

Stephen Taylor: Welcome to the season finale of ASAM Practice Pearls, a podcast series from the American Society of Addiction Medicine. I'm your host, Dr. Stephen Taylor.

Today, I want to start by talking about a situation I just encountered two days ago when I had a patient in my office who was really desperate and he talked about the fact that he had been injecting opioids and his latest problem was that he was severely addicted to Kratom. And he was coming in for help and really sounded desperate feeling as though this was his last chance to be able to get into recovery and was really excited, really happy to see me, highly motivated. He had experienced overdoses in the past and was just excited to be able to get into treatment, and we talked about how we would proceed and try to help him. And I was thinking about this particular patient this morning and realized that we still have so much work to do regarding the whole issue of overdoses in this country.

Yes, the numbers are down, and we now have a revision of data from the CDC that was out in January, 2025 that suggested that maybe the decline that we had been seeing in overdose rates was maybe reversing. But no, the good news is it seems as though the pattern is still in a decline in the overdose death rates, but we have patients that we take care of every day that remind us that we still have work to do.

And so, I come into this episode thinking about the fact that we are in International Overdose Awareness Day. We're going to be focusing on that issue for today's episode.

Thinking about this patient I just took care of two days ago really brings that home, that we have to think about preventing, responding to, and intervening in an overdose.

I have today the perfect individual to talk with about that issue, my friend, a colleague, Dr. Alex Walley, who specializes in overdose prevention.

Dr. Walley, please say hello to our audience.

Alex Walley: Thank you so much. I'm really grateful to ASAM for focusing on this topic on this day, August 31st, International Overdose Awareness Day. This is a day that we've recognized where I live in Massachusetts for several years now. It really causes me to reflect on the past, all the people that have been lost and the families that have been affected.

So, in Massachusetts, in our capital, Boston, in the front lawn, in front of the State House, there are 20,000 purple flags that are planted in the grass there. Each one representing a person, an individual who died in the previous 10 years. That's a very important reminder to me in the face of, we often focus on the numbers and the epidemiology, but thinking about the individuals who we've lost, and with every individual, there's a network of family members and friends who've been affected.

And so, even with the good news about the reduction in overdose deaths in the last year, the impact of the losses that we've had are still going to be felt long into the future.

And it's important for us to really think about the future because what we've learned is that there's things that you can do to really improve overdose. So, that's what I like to focus on. I hope we'll get to talk about a little bit today.

Stephen Taylor: You're absolutely right. You really teed that up for us nicely.

I'm actually going to go back and start with that whole issue of epidemiology. Where are we in terms of the numbers? What are the populations we need to be concerned about that can be affected? Which geographical areas? You mentioned Massachusetts, and that's a place that's near and dear to my heart. I went to school up there.

I spent five years of my life trying to get educated in Massachusetts. I now live in Jonesboro, Georgia. The patient I saw was in our office in Birmingham, Alabama. The fact of the matter is there isn't a place in this country that is spared, but what are the geographical areas that we need to be most concerned about that will be impacted, and what are the substances that are most involved?

Alex Walley: You're right, no community has been spared from overdose deaths, and that's really important. That's on the one hand. On the other hand, the experience of overdose deaths is specific to every community. Every community has its own drug supply, and it varies. And the people that are affected in those communities, they're their own groups and their own people, and they have their own stories.

And so, on the one hand, we have a national problem. On the other hand, I think a lot of the solutions lie in knowing the community and getting involved in one's community. As far as the current epidemiology, most experts agree that we're in what's called the fourth wave of the opioid crisis. The first wave in the early 2000s, built on or springing from prescription opioids being the source, really driving opioid overdose deaths in the 2000s.

Around 2009 to 2010 or so, there was a surge in many parts of the country in deaths affiliated with heroin use. So, the concept is that as we were clamping down on prescription opioid access, people were seeking more unregulated opioids like heroin, and that drove increases in overdose deaths. Then, around 2013, depending on where you were in the country, so in Massachusetts, other parts of New England, and Appalachia. In 2013, we saw surges in fentanyl, and that spread from east to west, so that in 2018, 2019, the West Coast was really getting hit fully by fentanyl in the unregulated drug supply. And they started to see huge surges in overdose deaths. This fentanyl wave, the third wave has been now followed by a combination of fentanyl and other novel substances, synthetic opioids in the drug supply plus stimulants.

So, over half of the overdose deaths that we're seeing now are involving fentanyl or other synthetic plus a stimulant, either cocaine, and some parts of the country, like New England. Cocaine is very common, or methamphetamine in other parts of the country, like the West Coast and in some parts of the South.

So, these drug trends are both national and regional, and it is important for people to really get to know what's going on in their community and who's being affected.

Stephen Taylor: That's so true. Just, again, you reminded me about the gentleman that I was referring to in my introduction. Methamphetamine was another of many substances that he had been using to a tremendous degree, and so you're right. Overdoses in many cases are not an overdose involving just a single substance. Very often it's combinations of substances that people are using when an overdose occurs.

Can you tell me what you think about this whole issue of racial geographic, or socioeconomic disparities? How do those factor into overdose patterns and access to care?

Alex Walley: So, this is a very important question that gets into this idea of, while we have a national problem, we have also localized conditions that we really need to understand. In some places, like Massachusetts, we have seen a relative drop in opioid overdose deaths among the white population, which is the majority population in Massachusetts.

At the same time, we saw, particularly around the pandemic, an increase in overdoses among Black, Hispanic, and our indigenous residents. I think that this reflects in Massachusetts and I think in many other parts of the country, issues around access to overdose prevention, harm reduction, and then treatment resources.

We know, following the decades-long war on drugs and mass incarceration, that particularly Black, Hispanic, and our indigenous folks have less access to high-quality addiction treatment and less access to harm reduction services. When the drug supply becomes more toxic, they have less access to the things that they need to keep themselves safe and healthy.

In other parts of the country, that disparity has really been seen between the rural/urban divide. There are many parts of the country that are rural where there are very little access to treatment or prevention, and when the drug supply changes, there's very little that people have to help protect them.

We see that reflected in surging overdose numbers in rural areas. One of the particularly problematic things that, at first, I didn't really believe it was a problem until I started seeing patients face to face in our hospital, maybe three or four years ago, was the problem of stimulants like cocaine and methamphetamine that were contaminated with fentanyl.

And so, you have people who may not even have an opioid use disorder whose drug of choice may be cocaine or methamphetamine, and they're unexpectedly or unwittingly exposed to fentanyl through their drug of choice of cocaine or methamphetamine. This also occurs for people who are using counterfeit prescription pills like benzodiazepines or even an opioid like oxycodone, sold as a prescription pill, but actually contains fentanyl.

That's actually very commonly how the illicit drug supply or the unregulated drug supply is packaged in some parts of our country. People are buying blue pills that are packaged like oxycodone, but are actually fentanyl. This really plays out geographically. There are racial and ethnic disparities that are very important for us as treatment providers to be aware of and to think of when we're designing our treatment programs and prevention programs and as well as the rural/urban differences that I mentioned.

Stephen Taylor: The other issue that's very closely related to what you've been talking about that came to mind as you were speaking is the whole issue of contaminants, and I'm talking about contaminants like, for example, medetomidine, or some of the other contaminants that people find in their substance that aren't even drugs that people use to get high generally speaking. I'm wondering, we now have to change the way we approach a patient who has experienced an overdose, don't we?

Alex Walley: Yes. So, you mentioned medetomidine, which is an Alpha-2 agonist. It's a cousin of dexmedetomidine, also known as precedex, which is used in the ICU for sedation. They are cousins of xylazine, which is a sedative used in large animals, not in humans, but has been a contaminant, particularly combined with fentanyl, fentanyl's, very short acting, and so I think we don't know for sure, but the intention of the people packaging these substances, is to extend the experience to make it longer, so that may somehow make it more appealing to folks.

The problem, of course, is that this causes prolonged sedation, and when it comes to overdose response for opioids, we really had the perfect antidote, which is naloxone, which you know, reverses an opioid overdose. But if you have one of these contaminants like xylazine or medetomidine on board, while the naloxone is effective in reducing respiratory depression, it isn't necessarily effective in reversing this sedation. And so, you have people who are responding by breathing more when they get naloxone, but they're not responding by waking up and being able to talk and walk. And what that leads to is more naloxone being administered because the rescuer feels like they haven't given enough.

However, more naloxone is not going to reverse the sedation or loss of alertness from xylazine or medetomidine. Only time will do that. The good news is that once the person is breathing enough, that protects their brain. Even if they take a while to come out of it, they will recover without injury. That gets into something I call compassionate overdose response.

We really need to be aware, like you said, that there are contaminants in the drug supply and that when somebody overdoses, we want to focus on restoring breathing as soon as possible to protect the brain.

Stephen Taylor: You've talked a little bit about compassionate overdose response, and I'd like to sort of delve into that a little bit more.

In terms of the whole issue of post-overdose care, what does that look like? How can clinicians effectively engage patients during that immediate post-overdose time?

Alex Walley: That's a great question, and that's one that we as healthcare providers have learned about over the almost 20 years now of this overdose crisis.

For the person who is overdosing, when somebody experiences an overdose, they lose consciousness. They don't have pain when they go into the overdose, they probably aren't going to experience fear at that time, like as they're going into the overdose. But, when they are rescued, and especially if they have opioid tolerance, if that rescue comes with naloxone, which it often does, the naloxone is many times going to precipitate withdrawal symptoms. Withdrawal symptoms in somebody with physical opioid dependence is a very uncomfortable feeling, and in somebody who has an opioid use disorder, withdrawal symptoms are the things that actually are driving their compulsive craving for more opioids. And so, the irony is that as the person goes into the overdose, they actually are not feeling any pain.

But if they come out of the overdose and experience precipitated withdrawal, they're going to be experiencing pain, compulsive craving, irritability, anxiety. So, part of the opioid use disorder means that their brain is going to be directed towards getting comfortable again, and that may even be more of the focus than the gratitude they have of surviving the overdose.

That's the mindset of the person who's being rescued from the overdose. For the person who's doing the rescuing, for them, it's very traumatic to see either their loved one or their friend, or in the case of first responders, they come onto the scene, and they see somebody who is unresponsive, not breathing, looking blue, quite ill.

That, for them, is very anxiety-provoking. They want to act, they want to save this person. They're really looking for the person to be back to normal, and they may not recognize that there's multiple sedating substances on board. The opioids, which will respond to the naloxone by restoring breathing, which preserves the brain and others, like I mentioned, xylazine, or benzodiazepines, or alcohol, which aren't going to respond in naloxone, and the person will stay sedated.

So, that drives the administration of a lot of naloxone early on, which is there to make the rescuer feel good, but it doesn't necessarily make the rescued feel good. And so, we want to really educate people to follow the American Heart Association.

Responding guidelines, which is to administer the minimum amount of naloxone that restores breathing, and then to support the person as they come out of the overdose.

That is the target. Now, that's easier said than done in all cases, and it's a lot easier for people with experience responding to overdoses than the person who's responding to their first overdose, but that is something that we're talking about now with compassionate overdose response.

So, then you have the restoration of breathing. You want that person, as they wake up, as they become more alert and aware, rather than peppering them with questions or asking them what happened, we want to reassure them that they're going to be all right. That they're okay now. And that's going to help counteract any of that anxiety and irritability that may be from too much naloxone.

It'll make the whole experience more comfortable and more likely that you can have a discussion around prevention and treatment than you could if somebody was being shouted at or in an anxious environment when they're rescued. It's a lot we're asking from the rescuers, but for those who are experienced, they can do this.

We do this in the hospital. I'm in the hospital right now. We had somebody who was over-sedated, and we started with the lowest dose naloxone that we could give, and we brought them back to breathing gradually, and then they woke up and came back to normal on their own. And we provided a supportive environment that can also be done in the community, particularly among those folks who've had experiences rescuing people in the past.

Stephen Taylor: I have for many years in talking to people about overdoses and using naloxone to reverse an overdose, have had a lot of fun getting people to laugh when I get them to think about the expectation that the person's going to wake up from their overdose after naloxone administration and be so grateful and appreciative because you've saved their lives and then helping people realize, no, they're more likely to wake up and start cussing you out, and being very angry and irritable and helping people understand why that's the case, but that's actually an important issue, this whole point about.

Conversations about overdose. Not just with the people who may be administering naloxone, but also with patients. How do you approach those conversations with people, with your patients, with the people you take care of who may be using stimulants or benzodiazepines or synthetic opioids? How do you approach those conversations with those folks about overdose risk?

Alex Walley: Well, thanks for asking this one, because I do have a way I like to do it. So, I'm a general internist and addiction specialist, so I see patients in primary care. I see them on an inpatient addiction consult service. I've worked in methadone programs in the past, and I've also worked on inpatient residential settings.

I've also worked in some harm reduction settings, but in all of those places, I like to ask this question, which is, what is your plan to keep yourself safe from overdose? So, take it head on, and ask them specifically about their experience before I start teaching or talking or sharing what I know, I want to know what their plan is.

As you can imagine in the treatment settings, sometimes patients are taken aback by that question. They say, "Well, doc, why are you asking me what my plan is to keep myself safe from overdose? I'm here seeking treatment. I'm not planning on overdosing in the future. I'm planning on being in treatment."

And I say to them, "Well, treatment is a fantastic plan to keep yourself safe from overdose, and that's a great plan A, and I want to fully endorse that plan. However, I know from my experience, this may not be true for you, but I know from my experience taking care of thousands of patients that lots of people come into treatment with intentions of never using again. But, some of those patients who were mine, they used again and they overdosed. And so, I need to ask you, what's your backup plan? If treatment doesn't work out for you, what's your plan to keep yourself safe from overdose?"

And oftentimes I get the response, especially those folks who are active in 12-Step, they say, "Well, I'm going to call somebody, somebody in my network, and let them know that I'm having cravings that I'm thinking about using."

And again, I say, "That is a fantastic plan. Having a supportive social network is key to us maintaining our recovery goals. And so, you should definitely do that. I need you to have a plan C for me, though. I need to know what you're going to do if you use again to keep yourself safe. What is your plan C?" Most people have thought about it, and in fact, they've been in that circumstance, and they can list some things, and the things I'm looking for them to list are that they're going to, first of all, use with other people, have somebody else there when they use. It turns out, even though most people actually use with other people, 90% of the overdose deaths occur in people who were alone when they use. Using alone is a really big issue. I want them to articulate a plan for me of how they're going to use with someone else.

Sometimes somebody's not going to be there, right? There's places now in New York City and Providence where we have overdose prevention centers where people can go and use in the presence of medical staff who can keep them safe. Not many places in the US do we have that. We also have these overdose prevention hotlines.

SafeSpot is one of them that I'm involved with that is a 24-hour, seven-day-a-week hotline that people can call to have someone stay on the line with them while they're using and implement a safety plan, a response plan if they stop responding. But the best thing is to have somebody there with them, if they're going to use, if they have somebody with them, they need to take turns.

I can't tell you how many people I've done treatment intakes on where they said, "I used with my friend, we both overdosed. I woke up and they didn't." And that is devastating to people. And so having the taking turns as part of the plan, starting low and going slow, that's another key part of the plan. We don't know what's in the drug supply.

And so, people who are using drugs, they should test their drugs before they go for their full dose. So, they have a sense of how strong it is. Then more and more there's drug checking. That means fentanyl test strips or xylazine test strips. In some places, there's also new technology that's coming on that's increasingly available around highly specific drug checking.

So, those are some of the things I'm looking for in people's plans. Then I also want people to tell me how they're going to keep other people safe, because one of the more rewarding things for people to do is to rescue someone else. To look out for each other, and one of the biggest interventions we have is naloxone.

And naloxone only works if there's someone else to give it to the person. We can't give naloxone to ourselves when we're overdosing. Someone else has to give it to us. So, I like to get people confident in their ability to rescue other people.

Stephen Taylor: That is so awesome. You know, many people I have worked with, including people in recovery, love to talk about the fact that addiction is a disease of isolation and indeed recovery.

And even the very first step in recovery for some people, which is overcoming an overdose, is a process of being with people and in a very literal, concrete way. You have to be with someone if you're experiencing an overdose in order for that person to be able to help you reverse that overdose and bring you back. Overdoses, as you say, 90% of the time, occur when a person is using by themselves.

It makes sense that recovering from an overdose, being brought out of an overdose requires that the person not be alone. They've got to be with someone else who can do that for them. The other thought that I had about this was, you know, there are data-driven tools that can play a role in overdose prevention, and I just wondered if you could speak a little bit about those.

Alex Walley: One of the places where we've made a lot of progress, both nationally and locally, is just knowing that overdoses are happening and being able to count them. So, I will say that as an important aside, that we have pretty severe criminalization of drug use in the United States, and when you criminalize a behavior, that is the ultimate way of stigmatizing it. As long as drug use is criminalized, people are going to hide the fact that they use drugs, and that means that we are not going to know everyone who's using drugs because there's serious consequences if people reveal that to others. And, similarly, if somebody overdoses and they survive, they may not call for help. That means that a lot of the drug use and a lot of the overdoses

are hidden. However, as I said, nationally and locally, there has been better accounting in real time for the overdoses that are happening and where there's an encounter with the health system.

Whether it's a non-fatal or a fatal overdose, one of those tools that's used in many jurisdictions is OD map, where first responders can report in without revealing the identity of the person who's overdosing that an overdose occurred, and then that allows for some hot spotting. There's something called Syndromic Surveillance, which many communities participate in that's sponsored by the Centers for Disease Control and Prevention.

Syndromic Surveillance is a system that focuses largely on non-fatal overdoses, and then there's another system that focuses on fatal overdoses called the SUDORS system, and there's a SUDORS dashboard at the CDC website that you can check out at the level of the state and get lots of details and characteristics about the overdoses that are happening in your state. So, I encourage folks to check out the SUDORS dashboard at the CDC.

So, those are some of the resources that we have that are data-driven tools that can help us know better about what's going on in our communities.

Stephen Taylor: Yeah, and that's so important. As is also the issue of changing policies or changing protocols that might help reduce those overdose deaths.

Once we have an idea in our particular community what the overdose death rates are and what the numbers say, then it's time to take action to try to reduce it, it seems to me. And what policy or protocol changes are you aware of that could help reduce overdose deaths or change the response protocols? And what can our listeners do to help with that?

Alex Walley: A lot of our listeners are addiction medicine providers like me, and so they're focused on treatment, I think. The good news with opioids is we have treatments that really work. We have FDA-approved medications, and we're seeing more formulations and delivery systems for those medications, which is increasing the choices that providers and patients have to provide really lifesaving medication for opioid use disorder. That's really good news. I still think, as a field, we have a legacy that's stuck in the past. It's changing, but I would like it to change more quickly, which boils down to the old way of thinking, which is that we really expect our patients to work hard for the treatment.

And I would like to turn that around when it comes to our treatments, where we do a better job of making the treatment work hard for the patients. So, the disease part of addiction is really the compulsive use, despite negative consequences. In order to make treatment compete with that, we really need to sweeten the side of treatment, and that means to me, really lower the barrier to treatment.

The irony, though, is that if I want to have a very successful treatment program where I have, you know, the highest retention, one of the easiest ways to do it is to make the barriers to treatment really high. So, I only let the most motivated people in, the people who really want it, right? If I only let the people who really want it in their success rate is going to be much higher than if I really focus on all the people who really need it or who really deserve it.

Or whose lives could be saved by it. That's a much broader group of people. Their motivation, their willingness to work hard for the treatment is not as great as that high barrier, more select group. I think we have fantastic tools for treatment for opioid use disorder, and some of this has happened in my world.

Right now, I'm working on our addiction consult service, where we are in a general hospital. We have our consult services focused on treating people's withdrawal in the hospital and making effective linkages to outpatient treatment when they leave. This is not an approach that was readily accessible in our area, and I think many places in the United States, people were expected to get through their hospitalization and then go find their treatment themselves.

We didn't leverage the fact that somebody was in the hospital for a complication for a substance use disorder to really start their addiction treatment in the hospital. They had to go and seek care at either an outpatient or residential facility. So, that's kind of what I mean.

Another example are like low-barrier bridge clinics where people can come in and get started on treatment the same day.

They don't have to go through a long intake process. I think there's a lot of promise with combining contingency management, which has been shown to be effective over and over and over again. Positive incentives for people initiating and staying retained in care. Other examples are like integrating housing programs with treatment, or educational programs or job programs with treatment.

So that's what I mean, making the treatment really work for the patient rather than focusing on the patient having to work for the treatment.

Stephen Taylor: I think that is excellent. That's incredibly valuable information, and it's the kind of approach that we, meaning all of us who are addiction specialists, which includes, as you point out, a majority of our listeners, need to be thinking about as we try to take care of folks with SUD and with OUD in particular.

Let me ask you this. Obviously, with much of the work that you have done, you are focused on encouraging new leaders in the field of addiction medicine, who will be the vanguard of making the kinds of changes in our field that you just alluded to, that we all need to be making.

Can you highlight the need to train the next generation of leaders and talk a little bit about your work in that regard, if you would please.

Alex Walley: Well, thanks for asking that. I'm a proud longtime, I think maybe 20-year ASAM member, and I've really had a lot of important inspiring relationships that have happened through ASAM.

And through that 20 years, I've had the opportunity to train people who want to come into this field. And for me personally, that's the most rewarding part of the work I get to do. It also sustains me. We see a lot of recovery. We see a lot of positive outcomes in this field, but it comes with a lot of trauma.

It comes with a lot of losses, and we're talking about overdose today, and there's no greater loss than an overdose death in our field. And so those things for me, they accumulate. And so, I need a way to figure out how to sustain and keep myself going. And one of the ways is really focusing on the next generation.

It just is so inspiring that people want to come into our field at this time. I do think it's an exciting time where you could really make a difference. There's increasing recognition of the field. For me, I'm the president of the American College of Academic Addiction Medicine, which is a collaborative organization with ASAM that's really focused on supporting addiction medicine fellowships and getting the next generation of folks trained to be excellent in the delivery of their care, to become researchers, to become teachers, and to become advocates for addiction medicine and the future.

I'm really glad that even in these somewhat uncertain times that many of us are facing, there are more and more people coming into our field, younger people coming into our field, and they're bringing energy and innovation with it. That really makes it exciting and makes me feel quite rewarded and enthusiastic in the future, despite the ongoing challenges that we face.

Stephen Taylor: I could not agree more. And of course we didn't mention it earlier, but I wanted to give you that opportunity to mention it now, that basically we're having a president's conversation here. You as the president of ACAM, the American College of Academic Addiction Medicine, and me as the president of ASAM, the American Society of Addiction Medicine.

That is a collaboration that is incredibly valuable, incredibly important, and will continue on into the future because of the extremely important work we have to do, which is highlighted just by this one issue among many others, the issue of overdoses and reversing overdoses. I've got to ask you, before we go, is there anything else that you would like to share with our listeners about navigating the overdose crisis?

Alex Walley: I will say stay humble. We see some bright spots with the reduction in overdose deaths, but substance use in our culture really moves in cycles, and there

are new things on the horizon that we don't know about yet. Stay humble and innovate would be the two things I guess I'd leave people with because when the unexpected arrives, we need to use our best tools to adapt and respond. That's one of the things that makes our field challenging, but also exciting, inspiring, and fulfilling.

Stephen Taylor: Again, I could not agree more. Thank you so much for that incredible pearl, as well as all of the other great information that you shared with us. Dr. Alexander Walley, president of the American College of Academic Addiction Medicine, Addiction Medicine Specialist, an expert on overdoses and overdose reversal and overdose prevention. It has been a great pleasure and honor to have you here on ASAM Practice Pearls. Thank you so much.

This concludes season one of ASAM Practice Pearls. We'd love to hear from you, our audience, and we'd like to know what other topics that you're interested in hearing more about in season two.

Please take our survey, which can be found in today's show notes, or email us at education@asam.org.

Thanks for listening to ASAM Practice Pearls and thank you for joining us and for all of the great work you do. We will see you next year for season two of ASAM Practice Pearls.