
NALOXONE AND OVERDOSE PREVENTION FOR LAW ENFORCEMENT

TOOLKIT

developed by:
RI DMAT/MRC
Naloxone and Overdose Prevention
Education Program of Rhode Island



in collaboration with :
Drug Overdose Prevention and Rescue Coalition
First Responders Workgroup

nopeRI.org
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The training curriculum was developed and implemented by NOPE-RI with assistance and guidance from the Training, Curricula, and Protocols Subcommittee of the Rhode Island Drug Overdose Prevention and Rescue Coalition.

The RI Medical Reserve Corps (RI MRC) identifies, trains, and organizes local healthcare volunteers able to assist in both large-scale state emergencies and/or smaller community based public health initiatives as an integral part of preparedness and response activities within the state of Rhode Island. Sponsored by the RI Disaster Medical Assistance Team (RI DMAT), the 501(c)3 organization strives to provide support to public health initiatives across the state in order to improve the health and wellness of Rhode Island, ultimately reducing the vulnerability of the population to disaster risk and improving response efforts.

NOPE-RI is a program of RI DMAT/MRC whose mission is to leverage that volunteer base to provide overdose prevention, recognition, and response training, specifically targeted towards law enforcement and public safety professionals and the medical community. In addition to in-person education, NOPE-RI serves as a clearinghouse for naloxone and overdose prevention training resources in the state, as well as supporting efforts to expand access to naloxone.

The Drug Overdose Prevention and Rescue Coalition is an integral part of the RI Department of HEALTH's Violence and Injury Prevention Program. This group of over 100 statewide stakeholders, including state police, local police, behavioral health and medical providers, Emergency Medical Services (EMS), and the recovery and treatment community. Four workgroups meet regularly to implement state strategic plan recommendations and identify opportunities for collaboration. The First Responder Workgroup focuses on the needs and opportunities within the law enforcement and public safety professions.

OVERVIEW

BACKGROUND

Drug overdose is the leading cause of accidental death for adults in Rhode Island, claiming multiple lives each week. Opioid overdose, involving both prescription pain medications and illicit drugs, is an issue that impacts all RI residents, regardless of socio-economic status, race, age or gender. Most overdose fatalities are preventable if bystanders and first responders have appropriate training and are prepared to respond in an effective manner.

This curriculum is designed to prepare law enforcement and other non-medical public safety professionals to recognize and respond to an overdose. This training also provides education that will assist agencies in implementing simple, cost-effective, evidence-based strategies to combat the epidemic of opioid abuse and overdose.

OUTLINE

1. Opioids and Overdose in RI (5 minutes)
 2. Addiction, Overdose, and Risk Factors (10 minutes)
 3. Overdose Recognition and Response (5 minutes)
 4. Law Enforcement Concerns (10 minutes)
 5. Hands-on Practice (15 minutes)
- 60 minutes total - 15 minutes are reserved for pre-test and post-test evaluations.

OBJECTIVES

At the end of this presentation, participants will be able to:

1. Identify risk factors for overdose
2. Recognize and respond effectively to an overdose
3. Give rescue breathing, through pocket mask, to an individual who is unconscious and not breathing effectively.
4. Administer intranasal (IN) naloxone to an individual thought to be experiencing an overdose.
5. Understand how the Good Samaritan Overdose Prevention Act (RIGL 21-28.8) applies to law enforcement, lay responders, and the individual experiencing an overdose.

TEACHING METHODS AND MATERIALS:

- Lecture
 - powerpoint presentation (see Appendix)
 - handouts (see Appendix B)
- Demonstration
 - intranasal naloxone (refilled with water/saline)
 - MAD nasal atomizer
 - CPR manikin
- Hands-on practice
 - intranasal naloxone (refilled with water/saline) and MAD nasal atomizer (approximately one set per 5 participants)
 - CPR manikin and mask (approximately one per 10 participants)
- Evaluation
 - Pre-test and post-test (see Appendix C)

SECTION 1: OPIOIDS AND OVERDOSE IN RHODE ISLAND

Objective

- Understand the scope and demographics of the opioid abuse and overdose epidemic nationally and in Rhode Island.

Time

5-10 minutes

Presentation

SLIDE 1 - INTRODUCTION

- Presenter introduces self, background, affiliations, and disclosures (if any).
- NOPE-RI is a program of RI DMAT/MRC. RI DMAT/MRC has been working in disaster preparedness and response and public health emergency response since 1990 (e.g. hurricanes and H1N1). NOPE is the first large-scale expansion into the chronic public health arena, with a focus on public safety and healthcare efforts surrounding the issues of opioid abuse, addiction and overdose. NOPE also serves as a resource for continuing education and program development.

SLIDE 3 - OPIOIDS AND OVERDOSE IN RI

- Opioid misuse and overdose are large problems, both in RI and nationally.
- The CDC has declared this to be an epidemic and the State of Massachusetts has declared a state of emergency around this issue.
- In RI and about half of the other states, overdose has replaced motor vehicle accidents as the leading cause of accidental death.

SLIDE 4 - CHART

- The rise in opioid overdose deaths correlates with the rising rate of prescription opioid sales as well as increasing admissions to treatment programs.

SLIDE 5 - MAP

- RI is in the lowest quarter of the states in terms of per-capita prescription opioid sales, but in the highest quarter for opioid overdose deaths.
 - Looking at the number of deaths per gram of prescribed opioids, RI is number two in the nation (behind New Mexico).
-

SLIDE 6 - OPIOIDS AND OVERDOSE IN RI

- Of concern is not only prescription opioids (like Vicodin, oxycodone, etc) but illicit opioids like heroin.
- Last year, RI saw about four fatal overdoses each week, whereas this year there have been an average of one a day. There were nearly 80 overdose deaths in the first quarter of this year, 60% of which have involved fentanyl. (update statistics as available)

SLIDE 7 - CHART

- Prescription opioid overdose deaths, while they make up a significant portion of the state's overdose deaths, have remained relatively stable over the past five years.
- The increase is in illicit opioid overdose deaths, which have doubled in this time period.
- The number of deaths in 2013 is unofficial and includes only confirmed overdoses. There are still some cases under investigation and we will have an official number and a breakdown when they are finished.
- The estimated 2013 number will only go up. and we are on track to double it this year.

SLIDE 8 - OPIOIDS AND OVERDOSE IN RI

- When many people think of opioid use, or drug use in general, they think of younger people.
- People who are dying of overdose at the highest rate are middle aged adults, between 40 and 60 years old.

SLIDE 9 - CHART

- About 2/3 of these deaths are men and 1/3 are women, however the rate of female opioid overdose deaths is one of the fastest growing statistics.

Activity (optional)

- If time/setting allows, ask participants to briefly describe their (professional) experience with drug abuse and/or overdose.
-

SECTION 2: ADDICTION, OVERDOSE, AND RISK FACTORS

Objectives

- Understand the etiology, pathophysiology, and social factors of opioid addiction and overdose.
- Identify risk factors for overdose.

Time

10 minutes

Presentation

SLIDE 11 - ADDICTION

- Opioid addiction, and any addiction, is a chronic, relapsing disease.
- There are physical changes to the brain and changes to the chemistry of the brain that change how people act, how they perceive things and how they respond to situations.
- The susceptibility to addiction has a very strong genetic component and when that is combined with an exposure to opioids (or other substances), there is a very high risk of developing an addiction.
- There is a misconception in the healthcare community, in the drug-user community, in public safety and in the public at large that once someone has gone through withdrawal and all of the substance is out of their body that they are cured of their addiction.
- However, because of the permanent changes to the brain and how it works, they still have that addiction even though they don't have any of the substance in their body.
 - Compare to other chronic diseases (heart disease, diabetes, etc) - a person with these conditions can keep them under control with the right medical care and lifestyle changes, but they are always there and can cause problems.

SLIDE 12 - HARM REDUCTION

- Our program falls under the harm reduction umbrella.
- This means is that we would like for no one to start misusing or abusing opioids and we would love to get everyone who is addicted into treatment and into recovery.
- However, we know that this isn't a realistic goal today and it isn't a realistic goal for 100% of the people long term.
- What harm reduction programs, including ours, do is ask How can we save people's lives? How can we improve their health? How can we improve their safety...while they continue to use and we encourage them to seek treatment.
- Many people's first reaction to these programs, healthcare providers and public safety professionals included, is that if naloxone is out in the community then it is endorsing drug use or that it will be seen as a safety net so that people can engage in risky drug use.

- While this is an understandable gut reaction, when we look at the programs that already exist in other areas, what we have found is that in NO case did increased access to naloxone lead to increased drug use.
- It did decrease the rate of opioid deaths, and in many areas decreased the overall drug usage and crime. It also was seen to increase the enrollment in opioid treatment programs.
- I'm allergic to bees. I have an epi-pen and I know that if I get stung, it will most likely save my life. But that doesn't encourage me to go out and start poking bee hives with a stick.
 - Alternative metaphor: Having a fire extinguisher in the house does not inspire people to try to burn them down.
- We will talk later about how naloxone works and how it's not a pleasant experience for the person who receives it. At the very least, it ruins their high, so they're not going to be looking to use this as a safety net.

SLIDE 13 - TOLERANCE

- Opioids bind to opioid receptors which are found throughout the body. The ones we are particularly worried about are in the brain. This is what causes their effects.
- When anyone, for any reason, is exposed to opioids for a period of time, their receptors become desensitized and it will now take MORE drug to cause the same effect.
- This is tolerance.
- On the flip side, when the drug is removed from someone's system for a period of time, those receptors come back to near-normal.
- Now, if they take the same amount that they did when their tolerance was high, it will have a much stronger effect, up to and including fatal overdose.

SLIDE 14 - TOLERANCE

- When we talk about people developing tolerance, we are talking about needing more drug to experience the "positive" effects of the drug, like pain relief, or euphoria.
- The way that opioids cause death is that they suppress a person's drive to breathe. They decrease the respiratory rate and therefore decrease the amount of oxygen that is getting to the body and the brain.
- No one can develop a tolerance to a lack of oxygen to the brain.

SLIDE 14 - FLOW CHART

- Often, a person starts off with a legitimate prescription for an opioid.
 - (Whether or not that prescription was truly needed for the person's illness or injury is another issue and one that we are addressing with medical providers.)
- Opioids are extremely addictive, and they developed a physiologic dependence on the drug. What this means, is if they stop taking the drug, they will experience symptoms of withdrawal.
- We have been relatively successful at getting medical providers to recognize when patients are becoming dependent on opioids or not using the drugs as prescribed and to stop prescribing to them.

- This sometimes has the unintended effect of causing people to seek other sources for those drugs, either from friends and family members or from strangers.
- This “non-medical use” often escalates to a true addiction, where the individual continues to use and seek out the drug, despite the negative consequences.
- Buying opioid pills on the street is expensive and buying heroin is relatively cheap.
- As their tolerance increases and they are using more and more of the drug, people switch over to heroin because they can get that same effect with less drug and for less money.
- Most people start off snorting heroin, but as their tolerance continues to increase and the cost of their use goes up, whoever they are getting their drugs from will suggest that they can get the same effect with less drug if they inject it.
- From there, they continue in the downward spiral of increased use and increased cost.
- This is the pathway we see in 80% of new heroin users. This is a completely different population than we were dealing with five or ten years ago.
- If you asked these people five years before, “would you ever consider injecting heroin?” they would say “no, I’m a teacher, I’m a doctor, I’m a college student”.
- This is a very different population than we were dealing with previously and not your stereotypical “junkie”.
- I’m sure that some of you in this room have friends or family members who are affected by this.

SLIDE 16 - CHART

- A very small percentage (orange) are getting their drugs from a dealer or other stranger.
- Most people (all blue) are getting them in some way from friends or family members, often for free.
- When we ask people why they are sharing their medications with others, they are almost never trying to get the person addicted or cause them any harm. Most people see it as helping them out and saving them a trip to the doctor and do not understand the unintended consequences.
- Again, we are working with medical providers and the community to communicate the message to properly dispose of un-used medications and about the dangers of sharing medications, particularly opioids.

SLIDE 17 - OVERDOSE

- An overdose, simply, is when there is too much drug in the body for it to continue functioning normally.
- In the case of opioids, there is a decrease in the respiratory rate which causes a lack of oxygen to the brain, and will cause death if there is no intervention.

SLIDE 18 - OVERDOSE RISK FACTORS

- The people who are most at risk for overdose are people who have a decreased tolerance due to a period of non-use.
 - Individuals leaving incarceration often return to the same social environment where they had been and resume their drug use.
 - If they use the same dose they were using before they were in prison, it is likely they will overdose and die.
 - People who are leaving detox or rehab facilities have that same risk if they relapse.
-

- Using opioids by ones self does not necessarily increase the risk of an overdose, but it does increase the risk of a fatal overdose since there is no one to provide any sort of intervention.
 - Mixing opioids with other opioids, with alcohol, with benzos, with certain prescription medication increases the risk of overdose. This also includes people taking a drug which is not what they think they are taking, whether it is mixed with fentanyl or contaminated in some other way.
 - Anyone with any sort of chronic or acute illness is at higher risk, specifically individuals with liver or respiratory disease.
 - Most opioids are excreted from the body through the liver, so if that process isn't working, they are going to accumulate in the body.
 - With respiratory conditions, if you have COPD, if you have sleep apnea, if you have asthma, if you have pneumonia, you're already a step or two down the road to respiratory failure, so it won't take as much of a drug effect to get all the way there.
-

SECTION 3: OVERDOSE RECOGNITION AND RESPONSE

Objectives

- Recognize and respond effectively to an overdose.
- Give rescue breathing, through a pocket mask, to an individual who is unconscious and not breathing effectively.
- Administer intranasal (IN) naloxone to an individual thought to be experiencing an overdose.

Time

5 minutes

Presentation

SLIDE 19 - OVERDOSE RECOGNITION

- The stereotypical scenario of someone dying with a needle in their arm does happen, but it is not the norm.
- Most overdoses are a process that occurs over 1-2 hours and there is a progression of decreasing breathing and decreasing consciousness which will end in the person's death if no intervention is made.
- The symptoms that are associated with an opioid overdose are exactly what you would expect for someone who isn't getting enough oxygen – slow or no breathing, can't be woken up, lips/fingernails are turning blue or grey, you might hear gurgling or snoring noises as they attempt to breathe.
- A note about small children (under 8yo) who get into a parent or caregiver's drugs...small children tend to compensate and compensate and then crash, so it is difficult to determine if they are fine because they didn't actually take anything or they are just compensating and are about to crash.
- Any child who is suspected of being exposed to opioids or other drugs should get evaluated and observed in the ED. This way if they DID take something, they will be in an environment with advanced medical care if they need it.

SLIDE 20 - NALOXONE (NARCAN)

- Naloxone, or Narcan, very simply reverses the effects of opioids. It only works on opioids and does not have any effect on alcohol, benzos, cocaine, or other drugs.
- If you give naloxone to someone with opioids in their system, it is going to reverse their effects. If it is given to someone with no opioids in their system, it is not going to have any effect.
- There are two forms of naloxone out in the community. The first is the injectable form which comes in a vial with a syringe. You draw up the whole vial (1cc) and inject it into a large muscle like the upper arm or thigh. This is what a lot of people have in the community because it is less expensive than the intranasal that you will have.
 - (Show 1mL naloxone vial if you have one.)
- Naloxone starts working in 3-5 minutes and lasts 30-90 minutes.
- Most kits we are distributing to the public have two doses.

- Some law enforcement agencies are only carrying one dose per kit due to short EMS response times.
- There are two scenarios where you would need a second dose. The first is in the rare instance where one dose is not enough. If you give one dose, wait five minutes, and haven't seen any effect, go ahead and give a second dose.
 - This is more likely in small children, because of the mismatch between drug dose and body weight, or with synthetic opioids like suboxone or street-fentanyl.
- The second instance is when someone didn't take our good advice to call 911, and it is now 30-90 minutes later and the naloxone is wearing off. Another dose can be given to buy another 30-90 minutes and hopefully get the person to the ED.

SLIDE 21 - NALOXONE

- The naloxone works by pushing the opioid off the receptors.
- It then binds to the receptor and prevents anything else binding to them.
- It doesn't remove the opioids from the system or neutralize them in any way, so they are still floating around in the bloodstream, waiting for the naloxone to wear off and cause a "re-overdose"
- When you give naloxone and remove all the opioids from the receptors, the person is going to feel like they are going into withdrawal (because they are) and you are going to see the symptoms associated with withdrawal. They may be in pain, pissed off, vomiting, sweating...
 - The dose that is given on rescue or in the ED is much higher than what is being given by lay or non-medical responders.
 - In hospitals/ambulances it is usually given IV so it takes effect more rapidly than when given IN (or IM).
 - With both of these factors, it is possible to see a person become violent or combative.
 - The dose you will be giving is a starter dose and it is absorbed through the nose much more slowly, causing a gentler withdrawal – you aren't going to see those combative reactions, they will just be a bit pissed off and in pain.
 - The city of Boston PD started using this exact same kind of nasal naloxone a few years ago. They looked at the first 500 administrations of it and they didn't have a single violent reaction.
- Because people will be in withdrawal after receiving naloxone, they may want to use again to relieve some of these symptoms. It is very important that they don't do this, as the original drugs that caused the overdose are still in their system and if they take more, they will only have a **STRONGER** overdose when the naloxone wears off.

SLIDE 22 - CHART

- The drugs that the person took are going to hang around in the bloodstream a lot longer than the naloxone is so it is important to get them to the ED in that window.

SLIDE 23 - NALOXONE

- Demonstrate how to assemble and administer naloxone and atomizer.
-

SLIDE 24 - OVERDOSE RESPONSE - LAW ENFORCEMENT

- If you believe that the person may be overdosing, make sure EMS is on its way.
 - This should happen for anyone who is unconscious or not breathing, regardless of the cause.
- Perform rescue breathing. (This will be demonstrated on slide 26.)
- If you have any reason to believe that opioids might be involved, give one dose of naloxone.
- Continue to rescue breathe until the person is breathing effectively on their own or EMS takes over.
 - A rule of thumb for determining adequate respirations (in adults) for non-medical personnel: Breathe every time your patient breathes. If you aren't comfortable, they aren't comfortable.
- If you have to leave the person for any reason, roll them on their side into the recovery position so that if they vomit, they will not breathe it in.

SLIDE 25 - OVERDOSE RESPONSE - LAW ENFORCEMENT

- The lay-responder response is almost identical.
- The main difference is that we highly stress the importance of calling 911 first.
- People are hesitant to call 911 if there is any illicit activity. (Discussed further on slide 35.)
- For this reason, we try to remove as many barriers as possible. We tell people that they don't have to mention drugs or overdose if they don't feel comfortable. All they need to say to trigger an appropriate EMS response is "someone isn't breathing".
- They also need to give an accurate description of their location.

SLIDE 26 - RESCUE BREATHING

- Demonstrate how to do rescue breathing using whatever barrier device/mask is used by the agency.
 - The most recent AHA guidelines for CPR state that compressions-only CPR is effective for adults who have a cardiac arrest.
 - Those same guidelines also state that rescue breathing is still necessary for people who have a primary respiratory problem (versus primary cardiac problem). The four main groups for whom this is likely the case are children, drowning, carbon monoxide poisoning, and drug overdose.
 - Most of the people we are dealing with are not breathing effectively, but their hearts are still beating. Therefore only rescue breathing is necessary.
-

SECTION 4: LAW ENFORCEMENT AND PUBLIC SAFETY CONCERNS

Objective

- Understand the goals of community naloxone distribution.
- Describe how the Good Samaritan Overdose Prevention Act (RIGL 21-28.8) applies to law enforcement, lay responders, and the individual experiencing an overdose.

Time

10 minutes

Presentation

SLIDE 28 - WHY WORRY ABOUT ADDICTION AND OVERDOSE?

- Overdose is a huge problem in RI and across the country. The largest economic cost is in lost productivity for people who aren't working because they are in rehab or in prison or because they died.
- A slightly smaller portion is healthcare costs associated with addiction and overdose. It takes \$14,000 more than average to care for someone with an active addiction each year.
- In RI, we spent \$31 million on overdose-related healthcare costs alone.
- The smallest portion of comes from law enforcement and corrections costs.
- Programs that distribute naloxone to law enforcement and to the general public have been implemented in other areas with great success.
- We know that people with basic training can recognize an overdose, give naloxone and save a life.
- This is a fairly new type of program, but it has been around just long enough to see the effects.
- In no cases has it increased the amount of drug use, and in most cases it has actually decreased drug use.
- In many cases there has been an increase in access to treatment due in part to the interventions surrounding these programs.

SLIDE 29 - CHART

- The (insert current number) overdose deaths we have seen this year aren't the whole picture.
- For each overdose death there are:
 - 10 people who are admitted to treatment for their addiction,
 - 32 people who receive emergency care for either a non-fatal overdose or other addiction-related issue,
 - 130 people who are truly addicted or dependent on opioids, and
 - 825 people who are using "non-medically". This means that they are using someone else's medications to self-treat a condition, or taking more than they are prescribed.
- If we look at the number of deaths we have had so far, extend it out over the whole year, and multiply it by 825, we are looking at about a quarter of the population of RI that is at risk of addiction or overdose.

SLIDE 30 - NALOXONE IN THE COMMUNITY

- These programs have been in existence for several years and have been very effective.
- Naloxone is an extremely safe drug. It has no serious side effects and it does not cause harm if administered to someone who doesn't need it.
- We have seen that people are able to identify an overdose and willing to administer naloxone
- Where these programs have been implemented, we have seen the rate of fatal overdose go down, we've seen the rate of drug use and drug-related crime go down, and we've seen the access to treatment increase.

SLIDE 31 - LAW ENFORCEMENT AND PUBLIC SAFETY RESPONSE

- Law enforcement is an important point of contact since most people who have an addiction will interact with the legal system at some point.
- This sort of intervention gives officers a different way of interacting with people.
- Quincy, MA was one of the first cities to implement a naloxone program and their Lieutenant says:
 - "The perception of the police in the city of Quincy has dramatically changed...people are now looking at us being able to assist them as opposed to only enforcers of the law."

SLIDE 32 - LIABILITY

- Most of you are not medical professionals and we aren't asking you to be medical professionals.
- Even in the medical field, with advanced diagnostics, it is difficult to tell the difference between someone who is overdosing and someone who has another medical problem, or to tell the difference between someone who is overdosing on opioids and someone who is overdosing on something else.
- All we are asking you to do is recognize that someone isn't conscious and isn't breathing. If you have any reason to believe that opioids might be involved, give naloxone.
- It will either help, or it won't hurt.
- You will be turning these people over to EMS, who will be turning them over to the hospital and everything will get sorted out in the end.

SLIDE 33 - LOGISTICAL CONCERNS

- The naloxone kits need to be stored out of direct light. The box it comes in takes care of that issue.
 - It also needs to be stored around room temperature. It shouldn't be stored in a car trunk or glove box where it will experience extreme hot or extreme cold temperatures.
 - Ideally, it should be carried on your person.
 - If naloxone is stored improperly, it causes the drug to become less effective or not effective at all. It will not cause any harm if it is administered.
 - If you are on the scene of an overdose and the only naloxone you have has been stored improperly (or is expired), go ahead and give it. It will either help, or it won't hurt.
-

SLIDE 34 - GOOD SAMARITAN OVERDOSE PREVENTION ACT

- There are two parts of the Good Samaritan Law.
- The first part states that anyone who administers naloxone to another person, regardless of who the prescription is for or who the naloxone was issued to, is granted immunity from criminal and civil liability for that act, as long as it was given “in good faith” (i.e. you thought the person was overdosing) and “with reasonable care” (i.e. in a manner that is consistent with what we are teaching you today).
- The second part states that anyone who provides assistance at the scene of an overdose, calling 911, rescue breathing, giving naloxone, etc, AND the person who they are caring for, can’t be prosecuted for drug possession.
- They can still be prosecuted for drug distribution or manufacture, and there is nothing in this law that prevents the seizing of any drugs or paraphernalia you find on scene.

SLIDE 35 - CALLING 911

- One of the biggest issues with the community implementation of naloxone programs is people’s hesitancy to call 911.
- Naloxone only works for 30-90 minutes, so it is imperative that the person gets to some sort of definitive medical care in that time period. The best way to do this is to call 911 and get EMS involved.
- People are scared to call 911 because they fear law enforcement involvement.
- The Good Samaritan Law is helping with this, but the only way to combat this perception issue is for people to have positive experiences with law enforcement on overdose scenes. It should be reinforced that they are there first to save a life.

SLIDE 36 - LAW ENFORCEMENT AND PUBLIC SAFETY RESPONSE

- Addiction and overdose are huge problems that affect law enforcement, the medical community, and the community at large.
- Law enforcement naloxone programs in other states have gone a long way towards helping this issue and we hope that we can do the same in Rhode Island.

SLIDE 37 - QUESTIONS?

- (Answer any questions that may arise. Defer questions that are better answered during hands-on session.)

SLIDE 38 - GOOD SAMARITAN OVERDOSE PREVENTION ACT

- (Full text of act, if needed for reference.)
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SECTION 5: HANDS-ON TRAINING

Objectives

- Demonstrate proficiency in rescue breathing.
- Demonstrate proficiency in intranasal (IN) naloxone (Narcan) administration.

Time

15 minutes

Activity

- Assign one instructor to each station.
 - Intranasal (IN) naloxone (required)
 - Intramuscular (IM) naloxone (optional)
 - Rescue breathing (required)
 - This station may be unstaffed IF all participants have been previously trained in CPR and there are not enough instructors.
- Split up participants into two or three groups, depending on number of stations.
- Have participants rotate through stations, approximately every five minutes

INTRANASAL STATION

- Demonstrate the preparation of intranasal naloxone.
- Clearly indicate the correct location and assembly (large end, screw on) of glass vial.
- Tell participants that half of the naloxone should be sprayed up each nostril, however if the amounts are inadvertently unequal, it is not a problem as long as the entire dose is delivered.
- The atomizer is preferred for nasal administration, however if is unavailable, the naloxone can just be squirted up the nose.
- Have all participants practice assembling.
- Refill syringes as necessary from a cup of water.

RESCUE BREATHING STATION

- Review and demonstrate both mouth-to-mask and mouth-to-mouth rescue breathing.
 - Have all participants practice, using the mask/barrier device they will be carrying in the field.
 - Clean manikin between each use.
-

SECTION 6: FREQUENTLY ASKED QUESTIONS

What are the side effects of naloxone?

Naloxone reverses opioid overdose and causes withdrawal. The most common symptoms of withdrawal are pain, nausea, vomiting, sweating, and anxiety. Less common are agitation, seizures, or irregular heartbeat. While opioid withdrawal can be dramatic and unpleasant, it is not life threatening.

Can people have violent reactions after naloxone administration?

It is possible an individual will become agitated and combative after going into withdrawal due to naloxone administration, however this is not likely with the relatively small dose used by lay-responders. Also, naloxone administered intranasally seems to provide a more gentle reversal with less acute withdrawal symptoms. The City of Boston did not report ANY violent reactions in over 500 administrations of nasal naloxone by non-medical personnel.

Will naloxone work on fentanyl, Suboxone, or other synthetic opioids?

Yes. Different drugs bind to opioid receptors with different strengths. Overdose on stronger-binding drugs will require more naloxone than others. Naloxone IS effective and should be given up to a dose that is effective. If you have 4mg, give 4mg - that's 4mg less than will have to be given by rescue/ED.

Does naloxone work on cocaine, methamphetamine, benzodiazepines, or alcohol?

No. Naloxone only works on opioids (heroin, morphine, fentanyl, methadone, etc). It will not have any effect on someone overdosing on another type of drug. However, if someone is overdosing on opioids AND another drug, naloxone will reverse the opioid part of the overdose and potentially help the person.

What if naloxone is given to someone who doesn't have any opioids in their system?

There are no adverse effects if someone is given naloxone who doesn't need it. If someone looks like they may be overdosing on opioids (unconscious, slow or no breathing), they should be given naloxone. If opioids are present, it will help, if they aren't, it won't hurt.

If someone has received naloxone for an overdose in the past, will it be effective if they overdose again?

Yes. The effects of naloxone only last 30-90 minutes and it is completely excreted from the body in 24-72 hours. There is no tolerance to naloxone, therefore the same dose will be equally as effective if given for another overdose.

Shouldn't drugs only be administered by EMS?

Many drugs have complicated dosing or can cause adverse effects if given to the wrong person. Naloxone comes in single-dose containers and does not cause any problems if given to someone not experiencing an opioid overdose. When given to someone who needs it, in a timely manner, naloxone can save a life. For these reasons, public safety and lay-responders are ideally suited to carry and administer naloxone. Such programs have been instituted across the country and internationally and have shown that with a minimum amount of training, non-medical personnel can identify an overdose and administer naloxone effectively, leading to many lives saved.

What is the difference between giving naloxone IM (injection), IN (nasal spray), or IV (intravenously)?

All of these routes of administration are equally effective and can be administered interchangeably to anyone experiencing an overdose. There is a slightly longer time to onset with IN than IM (and longer than IV). Naloxone is not effective if taken orally. Giving naloxone IN does not involve an exposed needle and therefore can be safer for the person administering it.

How many doses are necessary?

For most individuals, one dose (2mg IN or 0.4mg IM) is enough to let the person start breathing again. Some people may need more than one dose depending on their tolerance, how much they took, and what opioid they overdosed on. Children and people who overdose on synthetic opioids (fentanyl, suboxone, etc) are likely to need multiple doses.

What about people with cardiac issues?

There are NO contraindications to naloxone in the case of overdose. There are more risks associated with overdose when someone has a chronic health condition, so it is even more important that they get medical attention than someone who is otherwise healthy.

What if someone is pregnant?

There are NO contraindications to naloxone in the case of overdose. Opioids easily cross the placenta and affect the fetus. The best way to get oxygen to the fetus is to get oxygen to the mother. When naloxone is given it can induce withdrawal in both the mother and the fetus, therefore they MUST be evaluated in an appropriate medical setting (i.e. a hospital with OB services).

Is rescue breathing 100% necessary?

People die from opioid overdose because of a lack of oxygen (hypoxia) caused by slow or absent breathing. The only way to prevent permanent damage and death is to get oxygen into the person. Naloxone helps do this by allowing them to breathe on their own, but it takes 3-5 minutes to work. Permanent brain damage can occur after as little as 4 minutes without oxygen. Rescue breathing can provide oxygen until the person can breathe on their own. Always use a mask or barrier device to avoid contact with body fluids.

What about “hands-only” CPR?

Giving only chest compressions (not breaths) has been shown to be effective for adults who have a primary cardiac event (like a heart attack) and whose heart is not pumping effectively. The American Heart Association still recommends giving rescue breaths for anyone who has a primarily respiratory problem such as the case with children, carbon-monoxide poisoning, drowning, and DRUG OVERDOSE. Additionally, in the case of an opioid overdose, the individual's heart is still beating, they just aren't breathing effectively.

Can I be sued for administering naloxone?

The Good Samaritan Overdose Prevention Act (RIGL 21-28.8-3) provides civil and criminal immunity to an individual when they administer naloxone to another person “in good faith” and “with reasonable care”. The specific protections for law enforcement are being clarified and will be reflected in departmental policies.

Will increased naloxone availability lead to increase drug use?

No. While this is a common fear, naloxone distribution programs that have been studied have shown a DECREASE in risky drug use and an INCREASE in access to drug treatment programs. They have also been effective in reducing the overdose death rates in communities where programs are implemented.

What is the shelf-life of naloxone?

When manufactured, naloxone has approximately a two-year shelf-life. Most of the naloxone that is being distributed has an expiration date 12-18 months in the future. Always check the expiration date on your naloxone (found on the end of the box and on the vial) and follow your department's procedure for exchanging expired or near-to-expiration medications. The atomizers also have an expiration date after which they are no longer considered sterile. This is usually in the 4-5 year range.

How should naloxone be stored? Can I leave it in my car?

Naloxone must be kept at room temperature (59-86°F or 15-30°C). It should never be stored in a refrigerator or a vehicle glove box or trunk. It must also be stored out of direct light. Effective methods include leaving it in its box or storing in a standard orange medication bottle. If the only naloxone that you have is expired or has been stored improperly, and no other naloxone is immediately available, it may be given to a person experiencing an overdose. It may not be as effective, but it will not cause harm.

SECTION 7: TRAIN-THE-TRAINER

BACKGROUND

Drug abuse and overdose is a wide-reaching public health problem that affects those who use drugs, their families and friends, health care providers, public safety professionals, and the community as a whole. When law enforcement is equipped with the knowledge and resources to intervene and assist in reversing an overdose and saving a life, it helps to foster trust and collaboration between public safety professionals and the community at large.

This curriculum is designed to prepare law enforcement and other non-medical public safety professionals to recognize and respond to an overdose, teach these skills to their public safety peers, and serve as resources within their departments.

OBJECTIVES

At the end of this presentation, participants will be able to:

1. Identify risk factors for overdose
2. Recognize and respond effectively to an overdose
3. Give rescue breathing, through pocket mask, to an individual who is unconscious and not breathing effectively.
4. Administer intranasal (IN) naloxone to an individual thought to be experiencing an overdose.
5. Understand how the Good Samaritan Overdose Prevention Act (RIGL 21-28.8) applies to law enforcement, lay responders, and the individual experiencing an overdose.
6. Understand the basics of opioid addiction treatment and recovery.
7. Convey these objectives effectively to law enforcement peers.
8. Identify resources that can provide additional information and training.

OUTLINE


- | | |
|--|--------------|
| 1. Introduction | (15 minutes) |
| 2. Opioids and Overdose in RI | (15 minutes) |
| 3. Addiction, Overdose, and Risk Factors | (30 minutes) |
| 4. Overdose Recognition and Response | (15 minutes) |
| 5. Law Enforcement Concerns | (15 minutes) |
| 6. Current RI State Efforts | (15 minutes) |
| 7. Hands-on Practice | (60 minutes) |
| 8. Opioid Addiction Treatment and Recovery | (60 minutes) |
- 240 minutes total - 15 minutes are reserved for pre-test and post-test evaluations.

TEACHING METHODS:

- Lecture, demonstration, hands-on practice, small group discussion, evaluation
- Presentation slides available at www.nopeRI.org/law.html


APPENDIX A: PRESENTATION SLIDES

Presentation Slides - available at www.nopeRI.org/law.html



NALOXONE AND OVERDOSE PREVENTION
EDUCATION PROGRAM OF RHODE ISLAND


Law Enforcement and Public Safety



RHODE ISLAND


Ariel Engelman
NOPE-RI Coordinator

1



Opioids and Overdose in Rhode Island

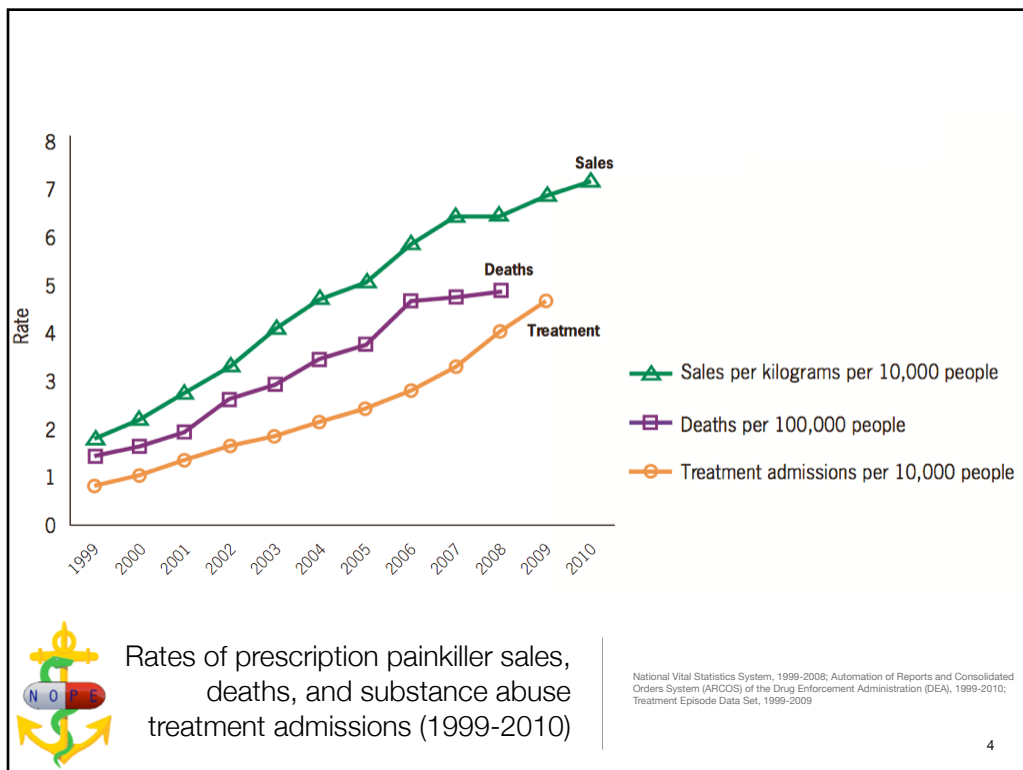
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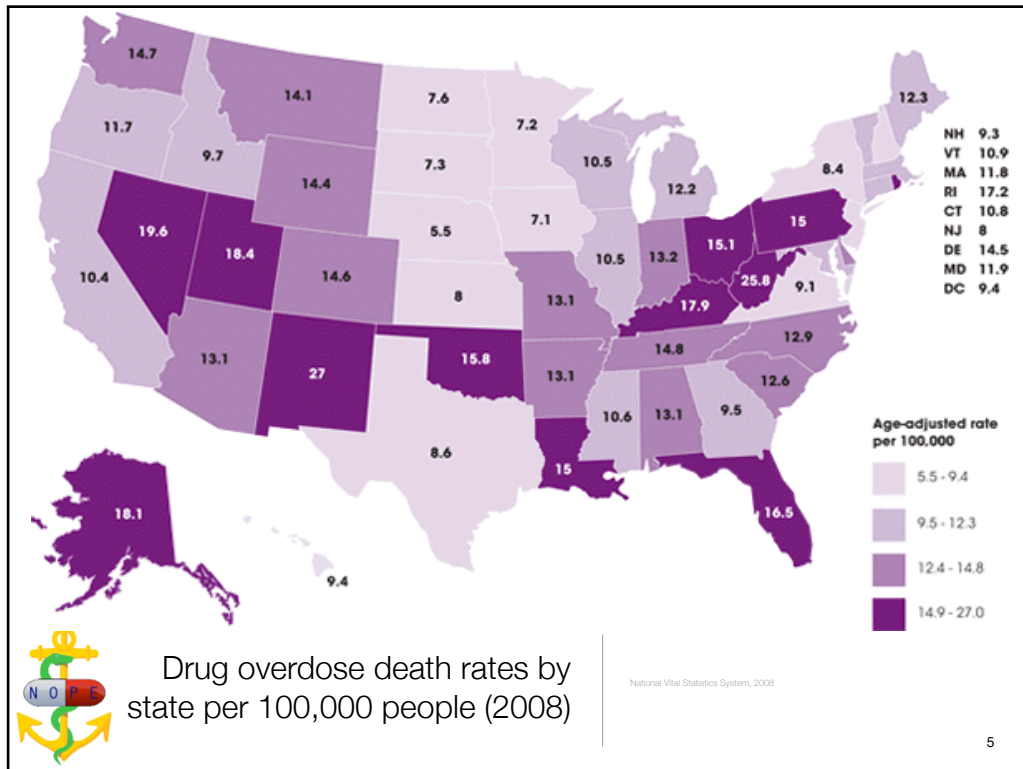


Opioids and Overdose in RI

- Over the past decade, opioid abuse has reached epidemic levels in Rhode Island and many other parts of the US.
- In RI and 28 other states plus Washington DC, drug overdose exceeds motor vehicle accidents as the leading cause of accidental death in adults.
- This rise in opioid abuse and fatal overdose correlates with increased rates of opioid prescriptions and a rise in addiction treatment admissions.

3

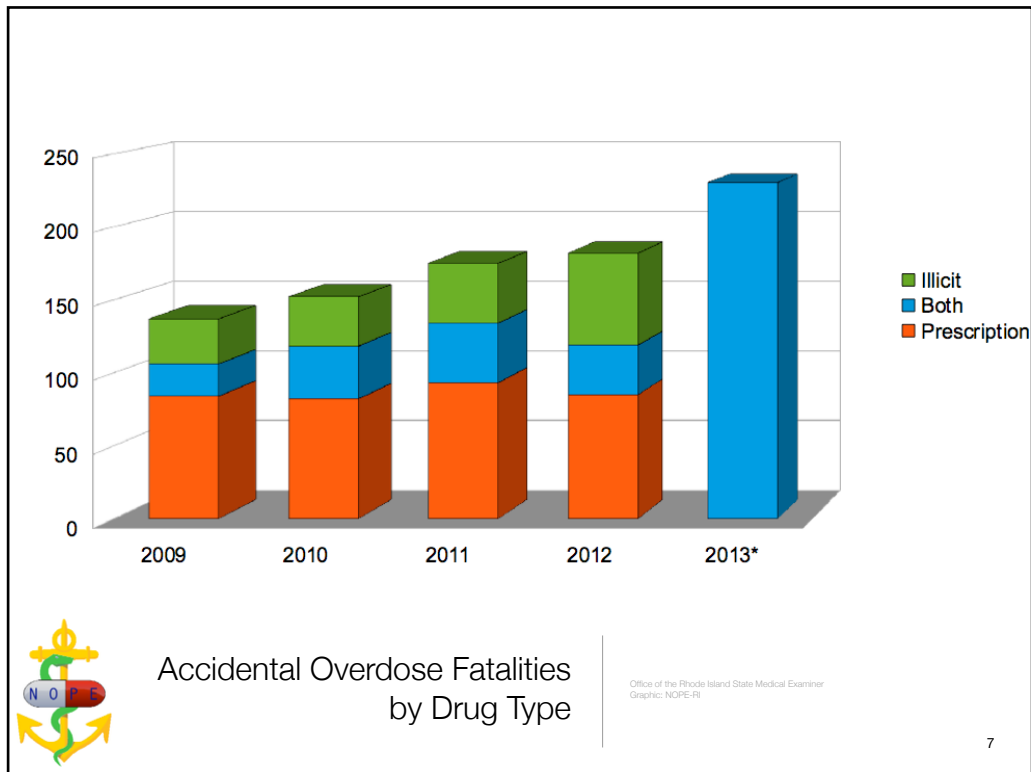




Opioids and Overdose in RI

- Of concern are both illicit opioids (e.g. heroin) and misuse of prescription opioids (oxycodone, hydrocodone, etc)
- In RI, prescription overdose deaths have remained relatively stable over the past five years. Illicit overdose deaths have doubled in this time period.
- As of mid-2013, the RI State Medical Examiner's Office reported about four accidental overdose deaths each week.
- As of April 2014, there have been 90 confirmed opioid overdose deaths.

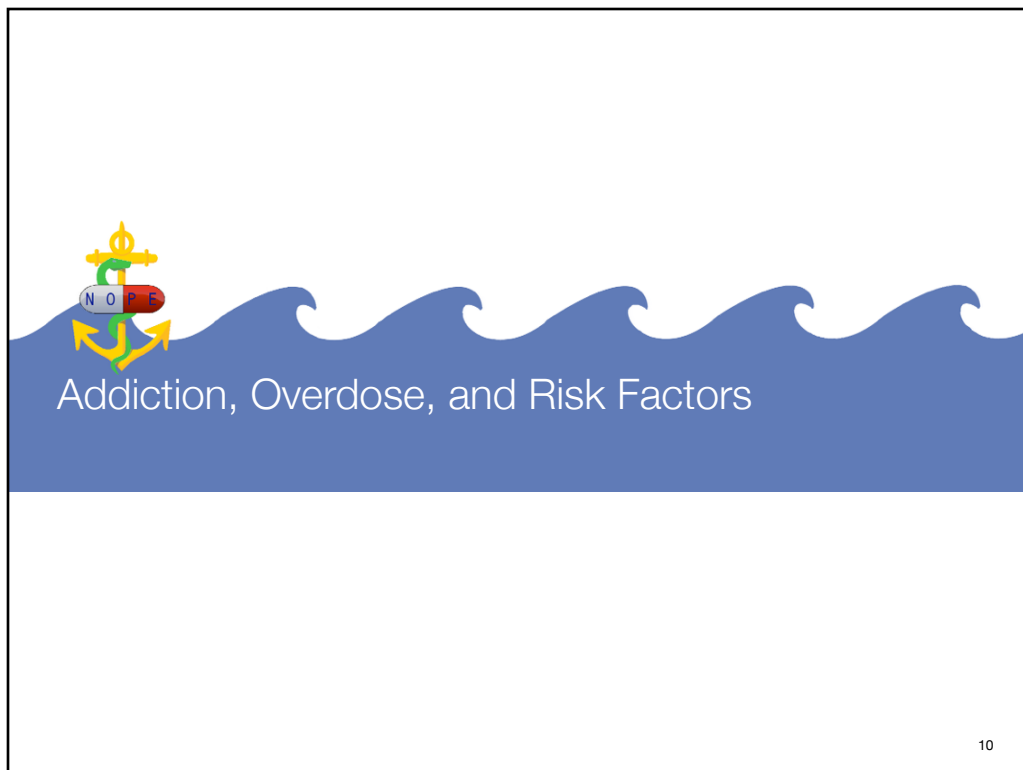
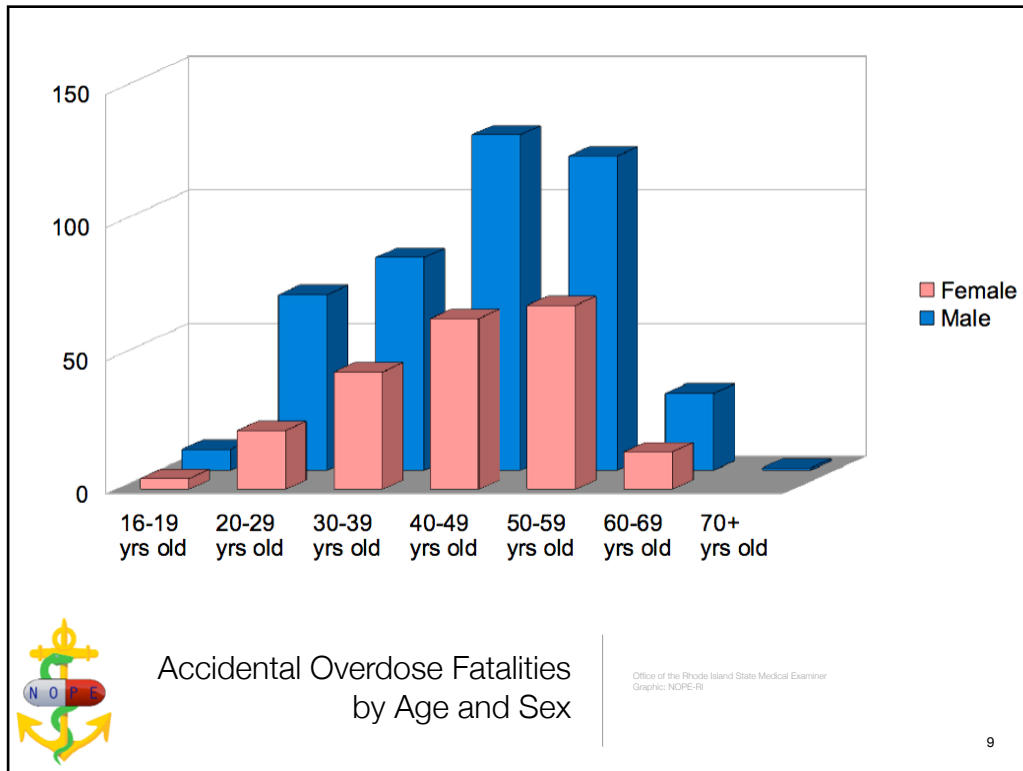
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Opioids and Overdose in RI

- While illicit drug use is most common in young adults, the highest rates of fatal overdoses occur in middle aged men, between 40 and 60 years old.
- Most overdose fatalities in women occur in this age range as well. Women currently make up one third of overdose deaths in all age ranges, but this gap is RAPIDLY closing.

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Addiction

- Opioid addiction is a chronic and relapsing disease characterized by a permanent change in the structure and function of the brain.
- Susceptibility to addiction has a strong genetic component, and when combined with exposure to opioids, dependence and addiction are likely to result.
- There is a misconception among the public, the medical community, law enforcement, and users themselves that addiction is cured once withdrawal has ceased and abstinence is achieved.


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Harm Reduction

- Overdose prevention education and naloxone distribution are feasible and cost effective methods that have been shown to reduce fatal overdose in communities and increase enrollment in drug treatment.
- Lay responders, armed with knowledge, skills, and resources, are willing and able to identify an overdose and administer naloxone, resulting in lives saved.
- Just as providing access to condoms and birth control does not lead to risky sexual behaviors, and prescribing epi-pens does not lead to rampant poking of bee hives, harm reduction strategies DO NOT increase drug use.
- Naloxone distribution and other harm reduction programs are not the solution to the opioid addiction epidemic; They help keep individuals alive so that they can work towards recovery.


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Tolerance

- Opioids bind at opioid receptors causing a spectrum of therapeutic, pleasurable, and potentially dangerous effects.
- Repeated exposure to opioids (for any reason) desensitizes opioid receptors and leads to a decrease in their number and density.
- It will now take more opioid to cause the same effect, (i.e. tolerance).
- When opioid receptors are not exposed to opioids for any period of time, the number and density of receptors returns to baseline.
- It will now take less opioid to cause the same effect.
- If the same amount of opioid is given, it will cause a stronger reaction.

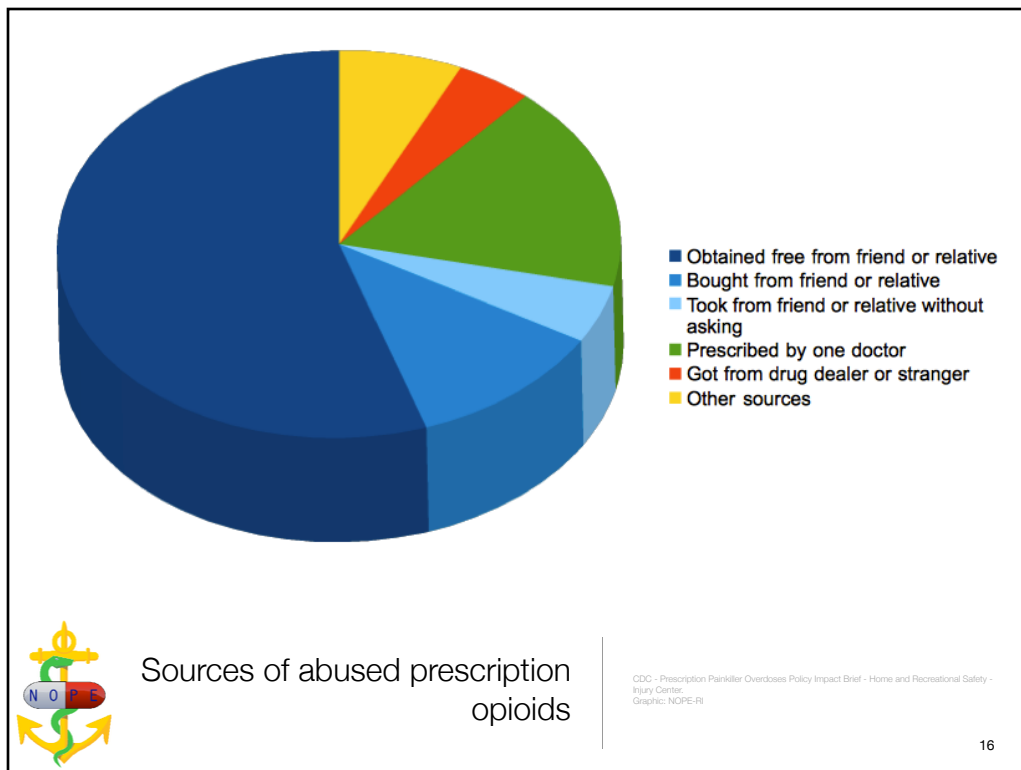
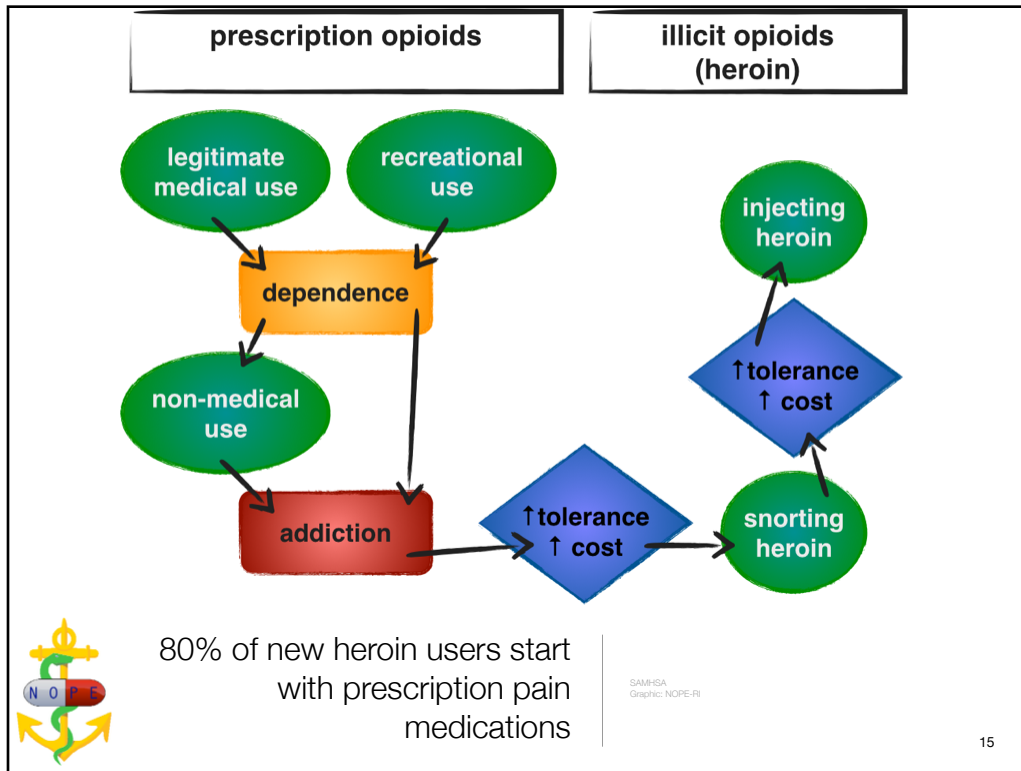
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Tolerance

- Individuals develop tolerance to the pleasurable effects of opioids (e.g. pain relief, feelings of euphoria, “high”)
- There is NO tolerance to the respiratory depression and hypoxia caused by increased doses of opioids.
- Therefore, as an individual increases the amount they are taking (or as the amount prescribed increases in order to achieve a therapeutic goal), the risk of overdose and death increases.
- Overdose is especially likely in those where the amount needed to get “high” is very close to the amount that causes them to stop breathing.

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Overdose

- An overdose occurs when a toxic amount of a drug or a toxic combination of drugs overwhelms the body.
- Opioid overdose is characterized by inadequate breathing (respiratory depression).
- This leads to a lack of oxygen in the body (hypoxia) which will lead to death if no intervention is made.

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Overdose Risk Factors

There is an increased likelihood of overdose when any of the following factors are present:

- Decreased tolerance due to recent abstinence
 - hospitalization
 - imprisonment
 - detox/rehab
- Solo opioid use
 - using in the absence of anyone who can recognize and respond to an overdose
- Mixing of opioids
 - with other opioids
 - with alcohol
 - with benzodiazepines
 - with prescription meds
 - with other known or unknown substances, e.g. fentanyl
- Acute or chronic illness
 - Hepatitis C
 - HIV/AIDS
 - pneumonia
 - sleep apnea
 - other liver or respiratory conditions



Overdose Recognition

Overdose can happen right after using, but usually occurs within 1-2 hours.

A person who overdoses will have some or all of the following symptoms:

- Can't be woken up
- Slow or no breathing
- Limp body
- Fingernails or lips turning blue
- Unable to speak or incoherent
- Vomiting or gurgling noises


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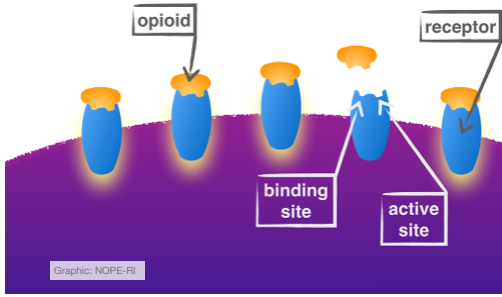
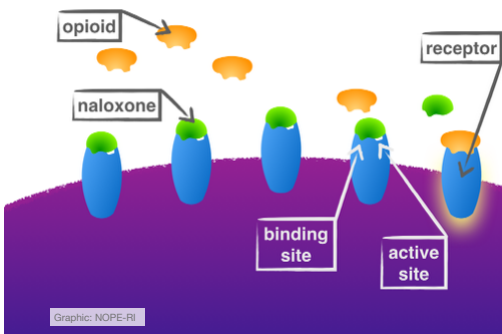
Naloxone (Narcan)

- Naloxone (Narcan) reverses the effects of opioids.
- It only works for opioid overdose (heroin, pain killers), not for other kinds of drugs (cocaine, meth).
- There are no adverse effects if naloxone is given to someone who is not overdosing on opioids, so when in doubt, give it.
- It can be injected into a large muscle (thigh or upper arm) or given through the nose with a special nasal atomizer.
- Naloxone starts working in 3-5 minutes and lasts for 30-90 minutes.
 - If there is no improvement in 5 minutes, give a second dose.
 - If the first dose wears off and they start to “re-overdose”, give another dose.

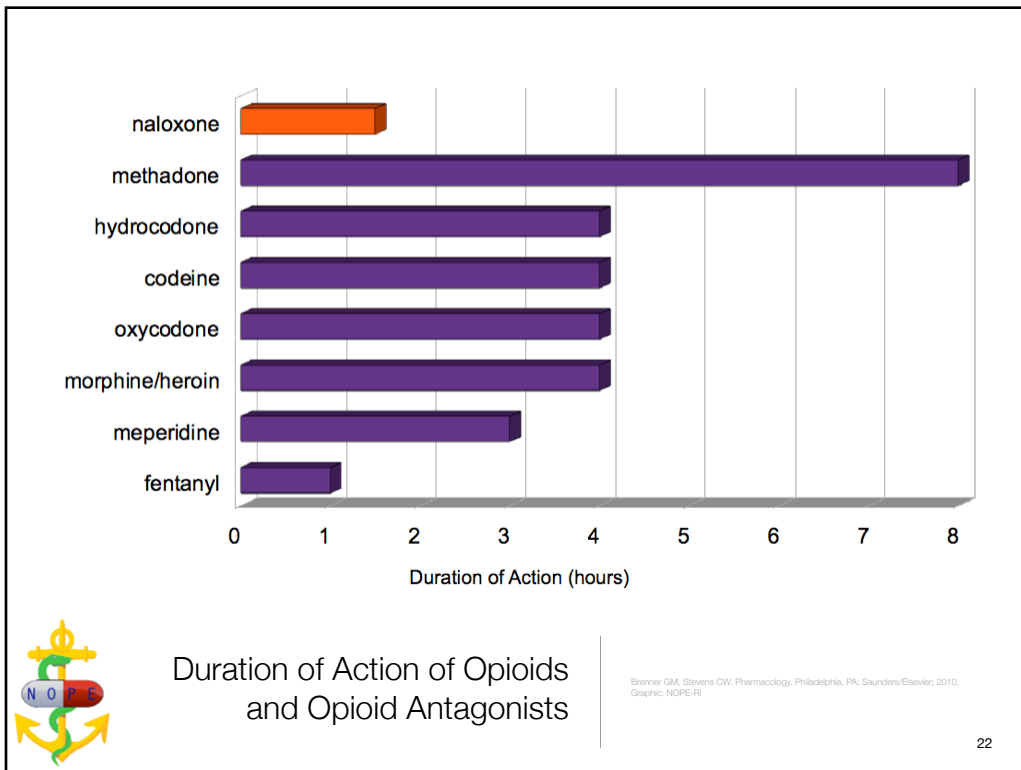
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- Naloxone works by “pushing” opioids off their receptors.
- It then binds to the opioid receptors and blocks opioids from binding.
- This rapid removal of opioids from receptors can cause symptoms of withdrawal, although the severity varies from person to person.
- The opioids have NOT been removed from the body or neutralized and will therefore re-attach as soon as the naloxone wears off in 30-90 minutes.






Graphic: NOPE-RI






Naloxone (Narcan)


INJECTABLE NALOXONE	NASAL NALOXONE
<ul style="list-style-type: none"> • Remove cap from naloxone vial and syringe • Insert needle through rubber plug • Pull back on plunger until there is 1cc in the syringe • Inject into a large muscle (thigh or upper arm) 	<ul style="list-style-type: none"> • Remove all caps • Screw glass vial into plastic tube • Screw nasal atomizer into plastic tube • Inject half of vial into each nostril
	

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Overdose Response - Law Enforcement

- If you can't wake someone up or they aren't breathing, make sure EMS is dispatched.
- Perform rescue breathing.
- If there are any indications that opioids might be involved, administer one dose of naloxone (Narcan).
- Keep rescue breathing until the naloxone starts to work or EMS arrives.
- If you have to leave for any reason, roll the person on their side into the recovery position.



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Overdose Response - Lay Responder

- If you can't wake someone up or they aren't breathing, CALL 911.
 - Tell them someone is not breathing. You don't have to mention drugs.
 - Give an accurate description of your location.
- Perform rescue breathing.
- Give naloxone (Narcan) if you have it.
- Keep rescue breathing until the naloxone starts to work.
- Stay with the person until help arrives. If you have to leave, roll the person on their side.



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Rescue Breathing

- Tilt the person's head back.
- Pinch nose.
- Seal your mouth over theirs.
 - Use a barrier device if you have one.
- Give 1 breath every 5 seconds.
- Keep going until help arrives or the person starts breathing on their own.



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Law Enforcement and Public Safety Concerns

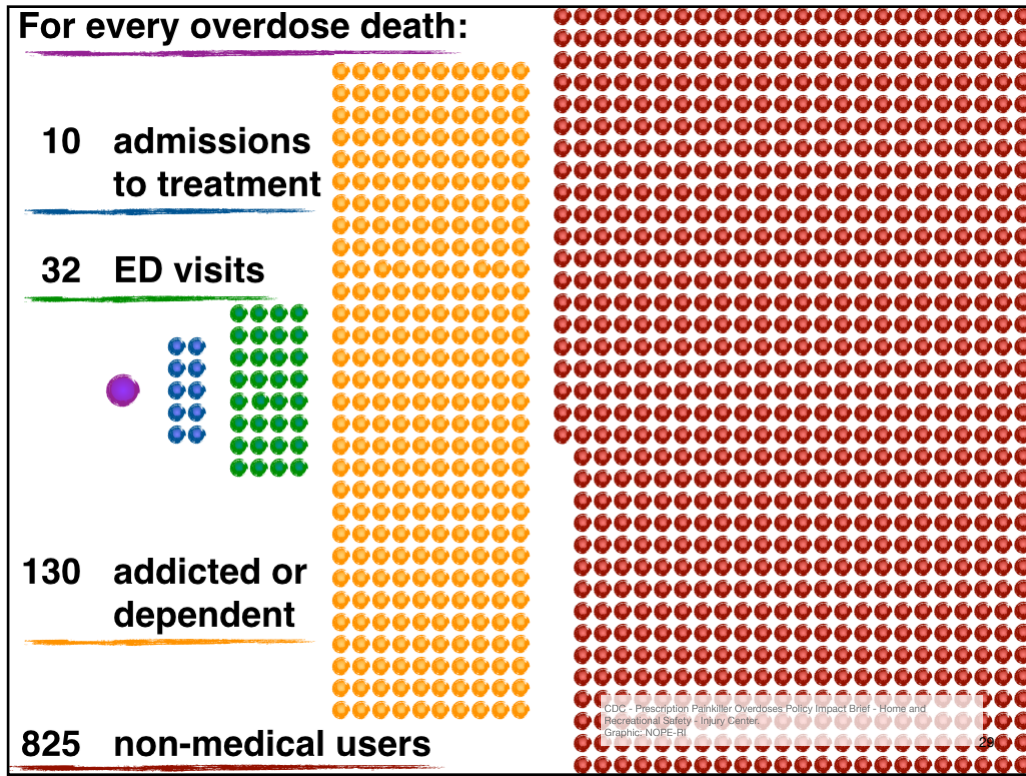

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Why worry about addiction and overdose?

- In 2009, the annual cost of opioid abuse and addiction was over \$56 billion.
 - The largest portion of this cost is in lost productivity
 - In RI, \$31 million was spent on healthcare costs due to overdose.
- Similar programs have shown that overdose deaths can be prevented by first responders and laypeople armed with education and naloxone.
- Preventing morbidity and mortality is not only socially and economically beneficial, it is the right thing to do.

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Naloxone in the Community

- Naloxone is safe
 - It is non-addictive and there is no potential for abuse
- Naloxone is effective
 - At-risk individuals and lay responders with minimal training are able to identify an overdose and administer naloxone
- Naloxone works
 - In areas that have implemented community overdose prevention education and naloxone distribution, death rates from overdose have gone down significantly.
 - There seems to be a “herd immunity” when a significant percentage of the population is prepared to respond to overdose.
- Naloxone saves lives
 - Both those who save lives with naloxone and those who have had their life saved are more likely to access substance abuse treatment.

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Law Enforcement and Public Safety Response

- Most individuals with a drug addiction will encounter law enforcement at some point.
- Overdose prevention education provides another tool or opportunity to engage with those who abuse drugs, their families, and the community at large.

"The perception of the police in the city of Quincy has dramatically changed...people are now looking at us being able to assist them as opposed to only enforcers of the law."

- Lt. Patrick Glynn, Quincy Police Department

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Liability

- Most law enforcement officers are not medical professionals and you are not being asked to function as such.
- Even with the most advanced levels of training, it is sometimes difficult to determine if an individual is suffering from an overdose or from another medical emergency. The specific substances involved in an overdose are often not obvious.
- As non-medical first responders, your task is to identify situations in which an opioid overdose is POSSIBLE or LIKELY and respond according to departmental policy.
- All of these individuals will be turned over to EMS, who, along with hospital staff, will determine the exact nature of illness.

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Logistical Concerns

- Naloxone must be stored out of direct light. Effective methods include leaving it in its box or storing in a standard orange medication bottle.
- Naloxone must be kept at room temperature (59-86°F or 15-30°C). It should never be stored in a refrigerator or a vehicle glove box or trunk.
- Certain cases can provide a temperature-controlled environment.
- If naloxone is stored improperly, it loses its effectiveness. It does not become harmful if administered.

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Good Samaritan Overdose Prevention Act

- Civil and criminal immunity for the “good faith” administration of naloxone by a layperson to someone experiencing an overdose.
- Anyone who seeks medical assistance for someone experiencing an overdose (e.g. calling 911, performing rescue breathing, administering naloxone) will not be charged with drug possession.
- Anyone who experiences a drug overdose and needs medical assistance will not be charged with drug possession.
 - Neither of these immunities extend to manufacture or distribution of drugs.
- The act of providing medical assistance (e.g. calling 911, performing rescue breathing, administering naloxone) may be used as a mitigating factor in criminal prosecution.

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Calling 911

- Naloxone works for only 30-90 minutes. In this time, it is imperative for the individual who overdosed to get to definitive medical care. The safest way and most efficient way for this to happen is for those on the scene to call 911.
- The biggest barrier to people calling 911 for an overdose is fear of law enforcement involvement. They fear legal repercussions for themselves and the person who overdosed.
- Good Samaritan laws help, but the only way practices change is when the attitudes and actions of both drug users AND public safety positively reinforce lifesaving actions.
- The more positive interactions between law enforcement and individuals at overdose scenes, the more likely they will be to call 911 the next time.

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Law Enforcement and Public Safety Response

- Drug abuse and overdose is a wide-reaching public health problem that effects those who use drugs, their families and friends, health care providers, public safety, and the community as a whole.
- When officers are equipped with the knowledge and resources to intervene and assist in reversing an overdose and saving a life, it helps to foster trust and collaboration between public safety personnel and the community at large.

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NOPE-RI a program of:

Ariel Engelman,
Coordinator


Naloxone and Overdose
Prevention Education Program of
Rhode Island

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(401) 316-9982
www.nopeRI.org



www.riresponds.org

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Good Samaritan Overdose Prevention Act

21-28.8-3. Authority to administer opioid antagonists – Release from liability.

(a) A person may administer an opioid antagonist to another person if:

- (1) He or she, in good faith, believes the other person is experiencing a drug overdose; and
- (2) He or she acts with reasonable care in administering the drug to the other person.

(b) A person who administers an opioid antagonist to another person pursuant to this section shall not be subject to civil liability or criminal prosecution as a result of the administration of the drug.

21-28.8-4. Emergency overdose care – Immunity from legal repercussions.

(a) Any person who, in good faith, without malice and in the absence of evidence of an intent to defraud, seeks medical assistance for someone experiencing a drug overdose or other drug-related medical emergency shall not be charged or prosecuted for any crime under RIGL 21-28 or 21-28.5, except for a crime involving the manufacture or possession with the intent to manufacture a controlled substance or possession with intent to deliver a controlled substance, if the evidence for the charge was gained as a result of the seeking of medical assistance.

(b) A person who experiences a drug overdose or other drug-related medical emergency and is in need of medical assistance shall not be charged or prosecuted for any crime under RIGL 21-28 or 21-28.5, except for a crime involving the manufacture or possession with the intent to manufacture a controlled substance or possession with intent to deliver a controlled substance, if the evidence for the charge was gained as a result of the overdose and the need for medical assistance.

(c) The act of providing first aid or other medical assistance to someone who is experiencing a drug overdose or other drug-related medical emergency may be used as a mitigating factor in a criminal prosecution pursuant to the controlled substances act.

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APPENDIX B: ADDITIONAL RESOURCES AND HANDOUTS

Fact Sheet - available at www.nopeRI.org/law.html

NALOXONE FACT SHEET FOR LAW ENFORCEMENT

BASICS

- Opioids are drugs related to opium poppies like heroin, morphine, fentanyl, codeine, methadone, and oxycodone.
- Opioid overdose occurs when an individual stops breathing due to the effects of the drugs.
- Naloxone (Narcan) reverses the effects of opioids, allowing an individual experiencing an opioid overdose to breathe normally.
- Naloxone is a prescription medication, but it is not a controlled substance (not scheduled), not addictive, and has no potential for abuse. It has been used in hospitals and by EMS for decades.
- Naloxone does not work for overdoses of benzodiazepines, cocaine, methamphetamine, or alcohol.
- In a mixed overdose (opioids and benzos, heroin and cocaine, etc), naloxone will help reverse the effects of the opioids, but will not have any effect on other substances present.

ADMINISTRATION

- Naloxone's effects begin in 3-5 minutes and last for 30-90 minutes.
- Rescue breathing must be performed until the naloxone takes effect in order to provide oxygen to the vital organs and prevent brain damage.
- It is imperative that an individual who has overdosed and was given naloxone be evaluated and monitored in a medical setting (i.e. emergency department) because the overdose can re-occur after the naloxone wears off.

STORAGE

- Naloxone must be stored out of direct light. Effective methods include leaving it in its box or storing in a standard orange medication bottle.
- Naloxone must be kept at room temperature (59-86°F or 15-30°C). It should never be stored in a refrigerator or a vehicle glove box or trunk.
- If naloxone is stored improperly, it loses its effectiveness. It does not become harmful if administered.

BENEFITS

- Increasing naloxone access does not increase drug use.
- Naloxone training can link people using drugs with essential resources.
- Training individuals to prevent, recognize and respond to overdoses provides an opportunity to recommend other health or treatment services.
- Existing law enforcement-naloxone programs have resulted in thousands of lives saved.

SIDE EFFECTS

- If naloxone is given to someone who is not experiencing an opioid overdose, there are no adverse effects.
- When naloxone is given to an individual experiencing an opioid overdose, they will begin breathing normally and also have symptoms of opioid withdrawal. These include pain, nausea, vomiting, sweating, and anxiety.
- With the dose of naloxone given by law enforcement, individuals very rarely become combative or violent.

LIABILITY

- With minimal training, non-medical first responders and laypeople can effectively recognize and respond to opioid overdose, including administering naloxone.
- The Good Samaritan Overdose Prevention Act (RIGL 21-28.8-3) provides civil and criminal immunity to an individual when they administer naloxone to another person "in good faith" and "with reasonable care". The specific protections for law enforcement are being clarified and will be reflected in departmental policies.

Pocket Card - available at www.nopeRI.org/resources.html

OVERDOSE RECOGNITION

Signs of overdose include:


Can't be woken up	Fingernails or lips turning blue
Slow or no breathing	Unable to speak/incoherent
Limp body	Vomiting or gurgling noises

OVERDOSE RESPONSE

1. Call 911 - tell them someone is not breathing
2. Rescue breathing
3. Give naloxone (Narcan)
4. Stay until help arrives. Roll the person on their side if you have to leave.

RESCUE BREATHING



1. Tilt head back
2. Pinch nose
3. Seal mask over their mouth and nose
4. Give 1 breath every 5 seconds
5. Keep going until help arrives or they breathe on their own



www.nopeRI.org

NALOXONE

- Naloxone starts working in 3-5 minutes and lasts 30-90 minutes.
 - Keep rescue breathing until naloxone starts to work.
 - If there is no improvement in 5 minutes, give another dose.
 - Naloxone may cause withdrawal symptoms - DO NOT let the person use more opioids

INJECTABLE NALOXONE	NASAL NALOXONE
<ol style="list-style-type: none"> 1. Remove cap from naloxone and syringe. 2. Insert needle through rubber plug. 3. Pull back on plunger until there is 1cc in the syringe. 4. Inject into a large muscle (thigh or upper arm). 	<ol style="list-style-type: none"> 1. Remove all three caps. 2. Screw glass vial into plastic tube. 3. Screw nasal atomizer into plastic tube 4. Inject half of vial into each nostril. 

Handout - available at www.health.ri.gov

Rhode Island has a Good Samaritan Law.
 Callers to 911 and overdose victims are protected from prosecution if drugs are found at the scene.

DON'T BE AFRAID TO CALL 9-1-1!

SAVE A LIFE. GET NALOXONE.

Naloxone is an antidote used to reverse a drug overdose from heroin or prescription pain medications.

health.ri.gov

Naloxone (Narcan®) is available without a prescription at ALL Walgreens locations across Rhode Island, and may be available at other pharmacies. The cost may be covered by your health plan and is covered by Medicaid.

**Addiction is a disease.
 Recovery is possible.
 Treatment is available.**

Free 24 hour Confidential Helpline:
CALL 2-1-1
www.bhddh.ri.gov/SA





APPENDIX C: EVALUATION

May 21, 2014

Dear Members of the Law Enforcement Community,

Deaths from overdose involving prescription opioid medications, heroin, and synthetic opiates are at unprecedented rates in the United States. To address this problem, the Office of National Drug Control Policy, joined by the US Attorney General's Office, other federal agencies, the RI Departments of Health and Public Safety, and the Police Chiefs Association endorse the training of first responders in overdose recognition and response including naloxone administration. In response to the RI epidemic of overdose deaths, the RI Department of Health, The Miriam Hospital and the RI Medical Reserve Corps have undertaken a statewide initiative to train law enforcement officers in overdose prevention and response, including the administration of naloxone, an overdose antidote.

We are conducting an evaluation of the program and training and seek your city's participation; this is a research study. All officers attending the trainings are eligible for taking part in the evaluation. Participation in the evaluation is entirely optional and officers can choose to stop participating at any time. Before and immediately after the training session, officers will be asked to complete a series of written questions regarding overdose, attitudes toward injury prevention, naloxone administration, and laws related to overdose prevention. The full evaluation will take no more than 20 minutes to complete (10 minutes for completing pre-training and 10 minutes for completing post-training forms), and all information is confidential and anonymous. The results of the evaluation will be prepared as a summary for state and local community planning efforts. The risks to study participants are minimal and are comparable to those experienced when taking part in any training evaluation during professional police activities.

The information provided by participants will be invaluable in evaluating how best to conduct overdose prevention and response trainings for first responders. Members of our research team will be in contact with you to discuss participation in the training evaluation.

If you have any questions about the evaluation, you can reach me, Traci Green, the Principal Investigator at (401) 444-3845.

Thank you,

Traci Green, PhD, MSc
Rhode Island Hospital, Department of Emergency Medicine
Chair, *Rhode Island Drug Overdose Prevention and Response Coalition*
Rhode Island Department of Health

APPENDIX D: MODEL POLICY

I. PURPOSE

The purpose of this policy is to establish guidelines and procedures governing the utilization of the Nasal Naloxone (Narcan) administered by members of the _____ Police Department.

This policy is intended to recognize the potential life-saving role officers play in their encounters with persons suffering from an apparent opioid overdose. As such, members need to recognize the signs and symptoms of a potential overdose as they attempt to protect and aid the individual at the earliest stage possible.

II. DEFINITIONS

- A. DRUG INTOXICATION – Impaired mental or physical functioning as a result of the use of physiological and/or psychoactive substances, i.e.: euphoria, dysphoria, apathy, sedation, attention impairment.
- B. EMS – “Emergency Medical Services” that provide pre-hospital emergency medical care; such practitioners provide out of hospital care for those with an illness or injury.
- C. MAD DEVICE – Mucosal Atomization Device – Intranasal mucosal Atomization Device used to deliver a mist of atomized medication that is absorbed directly into a person’s blood stream and directly into the brain and cerebrospinal fluid via the nose to brain pathway. This method of medication administration achieves medication levels comparable to injections.
- D. NALOXONE - an opioid receptor antagonist and antidote for opioid overdose produced in intramuscular, intranasal or intravenous forms.
- E. NARCAN - 2mg/2ml prefilled syringes compatible with the intranasal mucosal automation device (MAD) for nasal rescue.
- F. OPIOIDS – heroin, fentanyl, morphine, buprenorphine, codeine, hydromorphone, hydrocodone, oxycodone, methadone, oxycodone.
- G. OPIOID OVERDOSE – An acute condition including but not limited to extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death resulting from the consumption or use of an opioid, or another substance with which an opioid was combined, or that a layperson would reasonably believe to be an opioid-related drug overdose that requires medical assistance.
- H. UNIVERSAL PRECAUTIONS - is an approach to infection control to treat all human blood and certain human body fluids as if they were known to be infectious for HIV, HBV and other blood borne pathogens.

III. POLICY

It is the policy of the _____ Police Department to provide assistance to any person(s) who may be suffering from an apparent opioid overdose. Sworn members trained in accordance with the policy shall make every reasonable effort, to include the use of Naloxone, combined with rescue breaths, to revive the victim of any apparent drug overdose.

IV. PROCEDURES

A. TRAINING

1. Prior to issue, members shall be trained in the use of Naloxone by the Rhode Island Disaster Medical Assistance Team (DMAT); or designee.
2. Department recruits assigned to the Rhode Island Municipal Police Training Academy (or Providence Police Department Academy) shall receive training on to overdose emergencies, to include the use of Naloxone, as prescribed by the Police Officers Standards & Training Commission.
3. The Chief of Police, or his/her designee, shall ensure that appropriate personnel receive refresher training every ___ years that may be done in conjunction with First Aid/CPR Training.
4. The _____ shall serve as the coordinator responsible for administering the departments Nasal Narcan program. (NOTE: may add duties below)

B. ISSUANCE

1. Naloxone will be provided in a clearly marked kit for intranasal use.
 - a. Each intranasal Naloxone kit shall include:
 - Instructions for administering intranasal Naloxone;
 - One (1) (single-use) Luer-Lock prefilled syringe system; (NOTE: or two (2) if agency wishes)
 - One (1) MAD device, and
 - b. Members carrying Naloxone kit shall have a CPR face mask/barrier device available for mouth-to-mouth resuscitation.
2. All members of the Patrol Division are required to maintain the intranasal Naloxone kit and CPR face mask within their assigned cruiser at all times while on duty. (NOTE: may add Traffic and Community Policing Units)
3. Any sworn member not required by this policy to carry a intranasal Naloxone kit may elect to carry the intranasal Naloxone kit, provided they have been properly trained and have a CPR face mask available. (NOTE: consider civilian jailers)
4. The holding facility/booking area shall be equipped with an intranasal Naloxone kit and a CPR face mask.
5. Nasal Narcan kits will be stored with any defibrillators located at police headquarters.

C. USE OF NALOXONE

If a member of this department encounters the victim of what appears to be a drug overdose, the member shall follow the protocols outlined in their nasal Narcan training.

1. Maintain universal precautions throughout overdose incident;
 2. Notify communications of a possible opioid overdose in progress and request EMS response as well as a 2nd patrol unit to provide scene cover and control. (NOTE: additional patrol units is optional)
 3. Keep communications apprised of condition of overdose victim throughout overdose incident;
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4. Perform assessment - Check for unresponsiveness, vital signs such as breathing and pulse. [Is the subject awake and talking; responsive to verbal stimulation only; response to painful stimulation only; or completely unresponsive?]
5. Check for medic alert tags (around wrist, necklace or ankles; indicating pre-existing medical condition)
6. Prior to the administration of Naloxone, member on scene shall ensure the subject is in a safe location and remove any sharp or heavy objects from the subject's immediate reach.
7. The sudden onset of immediate opioid withdrawal may result in physical symptoms such as agitation, rapid heart rate, nausea, seizures, difficulty breathing.
8. Administer Naloxone using the approved MAD device;
9. Start rescue breaths using CPR face mask/barrier protection device and continue until victim is revived or EMS responds.
10. If after five (5) minutes of administering Naloxone, there is no improvement (victim remains unconscious, no breathing or pulse) and if available, one (1) additional dose of Naloxone may be administered. Continue rescue breaths using CPR face mask/barrier protection device until victim is revived or EMS responds.
11. Seize all illegal and/or non-prescribed narcotics found on the victim, or around the area of the overdose, and process in accordance with _____(specific PD property/evidence policy). (NOTE: may be BCI/Detective function in some departments)
12. Once used, the intranasal Naloxone device is considered bio-hazardous material and shall be turned over to EMS or hospital personnel for proper disposal immediately following administration.

V. REPORTING

After utilization of Naloxone members will:

- A. Prepare a "Naloxone Administration," no crime incident (OF) report in Records Management System (RMS) for documentation purposes to include a description of the individual's condition, behavior, the fact that Naloxone was deployed, medical response, hospital of transport, any narcotics seized and final outcome of department and medical personnel response.
 - B. If an arrest occurs on-scene, such report shall be linked to the above offense report and indicate whether the arrestee was the person who reported the suspected overdose. (NOTE: provides tracking for Good Samaritan Law)
 - C. The above reports shall be forwarded to _____. (NOTE: suggest assigned PD coordinator tracking narcan deployment, also narcotics unit suggested)
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VI. STORAGE and REPLACEMENT

- A. Inspection of the intranasal Naloxone kit shall be the responsibility of the member and shall be conducted during each scheduled shift.
 - 1. Check the expiration date found on either box or vial;
 - 2. Check condition of MAD device (considered sterile for approximately 4-5 years)
- B. Naloxone will be stored in accordance with manufacturer's instructions and in Department issued storage containers to avoid extreme cold, heat and direct sunlight.
- C. Missing, damaged or expired Naloxone kit(s) will be reported to _____. (NOTE: suggest PD coordinator)
- D. Requests for replacement Naloxone shall be made to_____.
- E. Patrol Division Supervisors shall conduct inspection of the Narcan kits on a _____ basis and denote the equipments condition in the line inspection report. (NOTE: Suggest at least monthly - CALEA standard)

VII. PROVISIONS

- A. In Accordance with RIGL 21-28.8-4, the 'Good Samaritan Law':
 - 1. Any person who experiences a drug overdose or other drug-related medical emergency and is in need of medical assistance cannot be charged or prosecuted for any crime under RIGL 21-28 (Uniform Controlled Substance Act) or 21-28.5 (Sale of Drug Paraphernalia) except for crimes involving the manufacture or possession with intent to manufacture or deliver a controlled substance, if the evidence for the charge was gained as a result of seeking medical assistance.
 - 2. Any person, who in good faith seeks medical assistance for someone experiencing a drug overdose or other drug-related medical emergency shall not be charged or prosecuted for any crime, except for the crimes described in VII, A, 1 above.
 - B. Under the RIGL 21-28.8-3, Authority to Administer Opioid Antagonist-Release from Liability, dated 2012, any person can administer Naloxone to another person if he or she, in good faith, believes the individual is experiencing a drug overdose and acts with reasonable care in administering the drug to the overdose victim.
 - C. Any member who administers Naloxone in accordance with this policy shall be deemed to be acting in compliance with RIGL 21-28.8-3 and not subject to civil liability or criminal prosecution.
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APPENDIX E: NALOXONE KITS

All prices are estimates and will vary depending on distributor and quantity ordered. Please contact your municipal EMS for assistance in ordering supplies. NOPE-RI is happy to consult with you regarding the contents of your kits, but is unable to provide logistical assistance in purchasing or assembling them at this time.

Item	Manufacturer	Quantity	Unit Price	Cost
Naloxone (2mg/2mL leur jet prefilled syringe)	Amphastar	2	\$30.00	\$60.00
MAD nasal atomizer	Teleflex	2	\$6.00	\$12.00
Nitrile gloves, pair	various	1	\$0.50	\$0.50
CPR mask/barrier device	various	1	\$7.00	\$7.00
Instruction pocket card	NOPE-RI	1	\$0.50	\$0.50
Carrying case	various	1	\$5.00	\$5.00
Total				\$ 85.00

APPENDIX F: DRUG COLLECTION/DISPOSAL UNITS

PURPOSE

To facilitate the anonymous collection and destruction of unused, unwanted, and expired prescriptions and other medications by providing Drug Collection Units (DCUs) accessible 24-hours a day at police department headquarters. Such programs help keep these medications off household shelves and out of the reach of children, teenagers, and potential thieves, while also serving to reduce the introduction of potentially harmful substances into the environment.

SUCCESS

The Warwick police Department collected over 175 pounds of prescriptions since February 2014. Providence Police and several other local departments have experienced similar success.

SCOPE

A list of DCU locations in Rhode Island can be found at: <http://www.noperi.org/drugdisposal.html>

POLICY

Warwick Police has a Prescription Drug Take-back directive available upon request.

Contact: Sergeant Joseph Petrarca
Accreditation Manager
Warwick Police Department
(401) 468-4330
joseph.a.petrarca@warwickri.com

VENDORS

Many Police Departments have utilized the following vendor who will provide specification and pricing. Current standard unit price is \$995.00. There is a smaller unit for \$695.00.

- www.medreturn.com

The Post Office may be able to donate an old mailbox which can be re-purposed.

FUNDING

Consider requesting funds through local City/Town Substance Abuse Prevention Task Force

DISPOSAL

Suggest BCI units handle disposal following procedures outlined in your policy. The RI DEA is helpful in providing guidance in this sensitive topic.

CVS has previously provided funding for DCUs. They will also promote the location of the DCU. Visit below site for details:

- www.cvs.com/safercommunities

SUGGESTIONS

- Hold press conference to raise awareness of DCU at your station.
- Post announcement in public buildings and treatment centers with permission.
- Provide sufficient signage at police station that visually depicts acceptable and not-accepted items. Provide instructions on where they can dispose of not-accepted items, i.e., syringes, aerosol cans, etc.
- Provide substance use treatment information/resources on display near the DCU.
- Notify ALL staff in your agency of the DCU at the station.

APPENDIX G: COMMUNITY FORUMS

WHAT YOU WILL NEED

- Time to plan – allow a couple of months to arrange site, set-up speakers, promote event, etc.
- Space – centrally located with adequate facilities and parking
- Volunteers – help promote event, copy materials for the event, set up, break down, greet attendees, etc.
- Speakers – see resources below for help with speakers
- Promotional efforts – press release and other marketing tools (social media, list serves, local paper, etc.)
- Handouts – see resources below for help with handouts
- Email sign-up sheet – for future communication and advocacy
- Refreshments – optional according to timing and length of event

INFORMATION OFTEN INCLUDED

- Background on overdose deaths in RI
- Current efforts to address overdose deaths
- What can the community do to decrease overdose deaths
- Addiction and Recovery information

RESOURCES

- The Miriam Hospital's Preventing Overdose and Naloxone Intervention (PONI)
 - mmckenzie@lifespan.org
 - Naloxone and Overdose Prevention Education Program of RI
 - www.nopeRI.org
 - RI Overdose Prevention and Rescue Coalition
 - jennifer.AndradeKoziol@health.ri.gov
 - RI Communities for Addiction Recovery Efforts
 - hcekala@ricares.org
 - RI Department of HEALTH
 - <http://www.health.state.ri.us/healthrisks/drugoverdose/>
 - RI Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals
 - <http://www.bhddh.ri.gov/misc/Narcan.php>
 - Community Education Programs: Drug Prevention and Early Intervention Education for Parents and Youth
 - <http://pact360.org/>
 - Local Prevention Task Force
 - <http://www.riprc.org/providers/>
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SAMPLE PRESS RELEASE

FOR IMMEDIATE RELEASE

CONTACT:

(name, title)
(organization)
(email)
(phone)

(ORGANIZATION) TO HOLD PUBLIC FORUM ON ADDICTION, OVERDOSE, AND RECOVERY

(date) (city, RI) — (organization) will hold a public forum regarding addiction, overdose, and recovery.

In response to the recent rise in accidental overdose deaths in Rhode Island, the event will provide information on how to avoid addiction risks such as prescription painkillers, advocate for non-opioid medications with your physician, recognize the warning signs of addiction, obtain treatment, and maintain and support for those in long-term recovery.

“People need to understand that addiction is a chronic disease, just like diabetes or high blood pressure,” said (director) of (organization). “We hope this forum will help people understand the disease of addiction, learn that recovery is possible, and take steps to save the life of someone who overdoses.”

The event is free and open to the public:

Overdose Prevention Community Forum, (day), (date), (time), (location), (address). The focus of this forum will be on (focus of forum).

The emcee will be (local dignitary).

Speakers include (speakers - politicians, behavioral health/medical providers, public health coordinators, parents of overdose victims, people in recovery, law enforcement, etc)

Space is limited. Please reserve a seat by e-mailing (email) or by calling (organization) at (phone).

OR

Seating is available on a first come, first served basis.

(one paragraph organization statement)

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APPENDIX H: GOOD SAMARITAN LAW

CHAPTER 21-28.8 – The Good Samaritan Overdose Prevention Act**§ 21-28.8-1 Short title.**

This chapter shall be known and may be cited as "The Good Samaritan Overdose Prevention Act".

§ 21-28.8-2 Definition.

"Opioid antagonist" is a drug which is a competitive antagonist that binds to the opioid receptors with higher affinity than agonists but does not activate the receptors, effectively blocking the receptor, preventing the human body from making use of opiates and endorphins.

§ 21-28.8-3 Authority to administer opioid antagonists – Release from liability.

- (a) A person may administer an opioid antagonist to another person if:
 - (1) He or she, in good faith, believes the other person is experiencing a drug overdose; and
 - (2) He or she acts with reasonable care in administering the drug to the other person.
- (b) A person who administers an opioid antagonist to another person pursuant to this section shall not be subject to civil liability or criminal prosecution as a result of the administration of the drug.

§ 21-28.8-4 Emergency overdose care – Immunity from legal repercussions.

- (a) Any person who, in good faith, without malice and in the absence of evidence of an intent to defraud seeks medical assistance for someone experiencing a drug overdose or other drug-related medical emergency shall not be charged or prosecuted for any crime under RIGL 21-28 or 21-28.5, except for a crime involving the manufacture or possession with the intent to manufacture a controlled substance or possession with intent to deliver a controlled substance, if the evidence for the charge was gained as a result of the seeking of medical assistance.
- (b) A person who experiences a drug overdose or other drug-related medical emergency and is in need of medical assistance shall not be charged or prosecuted for any crime under RIGL 21-28 or 21-28.5, except for a crime involving the manufacture or possession with the intent to manufacture a controlled substance or possession with intent to deliver a controlled substance, if the evidence for the charge was gained as a result of the overdose and the need for medical assistance.
- (c) The act of providing first aid or other medical assistance to someone who is experiencing a drug overdose or other drug-related medical emergency may be used as a mitigating factor in a criminal prosecution pursuant to the controlled substances act.

§ 21-28.8-5 Law enforcement reports.

In the first week of January, 2013 and each year thereafter, the attorney general shall, in cooperation with local law enforcement agencies and the state police, submit to the general assembly a report summarizing the impact of this chapter on law enforcement. The report shall include any incidents in which a law enforcement agency was barred, due to the immunity provisions of subsection 21-28.8-4(a), from charging or prosecuting a person under Rhode Island general law 21-28 or 21-28.5 who would have otherwise been so charged or prosecuted, and indicating whether the person was charged with, or prosecuted for, any other criminal offense resulting from the agency's response to the request for medical assistance.
