and criminalization of substance use. Stakeholders often described the needs of the community and people they were serving as much greater than their organization's capacity to meet that need. A lack of permanent infrastructure to support essential services was raised in the context of programs being dependent on limited grant funding, insufficient staffing capacity, and the limitations of some existing services like recovery homes that are not always responsive to the needs of people with OUD. Social and structural inequity was discussed as barriers that prevent people from participating fully in the treatment system and/or from gaining access altogether

"The fact that I can't control myself, that I'm such a dope addict, and that I keep doing something that I know is wrong to society. It's because society looks so down on it like, 'oh you're such a scumbag if you do this.' You know? And I feel like when I walk in there and tell them yea that's what I keep doing.... I'm not smoking weed, I'm not doing cocaine. No, I'm doing the worst shit of all, I'm doing heroin. You know what I mean? I feel like people are looking at me like, 'you dirty dump dog', you know?"

—SERVICE USER

Service User Factors and Experiences

Service user factors and experience comprised internalized stigma, descriptions of a low self- concept, and misinformation factors shared by stakeholders. Co-occurring mental health needs were also commonly raised throughout the interviews. These factors do influence a person's insight motivation, and desire to seek treatment, however, given the lack of power most service users have over the treatment system, these factors should be understood as a consequence of marginal-ization rather than a cause of it.

COVID-19 Pandemic-Related Barriers

COVID-19 barriers centered on changes in service availability overall due to physical distancing safety regulations and communication barriers due to limited technology access on the part of service users. An overall loss of access to services was the main challenge identified related to the pandemic. Specifically, loss of access included walk-in access that some clinics and programs employed prior to the outbreak, the loss of in-person provider visits that have resulted in delayed care, and increased wait times for receiving MOUD. In addition, some providers spoke about the loss of recovery-based support groups and having to transition to online groups, which left many service users without access to those services. A few providers also raised feelings of burnout from working in crisis for such a long time and without a clear end in sight.

"During COVID it's definitely become more difficult to access MAT services. I don't know what other FQHCs are doing but I think guidelines have been quite clear that we should not be allowing walk-ins or not advertising for walk-ins. So in order to begin or maintain a [buprenorphine] prescription right now it does feel like you need to have a cell phone and tons of our patients don't. So that's been a significant barrier to care that's specific to these times."

—FQHC/CHC PROVIDER

References

1 Drug Policy Alliance. Drug Overdose. https://www.drugpolicy.org/issues/drug-overdose

2 Chicago Department of Public Health. (2020). Mid-Year Chicago Opioid Update (p. 5)

3 Chicago Department of Public Health, and the Cook County Department of Public Health, (2019-2020). Cook County emergency depart-ment opioid-related survey [Excel file].

4 Illinois Department of Public Health, (2020). Opioid overdose-related ED visits 2017-2020 [Excel file].