Leadership Corner
A Conversation with Catherine Ahern: Community First Responder Program

Catherine "Katie" Ahern received her MSW in 2019, concentrating in macro social work and mental health, and earning a certificate in neuroscience and social work. Since then, she has been working in overdose prevention with experience in both state agencies and community-based programs, with roles involving research, program management and training & technical assistance. While set in a local New England needle exchange, she provided direct service, including drug checking services, HIV/STI testing and care connection, street outreach, health and safety provisions for sex workers, and personally responded to many overdose emergencies. Catherine is interested in applying data to action to guide naloxone distribution strategy, innovations in overdose prevention, and policy development. Outside of work, she can be found rock climbing or racing on Rhode Island's women's+ dragon boat team. We connected with Katie to explore how primary care providers can strengthen their role in overdose prevention — from getting naloxone into the hands of community members, to navigating stigma, to staying ahead of a rapidly changing drug supply.

Q **Since the majority of overdose deaths in RI are occurring in private residences, what are some ways that primary care providers can help get naloxone to people who may be in a position to respond to an overdose?**

A Families, friends and community members are our best resource in saving lives. Providers can screen not only for someone's personal substance use, but their proximity to substance use by asking "Are you the caregiver to someone who uses substances?" "Do you live with someone who uses substances?" To get naloxone into housing environments, where most fatal overdoses occur, we need to equip people in the home with the resources they need to keep their loved ones safe. For someone worried about a loved one's substance use, having this life-saving medication can also be an empowering tool in what can feel like a powerless situation.

Q **What barriers do people face related to accessing treatment for opioid use disorder that can be bridged by primary care providers and what role does stigma play?**

A We are still in the process of untethering ourselves from systems which severely punished substance use, the ramifications of which bleed into things like insurance coverage, treatment availability, and policies around involuntary treatment or incarceration. This institutionalized stigma is exacerbated when it intersects with other systems of oppression. For example, a pregnant person seeking substance use treatment may not only face increased interpersonal stigma, but face more punishing policies, making it a risk to seek help. Dismantling one's own unconscious biases helps improve individual patient outcomes, but reforming institutional and statewide policies will break down barriers for all. Find your spaces of influence to lend your voice and perspective!

Q **What novel substances in the unregulated drug supply might increase overdose risk and complicate the course of opioid withdrawal?**

A Most recently, medetomidine has been increasingly detected by drug checking programs in opioid samples in New England. While not an opioid itself, this sedative interacts with opioids to increase risk of overdose and has its own withdrawal symptoms, such as tachycardia, which may require ICU intervention. Individuals entering treatment may not be aware that they had been taking medetomidine and will be detoxing from that in addition to opioids. Access to drug checking services allows users to make informed decisions about what and how they use and may ultimately aid in looking out for risky withdrawal symptoms for those who stop or reduce their use. Treatment is already a psychologically and physically taxing process, accompanying people on this journey with compassion and grace in the time of an unregulated drug supply is the best support we can offer.