

ADOPTING NALOXONE STANDING ORDERS

TOOLKIT FOR NORTH CAROLINA
LOCAL HEALTH DEPARTMENTS

**N.C. Department of Health and Human Services
Division of Public Health**

Injury and Violence Prevention Branch

Local Technical Assistance and Training and Public Health Nursing and Professional
Development Branch

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North Carolina Department of Health and Human Services
Division of Public Health

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Governor

June 2015

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Acting Division Director

Dear N.C. Local Health Directors:

Medication and drug overdoses continue to impact our state and nation; we currently experience 1,000 overdose deaths a year in North Carolina.

The enactment of the *N.C. Good Samaritan Law/Naloxone Access* ([SL 2013-23](#)) provided a powerful tool to combat overdose deaths from this epidemic. The law was strengthened on June 19, 2015 when Governor McCrory signed the *Clarifying the Good Samaritan Law* ([SL 2015-94](#)).

These two laws enable widespread distribution and access to naloxone (Narcan[®]), an opioid overdose antagonist, and encourage people to call 911 for medical assistance in the event of an overdose. This also provides limited immunity from prosecution for reporting an overdose; gives immunity to prescribers, dispensers, and bystanders who administer naloxone; and, allows for third party prescribing and dispensing to a person at risk of experiencing an overdose or to a family member, friend, or other person in a position to assist.

Since passage of the *N.C. Good Samaritan Law/Naloxone Access*, communities across the state have established naloxone prescription, dispensing, and distribution programs:

- The N.C. Harm Reduction Coalition has distributed over 10,000 rescue kits and reported more than 575 reversals,
- Community Care of N.C. is distributing naloxone through their physician networks and pharmacies,
- The Orange County Health Department established one of the first local health department standing orders and distribution programs for naloxone,
- Twenty more local health departments in North Carolina are in the process or have adopted naloxone standing orders, and another 32 local health departments are in the planning stages of adopting standing orders.

The lessons learned from these initial programs have been collected in a newly developed toolkit to guide local health departments through the process of adopting naloxone standing orders and implementing naloxone distribution programs. The toolkit includes information on identifying and engaging internal stakeholders and external partners to establish buy-in, implementation tools (e.g. patient education and staff training materials, costs), lessons learned, and case studies.

We hope this toolkit will be a valuable resource as your local health department considers opportunities to prevent overdose deaths. A contact in the N.C. Injury and Violence Prevention Branch in the Division of Public Health is available to provide technical assistance needed in using the toolkit and can be reached at 919.707.5428. You can also email nidhi.sachdeva@dhhs.nc.gov.

Local health departments that have established naloxone programs are seeing positive results; they are playing a key role in reducing overdose deaths.

I encourage you to work with your staff and community partners to identify populations at risk (active drug users, acute and chronic pain patients, recent releases from prison/jail, family and loved ones who use opioids) and provide them access to naloxone and training. We encourage all local health departments to make naloxone widely available in their communities and thank you for joining us in this collaborative effort that is saving lives.


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EXECUTIVE SUMMARY

North Carolina today faces a deadly, and often overlooked, epidemic: unintentional drug overdose. As numbers of deaths caused by overdose continue to grow, drug overdose may soon become the leading cause of accidental death in our state. The North Carolina General Assembly passed a “Good Samaritan Law/Naloxone Access” that permits and encourages increased and widespread access to naloxone. Local health departments (LHD) can help make this happen.

This toolkit is intended for local health departments in North Carolina (NC) regardless of size, resources, or readiness to adopt a standing order for naloxone. After conducting interviews with LHDs and statewide partners working to prevent drug overdose, the Injury and Violence Prevention Branch’s (IVPB) Capstone team created this digital toolkit to assist LHDs with easily creating standing orders for naloxone dispensing and distribution.

Resources and recommendations come from numerous sources, including: 1) results of a 2015 Community Readiness Survey of NC LHD health directors, 2) interviews with counties that have been successful in adopting Naloxone standing orders, 3) community partners who have been influential in overdose prevention in NC, and 4) resources from literature and other advocacy organizations. This toolkit utilizes these diverse sources to demonstrate the ease of adopting and implementing standing orders for naloxone dispensing and distribution within NC LHDs through a comprehensive digital information portal. Using this document digitally preserves the user-friendly links to contacts and online resources. Anyone can access the materials in the appendices through this link: [Adopting Naloxone Orders: Appendices](#)

KEY DEFINITIONS

- **Overdose:** When a drug is swallowed, inhaled, injected, or absorbed through the skin in excessive amounts and injures the body. Overdoses are either intentional or unintentional. If the person taking or giving a substance did not mean to hurt themselves or others, then it is unintentional.
- **Opioid:** Chemicals either derived from the opium poppy or synthetically manufactured as pharmaceuticals. Opioids are analgesics (pain relievers), but can also cause respiratory depression. These drugs include heroin and prescription drugs such as methadone, oxycodone, and hydrocodone.
- **Naloxone:** A medication that temporarily binds to the same brain receptors as opioids, reversing all effects of the opioids (e.g. pain relief and respiratory depression). Naloxone is also known as Narcan®.
- **Standing Order:** A signed prescription order from a medical provider which describes the parameters for specified situations under which a health care provider may carry out specific orders for a patient presenting symptoms or needs addressed in the standing order – including treatment or dispensing medications (i.e. “if ___ happens, do ___”).
- **Protocol:** A procedure, written and signed by a physician, describing the process for distributing or administering naloxone by non-licensed personnel working in community based organizations, law enforcement, or other agency.

ADDITIONAL RESOURCES

In order to make this Toolkit more user-friendly, some resources have been included in [online folder](#). These valuable resources are helpful for gaining buy-in from stakeholders and partners within your community. For more information on any content in this toolkit and access to these materials from the Injury and Violence Prevention Branch, please email:

BeInjuryFreeNC@dhhs.nc.gov or
NaloxoneSaves@gmail.com



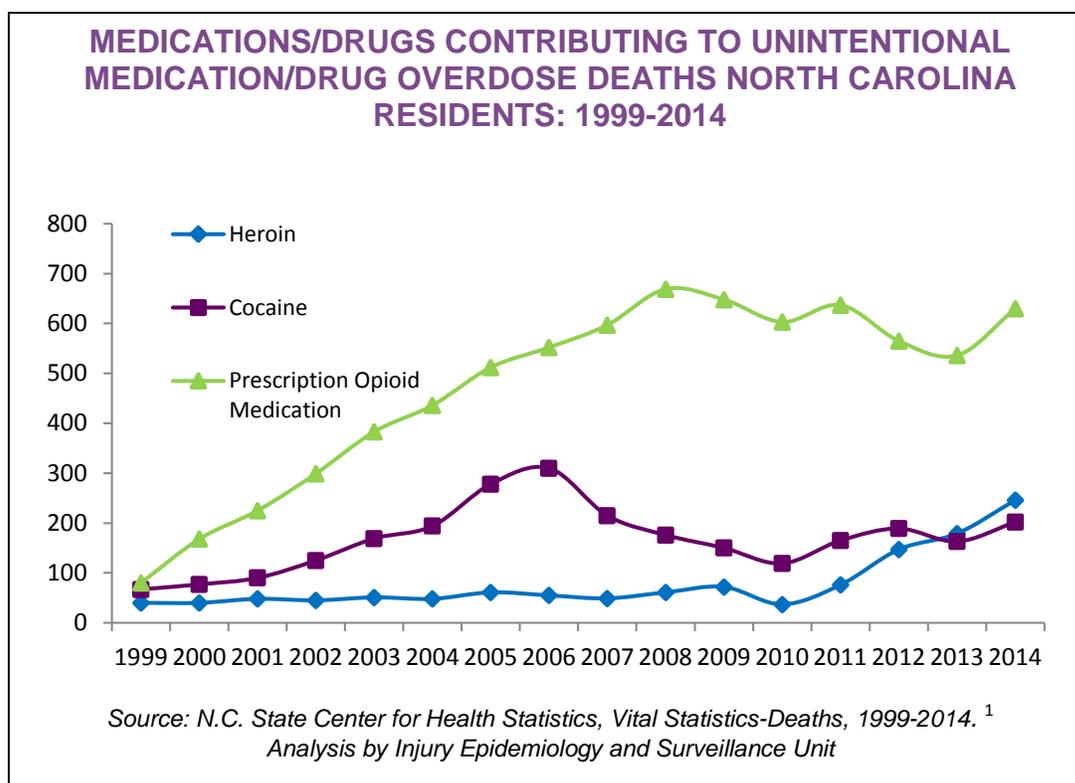
SECTION 1

BACKGROUND



UNDERSTANDING PRESCRIPTION DRUG AND OPIOID OVERDOSE IN NC

In North Carolina, the 2013 rate of unintentional medication or drug overdose deaths was 10.1 per 100,000 NC residents. This epidemic has increased by 333% since 1999, with prescription opioids greatly contributing to the increase in incidence of overdose deaths. Other drugs, such as heroin, have also contributed to an increase in the number of deaths in recent years. Between 2011 and 2012, the number of heroin-related deaths in NC nearly doubled from 79 deaths in 2010 to 148 deaths in 2012. Since 1999, 10,952 NC residents have lost their lives from unintentional poisonings. If current trends continue, unintentional poisoning deaths will surpass motor vehicle deaths as the leading cause of injury death in NC by 2017.



The public health burden of drug overdose is immense for both the medical system and the wider community. Nationally, emergency department visits for prescription drug poisoning or overdose have doubled in only five years. In NC, there were over 1000 deaths and nearly 4000 hospitalizations in 2012; and for every medication or drug overdose death, there were nearly four hospitalizations and over eight emergency department visits. Given increasing drug overdose trends and its severe impact on North Carolina's health system, drug overdose requires immediate attention and coordinated public health response.

PREVENTING DRUG OVERDOSE DEATHS BY INCREASING NALOXONE ACCESS

NALOXONE: THE OVERDOSE ANTIDOTE

Opioid overdose can be reduced through the use of naloxone (commercially known as Narcan[®] or Evzio[®]). It is an effective, quick acting, non-addictive prescription medication that can reverse overdose through an intramuscular injection, IV fluid, or a nasal spray (CDC, 2014). Naloxone blocks the effects of opioids in the brain and restores breathing in the person experiencing the overdose. Naloxone has no potential for abuse and laypersons can easily be trained to use it to reverse overdose. Work already being done at NC LHDs has shown this to be a method both feasible and acceptable to community members.

NC'S STATEWIDE STANDING ORDER

On June 20th, 2016, the State Health Director of North Carolina signed a standing order to authorize any pharmacist practicing in the state and licensed by the North Carolina Board of Pharmacy to dispense naloxone to any person who voluntarily requests naloxone and is:

- At risk of experiencing an opiate-related overdose
- A family member or friend of a person at risk of experiencing an opiate-related overdose
- In the position to assist a person at risk of experiencing an opiate-related overdose

NC'S GOOD SAMARITAN LAW/NALOXONE ACCESS

As of December 2014, 26 states and the District of Columbia have passed laws to increase community access to naloxone. One such policy is NC's Good Samaritan Law/Naloxone Access, which was adopted and immediately effective on April 9, 2013. "The purpose of the law is to remove the fear of criminal repercussions for calling 911 to report an overdose, and to instead focus efforts on getting help to the victim." "The Naloxone Access portion of the law also removes civil liabilities from doctors who prescribe and bystanders who administer naloxone."⁹ A copy of this law can be found in [Appendix 1-A](#) along with new clarifying legislation passed June 19, 2015 in [Appendix 1-B](#).

NC's Good Samaritan Law/Naloxone Access is considered one of the most comprehensive drug overdose prevention laws in the nation. The law changes the status quo surrounding drug overdose by addressing the lack of access to overdose reversal medication.¹⁰ Furthermore, the NC Good Samaritan Law/Naloxone Access attempts to address the fear of prosecution that individuals experiencing an overdose or witnesses of an overdose may have in seeking assistance from law enforcement or medical personnel. As such, the Good Samaritan Law/Naloxone Access creates a critical opportunity to reduce drug overdose deaths and improve access to naloxone for all North Carolinians.



FAQ: FACTS ABOUT NALOXONE

1. Naloxone only works for overdose cases caused by opioids.

True. Naloxone reverses the effects of opioids, such as heroin, methadone, morphine, opium, codeine, or hydrocodone. It does not reverse the effects of drugs such as benzodiazepines (drugs including diazepam, midazolam, or alprazolam), antihistamines (like pheniramine or phenergan), alcohol, or other sedatives (drugs such as phenobarbital) or stimulants such as cocaine and amphetamines.

2. Naloxone is not addictive.

True. Naloxone's only purpose is to reduce the effect of opioids. It is not possible for a person to become dependent on or abuse naloxone. It cannot make a person high.

3. Naloxone has very few to no serious negative side effects.

True. There are very few serious negative side effects of naloxone. One potential side effect of naloxone is that a person will experience opioid withdrawal. The risk of withdrawal increases for large doses of naloxone and for the strength of a person's drug dependency. Withdrawal symptoms can include aches, irritability, sweating, runny nose, diarrhea, nausea, and vomiting. **The risks of using naloxone are far fewer than the risks associated with a drug overdose.** If people experiencing drug overdose receive naloxone it can restore breathing and ultimately save lives.

4. A person cannot overdose on naloxone.

True. It is not possible to overdose on naloxone. Instead, a person may experience opioid withdrawal symptoms if they receive a large dose of naloxone while already having opioids in his or her system.

5. A person cannot develop a tolerance to naloxone.

True. Naloxone can work on a person who has used it in the past. It can be used in every opioid overdose situation no matter how many times a person has used naloxone previously. People may respond differently to naloxone each time, but that is likely due to how old the naloxone is, how it has been stored, and what types of drugs the person used.

Source: Naloxone Info, (n.d.)



FAQ: FACTS ABOUT NALOXONE

6. Naloxone can expire. It can also maintain its effectiveness under high temperatures, though not ideal.

True. To extend the lifetime of naloxone, it should be stored in a dark and dry place. Naloxone can become less effective over time and after being exposed to too much cold, heat or sunlight. Expired naloxone is not harmful, but it reduces its ability to prevent drug overdose.

Even after exposure to extreme temperature change, naloxone still works. In clinical [studies](#), naloxone maintained a concentration 89.62 +/- 1.33% even when subjected to ~21 and ~129 degrees Fahrenheit temperatures every twelve hours for 28 days. Nevertheless, it is recommended that naloxone be kept at room temperature and/or stored in UV ray resistant materials.

7. If you give naloxone to drug users, they will not use more drugs.

True. Studies report that naloxone does not encourage drug use, and in fact, has been shown to [decrease](#) it in some circumstances. By blocking the effects of opiates, naloxone can produce unpleasant withdrawal symptoms, which nobody wants, especially not an active drug user.

8. Naloxone may encourage drug users to seek treatment.

True. Death keeps people from seeking treatment! Naloxone gives people another chance to get help if they choose; and often, the near-death experience of drug overdose and being saved with naloxone acts as a catalyst to encourage people to get into treatment.

9. Naloxone does not make people violent.

True. While naloxone can cause confusion and "fight or flight" response when administered at high doses, in smaller amounts, naloxone rarely causes overdose victims to become combative.

10. Intramuscular naloxone is safe.

True. Many people avoid intramuscular naloxone because it involves the use of a syringe; however, it is just as safe and effective as naloxone administered through other measures, such as intranasal delivery. With intranasal naloxone, less is absorbed into the body, which means it can be slower to take effect, and is also less likely to cause withdrawal symptoms or induce combativeness. However, intramuscular naloxone has been shown to have a slightly quicker effect, which means that life-saving breathing function is restored sooner.

Source: *Naloxone Info*, (n.d.) and http://www.huffingtonpost.com/tessie-castillo/top-seven-crazy-myths-abo_b_5065414.html

STANDING ORDERS AND NALOXONE

Standing orders are a medical order that authorizes the dispensing of a medication to any person who meets criteria designated by the prescriber. Standing orders have been used in health departments for a long time. For example, health departments commonly have standing orders that allow RNs to administer and/or dispense antibiotics for sexually transmitted infections and tuberculosis if and when patients test positive or meet other disease criteria.



FAQ: DEFINITION OF A STANDING ORDER

A medical order that authorizes the dispensing of a medication, like naloxone, to any person who meets criteria designated by the prescriber.

Traditionally, a prescriber could only prescribe medicines to a person who they have a patient-provider relationship with; however, this arrangement does not work well in the naloxone context because 1) many of the people at high risk for overdose do not regularly see a prescriber, and, 2) naloxone cannot be self-administered if and when someone is experiencing an overdose (the victim is unconscious).

The NC legislature has changed the law so that prescribers can issue prescription or standing orders that authorize the dispensing or distribution of naloxone to any person who meets the criteria that the law specifies, even if they are not traditional patients of that provider. In the health department context this is actually how things have worked for a long time – nurses can dispense medications under standing orders without them being ordered for a specific patient.

Following the passage of NC's Good Samaritan Law/Naloxone Access, there was an effort to increase availability of naloxone in LHDs for individuals at risk for overdose. However, there was a small barrier – at the time, naloxone was not on the short list of medications that public health department nurses are authorized to dispense (formulary) in NC. The NC Department of Health and Human Services approached the North Carolina Board of Pharmacy to make a modification to the current formulary list and remove this barrier. This modification was supported by the NC Medical Board, which encourages the widespread distribution of naloxone. In January 2014, the NC Board of Pharmacy expanded the LHD nurses formulary to include naloxone. This ratification can be found in [Appendix 1-C](#) and 1-D and successfully broadens potential naloxone distribution in the state of North Carolina.

Since naloxone is now on that formulary, the health department's medical director just needs to write a standing order for naloxone to be dispensed by RNs in a local health department. This is still necessary after the 2016 statewide standing order directed toward pharmacies.

Another difference with naloxone is that it can be dispensed for use on another person, other than the person it was prescribed to. Under the Good Samaritan Law/Naloxone Access, a practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe naloxone to a *third party* – a family member, friend, or any other person in a position to assist a person at risk of experiencing an opiate-related overdose.



COUNTY FOCUS: ORANGE COUNTY

NURSES DISPENSE NALOXONE WITH STANDING ORDER

In 2013, the Orange County Health Department (OCHD) was the first in North Carolina to adopt a standing order to allow public health nurses to dispense naloxone to clinic patients. Having identified substance use, abuse, and overdose as priorities in the 2011 Community Health Assessment, OCHD was committed to evidence-based solutions to prevent overdose. The 2013 passage of NC's Good Samaritan Law/ Naloxone Access paved the way for standing orders. Public health nurses were a natural choice for naloxone kit dispensing given their significant clinical role.

PROTOCOLS FOR DISTRIBUTING NALOXONE BY COMMUNITY BASED ORGANIZATIONS OR OTHER AGENCIES

Following the passage of NC's Good Samaritan Law/Naloxone Access, there was an effort to increase availability of naloxone in the community for individuals at risk for overdose. The new law removed other barriers to naloxone access and use. When there is a protocol in place signed by a physician, naloxone can now be administered by lay health workers, first responders, law enforcement, and others who are more likely to witness an overdose or be in a better position to respond more quickly outside of a traditional medical setting. Also, naloxone protocols can be written to allow distribution to potential bystanders, such as friends or family, expanding 'just-in-time' access to naloxone.

Standing orders or protocols for naloxone dispensing are an effective and evidence-based strategy for increasing community access to naloxone. San Francisco, Colorado, and Massachusetts have developed standing orders through their city- and state- public health departments. In NC, the NC Harm Reduction Coalition (NCHRC) has developed a standing order similar to that of Massachusetts following the passage of NC's Good Samaritan Law/Naloxone Access. Under prescriptive authority of NCHRC's Medical Director, NCHRC outreach workers have dispensed over 11,000 overdose rescue kits resulting in over 627 confirmed overdose reversals as of July 6, 2015.

Great strides have been made in North Carolina, with numerous counties swiftly adopting standing orders to enable naloxone dispensing through their health departments. In just two years, eleven NC health departments have adopted standing orders, with many others in the process of adopting or in the midst of developing policy and protocols. These counties differ greatly in size, available resources, and geographic region. Furthermore, over 40 more health departments from across the state are keenly interested in starting this process in the near future. Based on these results, there is strong expectation that diverse counties can be successful in adopting standing orders and protocols.



COUNTY FOCUS: NC COUNTIES WITH LHD STANDING ORDERS AND PROTOCOLS

As of March 2015, the nine LHDs in NC that reported they already have standing orders for naloxone are in Alexander, Duplin, Durham, Hoke, Orange, Pender, Pitt, Union, and Wilkes counties. Many others are in the process of adopting their own standing orders and protocols for naloxone dispensing and distribution.

SPECIFICS FOR DISPENSING AND DISTRIBUTION LOCATIONS

Standing orders can be tailored to counties with diverse dispensing needs. NC LHDs can use one of three methods for dispensing naloxone within and from the health department. These differing methods for dispensing must be incorporated into the standing order document to ensure a clear process. Note: Please follow the NC Board of Pharmacy rules for storage, inventory and prescription reconciliation when dispensing from within the Health Department.

1. Internal Pharmacy within the LHD with a staff pharmacist
2. Contracted pharmacist that works for a certain number of hours at the LHD
3. Contracted pharmacy external to the LHD.

A standing order/protocol is critical to determine how health departments dispense naloxone. Numerous counties with adopted standing orders/protocols are in the process of implementing community education and outreach to engage a greater portion of their constituents.

ENGAGE INTERNAL STAKEHOLDERS AND EXTERNAL PARTNERS

Various stakeholders and partners should be involved in developing and implementing a naloxone standing order. For the purposes of this toolkit, key members to engage have been categorized as internal stakeholders, people involved in the adoption of standing orders at local health departments, and additional external partners, or community members and organizations that may not take part in the adoption of standing orders but will be impacted by changes in policy. Below are internal stakeholders and external partners, with those in bold are featured in depth throughout various sections of this document. This is not an exhaustive list. Suggestions for Stakeholder Engagement are provided in Section 2 as well as in Tailored Materials for Stakeholders and Partners noted in Sections 4 and 5, respectively.

<p>Internal Stakeholders</p> <p>Members of the local Health Department that are critical to adopting a LHD standing order process.</p> <p><i>Tailored Stakeholder Materials are available in Section 4.</i></p>	<ul style="list-style-type: none"> ✓ Medical Providers (Clinic Staff, Physicians, Nurses, Providers, Prescribers, Pharmacists, Directors) ✓ Health Director, Board of Health Members, and LHD Staff ✓ Legal Counsel ✓ Health educators, social workers, and home visitors ✓ County Commissioners
<p>External Partners</p> <p>Community members or external organizations that may not take part in adopting standing orders but will be impacted by the policy.</p> <p><i>Tailored Partner Materials are found in Section 5.</i></p>	<ul style="list-style-type: none"> ✓ Law enforcement ✓ First responders (EMS and Fire) ✓ Prisons and jails ✓ Departments on Aging ✓ Board of Pharmacy and External Pharmacists ✓ Older adult facilities and assisted living communities ✓ Pharmacies ✓ Hospitals, urgent care centers ✓ Homeless shelters ✓ Schools and universities ✓ Worksite wellness ✓ Veterans and military ✓ Local Management Entities (LME) and Managed Care Organizations (MCO) ✓ Substance abuse treatment services/ detox/rehabilitation clinics

SECTION 2

ENGAGING INTERNAL STAKEHOLDERS



Buy-in from a variety of stakeholders and groups both internal and external to the health department is critical to successfully implementing a naloxone standing order in a LHD. Considering all groups and planning tailored communication can help facilitate the adoption of a standing order and implementation of a LHD distribution program. The first step is to identify these key stakeholders and partners, who may include but are not limited to, those listed in Section 1. Once these key stakeholders and partners have been identified, buy-in can be gained through materials in the Educational and Training Resources folders. To access these materials in a format that can be customized to your county from the NC Injury and Violence Prevention Branch, please visit www.InjuryFreeNC.org. Appendix 3 contains valuable information and resources that can be tailored as well: [Adopting Naloxone Orders: Appendices](#).

EDUCATIONAL RESOURCES

One quick strategy that can be used to raise awareness and buy-in from key stakeholders, including the medical director and Board of Health members, is to provide research articles to accompany proposals. Several key articles provide examples of how standing orders for naloxone dispensing in LHDs have been successful and impactful. For example, if support for NC's Good Samaritan Law/Naloxone Access in general is needed, an article from the 2012 Public Health Law Conference, found in the Educational Resources folder, can be utilized as a resource. A 2011 Journal of Pain Medicine article, found in the Educational Resources folder, provides additional information on community impact and overdose deaths. This article demonstrates successes from rural North Carolina through the work of Project Lazarus, Inc. in Wilkes County. This work to distribute naloxone, led to the overdose death rate dropping from 46.6 per 100,000 in 2009 to 29 per 100,000 in 2010.

PATIENT EDUCATION RESOURCES FOLDER

As more and more LHDs adopt standing orders and protocols, more materials will be added to this [online folder](#) as it is collected. So, check back for updates and new additions.

TRAINING RESOURCES

Another opportunity for LHDs to increase stakeholder engagement and knowledge of how LHDs distribute naloxone is to provide a training session for nurses and staff. Training specific for Public Health Nurses must be arranged with an approved pharmacist. Please contact the NC Local Technical Assistance and Training and Public Health Nursing and Professional Development Branch and the NC Pharmacist for more information.

Denise M Perry, RPh, MS: Denise.Perry@wakegov.com

Phyllis M. Rocco, RN, BSN, MPH: Phyllis.Rocco@dhhs.nc.gov

The North Carolina Harm Reduction Coalition (NCHRC) offers free trainings to interested organizations and individuals, as well as provides resources for additional information and awareness. To date they have trained more than 100 local agencies and departments throughout the state on overdose response and needle stick prevention. Additional training materials can be found in the Training Resources folder. If you are interested in setting up training or want more information on North Carolina's Good Samaritan Law /Naloxone Access, please contact:

Robert Childs, MPH: robert.bb.childs@gmail.com

In addition, Regional Consultants or Chronic Pain Initiative (CPI) Coordinators with Project Lazarus of Community Care of North Carolina (CCNC) are also able to provide or arrange for training in some areas. Please contact:

CPI at CCNC, *Theo Pikoulas, PharmD:* tpikoulas@n3cn.org

Eastern Region, *Anne Thomas, MPH:* athomas@n3cn.org

Central Region, *Mark Sullivan, MSW:* msullivan@n3cn.org

Western Region, *Fred Brason:* fbrason@projectlazarus.org

TOOLS AND TRAINING RESOURCES FOLDER

To access these materials from the NC Division of Public Health, Injury and Violence Prevention Branch or for more information, please visit [this link](#) or contact:

BeInjuryFreeNC@dhhs.nc.gov or

NaloxoneSaves@gmail.com

HEALTH DIRECTOR, BOARD OF HEALTH MEMBERS, AND LHD STAFF

Health departments are well positioned to bring together community leaders, including local hospitals, the medical community, government, law enforcement, social services, and schools to address individual and community health concerns. LHDs are also critical in collecting and disseminating information on local issues that affect the health of our communities. Health Departments should take the following steps:

- Recognize opioid overdose as a public health concern
- Be part of or facilitate a community-wide task force/coalition that addresses substance abuse, mental health, and/or injury prevention (e.g. local Project Lazarus community coalitions). Organize interested parties from as many sectors as possible to create a community response to the issue of drug overdose
- Promote education among the medical community with respect to safe opioid prescribing practices and monitoring through the Controlled Substances Reporting System (CSRS)
- Educate the public regarding potential danger and proper use, storage, and disposal of prescription opioids
- Promote, lead, and support programs that supply naloxone, the antidote to opioid overdose
- Support increases in the availability of addiction treatment and chronic pain patient services
- Collect real time data pertaining to prescription drug overdose mortality, emergency department visits and hospitalizations pertaining to substance use, school based incidences, and local crime data regarding diversion and addiction.

MEDICAL PROVIDERS

CLINIC STAFF, PHYSICIANS, NURSES, PROVIDERS, PRESCRIBERS, PHARMACISTS, MEDICAL DIRECTORS

North Carolina is a leader in provider buy-in for naloxone distribution. Project Lazarus of Community Care of NC (CCNC), a community initiative that began in Wilkes County and has since been expanded statewide through CCNC, emphasizes that overdose prevention requires comprehensive approaches by providers as well as schools, law enforcement, and drug treatment centers. In addition, providers must feel comfortable prescribing naloxone as part of their normal clinical practice. The NC Medical Board released a statement of concern regarding the rise in overdose deaths, and encouraged programs to make opioid antagonists, such as naloxone, available to overdose victims or bystanders.

Providers have an important role in helping monitor opioid use through the Controlled Substance Reporting System (CSRS), North Carolina's Prescription Drug Monitoring Program (PDMP) Database. Helpful recommendations for providers trying to reduce the rise in prescription drug overdose are provided below.

TIPS FOR PROVIDERS - PRESCRIPTIONS FOR CONTROLLED SUBSTANCES

1. **Assess the patient.** Obtain a complete history of the patient's past use of drugs, over the counter preparations, and alcohol. If patients indicate that they have a history of using controlled substances, it requires further investigation.
2. **Select appropriate medication.** Depending on the severity of symptoms, the reliability of the patients in taking the medication, and the potential for the medication to produce dependency, consider co-prescribing naloxone if prescribing an opioid.
3. **Use the state prescription drug monitoring programs database.** This database, NC CSRS, can help providers identify patients who might be at risk of overdose.
4. **Obtain informed consent.** Informed consent ensures that the patient knows the risks and benefits of the medication.

Source: Project Lazarus, 2013

Medical providers have numerous priorities when consulting with a patient or following through with LHD processes and clinic protocol. When implementing an adopted naloxone standing order that addresses cost and liability concerns as well as clinic policies, consider these ideas for your general practice:

- Distribute naloxone kits that include training materials for patients
- Modify LHD policies and procedures to identify those persons at risk or those who may be in a position to assist those at risk, and to provide patient education and naloxone. This could be as simple as a screening question that asks: "Do you or someone you know take an opioid?" Do your best to integrate this into the normal clinic workflow or otherwise make sure that patients have it available and can take advantage of the service you are providing.
- Educate, advocate, and encourage the establishment of policies at local medical and treatment clinics to encourage consistent use of the CSRS to identify patients at risk for overdose
- Know local referral sources and become familiar with the referral process
- Advocate for or implement peer specialists and all support systems along the recovery-oriented system of care
- Advocate, educate, and introduce non-abstinence directed initiatives into publicly funded treatment. Non-abstinence directed treatment initiatives incorporate a spectrum of strategies such as safer drug use or managed drug use (prescriptions or other) to meet people who use drugs "where they are," addressing conditions of use along with the use itself. In effect, these initiatives accept any positive change as desirable to reduce the negative consequences of drug use.

MESSAGING BY PRIORITY AREA

LHDs have numerous priorities for keeping their communities safe and healthy. Many of these priority areas (e.g. chronic disease, substance abuse, suicide) can be directly linked to overdose prevention and can be used to gain buy-in for naloxone standing order adoption. A seven-question survey was conducted by the UNC Injury Prevention Research Center (IPRC) and the UNC IVPB Capstone team and administered to all NC LHD Health Directors. The purpose of this survey was to determine awareness of the Law, readiness to implement overdose prevention activities and to inform messaging for specific LHD priority areas. These tailored messages based on survey results can be used to garner support from internal LHD stakeholders, external partners, and community members. For detailed messaging information, see [Appendix 2-B](#).

LEGAL COUNSEL

NC's Good Samaritan Law/Naloxone Access ensures that it is legal for a health care practitioner, exercising reasonable care, to prescribe naloxone to anyone, including a person at-risk, a friend/family of a person at-risk, or anyone else in a position to assist in the event of an overdose. This law removes civil liabilities from prescribers and bystanders who administer naloxone. Both practices are recommended by CDC, endorsed by the Center for Law and Public Health, and encouraged by the NC Medical Board, NC Board of Pharmacy, NC State Legislature, and many others. North Carolina joins numerous states in protection of third-party administrators of naloxone from liability. An explanation of the law can be found in [Appendix 2-C](#).

It is recommended that you work with your county-level legal counsel/lawyers if needed.

SECTION 3

IMPLEMENTATION



STANDING ORDER PROCESSES

Creating a naloxone standing order is a straightforward process that can be adopted in any county. Many tools and resources already exist from LHDs that have adopted naloxone standing orders, and have been highly effective in helping other counties easily adopt and implement standing orders. A list of NC counties who have already adopted a standing order for naloxone is included in [Appendix 3-A](#). Examples of NC counties' standing orders are included in [Appendix 3-B](#). Please reach out to any of them to ask questions and share additional lessons learned.

As of spring 2015, over 20 local health departments have adopted or are in the process of adopting a naloxone standing order. This section examines the process of adopting these standing orders and lessons learned from successful counties.

IMPACT AND TRACKING

The overall impact of naloxone standing orders is undeniable, as they expand access to naloxone to save lives. Reporting overdose reversals or attempts is one of the biggest challenges that naloxone distribution programs face. Tracking systems for naloxone kits are one way in which counties can determine the impact of their standing orders. For instance, in Orange County, the health department is currently logging the number of kits dispensed and refilled through their pharmacy, as well as reasons for drug refill.

The University of North Carolina at Chapel Hill's Injury Prevention Research Center's (IPRC) [universal tracking number system \(Naloxonesaves.org\)](#) provides a statewide system for tracking naloxone kits and outcomes for attempted reversals. This system allows naloxone users to simply answer a few anonymous questions online and enter the naloxone kit number. It is highly recommended that LHDs utilize this tracking and kit numbering system to understand impact and track reach. Details on how to participate in this initiative can be found in [Appendix 3-C1](#). For more information on the naloxone saves tracking system, please email [IPRC](#).

Ideally, organizations dispensing and distributing naloxone will give people lots of easy reporting options. Consider text, phone, in-person, social media, online form, pre-stamped postcards and other less intrusive options; and this helpful article with a [list of tips](#) to tracking reversals.

Even with these tools, reversals and attempts are often underreported.

LESSONS LEARNED

For sample templates of a naloxone standing orders, see [Appendix 3-B](#). Successful counties have shared important lessons learned from adopting a naloxone standing order. A few of these have been mentioned above, but below is a summary of important lessons to consider when creating a naloxone standing order.

- **Focus on the positive.** The end result of adopting a standing order is that people will have access to a first aid tool that can save lives.
- **Data speak volumes.** Presenting drug overdose statistics to the community and health department staff is a powerful way to start a dialogue surrounding prevention and need.
- **Seek support from local coalitions.** These groups can help raise community awareness about the drug overdose epidemic and the usefulness of naloxone, and help distribute overdose reversal kits.
- **Adopting a standing order can be easier than you think.** Health departments in smaller communities found that it is fairly simple to adopt a standing order given that they already have strong relationships with key stakeholders and partners, in addition to statewide support.
- **Collaborate with clinic staff during program planning, implementation, and follow-up.** It is important for clinic staff to have a voice in the development of standing orders, as their work will be impacted directly.
- **Use existing resources instead of recreating the wheel.** National programs, such as the Harm Reduction Coalition, and local programs, such as the NC Harm Reduction Coalition, Project Lazarus of CCNC, and the Division of Public Health have many useful resources.
- **Funding can be brought in from numerous creative and diverse sources.** Successful counties found support through partnerships, donations, private, federal, state, and local sources.
- **Flexibility is key.** Health departments found that it is worthwhile to be open to the involvement of stakeholders and various avenues for distribution.



COUNTY FOCUS: ALEXANDER COUNTY ADOPTING A STANDING ORDER

In this tight-knit county, adopting a standing order was as simple as a signature. The Health Director wrote a standing order for naloxone distribution through the Alexander County Health Department. Having seen the data on the impact of drug overdose on the community, the Alexander County Medical Director immediately signed the standing order. Then, the Board of Health swiftly adopted the order and the county began distributing naloxone.

HOW TO MAKE A NALOXONE KIT AND PRICING INFORMATION

Creating a naloxone overdose rescue kit to distribute through a local health department is both easy and affordable. This guide will outline the cost differences between various routes of naloxone administration, buying commercially available naloxone, and the components of a complete kit.



FAQ: METHODS OF NALOXONE ADMINISTRATION

- Intramuscular
- Intranasal
- Auto-Injector (Evzio®)

Please note that the price of naloxone has been rising nationally, thus these prices are approximations and may have changed.

For a comprehensive guide to creating a kit and step-by-step instructions (patient education materials) for intramuscular, intranasal, and Evzio® administration, see [Appendix 3-D](#).

ROUTES OF ADMINISTRATION AND KITS

INTRAMUSCULAR ADMINISTRATION

Using this method, naloxone is administered using a needle to the upper arm muscle (deltoid), outer thigh or buttocks. This is the most affordable option for complete kit purchase. For step-by-step instructions for intramuscular administration, see [Appendix 3-D6](#).

Sample Kit Pricing and Purchase Options

1. Orange County Health Department: \$20.68 per kit
 - \$2.08 – CPR Mask (bought in bulk with other HD supplies)
 - \$0.02 – Alcohol prep pads x2 (bought in bulk with other HD supplies)
 - \$0.08 – Gloves (bought in bulk with other HD supplies)
 - \$2.95 – Case (so many options, Orange County uses a semi-hard, zippered eyeglass case with an imprint on it)
 - \$1.50 – Professionally printed education card (Orange County prints in house to minimize this cost)
 - \$0.15 – 2 Intramuscular syringes (bought in bulk with other HD supplies)
 - \$13.00 – 2 vials naloxone hydrochloride (0.4 mg/mL) (through pharmacy vendor)
2. NC Harm Reduction Coalition: \$10 donation per reversal kit. Free technical assistance provided. NCHRC kits include:
 - Ziploc bag with an external pouch
 - Printed prescription ¼ sheet, black and white
 - Tri-fold printed brochure, black and white
 - 2 IM syringes
 - 2 naloxone vials (0.4 mg/mL each)
 - UV protective zip lock bag to store naloxone vials

To order NCHRC kits, please contact Hyun Namkoong (hnamkoong88@gmail.com).

INTRANASAL ADMINISTRATION

There are two ways to deliver naloxone nasally – (1) into the nose via Narcan® nasal spray or (2) into the nose with a foam tip nebulizer, adapter, or atomizer.

- (1) Narcan® (naloxone hydrochloride) nasal spray is a take-home, hand-held, single-use device that does not require assembly. This makes it easier to administer, and it may be used in the event of an opioid overdose. It is FDA approved and can legally be prescribed by a physician or dispensed by pharmacists and LHDs. See [Appendix 3-D12](#) for more information including step-by-step instructions and ordering forms.

Sample kit pricing and purchase options for Narcan

Narcan is available at a reduced rate (public interest pricing) to LHDs and non-profit community at \$75 for two doses. These two doses can be split into two kits if desired.

- (2) The other nasal delivery method includes a foam tip (nebulizer, adapter, or atomizer) that is put on a syringe and then placed into the nostril. The use of the atomizer for intranasal naloxone has not been approved by the FDA (i.e., it is an "off-label" delivery method) and can be legally prescribed by a physician or dispensed by pharmacists. This option is more expensive than intramuscular administration, but many LHDs have found this option convenient. For step-by-step instructions in both English and Spanish for intranasal administration, please see [Appendix 3-D3](#).

Sample kit pricing and purchase options for nasal naloxone

Project Lazarus, Inc.: \$12 per kit + the cost of the nasal naloxone (~\$34+ per dose x recommended 2 doses) = ~\$80 and can be obtained through [Project Lazarus, Inc.](#), by completing the [form](#), scanning, and emailing back to rescuekit@projectlazarus.org or fax to 866-400-9915, or call 336-667-8100 and request by phone. Project Lazarus Inc. kits include:

- 1 box (hard square case with imprint)
- 2 nasal atomizers
- Instruction booklet
- DVD
- Good Samaritan card
- Kit location card
- (Naloxone sold separately, Two prefilled syringe doses 2mg/1mL vials
 - NDC 76329-3369-1

EVZIO AUTOINJECTOR

EVZIO is a take-home, hand-held, single-use naloxone auto-injector that may be used wherever an opioid overdose occurs. This is the most expensive option. For step-by-step instructions for EVZIO administration, please see [Appendix 3-D4](#).

Sample Kit Pricing and Purchase Options

EVZIO can be purchased online through the manufacturer [website](#).

BUYING NALOXONE

Source: NC Harm Reduction Coalition, 2012

Method of Administration	Manufacturer	Dosage and ordering information
Intramuscular	Hospira	0.4/mL in 10 mL multidose vial (NDC 0409-1219-01) and 1 mL single dose vial (NDC 00409-1215-01)
Intranasal	International Medication Systems (IMS)-Amphastar	2mg/mL (NDC 76329-3369-1)
	Adapt Pharma	4mg/mL (NDC 69547-353-02)
Auto-injector	EVZIO	0.4 mg/0.4 mL naloxone HCl solution in a pre-filled auto-injector

Some secondary distributors of medical products and medications also carry naloxone manufactured by these companies.

Health departments are not required to provide free naloxone kits to patients or community members. Charging a fee is an option. Also, when billing a patient's insurance for reimbursement for naloxone, keep in mind that NC Medicaid and some private insurance cover naloxone with copay. Some insurance may not cover the intranasal form of naloxone. If a patient has not obtained a rescue kit for free, they may have to pay the cash price for two nasal adaptive devices.

STORING AND LABELING NALOXONE

Source: NC Harm Reduction Coalition, 2012

Naloxone's shelf life is approximately two years. Naloxone should be kept out of direct light, and at room temperature (between 59 and 86 degrees Fahrenheit). However, naloxone is an impressively stable medication and can withstand some variations of extreme cold and heat and still retain potency. Naloxone should be labeled following all prescription requirements. The NC Board of Pharmacy has specified that the prescription label should be affixed to the kit in a stable manner. Naloxone inventory must be tracked and signed in and out of a pharmacy on a pharmacy log.¹⁵ If no in-house pharmacy or contracted pharmacist on site is available, an alternative naloxone tracking system must be provided for use by the proprietary pharmacy. Sample dispensing and distribution logs are included in [Appendix 3-C3](#).

DATA SOURCES

Data is helpful to make a case for adopting a standing order through your health department. Specifically, data can help gain staff, Board of Health, and community buy-in for naloxone standing orders. NC DETECT is a useful tool for county-level statistics on drug overdose in North Carolina. Additional sources of data are listed below.



FAQ: DATA SOURCES

- City and [State Health Departments](#)
- NC DETECT, Local emergency rooms
- Emergency Medical Services (Ambulance, Fire), NC PreMIS
- Injuryfreenc.org
- Community Health Assessments
- State or Local Offices of Vital Records
- Medical Examiner's or Coroner's Offices
- Police reports of drug arrests or calls



COUNTY FOCUS: WILKES COUNTY USING DATA TO ESTABLISH A STANDING ORDER

Wilkes County has a strong history of engaging community members to address overdose prevention. For buy-in to adopt a standing order through the Wilkes County Health Department, data has been key. By stressing the history of overdose within the county and sharing statistics about incidence, Wilkes County has been able to make strides towards the adoption of a standing order. County level data can be found through this [NC DETECT map](#).

SECTION 4

SUSTAINABILITY



OUTREACH TO COMMUNITY MEMBERS

Naloxone is intended to prevent drug overdose deaths, but its effectiveness depends on the number of people who have access to the medication. Thus, outreach and distributing naloxone to community members are important focuses of this toolkit.

LHDs have a unique role in serving communities and preventing drug overdose deaths. However, some members of the community, especially those at higher risk of overdose, may feel uncomfortable obtaining naloxone from an LHD clinic. A public awareness campaign and community education about naloxone and other prevention or harm reduction strategies should be a part of your overall overdose prevention effort.

First, it is important to gather information about overdose in your community. This could come from formal sources, such as NC DETECT (see below for more details), the Medical Examiner's office, or from community members who are involved in drug overdose prevention work, such as the DPH's IVPB. It is important to know the groups in your community that are at risk for drug overdose and potential locations for outreach. By providing education to groups at risk for opiate overdose or by targeting street level education in areas of high overdose incidence, we can actively impact overdose in our communities.

Law enforcement, other first responders, and correctional officers are partners well positioned to engage people at risk for drug overdose. Naloxone is often provided free to some law enforcement agencies, which makes them a key group to engage. These partnerships could also enable a greater range of response within the community. Data from these partners is invaluable to understanding prevalence and incidence of overdose.

Similar to the list of potential community stakeholders, possible sources of local data and information include the following:

High Risk Groups	Locations for Outreach
<ul style="list-style-type: none"> ● Active drug users ● Veterans ● Recently-released inmates ● Residents of rural and tribal areas 	<ul style="list-style-type: none"> ● Injection drug user hangouts ● Prisons and jails ● Methadone programs ● Hospital-based and private detoxification programs ● Local drug treatment centers

High Risk Groups	Locations for Outreach
<ul style="list-style-type: none"> ● People completing drug treatment/detox program ● Some young adults ● Chronic pain patients 	<ul style="list-style-type: none"> ● Pharmacies and local health-care clinics ● Mental and behavioral health centers ● HIV/AIDS service organizations and other community-based organizations ● Laundromats and parking lots ● Senior centers ● Churches, Faith-based organizations ● Schools ● Syringe exchange programs in other cities and states

FUNDING OPPORTUNITIES

Funding for a naloxone distribution program can be obtained through numerous funding sources at the private, federal, state, and local levels. Options also exist for cost saving measures through partnerships and sponsorships.

PRIVATE

Many local and national foundations provide funding for work done through new and innovative programs. As naloxone distribution is a budding and evidence-based intervention, some local health departments have had success obtaining private funding (e.g. foundations, donors) to purchase supplies. Hospital foundations or funds under community benefit programs may also be sources of funding.

FEDERAL

There are numerous funding sources that provide support for overdose related programs through diverse federal channels. Many times, funding is provided through Health and Human Services (HHS), Department of Justice, and Substance Abuse and Mental Health Service Administration. For data and justification for grant writing purposes, see [Appendix 4-A](#).

STATE AND LOCAL

Numerous counties have leveraged state and local funding to adopt standing orders. LHDs can seek funding through the local governments' general fund to fund the purchase of naloxone. Counties with adopted standing orders recommend seeking funding through county funds, local foundations, and funding agencies. Some counties have also reached out to the Board of Health and County Commissioners for funding. Statewide agencies such as the Chronic Pain Initiative and Project Lazarus of CCNC, Division of Public Health Chronic

COUNTY FOCUS: DURHAM COUNTY FUNDING NALOXONE DISTRIBUTION

Durham was quick to seek out funding from diverse sources following the adoption of their widely supported naloxone standing order. They reached out to state advocacy organizations, the Durham County Commissioners, and county Health Department for funding. They were also awarded state funding to specifically focus on naloxone kit purchases. Durham County was easily able to fund the bulk of their dispensing by connecting with existing partners within their community.

Disease and Injury Section, NC Injury and Violence Prevention Branch, and Project Lazarus, Inc. also provide financial and resource support for LHDs interested in purchasing naloxone and beginning distribution programs.

PARTNERSHIPS AND SPONSORSHIPS

Several local health departments with adopted standing orders suggest partnering with surrounding counties to purchase naloxone at a bulk rate. This effective practice allows for widespread regional distribution and highly discounted prices. Some LHDs also choose to charge a fee for naloxone to assist in offsetting the cost of purchasing naloxone.

LHDs can also partner with county groups that will be directly impacted by the distribution of naloxone, such as EMS (Emergency Medical Services), Department on Aging and senior centers, Local Management Entity/Managed Care Organization (LME/MCO) agencies on mental health, law enforcement, and substance abuse treatment services. These creative collaborations provide opportunities to increase reach within the community and funding options. Funding can also be reallocated from existing programs or through Medicaid (which covers naloxone). Resources can also be sought from universities or other educational and medical institutions that are interested in conducting research on overdose prevention.

Companies that distribute and manufacture naloxone are often open to providing donations to new and effective programs nationwide. These donations can be made directly to the LHD or may often be distributed through a community partner, such as law enforcement agencies.

SECTION 5

BUILDING PARTNERSHIPS



External and community organizations may not take part in passing a standing order, but may be impacted by the dispensing of naloxone in health departments. Examples of such partnerships may include first responders, including law enforcement and emergency medical services (EMS), local prisons and jails, the Department on Aging, senior centers, and pharmacies.

LAW ENFORCEMENT

Law enforcement is often the first to be called in an emergency overdose, and as such, they can swiftly respond and administer naloxone. To establish a protocol for law enforcement to administer naloxone, a memorandum of agreement between county EMS and the local law enforcement agency may be helpful. See [Appendix 5-A](#) for a sample memorandum of agreement for the use of naloxone by first responders. Next, it is critical to provide law enforcement the knowledge and tools needed to administer naloxone in the community. For information on the NC Harm Reduction Coalition free one-session law enforcement training on handling an opioid overdose, please contact:

Robert Childs: robert.bb.childs@gmail.com

An example of a law enforcement Incident Report form is included in [Appendix 5-B](#) to track and monitor the use of naloxone. A current list of law enforcement who are carrying naloxone can be found here on the NCHRC website: [Law enforcement carrying naloxone](#).

The NC Office of EMS has also sponsored an opioid overdose prevention training for law enforcement and first responders, ideally to be delivered by local EMS. The training is available here: <http://www.ncems.org/pdf/OpioidOverdosePrevention.pdf>.

FIRST RESPONDERS (EMS AND FIRE)

Developing statewide protocols for first responder naloxone administration is a promising strategy to improve overdose response and naloxone use. NC EMS vehicles are equipped with naloxone and can provide crucial assistance in cases of overdose. It is essential to ensure that EMS providers are aware of increased distribution of naloxone within the community and that they are privy to any new information on legal policy in the community or state. Expanding naloxone access to fire departments and responders can reduce the time between discovering an overdose victim and when they receive emergency medical assistance. Fire department protocols are similar to the law enforcement protocols discussed in the previous section. [Appendix 5-A](#) contains an example of a memorandum of agreement that can be used to help expand the distribution of naloxone to first responders.

JAILS AND PRISONS

Upon re-entry back into the community, some formerly incarcerated individuals are at a heightened risk of overdose mortality within the first weeks of release. Overdose prevention programs should focus on treatment and services within jails and prisons, and train those at-risk to administer naloxone upon release. In February 2015, the Durham jail became the first in North Carolina to dispense naloxone kits to inmates as they are leaving the facility.

DEPARTMENT ON AGING

Older adults are another potential high-risk population for drug overdose because they often have multiple prescription drug medications and complicated health conditions. Older adults are also a potential risk group for suicide with a strong connection to intentional medication-based overdose. Communities should take care to ensure that outreach occurs in this setting and that representatives at Senior Centers and the Department on Aging are actively engaged following the adoption of an LHD standing order.

PHARMACISTS

Another strategy to increase naloxone availability is to build on pharmacist, patient, and physician interactions. This includes pharmacist training and educating patients on how to use their opioid medications, but also informing them on the benefits of naloxone and then requesting a prescription from physicians if patients express interest. Pharmacists in communities with increased efforts for naloxone distribution should ensure that they consistently carry a full stock of naloxone. For a list of pharmacies currently distributing naloxone, please visit <http://www.naloxonesaves.org>.

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APPENDIX 1

BACKGROUND

1-A	NC Good Samaritan Law/Naloxone Access, S.L. 2013-23, S.B. 20
1-B	Clarifying the Good Samaritan Law, S.L. 2015-94, S.B. 154
1-C	North Carolina Board of Pharmacy – “Order of the Board” January 21, 2014
1-D	Proposed Amendments to Rule 21 NCAC 46 .2401 and .2403 – Dispensing in Health Departments, February 2014
1-E	Naloxone letter to Health Directors from Danny Staley, June 2015
1-F	NC Naloxone Pharmacy Standing Order, S.L. 2016-2017, S.B. 734

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

SESSION LAW 2013-23
SENATE BILL 20

AN ACT TO PROVIDE LIMITED IMMUNITY FROM PROSECUTION FOR (1) CERTAIN DRUG-RELATED OFFENSES COMMITTED BY AN INDIVIDUAL WHO SEEKS MEDICAL ASSISTANCE FOR A PERSON EXPERIENCING A DRUG-RELATED OVERDOSE AND (2) CERTAIN DRUG-RELATED OFFENSES COMMITTED BY AN INDIVIDUAL EXPERIENCING A DRUG-RELATED OVERDOSE AND IN NEED OF MEDICAL ASSISTANCE; TO PROVIDE IMMUNITY FROM CIVIL OR CRIMINAL LIABILITY FOR (1) PRACTITIONERS WHO PRESCRIBE AN OPIOID ANTAGONIST TO CERTAIN THIRD PARTIES AND (2) CERTAIN INDIVIDUALS WHO ADMINISTER AN OPIOID ANTAGONIST TO A PERSON EXPERIENCING A DRUG-RELATED OVERDOSE; AND TO PROVIDE LIMITED IMMUNITY FROM PROSECUTION FOR CERTAIN ALCOHOL-RELATED OFFENSES COMMITTED BY PERSONS UNDER THE AGE OF 21 WHO SEEK MEDICAL ASSISTANCE FOR ANOTHER PERSON.

The General Assembly of North Carolina enacts:

SECTION 1. Article 5 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-96.2. Drug-related overdose treatment; limited immunity.

(a) As used in this section, "drug-related overdose" means an acute condition, including mania, hysteria, extreme physical illness, coma, or death resulting from the consumption or use of a controlled substance, or another substance with which a controlled substance was combined, and that a layperson would reasonably believe to be a drug overdose that requires medical assistance.

(b) A person acting in good faith who seeks medical assistance for an individual experiencing a drug-related overdose shall not be prosecuted for (i) a misdemeanor violation of G.S. 90-95(a)(3), (ii) a felony violation of G.S. 90-95(a)(3) for possession of less than one gram of cocaine, (iii) a felony violation of G.S. 90-95(a)(3) for possession of less than one gram of heroin, or (iv) a violation of G.S. 90-113.22 if the evidence for prosecution under those sections was obtained as a result of the person seeking medical assistance for the drug-related overdose.

(c) A person who experiences a drug-related overdose and is in need of medical assistance shall not be prosecuted for (i) a misdemeanor violation of G.S. 90-95(a)(3), (ii) a felony violation of G.S. 90-95(a)(3) for possession of less than one gram of cocaine, (iii) a felony violation of G.S. 90-95(a)(3) for possession of less than one gram of heroin, or (iv) a violation of G.S. 90-113.22 if the evidence for prosecution under those sections was obtained as a result of the drug-related overdose and need for medical assistance.

(d) Nothing in this section shall be construed to bar the admissibility of any evidence obtained in connection with the investigation and prosecution of other crimes committed by a person who otherwise qualifies for limited immunity under this section."

SECTION 2. Article 5 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-106.2. Treatment of overdose with opioid antagonist; immunity.

(a) As used in this section, "opioid antagonist" means naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of a drug overdose.

(b) A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose. As an indicator of good faith, the



practitioner, prior to prescribing an opioid under this subsection, may require receipt of a written communication that provides a factual basis for a reasonable conclusion as to either of the following:

- (1) The person seeking the opioid antagonist is at risk of experiencing an opiate-related overdose.
- (2) The person other than the person who is at risk of experiencing an opiate-related overdose, and who is seeking the opioid antagonist, is in relation to the person at risk of experiencing an opiate-related overdose:
 - a. A family member, friend, or other person.
 - b. In the position to assist a person at risk of experiencing an opiate-related overdose.

(c) A person who receives an opioid antagonist that was prescribed pursuant to subsection (b) of this section may administer an opioid antagonist to another person if (i) the person has a good faith belief that the other person is experiencing a drug-related overdose and (ii) the person exercises reasonable care in administering the drug to the other person. Evidence of the use of reasonable care in administering the drug shall include the receipt of basic instruction and information on how to administer the opioid antagonist.

(d) All of the following individuals are immune from any civil or criminal liability for actions authorized by this section:

- (1) Any practitioner who prescribes an opioid antagonist pursuant to subsection (b) of this section.
- (2) Any person who administers an opioid antagonist pursuant to subsection (c) of this section."

SECTION 3. Chapter 18B of the General Statutes is amended by adding a new section to read:

"§ 18B-302.2. Medical treatment; limited immunity.

Notwithstanding any other provision of law, a person under the age of 21 shall not be prosecuted for a violation of G.S. 18B-302 for the possession or consumption of alcoholic beverages if law enforcement, including campus safety police, became aware of the possession or consumption of alcohol by the person solely because the person was seeking medical assistance for another individual. This section shall apply if, when seeking medical assistance on behalf of another, the person did all of the following:

- (1) Acted in good faith, upon a reasonable belief that he or she was the first to call for assistance.
- (2) Used his or her own name when contacting authorities.
- (3) Remained with the individual needing medical assistance until help arrived."

SECTION 4. This act is effective when it becomes law.
In the General Assembly read three times and ratified this the 4th day of April, 2013.

s/ Daniel J. Forest
President of the Senate

s/ Thom Tillis
Speaker of the House of Representatives

s/ Pat McCrory
Governor

Approved 4:39 p.m. this 9th day of April, 2013

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015**

**SESSION LAW 2015-94
SENATE BILL 154**

AN ACT TO CLARIFY THE OPERATION OF THE LIMITED IMMUNITY FROM PROSECUTION FOR CERTAIN DRUG- OR ALCOHOL-RELATED OFFENSES COMMITTED BY AN INDIVIDUAL EXPERIENCING A DRUG- OR ALCOHOL-RELATED OVERDOSE AND AN INDIVIDUAL WHO SEEKS MEDICAL ASSISTANCE FOR AN INDIVIDUAL EXPERIENCING A DRUG- OR ALCOHOL-RELATED OVERDOSE; TO PROVIDE ADDITIONAL REQUIREMENTS AND CONDITIONS THAT MUST BE MET BEFORE THE LIMITED IMMUNITY IS ESTABLISHED; TO PROVIDE THAT A PERSON SHALL NOT BE SUBJECT TO ARREST OR REVOCATION OF PRETRIAL RELEASE, PROBATION, PAROLE, OR POST-RELEASE IF BASED UPON AN OFFENSE FOR WHICH THE PERSON IS IMMUNE FROM PROSECUTION; TO PROVIDE THAT A LAW ENFORCEMENT OFFICER SHALL NOT BE SUBJECT TO CIVIL LIABILITY FOR ARRESTING OR CHARGING A PERSON ENTITLED TO IMMUNITY FROM PROSECUTION IF THE LAW ENFORCEMENT OFFICER ACTED IN GOOD FAITH; TO PROVIDE THAT A PHARMACIST MAY DISPENSE AN OPIOID ANTAGONIST UPON RECEIVING A PRESCRIPTION ISSUED IN ACCORDANCE WITH G.S. 90-106.2; AND TO PROVIDE THAT A PHARMACIST WHO DISPENSES AN OPIOID ANTAGONIST IN ACCORDANCE WITH G.S. 90-106.2 IS IMMUNE FROM CERTAIN CIVIL OR CRIMINAL LIABILITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-96.2 reads as rewritten:

"§ 90-96.2. Drug-related overdose treatment; limited immunity.

(a) As used in this section, "drug-related overdose" means an acute condition, including mania, hysteria, extreme physical illness, coma, or death resulting from the consumption or use of a controlled substance, or another substance with which a controlled substance was combined, and that a layperson would reasonably believe to be a drug overdose that requires medical assistance.

(b) ~~A person acting in good faith who seeks medical assistance for an individual experiencing a drug-related overdose shall not be prosecuted for (i) a misdemeanor violation of G.S. 90-95(a)(3), (ii) a felony violation of G.S. 90-95(a)(3) for possession of less than one gram of cocaine, (iii) a felony violation of G.S. 90-95(a)(3) for possession of less than one gram of heroin, or (iv) a violation of G.S. 90-113.22 if the evidence for prosecution under those sections was obtained as a result of the person seeking medical assistance for the drug-related overdose.~~Limited Immunity for Samaritan. – A person shall not be prosecuted for any of the offenses listed in subsection (c3) of this section if all of the following requirements and conditions are met:

- (1) The person sought medical assistance for an individual experiencing a drug-related overdose by contacting the 911 system, a law enforcement officer, or emergency medical services personnel.
- (2) The person acted in good faith when seeking medical assistance, upon a reasonable belief that he or she was the first to call for assistance.
- (3) The person provided his or her own name to the 911 system or to a law enforcement officer upon arrival.
- (4) The person did not seek the medical assistance during the course of the execution of an arrest warrant, search warrant, or other lawful search.



(5) The evidence for prosecution of the offenses listed in subsection (c3) of this section was obtained as a result of the person seeking medical assistance for the drug-related overdose.

(c) ~~A person who experiences a drug-related overdose and is in need of medical assistance shall not be prosecuted for (i) a misdemeanor violation of G.S. 90-95(a)(3), (ii) a felony violation of G.S. 90-95(a)(3) for possession of less than one gram of cocaine, (iii) a felony violation of G.S. 90-95(a)(3) for possession of less than one gram of heroin, or (iv) a violation of G.S. 90-113.22 if the evidence for prosecution under those sections was obtained as a result of the drug-related overdose and need for medical assistance.~~ Limited Immunity for Overdose Victim. – The immunity described in subsection (b) of this section shall extend to the person who experienced the drug-related overdose if all of the requirements and conditions listed in subdivisions (1), (2), (4), and (5) of subsection (b) of this section are satisfied.

(c1) Probation or Release. – A person shall not be subject to arrest or revocation of pretrial release, probation, parole, or post-release if the arrest or revocation is based on an offense for which the person is immune from prosecution under subsection (b) or (c) of this section. The arrest of a person for an offense for which subsection (b) or (c) of this section may provide the person with immunity will not itself be deemed to be a commission of a new criminal offense in violation of a condition of the person's pretrial release, condition of probation, or condition of parole or post-release.

(c2) Civil Liability for Arrest or Charges. – In addition to any other applicable immunity or limitation on civil liability, a law enforcement officer who, acting in good faith, arrests or charges a person who is thereafter determined to be entitled to immunity under this section shall not be subject to civil liability for the arrest or filing of charges.

(c3) Covered Offenses. – A person shall have limited immunity from prosecution under subsections (b) and (c) of this section for only the following offenses:

(1) A misdemeanor violation of G.S. 90-95(a)(3).

(2) A felony violation of G.S. 90-95(a)(3) for possession of less than one gram of cocaine.

(3) A felony violation of G.S. 90-95(a)(3) for possession of less than one gram of heroin.

(4) A violation of G.S. 90-113.22.

(d) ~~Nothing~~ Construction. – Nothing in this section shall be construed to ~~bar~~ do any of the following:

(1) Bar the admissibility of any evidence obtained in connection with the investigation and prosecution of (i) other crimes committed by a person who otherwise qualifies for limited immunity under this section or (ii) any crimes committed by a person who does not qualify for limited immunity under this section.

(2) Limit any seizure of evidence or contraband otherwise permitted by law.

(3) Limit or abridge the authority of a law enforcement officer to detain or take into custody a person in the course of an investigation of, or to effectuate an arrest for, any offense other than an offense listed in subsection (c3) of this section.

(4) Limit or abridge the authority of a probation officer to conduct drug testing of persons on pretrial release, probation, or parole."

SECTION 2. G.S. 18B-302.2 reads as rewritten:

"§ 18B-302.2. Medical treatment; limited immunity.

(a) Limited Immunity for Samaritan. – Notwithstanding any other provision of law, a person under the age of 21 shall not be prosecuted for a violation of G.S. 18B-302 for the possession or consumption of alcoholic beverages if law enforcement, including campus safety police, became aware of the possession or consumption of alcohol by the person solely because the person was seeking medical assistance for another individual. This section shall apply if, when seeking medical assistance on behalf of another, the person did all of the following: all of the following requirements and conditions are met:

(1) The person sought medical assistance for an individual experiencing an alcohol-related overdose by contacting the 911 system, a law enforcement officer, or emergency medical services personnel.

(1a) Acted The person acted in good faith, faith when seeking medical assistance, upon a reasonable belief that he or she was the first to call for assistance.

- ~~(2) Used—The person provided his or her own name when contacting authorities to the 911 system or to a law enforcement officer upon arrival.~~
- ~~(3) Remained with the individual needing medical assistance until help arrived.~~
- ~~(4) The person did not seek the medical assistance during the course of the execution of an arrest warrant, search warrant, or other lawful search.~~
- ~~(5) The evidence for prosecution of a violation of G.S. 18B-302 for the possession or consumption of alcoholic beverages was obtained as a result of the person seeking medical assistance for the alcohol-related overdose.~~

(b) Limited Immunity for Overdose Victim. – The immunity described in subsection (a) of this section shall extend to the person who needed medical assistance if the requirements in subdivisions (1), (1a), (4), and (5) of subsection (a) are satisfied.

(c) Probation or Release. – A person shall not be subject to arrest or revocation of pretrial release, probation, parole, or post-release if the arrest or revocation is based on an offense for which the person is immune from prosecution under subsection (a) or (b) of this section. The arrest of a person for an offense for which subsection (a) or (b) of this section may provide the person with immunity will not itself be deemed to be a commission of a new criminal offense in violation of a condition of the person's pretrial release, condition of probation, or condition of parole or post-release.

(d) Civil Liability for Arrest or Charges. – In addition to any other applicable immunity or limitation on civil liability, a law enforcement officer who, acting in good faith, arrests or charges a person who is thereafter determined to be entitled to immunity under this section shall not be subject to civil liability for the arrest or filing of charges."

SECTION 3. G.S. 90-106.2 reads as rewritten:

"§ 90-106.2. Treatment of overdose with opioid antagonist; immunity.

...

(b) A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose. As an indicator of good faith, the practitioner, prior to prescribing an opioid under this subsection, may require receipt of a written communication that provides a factual basis for a reasonable conclusion as to either of the following:

- (1) The person seeking the opioid antagonist is at risk of experiencing an opiate-related overdose.
- (2) The person other than the person who is at risk of experiencing an opiate-related overdose, and who is seeking the opioid antagonist, is in relation to the person at risk of experiencing an opiate-related overdose:
 - a. A family member, friend, or other person.
 - b. In the position to assist a person at risk of experiencing an opiate-related overdose.

(b1) A pharmacist may dispense an opioid antagonist to a person described in subsection (b) of this section pursuant to a prescription issued in accordance with subsection (b) of this section. For purposes of this section, the term "pharmacist" is as defined in G.S. 90-85.3.

...

(d) All of the following individuals are immune from any civil or criminal liability for actions authorized by this section:

- (1) Any practitioner who prescribes an opioid antagonist pursuant to subsection (b) of this section.
- (2) Any pharmacist who dispenses an opioid antagonist pursuant to subsection (b1) of this section.
- ~~(3)~~ (3) Any person who administers an opioid antagonist pursuant to subsection (c) of this section."

SECTION 4. This act becomes effective August 1, 2015, and applies to offenses committed on or after that date.

In the General Assembly read three times and ratified this the 10th day of June, 2015.

s/ Daniel J. Forest
President of the Senate

s/ Tim Moore
Speaker of the House of Representatives

s/ Pat McCrory
Governor

Approved 10:05 a.m. this 19th day of June, 2015

Jack W. Campbell, IV
Executive Director

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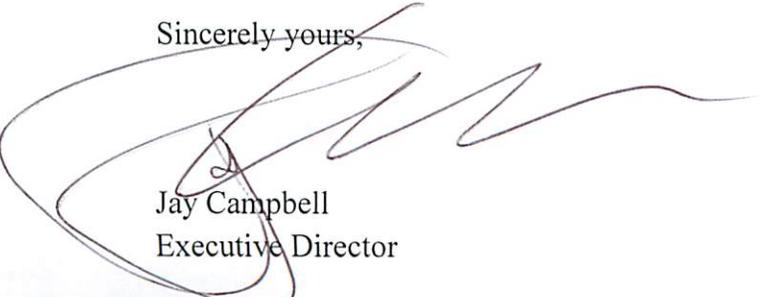
Theo Pikoulas
Associate Director of Behavioral Health Pharmacy Programs
Community Care of North Carolina
2300 Rexwoods Drive, Suite 100
Raleigh, NC 27607

Dear Theo:

Thank you for your letter of February 11, in which you inquired about my opinion on the prescribing of naloxone by standing order pursuant to G.S. § 90-106.2 (commonly known as the “Good Samaritan Act”).

The statute is clear on this matter. Paragraph (b) specifically authorizes a “practitioner acting in good faith and exercising reasonable care” to prescribe naloxone “directly or by standing order.” (emphasis added). Accordingly, a health-care provider authorized by state law to prescribe drugs could write a standing order for the dispensing of naloxone by a pharmacist to any of the persons authorized to receive a prescription under the statute.

Sincerely yours,



Jay Campbell
Executive Director

cc: David Henderson, Executive Director, North Carolina Medical Board

21 NCAC 46 .2401 MEDICATION IN HEALTH DEPARTMENTS

A registered nurse employed by a local health department may dispense prescription drugs or devices under the following conditions:

- (1) Drugs or devices may be dispensed only to health department ~~patients;~~ patients, with the exception of opioid antagonists, which may be dispensed either to health department patients or to others as permitted by G.S. 90-106.2;
- (2) No drugs or devices may be dispensed except at health department clinics;
- (3) The health department shall secure the services of a pharmacist-manager who shall be responsible for developing and supervising a system of control and accountability of all drugs dispensed from the health department;
- (4) Only the general categories of drugs or devices listed in Rule .2403 may be dispensed by a health department registered nurse;
- (5) All drugs or devices dispensed pursuant to G.S. 90-85.34A and these rules shall be packaged in suitable safety-closure containers, where appropriate, and shall be properly labelled (including necessary auxiliary labels) so as to provide information necessary for use and all other information required by state and federal law;
- (6) A suitable and perpetual record of drugs or devices dispensed shall be maintained in the health department. The pharmacist-manager shall verify the accuracy of the records at least weekly, and where health department personnel dispense to 30 or more patients in a 24-hour period per dispensing site, the pharmacist-manager shall verify the accuracy of the records within 24 hours after dispensing occurs;
- (7) The duties of the pharmacist-manager set out in Paragraphs (1) through (6) in this Rule may be delegated to a pharmacist licensed by the Board. The pharmacist-manager shall remain personally responsible for compliance with all statutes, rules, and regulations governing the practice of pharmacy and dispensing of drugs.

History Note: Authority G.S. 90-85.6; 90-85.34A; 90-106.2;
Eff. March 1, 1987;
Amended Eff. August 1, 2014; May 1, 1989.

21 NCAC 46 .2403 DRUGS AND DEVICES TO BE DISPENSED

(a) Pursuant to the provisions of G.S. 90-85.34A(a)(3), prescription drugs and devices included in the following general categories may be dispensed by registered nurses in local health department clinics when prescribed for the indicated conditions:

- (1) Anti-tuberculosis drugs, as defined by the latest edition of Drug Facts and Comparisons, as published by Facts and Comparison Div., J.B. Lippincott Co., or as recommended by the Tuberculosis Control Branch of the North Carolina Division of Health Services, when used for the treatment and control of tuberculosis;
- (2) Anti-infective agents used in the control of sexually-transmitted diseases as recommended by the United States Centers for Disease Control;
- (3) Natural or synthetic hormones and contraceptive devices when used for the prevention of pregnancy;
- (4) Topical preparations for the treatment of lice, scabies, impetigo, diaper rash, vaginitis, and related skin conditions; ~~and~~
- (5) Vitamin and mineral ~~supplements; and supplements.~~
- (6) Opioid antagonists prescribed pursuant to G.S. 90-106.2.

(b) Regardless of the provisions set out in this Rule, no drug defined as a controlled substance by the United States Controlled Substances Act, 21 U.S. Code 801 through 904, or regulations enacted pursuant to that Act, 21 CFR 1300 through 1308, or by the North Carolina Controlled Substances Act, G.S. 90-86 through 90-113.8, may be dispensed by registered nurses pursuant to G.S. 90-85.34A.

History Note: Authority G.S. 90-85.6; 90-85.34A; 90-106.2;
Eff. March 1, 1987;
Amended Eff. August 1, 2014; May 1, 1989.



**North Carolina Department of Health and Human Services
Division of Public Health**

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

June 2015

Danny Staley
Acting Division Director

Dear N.C. Local Health Directors:

Medication and drug overdoses continue to impact our state and nation; we currently experience 1,000 overdose deaths a year in North Carolina.

The enactment of the *N.C. Good Samaritan Law/Naloxone Access* ([SL 2013-23](#)) provided a powerful tool to combat overdose deaths from this epidemic. The law was strengthened on June 19, 2015 when Governor McCrory signed the *Clarifying the Good Samaritan Law* ([SL 2015-94](#)).

These two laws enable widespread distribution and access to naloxone (Narcan[®]), an opioid overdose antagonist, and encourage people to call 911 for medical assistance in the event of an overdose. This also provides limited immunity from prosecution for reporting an overdose; gives immunity to prescribers, dispensers, and bystanders who administer naloxone; and, allows for third party prescribing and dispensing to a person at risk of experiencing an overdose or to a family member, friend, or other person in a position to assist.

Since passage of the *N.C. Good Samaritan Law/Naloxone Access*, communities across the state have established naloxone prescription, dispensing, and distribution programs:

- The N.C. Harm Reduction Coalition has distributed over 10,000 rescue kits and reported more than 575 reversals,
- Community Care of N.C. is distributing naloxone through their physician networks and pharmacies,
- The Orange County Health Department established one of the first local health department standing orders and distribution programs for naloxone,
- Twenty more local health departments in North Carolina are in the process or have adopted naloxone standing orders, and another 32 local health departments are in the planning stages of adopting standing orders.

The lessons learned from these initial programs have been collected in a newly developed toolkit to guide local health departments through the process of adopting naloxone standing orders and implementing naloxone distribution programs. The toolkit includes information on identifying and engaging internal stakeholders and external partners to establish buy-in, implementation tools (e.g. patient education and staff training materials, costs), lessons learned, and case studies.

We hope this toolkit will be a valuable resource as your local health department considers opportunities to prevent overdose deaths. A contact in the N.C. Injury and Violence Prevention Branch in the Division of Public Health is available to provide technical assistance needed in using the toolkit and can be reached at 919.707.5428. You can also email nidhi.sachdeva@dhhs.nc.gov.

Local health departments that have established naloxone programs are seeing positive results; they are playing a key role in reducing overdose deaths.

I encourage you to work with your staff and community partners to identify populations at risk (active drug users, acute and chronic pain patients, recent releases from prison/jail, family and loved ones who use opioids) and provide them access to naloxone and training. We encourage all local health departments to make naloxone widely available in their communities and thank you for joining us in this collaborative effort that is saving lives.

Danny Staley
Acting Division Director
N.C. Division of Public Health

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**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015**

**SESSION LAW 2016-17
SENATE BILL 734***

AN ACT AUTHORIZING THE STATE HEALTH DIRECTOR TO PRESCRIBE OPIOID ANTAGONIST BY MEANS OF A STATEWIDE STANDING ORDER, WITH IMMUNITY FROM CIVIL AND CRIMINAL LIABILITY FOR SUCH ACTION, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-106.2 is recodified as G.S. 90-12.7.

SECTION 2. G.S. 90-12.7, as enacted by Section 1 of this act, reads as rewritten:

"§ 90-12.7. Treatment of overdose with opioid antagonist; immunity.

(a) As used in this section, "opioid antagonist" means naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of a drug overdose.

(b) The following individuals may prescribe an opioid antagonist in the manner prescribed by this subsection:

(1) A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose. As an indicator of good faith, the practitioner, prior to prescribing an opioid under this subsection, may require receipt of a written communication that provides a factual basis for a reasonable conclusion as to either of the following:

~~(1)~~a. The person seeking the opioid antagonist is at risk of experiencing an opiate-related overdose.

~~(2)~~b. The person other than the person who is at risk of experiencing an opiate-related overdose, and who is seeking the opioid antagonist, is in relation to the person at risk of experiencing an opiate-related overdose:

~~a.1.~~ A family member, friend, or other person.

~~b.2.~~ In the position to assist a person at risk of experiencing an opiate-related overdose.

(2) The State Health Director may prescribe an opioid antagonist pursuant to subdivision (1) of this subsection by means of a statewide standing order.

(b1) A pharmacist may dispense an opioid antagonist to a person described in ~~subsection (b) subdivision (b)(1)~~ of this section pursuant to a prescription issued ~~in accordance with pursuant to~~ subsection (b) of this section. For purposes of this section, the term "pharmacist" is as defined in G.S. 90-85.3.

(c) A person who receives an opioid antagonist that was prescribed pursuant to subsection (b) of this section may administer an opioid antagonist to another person if (i) the person has a good faith belief that the other person is experiencing a drug-related overdose and (ii) the person exercises reasonable care in administering the drug to the other person. Evidence of the use of reasonable care in administering the drug shall include the receipt of basic instruction and information on how to administer the opioid antagonist.

(d) All of the following individuals are immune from any civil or criminal liability for actions authorized by this section:

(1) Any practitioner who prescribes an opioid antagonist pursuant to subsection (b) of this section.



- (1a) Any pharmacist who dispenses an opioid antagonist pursuant to subsection (b1) of this section.
- (2) Any person who administers an opioid antagonist pursuant to subsection (c) of this section.
- (3) The State Health Director acting pursuant to subsection (b) of this section."

SECTION 3. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 16th day of June, 2016.

s/ Daniel J. Forest
President of the Senate

s/ Tim Moore
Speaker of the House of Representatives

s/ Pat McCrory
Governor

Approved 1:22 p.m. this 20th day of June, 2016

APPENDIX 2

ENGAGING INTERNAL STAKEHOLDERS

2-A	Checklist: How to Adopt a Naloxone Standing Order
2-B	Communication: Tailored Priority Area Messaging – Making your case
2-C	NC Public Health Law: Explanation of S.L. 2013-23 (S20), Good Samaritan Law/Naloxone Access
2-D	Legal Interventions to Reduce Overdose Mortality in North Carolina – Fact Sheet
2-E	C. Davis, S. Webb, and S. Burris. <i>Changing Law from Barrier to Facilitator of Opioid Overdose Prevention</i> . 2012 Public Health Law Conference: Practical Approaches to Critical Challenges. Spring 2013.

HOW TO ADOPT A NALOXONE STANDING ORDER

1. IDENTIFY ALL INTERNAL STAKEHOLDERS AND EXTERNAL PARTNERS

- Identify stakeholders necessary to support adopting a standing order
- Reach out to stakeholders to determine if they are on board
- Provide educational materials to stakeholders

2. ENGAGE INTERNAL STAKEHOLDERS WITHIN THE LHD

Health Director

- Use provided template to tailor standing order language
- Continue to encourage internal stakeholders within the LHD of the ease of adopting a standing order by providing educational resources and data of overdose prevalence

Board of Health and Medical Director

- Assist Health Director in tailoring standing order
- Provide opportunities to present educational information to health department staff

Pharmacists

- Explain Board of Pharmacy allowance of Naloxone
- Share information about tailoring standing order to county pharmacy type (external, contract pharmacist, or contract pharmacy)
- Provide opportunities to present educational information to health department staff

Nursing Director and Nurses

- Share information about clinic procedures for standing order tailoring

3. ADOPT THE STANDING ORDER

- Encourage any internal stakeholders and external partners of the benefits of overdose prevention and increasing naloxone access by sharing data and educational resources
- Medical director signs the standing order

4. IMPLEMENT AND SUSTAIN NALOXONE DISTRIBUTION PROGRAM

Internal Stakeholders

- Seek out funding for Naloxone purchase through diverse strategies provided in toolkit
- Purchase naloxone and assemble naloxone kits
- Arrange for pharmacist to train nurses in naloxone distributing procedures
- Complete nurse trainings for naloxone distributing
- Train and educate health educators, social workers, and other LHD staff

External Partners

- Gain data from external community partners for county trends and risk groups
- Connect with community partners for outreach and distribution outside of the LHD

Tailored Priority Area Messaging

Priority Area	Data to Support Connection to Overdose Prevention	Messaging for Naloxone Standing Order
Chronic disease	<p>Opioid prescriptions are commonly used in chronic disease management. In North Carolina, and across the US, overdose from opioid analgesics (methadone, oxycodone, hydrocodone) are the most common causes of unintentional poisoning deaths (Austin & Finkbeiner, 2013).</p>	<p>Opioids are important tools to help those with chronic pain and those who have cancer and other serious illnesses. However, when used incorrectly, these medications can end a life. Investigations have revealed that many of those dying are pain patients who may not have received or understood instructions from their doctors or pharmacists. Co-prescribing naloxone can prevent these deaths (adapted from Project Lazarus).</p>
Substance abuse	<p>In 2011, 4,102 people died as an unintended consequence of heroin overdoses across the US (CDC), compared to 2,789 deaths in 2010—a 47 percent increase in a single year (National Institutes of Health, 2014).</p> <p>Naloxone injection has been approved by FDA and used for more than 40 years by emergency medical services (EMS) personnel to reverse opioid overdose and resuscitate persons who otherwise might have died in the absence of treatment (SAMHSA, n.d.).</p>	<p>Opioid overdose-related deaths can be prevented when naloxone is administered in a timely manner. During the period of time when an overdose can become fatal, respiratory depression can be reversed by giving the individual naloxone.</p> <p>Since the Overdose Prevention Project (OPP) became operational August 1, 2013 NCHRC has dispensed over 8,800 overdose rescue kits that include naloxone (as of 3/20/2015) and have received 397 confirmed reports that the lifesaving medication was administered successfully by lay individuals across North Carolina.</p>
Suicide	<p>In the US, poisoning is a leading method in suicide deaths, and drugs and/or alcohol make up 75% of suicide deaths due to poisoning. Prescription drugs such as those in the opioid, benzodiazepine, and antidepressant class (e.g. oxycodone, diazepam, and fluoxetine) were the leading type used in suicide deaths. From 2005 to 2007, 79% of suicides due to substance overdose were due to prescription drugs only (n=2165). (CDC, n.d.).</p>	<p>As we move to prevent suicide by limiting people's access to lethal means- drug overdose must be considered, as it is the leading method causing suicide deaths. Increasing access by citizens to naloxone can assist in preventing suicides via overdose. Thus co-prescribing and naloxone standing orders through LHDs are vital to addressing the issue of suicide in NC counties.</p>

North Carolina Public Health Law

S.L. 2013-23 (S 20). Good Samaritan Law/Naloxone Access

[S.L. 2013-23 \(http://ncleg.net/EnactedLegislation/SessionLaws/PDF/2013-2014/SL2013-23.pdf\)](http://ncleg.net/EnactedLegislation/SessionLaws/PDF/2013-2014/SL2013-23.pdf) enacts several provisions intended to encourage individuals to seek help for themselves or others experiencing drug overdoses or alcohol-related medical emergencies. It also establishes the conditions under which a health care provider may prescribe naloxone (an antidote to opiate overdoses) to a person at risk of experiencing an opiate-related drug overdose, or to someone who may be in a position to assist such a person.

The legislation enacts G.S. 90-96.2, which provides limited immunity from prosecution for certain drug-related offenses committed by a person who experiences a drug overdose and needs medical assistance, as well as for a person who seeks medical assistance for a person experiencing a drug overdose. The offenses for which immunity may apply include use or possession of drug paraphernalia and possession of certain small amounts of controlled substances. The immunity from prosecution applies only if the evidence was obtained as a result of the need for medical assistance by the person experiencing the overdose, or as a result of the good faith actions of an individual in seeking medical assistance for another person's overdose.

New G.S. 90-106.2 authorizes a "practitioner" to prescribe naloxone hydrochloride, an opiate antagonist that acts to mitigate the harmful effects of opiate overdoses. (The term practitioner is defined by the NC Controlled Substances Act to include certain health care providers and facilities that are permitted by law to distribute, dispense, or administer controlled substances. G.S. 90-87(22).) The practitioner may, directly or by standing order, prescribe naloxone to a person at risk of experiencing an opiate-related overdose, or to a family member, friend, or other person who may be in a position to assist a person at such risk. The practitioner must exercise reasonable care and act in good faith. In order to show good faith, the practitioner may require a written statement of the factual basis for the conclusion that the person qualifies for the prescription because he or she is either at personal risk of an opiate overdose, or in a position to assist a person at risk of an opiate overdose. A practitioner who prescribes naloxone pursuant to this new law is immune from civil or criminal liability that might otherwise arise.

The new law also authorizes a person who receives a naloxone prescription because he or she is in a position to assist at-risk persons to administer the naloxone to another person, provided he or she believes in good faith the other person is experiencing an overdose and exercises reasonable care. A person who receives a prescription in order to assist others should receive basic instruction and information in the administration as naloxone in advance, as the statute provides that this constitutes evidence of the use of reasonable care. A person who administers naloxone pursuant to this provision is immune from civil or criminal liability that might otherwise arise.

Finally, the legislation enacts new G.S. 18B-302.2, which provides that a person under the age of 21 who seeks medical assistance for another will not be prosecuted for underage possession or consumption of alcohol, if law enforcement becomes aware of the violation solely because the person sought medical assistance on behalf of another. To qualify for this limited immunity, the underage person must have a reasonable and good-faith belief that he or she was the first to call for assistance, must use his or her own name when contacting authorities, and must remain with the individual who needs the medical assistance until help arrives.



LEGAL INTERVENTIONS TO REDUCE OVERDOSE MORTALITY IN NORTH CAROLINA

Fact Sheet

Background

Fatal drug overdose is a nationwide epidemic that claims the lives of over 36,000 Americans every year.¹ The situation is particularly acute in North Carolina, where overdose deaths have increased more than 300 percent in just over a decade, from 297 in 1999 to 1,140 in 2011.² This increase is mostly driven by prescription opioids such as oxycontin and hydrocodone, which now account for more overdose deaths than heroin and cocaine combined.³ Opioid overdose is typically reversible through the timely administration of naloxone, a drug that reverses the effects of opioids, and the provision of other emergency care.⁴ However, access to naloxone and other emergency treatment is often limited by laws that a) make it difficult for those likely to be in a position to reverse an overdose to access the drug and b) discourage overdose witnesses from calling for help.⁵ In an attempt to reverse this unprecedented increase in preventable overdose deaths, a number of states have recently amended those laws to increase access to emergency care and treatment for opiate overdose.⁶

In 2013, North Carolina joined their ranks. Senate Bill 20, “Good Samaritan Law/Naloxone Access,” was passed by overwhelming majorities in the state House and Senate and was signed by the Governor on April 9, 2013. The law went into effect immediately.⁷ As explained in more detail below, the law provides limited immunity from prosecution for possession of certain drugs and drug paraphernalia for individuals who experience a drug overdose and are in need of medical care and for those who seek medical care in good faith for a person experiencing an overdose. The bill also provides limited immunity from certain underage drinking offenses for minors who seek help in the event of an alcohol overdose. Finally, the bill establishes limited civil and criminal immunity for medical professionals who prescribe naloxone, and laypeople who administer it to a person suspected of suffering from an opioid overdose.

Limited Immunity for Possession of Certain Drugs

In many cases, overdose bystanders may fail to summon medical assistance because they are afraid that doing so may put them at risk of arrest and prosecution for drug-related crimes.⁸ SB20 attempts to address this problem by providing limited immunity from prosecution for possession of certain drugs for both a person acting in good faith who seeks medical assistance for an individual experiencing a drug-related overdose and the person suffering from the overdose where the evidence for prosecution was obtained as a result of the seeking of medical assistance. The law provides immunity from possession charges only; it provides no protection for other crimes such as the sale of illegal drugs.

Mainly because of how the state Controlled Substances Act is written, the drugs and quantities covered by SB20 are slightly complicated.⁹ We provide below a complete list of the drugs and quantities for which a person may not be prosecuted if the requirements described above are met, and an incomplete list of drugs and quantities for which the bill does not grant immunity.



Complete List of Drugs and Quantities Covered by SB20

- Less than one gram of cocaine
- Less than one gram of heroin
- Less than one gram of Methylendioxypropylone (MDPV)
 - *This is one of the drugs commonly known as “bath salts”*
- Less than 100 tablets, patches or other dosage units of most, but not all, Schedule II, III, or IV drugs¹⁰
 - *This includes most common prescription drugs including Vicodin, Percocet, OxyContin, Opana, Suboxone, methadone and other opioid pain relievers except hydromorphone drugs such as Dilaudid and Exalgo (see below); Ritalin, Adderall, and some other stimulants (see below); Xanax, Klonopin, Valium and other benzodiazepines; Ambien, Lunesta, Sonata and other sleep aids; and testosterone steroids.*
- Four or fewer “tablets, capsules, or other dosage units or equivalent quantity” of hydromorphone
 - *Brand names Dilaudid and Exalgo*
- Any quantity of a Schedule V drug
 - *These are generally non-prescription drugs that can only be sold by a pharmacist, such as cough syrup with codeine*
- One and one-half ounces or less of marijuana
- 21 grams or less of a synthetic cannabinoid or any mixture containing a synthetic cannabinoid
 - *These are synthetic marijuana products, such as those sold as “Spice” or “K-2”*
- Three-twentieths of an ounce or less of hashish

If a drug and quantity is not in the above list, the new law does not provide immunity for its possession. A non-exclusive list of the drugs and quantities for which immunity is not granted follows.

Incomplete List of Drugs and Quantities Not Covered by SB20

- One gram or more of cocaine
- One gram or more of heroin
- One gram or more of methylenedioxypropylone (MDPV)
- Any quantity of any Schedule I drug *except* heroin or MDPV, for which immunity is granted for quantities less than one gram (see above)
 - *Schedule I drugs are those that cannot be prescribed for any purpose. They include LSD, MDMA/Ecstasy, and ibogaine, among others*
- Any quantity of methamphetamine
- Any quantity of amphetamine¹¹
- Any quantity of phencyclidine (PCP)
- Any salt, isomer, salts of isomers, compound, derivative, or preparation of methamphetamine, amphetamine, phencyclidine, or cocaine
- Any quantity of coca leaves and any salt, isomer, salts of isomers, compound, derivative, or preparation of coca leaves
- Any quantity of synthetic tetrahydrocannabinols or tetrahydrocannabinols isolated from the resin of marijuana

Limited Immunity for Possession of Drug Paraphernalia

The law also provides immunity from prosecution for possession of [drug paraphernalia](#) for both the person who seeks medical assistance in good faith for a person experiencing an overdose and the person in need of help, if the evidence for the charge was obtained as a result of the call for medical assistance. Drug paraphernalia includes syringes, baggies, cookers and similar instruments used or intended to be used with activities that violate the Controlled Substances Act.¹²

Limited Immunity for Possession and Consumption of Alcohol

Under the terms of the law, a person under the age of 21 who seeks medical assistance for another “shall not be prosecuted” for unlawful possession or consumption of alcohol if he or she acts in good faith and upon a reasonable belief that he or she was the first to call for assistance. The person must provide his or her own name when contacting

authorities and remain with the person needing medical assistance until help arrives. This alcohol-related immunity applies only to the person who seeks help, not the person needing medical assistance.

Additionally, Both Duke and Elon universities have written policies that encourage alcohol overdose bystanders to seek medical assistance by providing limited immunity from sanction under university alcohol rules for underage students who seek medical help for a person experiencing an alcohol overdose.¹³ As the Elon policy notes, “[t]he university’s main concern is getting the proper care for the student in need.”¹⁴

Increased Access to Naloxone

The law also takes several steps to make it easier for those likely to be in the position to save a life to do so by administering naloxone, the standard treatment for opioid overdose. First, the bill authorizes a medical professional otherwise permitted to prescribe naloxone to prescribe the drug to a person at risk of experiencing an overdose as well as a family member, friend, or other person “in a position to assist a person at risk of experiencing an opiate-related overdose.” These changes should help increase access to the drug, since in general prescriptions are not permitted to be written for persons the practitioner has not personally examined, even though the friends and family members of a person at high risk for overdose are often the ones to seek help from a trusted practitioner.

Further, the bill permits physicians to prescribe the drug via standing order, so that persons operating under the direction of a prescriber can offer the drug where clinically indicated even where the recipient was not examined by the prescriber. Since it can often be difficult to access a professional with prescribing privileges, this change can be expected to increase access as well. Finally, the bill authorizes a person who receives naloxone under the terms of the bill to administer it to another person in the event of an overdose, so long as they exercise reasonable care in doing so.¹⁵

Both practitioners who prescribe the drug as authorized in the law and laypeople who administer it are immune from any civil or criminal liability for those actions.

In March, 2013 the North Carolina Medical Board modified its Position Statement on drug overdose prevention to note that it is “encouraged by programs that are attempting to reduce the number of drug overdoses by making available or prescribing an opioid antagonist such as naloxone to someone in a position to assist a person at risk of an opiate-related overdose.” In the Statement, the Board encourages “its licensees to cooperate with programs in their efforts to make opioid antagonists available to persons at risk of suffering an opiate-related overdose.”¹⁶ That same month the Board modified its position statement on third party prescription to note that prescribing to a patient that the practitioner has not personally examined is permitted in certain instances, including “prescribing an opiate antagonist to someone in a position to assist a person at risk of an opiate-related overdose.”¹⁷

SUPPORTERS



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- ¹ MARGARET WARNER, ET AL., NAT'L CTR. FOR HEALTH STATISTICS, DRUG POISONING DEATHS IN THE UNITED STATES, 1980–2008 (2011).
- ² INJURY AND VIOLENCE PREVENTION BRANCH, NORTH CAROLINA DIVISION OF PUBLIC HEALTH, PRESCRIPTION & DRUG OVERDOSES (2013), available at <http://injuryfreenc.ncdhhs.gov/About/PoisoningOverdoseFactSheet2013.pdf>
- ³ *Id.*
- ⁴ See C. Baca, et al., *Take-home Naloxone to Reduce Heroin Death*, 100 ADDICTION 1823 (2005); Centers for Disease Control and Prevention, *Community-Based Opioid Overdose Prevention Programs Providing Naloxone – United States*, 2010, 61 MORBIDITY AND MORTALITY WEEKLY REPORT 101 (2012).
- ⁵ See Davis CS, Webb D, Burris S. *Changing Law from Barrier to Facilitator of Opioid Overdose Prevention*, 41 JOURNAL OF LAW, MEDICINE AND ETHICS 33 (2013).
- ⁶ For a comprehensive list of other state efforts, see NETWORK FOR PUBLIC HEALTH LAW, LEGAL INTERVENTIONS TO REDUCE OVERDOSE MORTALITY: NALOXONE ACCESS AND GOOD SAMARITAN LAWS (2013), available at <http://www.networkforphl.org/asset/qz5pvn/network-naloxone-10-4.pdf>.
- ⁷ The bill, Session Law 2012-23, will be codified at N.C.G.S. § 90-96.2 (Good Samaritan provisions), § 90-106.2 (naloxone access provisions), and § 18B-302.2 (alcohol provisions).
- ⁸ Karin Tobin, et al., *Calling emergency medical services during drug overdose: an examination of individual, social and setting correlates*, 100 ADDICTION 397 (2005); Robin A. Pollini, et al., *Response to Overdose Among Injection Drug Users*, 31 AMERICAN JOURNAL OF PREVENTIVE MEDICINE 261 (2006).
- ⁹ Immunity is provided for “a misdemeanor violation of G.S. 90-95(a)(3), (ii) a felony violation of G.S. 90-95(a)(3) for possession of less than one gram of cocaine, (iii) [and] a felony violation of G.S. 90-95(a)(3) for possession of less than one gram of heroin..”
- ¹⁰ The 100-dosage unit limit is for all drugs combined.
- ¹¹ The relevant section of the state Controlled Substances Act places the following amphetamine and amphetamine-like drugs in Schedule 2: Amphetamine, its salts, optical isomers, and salts of its optical isomers, Phenmetrazine [Preludin, no longer manufactured] and its salts, Methamphetamine, including its salts, isomers, and salts of isomers, Methylphenidate [Ritalin], Phenylacetone [an amphetamine precursor], and Lisdexamfetamine [Vyvanse, and a component of Adderall], including its salts, isomers, and salts of isomers. N.C.G.S. § 90-90(3)(a)-(f). The section of the act prohibiting possession of certain drugs makes it a felony to possess any amount of “amphetamine.” N.C.G.S. § 90-95(d)(2). We assume that the legislature intended to refer to only “amphetamine” as listed in N.C.G.S. § 90-90(3)(a) and not the other amphetamine-type drugs listed above; since if it intended to capture all amphetamine-type drugs it could have referred to the entirety of N.C.G.S. § 90-90(3).
- ¹² See N.C.G.S. § 90-113.21.
- ¹³ See ELON UNIVERSITY, ALCOHOLIC BEVERAGES AND POLICIES, available at <http://www.elon.edu/e-web/students/handbook/violations/alcohol.xhtml>, DUKE UNIVERSITY, ALCOHOL POLICY, available at <http://studentaffairs.duke.edu/conduct/z-policies/alcohol-policy>.
- ¹⁴ ELON, supra note 13.
- ¹⁵ Under the terms of the bill, “Evidence of reasonable care shall include the receipt of basic instruction and information on how to administer the opioid antagonist,” but such instruction is not required to be delivered and its receipt is not required to gain the law’s protection.
- ¹⁶ NORTH CAROLINA MEDICAL BOARD, DRUG OVERDOSE PREVENTION (2013), available at http://www.ncmedboard.org/position_statements/detail/drug_overdose_prevention.
- ¹⁷ See NORTH CAROLINA MEDICAL BOARD, CONTACT WITH PATIENTS BEFORE PRESCRIBING (2013), available at http://www.ncmedboard.org/position_statements/detail/contact_with_patients_before_prescribing

Changing Law from Barrier to Facilitator of Opioid Overdose Prevention

Corey Davis, Damika Webb, and Scott Burris

Background

Drug overdose has recently surpassed motor vehicle accidents to become the leading cause of unintentional injury death in the United States.¹ The epidemic is largely driven by opioids such as oxycodone, hydrocodone, and methadone, which kill more Americans than heroin and cocaine combined.² The demographics of overdose have changed over the past few decades as well: according to the latest data, the average overdose victim is now a non-Hispanic white man aged 45-54.³

These deaths — over 16,000 per year — are almost entirely preventable. Opioid overdose kills by slowly depressing respiration, a process that can take several hours.⁴ It can be quickly and effectively reversed by the timely administration of naloxone, an opioid antagonist that works by displacing opioids from the brain receptors to which they attach, reversing their depressant effect.⁵ Naloxone, also known as Narcan, has many benefits and minimal risks.⁶ Although it is a prescription drug, it is not a controlled substance and has no abuse potential.⁷ It is regularly carried by medical first responders, and can be administered by ordinary citizens with little or no formal training.⁸ Yet, this life-saving drug is often not available when and where it is needed.

Law is a primary driver of this lack of access. Because opioid overdose often occurs when the victim is with friends or family members, those people may be the best situated to act to save his or her life

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by administering naloxone.⁹ Unfortunately, neither the victim nor his or her companions typically carry the drug.¹⁰ Naloxone is available only via prescription, and state practice laws generally discourage or prohibit the prescription or dispensing of drugs to a person other than the intended recipient (a process referred to as third-party prescription).¹¹ But prescribers are in short supply, and people at risk of overdose may be uncomfortable with requesting a naloxone prescription or may not have the knowledge and foresight to do so. Even where the request is made, some prescribers are wary of prescribing naloxone because of liability concerns.¹²

Evidence shows that overdose bystanders are willing and able to safely administer naloxone in an overdose situation.¹³ However, since bystanders often do not have the drug, they must call 911 to summon the first responders who do. Unfortunately, they often refrain from doing so because they fear arrest and prosecution — a fear that evidence suggests may be justified.¹⁴ When first responders are summoned, it is often too late: a review of medical examiner data in North Carolina showed that over half of accidental overdose victims died by the time paramedics arrived.¹⁵

These legal barriers are unintended consequences of attempts to address other problems. The public interest is, in general, served by regulatory control of prescription medications, which may include criminal sanctions to deter unauthorized distribution and use. However, laws directed towards that end have an extraordinarily severe side effect: thousands of preventable deaths every year. These laws can be modified to remove their negative effect while sustaining their original intent, and doing so presents a critical opportunity to save many lives at little or no cost.

Saving Lives by Changing Laws

Despite the high and rising number of people felled by opioid overdose, this preventable epidemic initially received little notice outside of the occasional celebrity death. This has changed. Perhaps as a result of the shifting demographics of overdose victims combined with increased awareness, a number of states have recently acknowledged and attempted to address the problem by modifying state law.¹⁶ These legislative amendments have two separate but related aims. The first is to encourage the prescription and use of nalox-

An additional two states have passed laws explicitly requiring (AK) or permitting (MD) courts to take the fact that a Good Samaritan summoned medical assistance into account at sentencing even where the Good Samaritan is convicted of a crime. All require that the caller have a good-faith belief that a medical emergency exists when he or she summons aid, and most provide protection only for crimes that were discovered pursuant to the seeking of assistance.

Unlike some earlier attempts to modify laws to reduce health risks to drug users (in the area of

The public interest is, in general, served by regulatory control of prescription medications, which may include criminal sanctions to deter unauthorized distribution and use. However, laws directed towards that end have an extraordinarily severe side effect: thousands of preventable deaths every year. These laws can be modified to remove their negative effect while sustaining their original intent, and doing so presents a critical opportunity to save many lives at little or no cost.

one by removing the possibility that medical professionals who prescribe the drug and lay administrators (such as the family members and friends of the overdose victim) who administer it will face legal or regulatory sanction for doing so. The second is to encourage bystanders to summon emergency responders by ensuring that they will not face prosecution as a result of that selfless act.

In 2001, New Mexico became the first state to amend its laws to make it easier for medical professionals to provide naloxone, and for lay administrators to use it without fear of legal repercussions.¹⁷ As of January 1, 2013, seven other states (NY, IL, WA, CA, RI, CT, and MA) made similar changes. Most of these laws explicitly remove the possibility of civil liability for prescribers and administrators acting in good faith to prevent overdose, and some remove the possibility of criminal penalties for prescribers and those who possess or administer the drug. Four of the eight also explicitly or implicitly permit third-party prescription.¹⁸

In 2007, New Mexico again took the lead in amending state law to encourage Good Samaritans to summon aid during an overdose. As of January 1, 2013, nine other states (WA, NY, CT, IL, CO, RI, FL, MA, and CA) have followed suit. The protection offered by these laws varies slightly.¹⁹ While all of the laws protect both the Good Samaritan and victim from prosecution for possession of controlled substances, three extend that protection to drug paraphernalia as well.

syringe exchange, for example), amendments targeted at reducing overdose deaths have seen little organized opposition and have passed in states across the political spectrum. They have received support from a number of governmental and non-governmental actors, including the Office of National Drug Control Policy, the U.S. Conference of Mayors, the American Medical Association, and the American Public Health Association.²⁰ The Florida Sheriff's Association and the Florida Police Benevolent Association supported Florida's Good Samaritan law, which the state legislature passed nearly unanimously in 2012.²¹

Evaluation of the effects of these laws is urgently needed, but early reports are encouraging. The CDC recently reported that at least 188 community-based overdose prevention programs now distribute naloxone. To date, those programs provided naloxone, as well as training in how to recognize overdose and counteract it, to over 50,000 people, resulting in over 10,000 overdose reversals.²² A study from Washington, which enacted a Good Samaritan act in 2010, found that 88 percent of drug users surveyed indicated that they would be more likely to summon emergency personnel during an overdose as a result of the legal change.²³

Next Steps

Other legal barriers should be addressed as well. A chief barrier to greater naloxone access is the drug's

prescription status; if it were available over-the-counter, many of the ancillary legal issues would disappear. The FDA held hearings on this issue in April, 2012, but the process to make a prescription drug available over the counter is lengthy and often expensive.²⁴ However, alternative policy and regulatory measures can increase access in the meantime. Legislatures and licensing bodies could encourage physicians to prescribe naloxone with every opioid prescription and grant pharmacists the authority to prescribe and dispense it in their stead. Those insurance policies that do not currently cover the drug should be required to do so. Some states do not permit low-level first responders to administer the drug, a shortcoming that can be easily rectified.

In addition, states considering naloxone access and Good Samaritan bills can take steps to enhance the incentives for providing naloxone and seeking emergency help. Naloxone access bills should explicitly permit third party prescription and distribution via standing order, so that the friends and family members of a person at heightened risk of overdose can more easily access the drug. Likewise, Good Samaritan laws should extend their grant of immunity to all minor crimes discovered as a result of the caller seeking help during an overdose emergency, not just those that are drug-related. Furthermore, Good Samaritan laws should provide protection from arrest, as well as charge and prosecution. Bills should also include an education component that targets medical and law enforcement professionals as well as patients and the public. Finally, these laws should be rigorously evaluated to determine if they are having the intended effect, and to suggest changes in their scope or means of implementation.

As with most public health problems, there is no magic bullet for preventing opioid overdose deaths. Initial efforts to combat the epidemic, including monitoring of prescription opioid medications, diversion prevention efforts, improved access to pain care, and drug treatment services have proven insufficient.²⁵ While those interventions are a part of the solution, they must be combined with common-sense legal change of the type outlined above.

Conclusion

Opioid overdose kills thousands of Americans every year. Many of these deaths are preventable through the timely provision of a cheap, safe, and effective drug and the summoning of emergency responders. Preliminary evidence and common sense suggest that laws that encourage the prescription and use of naloxone and the transformation of bystanders into Good Samaritans will reduce opioid overdose deaths. Since

such laws have few negative effects, can be implemented at little or no cost, and have the potential to save both lives and resources, they represent some of the lowest-hanging public health fruit available to policymakers today.

Resources

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4. D. Kim, K. S. Irwin, and K. Khoshnood, “Expanded Access to Naloxone: Options for Critical Response to the Epidemic of Opioid Overdose Mortality,” *American Journal of Public Health* 99, no. 3 (2009): 402–407, at 403.
5. *Id.*
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7. 21 U.S.C. § 801 (1970), 21 C.F.R. § 1308 (1985).
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9. T. Lagu, B. J. Anderson, and M. Stein, “Overdoses among Friends: Drug Users Are Willing to Administer Naloxone to Others,” *Journal of Substance Abuse Treatment* 30, no. 2 (2006): 129–133.
10. K. Tobin et al., “Calling Emergency Medical Services during Drug Overdose: An Examination of Individual, Social and Setting Correlates,” *Addiction* 100, no. 3 (2005): 397–404; R. A. Pollini et al., “Response to Overdose among Injection Drug Users,” *American Journal of Preventive Medicine* 31, no. 3 (2006): 261–264, at 262.
11. See Beletsky, *infra* note 12; S. Burris et al., “Stopping an Invisible Epidemic: Legal Issues in the Provision of Naloxone to Prevent Opioid Overdose,” *Drexel Law Review* 1 (2009): 273–339.
12. L. Beletsky et al., “Physicians’ Knowledge of and Willingness to Prescribe Naloxone to Reverse Accidental Opiate Overdose: Challenges and Opportunities,” *Journal of Urban Health* 84, no. 1 (2007): 126–136, at 127; S. Burris et al., “Legal Aspects of Providing Naloxone to Heroin Users in the United States,” *International Journal of Drug Policy* 12, no. 3 (2001): 237–248.
13. See K. H. Seal et al., “Attitudes about Prescribing Take-Home Naloxone to Injection Drug Users for the Management of Heroin Overdose: A Survey of Street-Recruited Injectors in the San Francisco Bay Area,” *Journal of Urban Health: Bulletin of the New York Academy of Medicine* 80, no. 2 (2003): 291–301; Lagu et al., *supra* note 9.
14. K. Tobin, et al., “Calling Emergency Medical Services during Drug Overdose: An Examination of Individual, Social and Setting Correlates,” *Addiction* 100, no. 3 (2005): 397–404, at 398.
15. C. Sanford, ed., *Findings and Recommendations of the Task Force to Prevent Deaths From Unintentional Drug Overdoses in North Carolina*, 2003, available at <<http://www.injuryforenc.ncdhhs.gov/About/TaskForcePreventDrugDeaths.pdf>> (last visited January 8, 2013).
16. For an updated interactive database of these laws, visit the “Naloxone OD Prevention Laws Map,” available at <<http://lawatlas.org/>> (last visited January 8, 2013).
17. N.M. STAT. ANN. § 24-23-1 (West 2008); N.M. STAT. ANN. § 24-23-2 (West 2008).
18. For an updated interactive database of these laws, visit the “Naloxone OD Prevention Laws Map,” available at <<http://lawatlas.org/>> (last visited January 8, 2013).
19. *Id.*

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20. See “U.S. Conference of Mayors, 2008 Adopted Resolutions – Saving Lives, Saving Money: City-Coordinated Drug Overdose Prevention,” *available at* <http://www.usmayors.org/resolutions/76th_conference/chhs_16.asp> (last visited January 8, 2013); “AMA Adopts New Policies at Annual Meeting,” *available at* <<http://www.ama-assn.org/ama/pub/news/news/2012-06-19-ama-adopts-new-policies.page>> (last visited January 8, 2013); “Preventing Overdose Through Education and Naloxone Distribution,” *available at* <<http://www.apha.org/advocacy/policy/>> (last visited January 8, 2013); A. Knopf, “Kerlikowske Promotes Naloxone in Face of FDA Barriers,” *Alcohol and Drug Abuse Weekly* 24 (August 27, 2012), *available at* <<http://www.alcoholismdrugabuseweekly.com/sample-article/kerlikowske-promotes-naloxone-in-face-of-fda-barriers.aspx>> (last visited January 8, 2013).
21. See “911 Good Samaritan Act Bill Protects Those Who Seek Help,” *available at* <<http://www.tampabay.com/opinion/letters/wednesdays-letters-bill-protects-those-who-seek-help/1223270>> (last visited January 8, 2013).
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23. C. Banta-Green, “Washington’s 911 Good Samaritan Overdose Law: Initial Evaluation Results,” November 2011, *available at* <<http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2011-05.pdf>> (last visited January 8, 2013).
24. See Burris, et al., *supra* note 11, at 278-279.
25. See N. Dasgupta, C. Sanford, S. Albert, and F. Brason, “Opioid Drug Overdose: A Prescription for Harm and Potential for Prevention,” *American Journal of Lifestyle Medicine* 4, no. 1 (2010): 32-37, at 34.
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APPENDIX 3

IMPLEMENTATION

3-A List of Local Health Departments with Standing Orders/Protocols

3-B Sample Standing Order Template (with county examples)

- 1 – Template Naloxone Clinic Protocol
- 2 – Durham County DPH HD 58 Naloxone Policy
- 3 – Orange County HD Naloxone Standing Order
- 4 – Wake County HD Naloxone Standing Order

3-C Tools and Training for Providers

- 1 – 1-pager Primer Naloxone Tracking Reversals Reporting
- 2 – Naloxone Labeling System Evaluation Plan
- 3 – Naloxone Dispensing Logs
- 4 – Patient Counseling Sheet (English and Spanish)
- 5 – Overdose Rescue and Naloxone Training Sample Curriculum
- 6 – Sample Staff Naloxone Trainings
- 7 – Naloxone Clinic Protocol Used by OCHD
- 8 – Pre/Port Training Questionnaire
- 9 – Instructions to Healthcare Workers on Prescribing and Billing for Naloxone
- 10 – Prescribe to Prevent Instructions
- 11 – Drug Abuse Screening Test
- 12 – SBIRT Audit Screening Test
- 13 – SBIRT DAST 10 Question Screening Test
- 14 – SBIRT Scoring

3-D Patient Education

- 1 – Photo of Naloxone Kit
 - 2 – What is an opioid overdose? (San Francisco Dept. of PH)
 - 3 – Instructions and Kit Assembly (English and Spanish)
 - 4 – Evzio Patient Information
 - 5 – Narcan Kit Label
 - 6 – NCHRC OD Prevention and Survival Pamphlet
 - 7 – Quick and Dirty Training – DOPE Narcan Training Checklist
 - 8 – OC Palm Pocket Cards/Kit Insert (English and Spanish)
 - 9 – Clinic Flyers
 - 10 – Naloxone Overdose Patient Guide
 - 11 – Project Lazarus Overdose Prevention Manual and files (English and Spanish)
 - 12 – Narcan Use and Ordering
 - i – Narcan Use Guide
 - ii – Narcan Purchase Order
 - iii – Narcan Customer Maintenance
 - iv – Narcan Credit Application
 - v – Narcan Terms and Conditions
 - vi – Adapt Purchase Order Form (Excel)
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NC COUNTIES WITH STANDING ORDERS

LOCAL HEALTH DIRECTORS' CONTACT INFORMATION FOR COUNTIES WITH STANDING ORDERS

County	Contact
<p>ALEXANDER</p>	<p>Director: LEEANNE WHISNANT</p> <p>Contact Information Email: lwhisnant@alexandercountync.gov Phone: (828) 632-9704 Fax: (828) 632-9008 Website: http://www.co.alexander.nc.us/health/health.htm Address: 338 1st Avenue SW, Suite 1 Taylorsville, NC 28681</p>
<p>DUPLIN</p>	<p>Director: Ila Davis</p> <p>Contact Information Email: ilad@duplincountync.com Phone: (910) 296-2130 Fax: (910) 296-2139 Website: http://www.duplincountync.com Address: 340 Seminary Street, Po Box 948, Kenansville, NC 28349</p>
<p>DURHAM</p>	<p>Director: Gayle B. Harris</p> <p>Contact Information Email: gharris@dconc.gov Phone: (919) 560-7650 Fax: (919) 560-7652 Website: http://www.dconc.gov/publichealth Address: 414 East Main Street, Durham, NC 27701</p>
<p>FORSYTH</p>	<p>Director: Marlon Hunter</p> <p>Contact Information Email: huntermb@forsyth.cc Phone: (336) 703-3100 Fax: 336-748-3292 Website: http://www.co.forsyth.nc.us/publichealth/default.aspx Address: 799 North Highland Avenue, Winston-Salem, NC 27101</p>

County	Contact
HOKE	<p>Director: Helene Edwards</p> <p>Contact Information Email: hedwards@hokehealth.org Phone: (910) 875-3717 Fax: (910) 875-6351 Website: http://www.hokecounty.net Address: 683 East Palmer Road, Raeford, NC 28376</p>
JOHNSTON	<p>Director: Dr. Marilyn Pearson</p> <p>CONTACT INFORMATION Email: marilyn.pearson@johnstonnc.com Phone: (919) 989-5200 Fax: (919) 989-5208 Website: http://www.johnstonnc.com/mainpage.cfm?category_level_id=450 Address: 517 N Bright Leaf Blvd, Smithfield, NC 27577</p>
ORANGE	<p>Director: Colleen Bridger</p> <p>Contact Information Email: cbridger@co.orange.nc.us Phone: (919) 245-2400 Fax: (919) 644-3007 Website: http://www.co.orange.nc.us/health Address: 300 West Tryon Street, Po Box 8181, Hillsborough, NC 27278</p>
PENDER	<p>Director: Carolyn Moser</p> <p>Contact Information Email: cmoser@pendercountync.gov Phone: (910) 259-1230 (main) Fax: (910) 259-1258 Website: http://www.penderhealthdept.com Address: 803 S Walker Street, Burgaw, NC 28425</p>
PITT	<p>Director: John Morrow, MD</p> <p>Contact Information Email: jhmorrow@pittcountync.gov Phone: (252) 902-2305 Fax: (252) 413-1446 Website: http://www.pittcountync.gov/depts/health Address: 201 Government Circle, Greenville, NC 27834</p>

County	Contact
UNION	<p>Director: Phillip Tarte</p> <p>Contact Information Email: philliptarte@co.union.nc.us Phone: (704) 296-4800 Fax: (704) 296-4807 Website: http://www.co.union.nc.us/gov_offices/health/health.htm Address: 1224 West Roosevelt Blvd, Monroe, NC 28110</p>
WAKE	<p>Director: Sue Lynn Ledford</p> <p>Contact Information Email: sue.ledford@co.wake.nc.us Phone: (919) 250-4516 Fax: (919) 250-3984 Website: http://www.wakegov.com Address: 10 Sunnybrook Road, PO Box 14049, Raleigh, NC 27620-4049</p>
WILKES	<p>Director: Ann Absher, RN, MPH</p> <p>Contact Information Email: aabsher@wilkescounty.net Phone: (336) 651-7464 Fax: (336) 651-7389 Website: http://www.wilkeshealth.com Address: 306 College Street, Wilkesboro, NC 28697</p>

Please check www.naloxonesaves.org for an up-to-date list.

If you know of additional NC Local Health Departments with standing orders for Naloxone, please email NaloxoneSaves@gmail.com so that this list can be updated.

(Insert Name of Organization here) Naloxone (Narcan) Protocol

I. GOAL

- A. To address the growing problem of morbidity and mortality due to overdose of synthetic or natural opioids in North Carolina and Orange County
- B. To provide increased access to naloxone hydrochloride (Narcan), a medication indicated for the reversal of opioid overdose, for individuals at risk of an opioid overdose, or for those in a position to assist individuals at risk of an opioid overdose pursuant to NC SB 20

II. ELIGIBILITY CRITERIA

- A. Clients report being at risk of an opiate-related overdose or in a position to assist a family member, friend, or other person at risk of experiencing an opiate-related overdose.
- B. Client may present in any existing OCHD program during screening by OCHD staff, or may call to make a stand-alone appointment with an available Communicable Disease Nurse for screening, education, and distribution of a naloxone kit.

III. FEES

- A. There is no fee for the client associated with naloxone screening, education, or provision of an OCHD Overdose Rescue Kit, which includes naloxone.
- B. Clients being seen for other services or visits at the OCHD will be charged according to that program's fee policy.
- C. Policies are followed as specified in the agency Administrative Policy and Procedure Manual.

IV. SERVICE PROVIDERS

- A. Clinical providers authorized to dispense naloxone at the OCHD include:
 - Physicians/residents, Nurse Practitioners, and/or Physician's Assistants who function under the supervision of the Medical Director and have obtained approval to practice medical acts by the North Carolina Board of Medical Examiners.
 - Registered Nurses who have been appropriately trained by the NC Board of Pharmacy approved training.
- B. All orders are documented in the client's medical record.
- C. Nursing and allied health providers are authorized to provide screening and education related to the OCHD Overdose Rescue Kit at the OCHD.

V. PHARMACY

- A. OCHD maintains two limited service permits (one for each clinical site) from the N.C. Board of Pharmacy.
- B. Dispensing of pharmaceuticals to OCHD clients is in accordance with North Carolina Pharmacy Laws and the North Carolina Board of Pharmacy.
- C. Naloxone is listed under the OCHD primary care formulary and is maintained in the pharmacy at each clinical site. (See Appendix H of the Primary Care Program Protocol).
 - Authorized dispensers must document on the naloxone dispensing record all dispensed naloxone kits. (See Appendix D of the Pharmacy Program Protocol)
- D. All protocols and procedures related to the pharmacies are found in the OCHD Pharmacy Protocol Manual which is located in each clinical pharmacy.

VI. INTERPRETER SERVICES

- A. Clients who require the assistance of an interpreter are referred to the OCHD Language

Coordinator who advises them of available OCHD services and their right to an interpreter either provided by OCHD or an interpreter or signer of their choosing.

- B. The Health Department uses the certified sign interpreter/translator list provided by the Raleigh Regional Resource Center. This list is kept by the OCHD Language Coordinator, his/her backup and both Clinic Coordinators. The OCHD Language Coordinator is contacted when a signer is needed.
- C. The Waiver of Health Department Interpretive Services form is completed when interpretive Services of a family member or friend are used. (See Appendix N.)
- D. Interpreters are pre-arranged by the OCHD Language Coordinator who screens all contracted interpreters and volunteers for level of proficiency before assigning them to clinic clients.
- E. Non-English speaking clients who walk into clinic can be assisted by using TeleLanguage, access # 1-800-514-9237 or Fluent, 1-877-948-9680 (See Appendix AA). The receptionist may use a Language Identification Card to determine the language a client speaks.
- F. Clients who are seen with interpreter or signer assistance will need the interpreter to witness any informed consents that are required. If TeleLanguage or Fluent is used, the interpreter # and/or name are documented on the consent form.

VII. VISIT PROTOCOL

Client will be screened in one of two ways: 1) Through an existing OCHD appointment or 2) By calling to make a naloxone-only appointment

A. Screening - Existing Appointments

- a. Screen client by asking a question like, *“We have a new program here at the Health Department to protect people from drug overdose. Do you or someone you know take prescription pain medicine such as oxycodone (oxys or roxys), hydrocodone, fentanyl, methadone, or use heroin?”*

- i. If the answer is yes, gauge client's interest with a brief explanation:

1. Prescription opioid painkillers can be an effective pain management tool
2. The number of overdoses and deaths from these medicines has increased across the United States and in North Carolina.
3. Our new program is a way to protect people who use prescription opioid painkillers or other opioids, like heroin, from overdosing.
4. Naloxone (Narcan) can be given to someone experiencing an opioid overdose to re-start their breathing
5. Naloxone (Narcan) is free at OCHD
6. To get the medicine, watch a short video before the end of the visit, ask any questions, and get the medicine for free.

- ii. See Education and Dispensing section below for education and dispensing of kit.

- iii. If the answer is no, let people know that they can participate in the future by asking at their regular appointment or calling to make an appointment.

B. Screening – Naloxone Only Appointment

- a. Client will call to make a naloxone-only appointment.
- b. The MOA will make the appointment for client as “Adult Health – Other” with available CD Nurse.
- c. See Education and Dispensing section below for education and dispensing of kit.

 Public Health	
Policy Name:	Naloxone Kit Distribution
Policy Number:	HD: 58
Effective Date:	01/07/2015

Policy:

The Durham County Department of Public Health (DCoDPH) provides naloxone kits to opioid users, family members, friends or domestic partners of active opiate users in accordance with NC Senate Bill 20, for the purpose of providing greater access to naloxone in order to reduce opiate overdoses.

Purpose:

To clearly describe the process by which naloxone kits are provided directly by the DCoDPH to the opiate user, family members, friends or domestic partners of active opiate users for the purpose of providing greater access to naloxone and reducing opiate overdoses.

Definition:

1. Naloxone (also known as Narcan®) is a medication called an “opioid antagonist” which is used to counter the effects of opioid overdose.
2. Clinic provider- for the purposes of this policy, a clinic provider is a licensed Nurse Practitioner (NP) or a certified Nurse Midwife (CNM) employed with or contracted by the DCoDPH.

Procedures:

I. Standards for dispensing naloxone kits

1. Individuals 18 years of age or older who present to DCoDPH Central Registration, and request a naloxone kit, will be directed to the DCoDPH Pharmacy after the registration process is completed.
2. Clients who receive clinic services from a clinic provider and are assessed through a routine exam, to be in need of a naloxone kit (self-report by client, obvious clinical

- evidence of drug use) will receive education and a prescription for a naloxone kit from the clinic provider, as described in Section III below.
3. The DCoDPH Medical Director will be consulted if an individual under the age of 18 requests a naloxone kit. The situation will be discussed to determine a course of action. Other agencies (such as Department of Social Services (DSS) will be consulted, if indicated.
 4. Naloxone kits are dispensed by the DCoDPH Pharmacy under a standing order issued by the DCoDPH Medical Director or as prescribed by a DCoDPH clinic provider .
 5. Each naloxone kit contains:
 - a. Two 0.4mg/ml vials of naloxone hydrochloride
 - b. Two 3ml 25 g syringes
 - c. Rescue breathing mask
 - d. Two sets of non-latex gloves
 - e. Two alcohol pads
 - f. Printed materials regarding overdose prevention and treatment, to include information regarding recognizing and responding to suspected opioid overdose and the importance of summoning emergency responders.
 6. Each individual who requests a naloxone kit (whether the initial kit, or any subsequent refill) must receive screening and education from a DCoDPH licensed pharmacist and/or clinic provider before a kit is dispensed.
 7. A clinic provider or the DCoDPH Medical Director will be consulted if any concerns about dispensing a kit to the individual arise during any part of the screening or education process (i.e, refill).
 8. Individuals (identified user) are strongly encouraged to bring someone with them to the visit.

II. When an individual presents at the DCoDPH Pharmacy, the pharmacist will

1. **Screen** the individual
 - a. Confirm that the individual is 18 years of age or older
 - b. Contact DCoDPH Medical Director if individual is under 18 years of age
 - c. Clarify that the individual who requests a kit has a personal need for it or is in a position to assist a family member, friend, or other person at risk of experiencing an opiate-related overdose
 - d. Verify that individual reports no known sensitivity or allergy to naloxone hydrochloride

- e. Consult with a clinic provider or the DCoDPH Medical Director if any concerns about dispensing a kit to the individual arise during any part of the screening or education process (i.e, refill in a short time frame 30 days or less)

2. **Educate** the individual

- a. Provide a brief description of what naloxone is and what it does when used as intended
- b. Discuss possible side effects of naloxone such as
 - chest pain, fast or irregular heartbeats;
 - dry cough, wheezing, feeling short of breath;
 - sweating, severe nausea or vomiting;
 - severe headache, agitation, anxiety, confusion, ringing in your ears;
 - seizure (convulsions);
 - slow heart rate, weak pulse, fainting, slow breathing
- c. Note that these side effects may appear within minutes of naloxone administration and subside in approximately 2 hours.
- d. Describe signs of an overdose
 - Awake, but unable to talk
 - Body is very limp
 - Face is very pale or clammy
 - Fingernails and lips turn blue or purplish black
 - For lighter skinned people, the skin tone turns bluish purple, for darker skinned people, it turns grayish or ashen.
 - Breathing is very slow and shallow, erratic, or has stopped
 - Pulse (heartbeat) is slow, erratic, or not there at all
 - Choking sounds, or a snore-like gurgling noise (sometimes called the “death rattle”)
 - Vomiting
 - Loss of consciousness
 - Unresponsive to outside stimulus
- e. Review how to respond to an overdose
 - Call 911
 - Administer naloxone from kit
 - Remain with person until EMS (911) arrives
 - Initiate rescue breathing if needed

- f. Show video which demonstrates how to administer naloxone and perform rescue breathing
- g. Verify individual's understanding of information provided

3. Dispense a naloxone kit

- a. Review and explain all items in the naloxone kit to the individual
 - Two 0.4 mg/ml vials of naloxone hydrochloride
 - Two 3 ml 25 g syringes
 - Rescue breathing mask
 - Two sets of non-latex gloves
 - Two alcohol pads
 - Printed materials regarding overdose prevention and treatment, to include information regarding recognizing and responding to suspected opioid overdose and the importance of summoning emergency responders
- b. Demonstrate/simulate to the individual how to correctly use items in the kit
 - Remove lid from naloxone vial
 - If practical, don gloves and prepare injection site with alcohol pad
 - Insert syringe into vial and draw up 1ml – entire contents of vial
 - Administer 1ml of naloxone via intramuscular injection into upper arm, buttock or thigh
 - Monitor respiration and responsiveness of naloxone recipient
 - If no response in 3-5 minutes, administer second 1ml of naloxone via the same route.
- c. Explain that naloxone in kit will expire and is good only if used within 12 months from date dispensed

4. Follow Up and Referral

After dispensing the kit, the pharmacist will

- a. Complete DCoDPH Naloxone Kit Medication and Education Distribution Log
- b. Ensure all items on the *Naloxone Screening Checklist* were discussed with individual
- c. Instruct client/parent/guardian to call the DCoDPH Pharmacy (919-560-7632) if there are questions or concerns about the kit or how to use the kit
- d. Encourage individual to communicate with primary care provider regarding overdose, use of naloxone, and availability of behavioral health and substance abuse services

- e. Provide referral for Behavioral Health services.
- f. Refer individual as needed for other needed services (i.e. Women’s Clinics, Adult Health (STD/HIV) Clinic, WIC, DSS, other providers and clinics, etc.)
- g. Assure that each individual who receives a naloxone kit initials the *DCoDPH Naloxone Kit Medication and Education Distribution Log* to indicate receipt of the naloxone kit, educational materials and a Behavioral Health referral
- h. Provide the naloxone kit at no charge to individuals when the visit is associated with a naloxone screening and education only

III Clinic setting

1. Clients who receive clinic services and are assessed by a clinic provider, through a routine exam, to be in need of a naloxone kit (self-report by client, obvious clinical evidence of drug use) will receive education from the clinic provider, as described above in Section II. 2.
2. After providing education to the client, the clinic provider will
 - a. Write a prescription (hard copy) for a naloxone kit and direct the client to the DCoDPH pharmacy. The provider is available to the pharmacy if questions arise related to the prescription.
 - b. Document all care and services provided in the client’s electronic medical record, ensuring all items on the Naloxone Checklist were discussed with client.
 - c. Encourage the client to communicate with primary care provider regarding overdose, use of naloxone, and availability of behavioral health and substance abuse services
 - d. Provide referral for Behavioral Health services.
 - e. Refer client, as needed, for other needed services (i.e. Women’s Clinics, Adult Health (STD/HIV) Clinic, WIC, DSS, other providers and clinics, etc.)

Appendices:

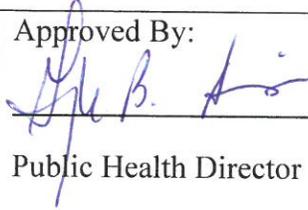
1. Appendix A: Pharmacy – Naloxone Screening Checklist
2. Appendix B: DCoDPH Behavioral Health Referral Form
3. Appendix C: DCoDPH Naloxone Kit Medication and Education Distribution Log

References and Resources:

1. Session Law 2013-23, NC Senate Bill 20
2. NC GS § 90-96.2. Drug-related overdose treatment; limited immunity
3. NC GS § 90-106.2. Treatment of overdose with opioid antagonist; immunity
4. DCoDPH Adult Health (HIV/STD) Clinic Policy and Procedure, Naloxine Dispensing 2015

CHANGE HISTORY:

Version	Date	Comments
A	1/07/2015	Original document.
B	3/30/2015	Changed process to Pharmacy dispensing under Medical Director standing order; clarified roles and responsibilities by disciplines
Annual Review		

Approved By:  <hr/> Public Health Director	Program Area(s) Affected: DCoDPH Workforce
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**Pharmacy:
Naloxone Screening Checklist**

- Confirm individual is 18 years of age or older, knows someone or self-reports he/she takes prescription pain medication such as Oxycodone, (Oxys or Roxys), Hydrocodone, Fentanyl, Methadone, or uses Heroin.
- Explain what naloxone does when used correctly; discuss possible side effects of naloxone
- Explain/describe signs of an overdose
- Educate on how to respond to an overdose
- Stress the importance of calling 911 in overdose situations
- Stress the importance of staying with the person until help arrives.
- Review all items in the naloxone kit
- Play video or demonstrate how to administer naloxone and perform rescue breathing
- Encourage opioid user to communicate with primary care provider regarding use of naloxone
- Refer individual for other needed services (i.e.: Adult Health, Immunization Clinic, Family Planning, other providers, etc.)
- Provide Behavioral Health referral
- Ask if individual has other questions, concerns

Appendix B



Public Health



Durham County Department of Public Health

REFERRAL FORM: ALLIANCE BEHAVIORAL HEALTHCARE (800) 510-9321

DATE/TIME	PROVIDER MAKING REFERRAL:
Name of Person Referred:	Referring Agency: Durham County Department of Public Health 414 E. Main Street Durham, NC 27701 Phone: 919-560-7600
Address/Zip Code	Provider Comments:
Date of Birth: (MM/DD/YY)	
Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> One or more races <input type="checkbox"/> Other: _____ Ethnicity: Hispanic/Latino Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Provider Signature:
Reason for Referral You have received a naloxone kit from Durham County Department of Public Health. You are also being referred for substance abuse and/or behavioral health treatment options. This referral will give you information to access Substance Abuse/Mental Health services through Alliance Behavioral HealthCare and the Alliance Provider Network.	
Call the 24 hour toll-free Alliance Access and Information Line at (800) 510-9132 The Qualified Professionals who answer the Alliance Access and Information Line will: <ul style="list-style-type: none"> • Be able to screen and enroll you for services • Give you information on community resources for behavioral health, substance abuse and disability issues • Arrange for an emergency face to face assessment and crisis intervention • Refer you for services to Alliance's local network of providers 	

DCoDPH Naloxone Kit Medication and Education Distribution Log

Appendix C

Date	Clinic Provider	Pharmacist Name	Patient Education and Behavioral Health Referral Received (initial below)	Naloxone Kit and Counseling received from Pharmacist (initial below)
			<p>Naloxone Kit Prescription Information <i>Verification of Medication, Behavioral Referral and Education</i></p> <p>Patient Education and Behavioral Health Referral Received (initial below)</p>	<p>Naloxone Kit and Counseling received from Pharmacist (initial below)</p>
			<p>Naloxone Kit Prescription Information <i>Verification of Medication, Behavioral Referral and Education</i></p> <p>Patient Education and Behavioral Health Referral Received (initial below)</p>	<p>Naloxone Kit and Counseling received from Pharmacist (initial below)</p>

“Working with our community to prevent disease, promote health, and protect the environment.”

Orange County Health Department Naloxone (Narcan) Standing Order

Naloxone is indicated for the reversal of opioid overdose induced by natural or synthetic opioids and exhibited by respiratory depression or unresponsiveness. It is contraindicated in patients known to be hypersensitive to naloxone hydrochloride.

This standing order covers the possession and distribution of naloxone kits, to include naloxone hydrochloride, intramuscular syringes, alcohol pads and related injection supplies, and overdose prevention materials.

Registered Nurses (RN) at the Orange County Health Department, who have been appropriately trained by the NC Board of Pharmacy training, may possess and distribute naloxone kits to a person at risk of experiencing an opiate-related overdose or a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose.

Assessment:

Subjective Findings:

- Client is at risk of experiencing an opiate-related overdose or is in a position to assist a family member, friend, or other person at risk of experiencing an opiate-related overdose.
- Client reports no known sensitivity or allergy to naloxone hydrochloride.

Objective findings:

- Client is oriented to person, place, and time and able to understand and learn the essential components of overdose response and naloxone administration.

Plan of Care:

- Provide education regarding preventing, recognizing, and responding to a suspected opioid overdose.
- Dispense one naloxone kit, to include at a minimum:

For intramuscular injection kits:

- Prescription label
- Two 1mL vials of naloxone hydrochloride
- Two intramuscular syringes (at least 1 inch)
- Disposable CPR shield
- Alcohol pads and gloves
- Instructions for use
- Printed materials regarding overdose prevention and treatment, to include information regarding recognizing and responding to suspected opioid overdose and the importance of summoning emergency responders

Nursing/Provider Actions:

- Screen client for contraindications/precautions to prescription or dispensing.
- If a contraindication/precaution exists, refer client to medical provider for evaluation.
- Show Opioid Overdose Prevention video (if available) to client and answer any client questions.
- Authorized dispenser will dispense naloxone kit and explain contents to client.
- Authorized dispenser will log all dispensed kits on a form approved by the ordering physician.
- Provide information and/or referral for substance abuse or behavioral health treatment options.

Follow Up Requirements:

- Instruct client/parent/guardian to call medical provider if questions, concerns or problems arise.
- Instruct client/parent/guardian to return for refill as needed, subject to use and expiration of naloxone (18 months).
- Encourage opioid user to communicate with primary care provider regarding overdose, use of naloxone, and availability of behavioral health services.
- Refer client as needed for other needed services (i.e. well child care, WIC, Maternity Care Coordination, Child Care Coordination, Health Check, other providers, etc.).

Legal Authority:

- Nurse Practice Act, G.S. 90-171.20 (7) (f) & (8) (c)
- Good Samaritan Law/Naloxone Access, G.S. 90-106.2

Indications and Usage

- Naloxone is indicated for the complete or partial reversal of opioid overdose induced by natural or synthetic opioids and exhibited by respiratory depression or unresponsiveness.

Precautions

- Pre-existing cardiac disease or seizure disorder
- Persons who are known or suspected to be physically dependent on opioids (including newborns of mothers with narcotic dependence. Reversal of narcotic effect will precipitate acute abstinence syndrome.)
- Use in Pregnancy:
 - Teratogenic Effects: pregnancy category C, no adequate or well-controlled studies in pregnant women.
 - Non-teratogenic Effects: Pregnant women known or suspected to have opioid dependence often have associated fetal dependence. Naloxone crosses the placenta and may precipitate fetal withdrawal symptoms as well.
- Nursing Mothers: caution should be exercised when administering to nursing women due to transmission in human milk. Risks and benefits must be evaluated.
- Geriatric Use: choose lower range doses taking precautions for potential decreased hepatic, renal and cardiac function, as well as, concomitant disease and other drug therapy.
- If a contraindication/precaution exists, refer client to medical provider for evaluation.

Contraindications

- Patients known to be hypersensitive to naloxone hydrochloride.
- If a contraindication/precaution exists, refer client to medical provider for evaluation.

Adverse Reactions

- Adverse reactions are related to reversing dependency and precipitating withdrawal (fever, hypertension, tachycardia, agitation, restlessness, diarrhea, nausea/vomiting, myalgias, diaphoresis, abdominal cramping, yawning, sneezing.) These symptoms may appear within minutes of Naloxone administration and subside in approximately 2 hours. The severity and duration of the withdrawal syndrome is related to the dose of naloxone and the degree of opioid dependence.
- Adverse effects beyond opioid withdrawal are rare.

Dosage and Administration

Intramuscular Injection

Dosage

- 1 mL vial of 0.4 mg/mL naloxone
- Administer with at least a 1 inch needle

Administer naloxone to a person suspected of an opioid overdose with respiratory depression or unresponsiveness as follows:

1. If practical, activate emergency medical services
2. If indicated, initiate rescue breathing
3. Remove lid from naloxone vial
4. Insert syringe into vial and draw up 1mL of naloxone
5. If practical, don gloves and prepare injection site with alcohol pad
6. Administer 1mL of naloxone via intramuscular injection into upper arm, buttock or thigh
7. Continue rescue breathing and monitor respiration and responsiveness of naloxone recipient
8. If no response in 3-5 minutes, repeat naloxone.

This standing order shall remain in effect for one (1) year, until May 31, 2015.

Approved by: _____
Medical Director

Date: _____



Standing Order for Dispensing/Distributing Naloxone

HCL.PHM Standard 600 1.0

	Countywide or	X	Department: Human Services	X	Division(s): Health Clinics
Supersedes: "N/A"					Original Effective Date:
Authority: :					
<ul style="list-style-type: none"> - NC Senate Bill 2013 SESSION LAW 2013-23 - NC GS 90-96.2 Drug-related overdose treatment; limited immunity - NC GS 90-106.2 Treatment of overdose with opioid antagonist; immunity - NC Board of Pharmacy 21 NCAC 46 .2401 MEDICATION IN HEALTH DEPARTMENTS 					
Originating Department/Division/Section/Work Unit:					
Human Services/Health Clinics/Pharmacy Services					

Approved: PENDING

I. **Purpose:** To provide a **consistent** standard for the prescribing, dispensing and distribution of Naloxone Hydrochloride approved by the Federal Food and Drug Administration for the treatment of opioid drug overdose in accordance with NC State Law 2013-23 and for the purpose of providing greater access to naloxone in order to reduce opiate overdoses. The Good Samaritan Law/Naloxone Access (S.L. 2013-23) protects the WCHS staff and Wake County Government from liability as a result of prescribing, dispensing and distribution of naloxone kits for opiate overdose.

II. **Description:**

A. Assessment

1. Subjective Findings

- a. Individual presents and is at risk or is in close contact to a person at risk of an opioid drug overdose.
- b. A person who will come into direct contact with an individual who is at risk or is in close contact to a person at risk of a drug overdose, including but not limited to family member, friend, or other person, etc.

2. Objective Findings

- a. Verbal confirmation that the individual who requests a kit is at risk of experiencing an opiate-related overdose; and/or is in a position to assist a family member, friend, or other person at risk of experiencing an opiate related overdose.

B. Plan of Care

1. Implementation

a. Naloxone kits include:

- Two 0.4mg/ml vial 1ml of naloxone
- Two 3ml syringes
- Two alcohol pads

- Two gloves
- CPR mask
- Printed instructions
- Behavioral Health contact card
- Self addressed Post Card (Appendix C)
- Sticker containing: tracking number, cell phone number, and website

b. Dispensing of the Naloxone Kits

- Pharmacist will prepare pre-labeled naloxone kits for dispensing or distribution outside of the pharmacy.
- Pharmacist will put a sticker containing tracking number, cell phone number, and website on each kit.
- Naloxone kits will be dispensed by the WCHS pharmacist, public health nurse, physician, or physician extender under a standing order issued by WCHS Medical Director (Appendix A) or with a prescription presented in the pharmacy.
- Pharmacist , public health nurse, physician or physician extender can dispense to a distributor who will deliver the naloxone kit to an individual who is at risk or in close contact to a person at risk.
- Each individual who receives a kit must receive education and/or training on how to use the kit.

c. Dispensing of Naloxone Kits to Community Partners

- The WCHS pharmacist will dispense naloxone kits to the partnering facilities including but not limited to Wakebrook, Holly Hill Hospitals, Wake County Jail , etc. who will distribute the kits and document on a distribution log sheet the name and address of the patient to whom the naloxone kit is given (Appendix B)
- The completed distribution log sheets will be returned to the Wake County human Services Pharmacy within 48 hours of completion or at least monthly if log not completed.
- Approved Community Pharmacies may dispense Naloxone kits using Wake County Human Services' Naloxone Standing Order.

d. Distribution of the Naloxone Kits

- Distributor will obtain a dispensed naloxone kit for from the WCHS Pharmacy or from a WCHS public health nurse, physician, or physician extender. Distributor will initial that they received the Naloxone kit on the WCHS pharmacy sign out log. (Appendix A)

- Distributor will be responsible for explaining the proper use of the kit to the individual and will record the initial of the person who received the kit. (Appendix B)

C. Follow-up Requirements

1. Tracking will consist of dispensing and distribution sign out logs (Appendix A and B)

Dispensed Naloxone Kits will be tracked using 3 methods:

- Rx number
- Name of community partner or patient name
- Tracking kit number

Distributed kits will be tracked at the site of distribution by:

- Distributor will fill out the WCHS/NC Harm Coalition distribution log.
- Distributor will send the completed log to WCHS within 48 hours of completion or at least monthly if log not completed.
- Data from log will be recorded on excel spreadsheet (Appendix D)
- Spreadsheet will be located in password protected pharmacy folder on the S drive.

End User data will be tracked in three ways:

- Naloxonesaveslives.org where kit number is recorded once kit is used. Program will send information to WCHS
- Stamped postcard that is provided with the kit and mailed to WCHS after kit is used.
- Text or phone call
- After 6 months and annually, data will be analyzed to show distribution sites and naloxone kits that have been used.
- After 6 months and annually, data will be analyzed to show distribution sites and naloxone kits that have been used.

III. Definitions:

- A. WCHS: Wake County Human Services
- B. Dispense means preparing and packaging a prescription drug or device in a container and labeling the container with information required by State and federal law for subsequent administration is dispensing.
- C. Distribute/Deliver means the actual transfer of a drug, a device, or medical equipment from one person to another.
- D. Naloxone Hydrochloride (also known as Narcan® or Evzio®) is a medication called an “opioid antagonist” which is used to counter the effects of opioid overdose.
- E. Dispenser can be a pharmacist, Public Health Nurse with dispensing training in accordance with NC Board of Pharmacy 21 NCAC 46 .2401, or physician, physician

NC Distribution of Naloxone/Narcan

A Tracking & Monitoring How To

Introduction

The NC Harm Reduction Coalition, UNC Injury Prevention & Research Center (IPRC) and a coalition of local partners are coordinating a pilot tracking system for Naloxone distribution to individuals for overdose reversals. This pilot has already been initiated with the NC Harm Reduction Coalition, Orange County Health Department, Community Care of NC Networks, and a number of other organizations. This short document serves as a primer to organizations beginning naloxone distribution so they can participate in the statewide tracking and evaluation initiative.

Our organization is considering Naloxone distribution. What do I need to know so our organization can participate in the statewide tracking and monitoring initiative?

In very brief, three things:

- Label your naloxone OD reversal kits with a unique ID and the data collection website (naloxonesaves.org)
- Distribute the kits as widely as possible
- Encourage kit recipients to report every opioid overdose reversal attempt

That's it! This enables future data collection and reporting back to distributing organizations. These goals are accomplished by the kit label described below.

How to label your naloxone OD reversal kits

OD reversal kit labels (see below for a description of the labels) are placed as close to the naloxone vial as possible and inside the kit so they are less likely to be lost. For example, the NC Harm Reduction Coalition is placing the labels on the UV protective bag holding the naloxone vials inside the kit. The Orange County Health Department and Project Lazarus, Inc. place labels on the inside of the kit on the underside of the lid.

How to make a label for your naloxone OD reversal kit

Kit labels are easy to make on **regular A4 label paper and any black and white printer**. Each label contains a short sentence about the tracking program, a website for self-report of use and a kit number for tracking purposes. The label text will read as follows:

Used a kit? Please share your experience!
Go to www.naloxonesaves.org
to answer a few short, anonymous questions.
Kit#: AAA-##-###



Kits are labeled with an alpha-numeric code with three parts separated by dashes. The first part will be a county code, the second a distributor number, and lastly a kit number.

Aspect name	Description
County code	Three-letter county code (Project Lazarus, Inc., NCHRC and CCNC are considered "counties")
Distributor code	2-digit distributor identifier (e.g. 1=Health Department, 2=Police, 3=Fire, ... , or CCNC network)
Kit number	Sequential enumeration starting at 1 (Variable length)

Example label numbers:

- ORA-01-42 [Orange County, Health Department, Kit #42]
- PRL-00-33 [ProLaz Inc., Kit #33]
- CCN-12-789 [CCNC, Northern Piedmont, Kit # 789]

In order to ensure no two organizations are using the same organization / entity identifiers, please contact UNC IPRC (aaa@unc.edu or jprcoverdose@gmail.com) to confirm a unique ID for your statewide or county-level organization. UNC IPRC can send you a printable template of kit numbers if that helps.

What might we additionally like to track?

Many organizations track additional information during kit distribution. For instance, Orange County Health Department records kit numbers in a single Naloxone log in their pharmacy and in their EMR under Patient notes. Police departments and EMS departments have their own specific additional systems for professional use of Naloxone / Narcan. (IPRC can give samples of these policies or forms). Your organization may decide to track additional information elsewhere besides labeling kits, but labeling kits for distribution to community members based on the previous section is the minimum that the coalition needs for the current reporting pilot.

Naloxone Tracking and Evaluation Proposal/Plan



Take-home naloxone labeling system and evaluation plan

Context

Naloxone, the antidote for opioid overdose, is starting to be distributed to pain patients, drug users, and concerned family members to prevent deaths in North Carolina through bystander administration.

Problem Statement

Local health departments, civil society organizations, substance abuse treatment clinics, physicians networks, and others have begun distributing naloxone in their local areas; first responders and others are becoming increasingly involved after authorization legislation was enacted in 2013 by the General Assembly. Centralized data collection would improve assessment of the relative feasibility, utilization, and effectiveness of this intervention. North Carolina benefits from a well-connected group of motivated individuals who are working on this intervention, as well as a robust scientific data environment. In this proposal we intend to leverage these two factors to create a tracking system and evaluation plan for take-home naloxone.

Values

An evaluation plan (and the labeling system) will be **efficient** in that it minimizes excessive or repeat reports and consolidates collection from as few discrete distribution networks as possible. It will be **robust**, allowing for data depth at the level individuals and organizations need. It will be **trusted**, both by users because of the anonymity provided them and their belief in its utility to their community, and by responders because of its usefulness in documenting their missions. Study data will be reported back to each distributing organization and be useful to that organization's operations and evaluation.

Approach

We suggest a combination of a **Labeling System** and a **Web-based data collection**.

Research Objectives

1. To assess the feasibility and acceptability of implementing a multi-party tracking system for take-home naloxone.
2. To document utilization proportion of take-home naloxone, and determine how it differs by distribution modality: i.e., street outreach, health departments, first responders, pain patients, and drug treatment programs.
3. To document the length of time between take-home naloxone distribution and utilization, and determine how time-to-utilization rates differ by distribution modality.

Potential Partners

- NC Harm Reduction Coalition (NCHRC)
- Injury Prevention Research Center, UNC
- Injury and Violence Prevention, Division of Public Health
- DHHS nurse responsible for training on naloxone
- Project Lazarus and Community Care of NC
- EMS Performance Improvement Center
- NC DETECT
- NC Health Departments
- Police and fire officials
- Others?

Stage One (Summer 2014) – Pilot data collection system

Focus on peer-distribution via NCHRC, Project Lazarus, Inc., Community Care of NC, and Orange County Health Department. These sources are already distributing take-home naloxone.

Stage Two (Fall 2014) – Statewide take-home naloxone

Expand to include peer-distribution via other health departments, first responders, and others.

Stage Three (TBD) – Professionally administered naloxone

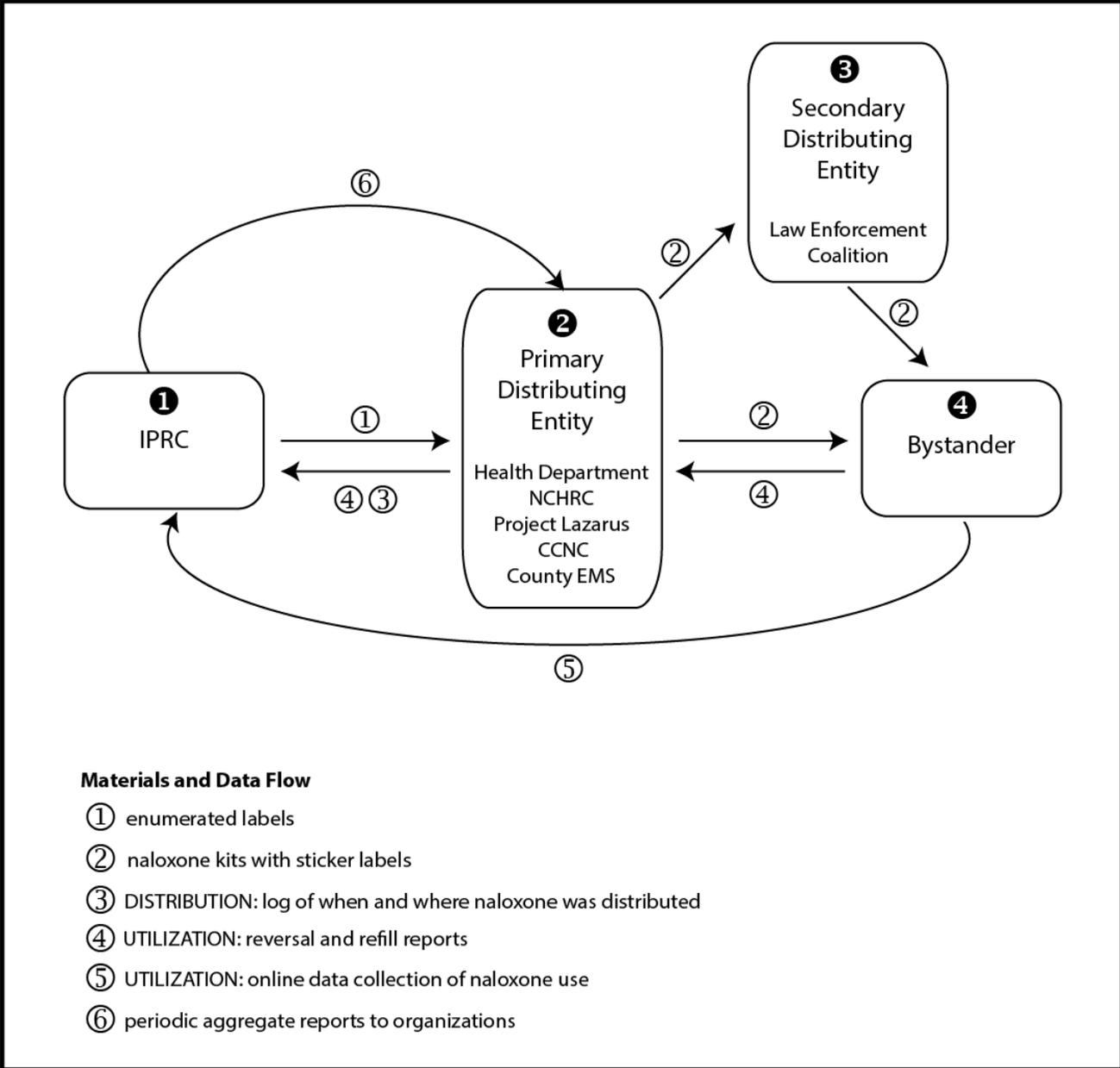
Use secondary data sources (NC DETECT PreMIS, FireHouse, pharmacy logs, etc.) to collect additional information on naloxone administration by first responders and emergency medical personnel.

Labeling System: Information Flow

The labeling system is built on mark-and-capture philosophy. The Labeling System will be kept as simple as possible to maximize partner adherence and data quality. The system will accommodate phone-ins or web-use of by lay users and peer network.

There are four entities who either hold data or naloxone: IPRC, the primary and secondary distributing entities, and the bystander who reports naloxone administration.

There are six potential transfers of either naloxone or information. These are illustrated in the figure below.



For each label there will be three points of data collection: 1) from IPRC to the organization distributing naloxone; 2) the point of distribution to a potential end user, and 3) the point of administration. The labeling system will be implemented using a duplicate label paradigm. The organization purchasing the naloxone will be responsible for recording where (county) and when (date) it is distributed in a log. (The analogous system is pharmacy tracking for signatures for picking up controlled substances prescriptions.) These logs will be collected and used to determine when a kit was released. When a kit is used, we hope that the experience will be entered in the study database by one or more of the following: 1) the end user (via web-based reporting), 2) distribution entity (via refills, replacement), or 3) by emergency personnel (EMS on scene). A kit could be used twice (since there are two vials within each kit), so there is a chance for duplicate kit numbers with potentially a different use date. If possible, the physical kit could be relabeled before released again after a refill.

Labeling System: Coded Distribution

Kits will be labeled with an alpha-numeric code with three parts separated by dashes. The first part will be a county code, the second a distributor number, and lastly a kit number.



Aspect name	Description
County code	Three-letter county code (Project Lazarus, Inc., NCHRC and CCNC are considered “counties”)
Distributor code	2-digit distributor identifier (e.g. 1=Health Department, 2=Police, 3=Fire, ... , or CCNC network)
Kit number	Sequential enumeration starting at 1 (Variable length)

Example label numbers:

- **ORA-01-42** [Orange County, Health Department, Kit #1]
- **PRL-00-33** [ProLaz Inc., Kit #33]
- **CCN-12-789** [CCNC, Northern Piedmont, Kit # 789]

Please see the Appendix A for a code dictionary.

Survey: Web address and Content

User/peer kits will need at least two parts: (1) a kit-connected flyer or label clarifying anonymity and importance/buy-in and (2) an easy-to-read web address.

The survey will be embedded in an easy to remember website (naloxonesaves.org). This website may eventually grow to serve as a multi-partner clearinghouse for information on naloxone access, legislation and use in North Carolina.

The survey itself: (1) reiterates and clarifies issues related to anonymity, confidentiality, and importance/buy-in, (2) describes the use of this data, and (3) presents the questions themselves.

The questions are presented in an order that balances importance and emotional content; and, to account for the likelihood of incomplete surveys, are ordered by relevance to the evaluation.

Survey questions are included in Appendix B.

Data Home

UNC Injury Prevention Research Center will house this data survey, will maintain the naloxonesaves.org website, and has already secured IRB approval.

Required Training for Evaluation Plan

As part of the “roll-out” training for naloxone distributors, the following training points need to be communicated for this labeling schema and website. This is just a preliminary list and will be expanded as new partners begin distributing naloxone.

- Teaching how to apply easy-to-use labels on kits. Labels should be placed as close to the naloxone vial as possible and inside the kit so they are less likely to be lost. For example, the NC Harm Reduction Coalition is placing the labels on the UV protective bag holding the naloxone vials inside the kit. The Orange County Health Department and Project Lazarus, Inc. will place labels on the inside of the kit on the underside of the lid. Sharpies and other low-cost methods should also work.
- Outreach workers and health department staff distributing naloxone kits will need to encourage those receiving the kits to report when and if they use the kit and direct them to the naloxonesaves.org website to report the overdose.
- Because all administrations of Naloxone in the field by Police or Fire should require an EMS call, Police and Fire need to be trained to give the label or kit to EMS to document and dispose of. This funnels documentation to EMS (who are already trained in documenting into a medical record that is captured by NC DETECT). Police and fire could code these kits in their incident reports or FireHouse data systems as appropriate for further depth.
- According to EMS, this collaboration with Police and Fire is also an opportunity to train on related activities of hands-only CPR and defibrillation, and in general tie support service communication together for better future collaboration.
- EMS could act as a partner for tracking kit usage. Likely would be recorded in notes anyway – just need to add kit number to documentation. Perhaps should include in standard “Sharps securing” protocols.



Appendix A

Code Dictionary

EXAMPLES

ORA-01-42 [Orange County, Health Department, Kit #1]

PRL-00-33 [ProLaz Inc., Kit #33]

CCN-12-789 [CCNC, Northern Piedmont, Kit # 789]

Aspect name	Description
County code	Three-letter county code (Project Lazarus, Inc., NCHRC and CCNC are considered “counties”)
Distributor code	2-digit distributor identifier (e.g. 1=Health Department, 2=Police, 3=Fire, ... , or CCNC network)
Kit number	Sequential enumeration starting at 1 (Variable length)

NC COUNTY OR OTHER ENTITY	COUNTY CODE
NC Alamance	ALA
NC Alexander	ALE
NC Alleghany	ALL
NC Anson	ANS
NC Ashe	ASH
NC Avery	AVE
NC Beaufort	BEA
NC Bertie	BER
NC Bladen	BLA
NC Brunswick	BRU
NC Buncombe	BUN
NC Burke	BUR
NC Cabarrus	CAB

NC Caldwell	CAL
NC Camden	CAM
NC Carteret	CAR
NC Caswell	CAS
NC Catawba	CAT
NC Chatham	CHA
NC Cherokee	CHE
NC Chowan	CHO
NC Clay	CLA
NC Cleveland	CLE
NC Columbus	COL
NC Craven	CRA
NC Cumberland	CUM
NC Currituck	CUR

NC Dare	DAR
NC Davidson	DAV
NC Davie	DAI
NC Duplin	DUP
NC Durham	DUR
NC Edgecombe	EDG
NC Forsyth	FOR
NC Franklin	FRA
NC Gaston	GAS
NC Gates	GAT
NC Graham	GRA
NC Granville	GRN
NC Greene	GRE
NC Guilford	GUI
NC Halifax	HAL
NC Harnett	HAR
NC Haywood	HAY
NC Henderson	HEN
NC Hertford	HER
NC Hoke	HOK
NC Hyde	HYD
NC Iredell	IRE
NC Jackson	JAC
NC Johnston	JOH
NC Jones	JON
NC Lee	LEE
NC Lenoir	LEN
NC Lincoln	LIN
NC Macon	MAC
NC Madison	MAD
NC Martin	MAR
NC McDowell	MCD
NC Mecklenburg	MEC
NC Mitchell	MIT
NC Montgomery	MON
NC Moore	MOO
NC Nash	NAS
NC New Hanover	NEW
NC Northampton	NOR

NC Onslow	ONS
NC Orange	ORA
NC Pamlico	PAM
NC Pasquotank	PAS
NC Pender	PEN
NC Perquimans	PER
NC Person	PES
NC Pitt	PIT
NC Polk	POL
NC Randolph	RAN
NC Richmond	RIC
NC Robeson	ROB
NC Rockingham	ROC
NC Rowan	ROW
NC Rutherford	RUT
NC Sampson	SAM
NC Scotland	SCO
NC Stanly	STA
NC Stokes	STO
NC Surry	SUR
NC Swain	SWA
NC Transylvania	TRA
NC Tyrrell	TYR
NC Union	UNI
NC Vance	VAN
NC Wake	WAK
NC Warren	WAR
NC Washington	WAS
NC Watauga	WAT
NC Wayne	WAY
NC Wilkes	WIL
NC Wilson	WIS
NC Yadkin	YAD
NC Yancey	YAN
NC Harm Reduction Coalition	HRC
Community Care of NC (CCNC)	CCN
Project Lazarus, Inc	PRL

CCNC NETWORK - DISTRIBUTOR	CCNC CODE
Accesscare	ACS
Carolina Collaborative Community Care	CCC
Carolina Community Health Partnership	CCH
Community Care of Greater Mecklenburg	CGM
Community Care of Eastern Carolina	CEC
Community Care of Southern Piedmont	CSP
Community Care of the Lower Cape Fear	LCF
Community Care of the Sandhills	CSH
Community Care of Wake & Johnston	CWJ
Community Care of Western Carolina	CWC
Community Health Partners	CHP
Northern Piedmont Community Care	NPC
Northwest Community Care	NWC
Partnership for Community Care	PCC

DISTRIBUTOR	CODE NUMBER
County Health Department	1
Pharmacy	2
County Coalition	3
Police Department	4
Fire Department	5
County EMS	6
Substance Abuse Treatment	7
Pain Clinic	8

Appendix B

NaloxoneSaves.org: Reversal Survey Questions

Welcome to naloxonesaves.org!

These questions are only for community members who directly used naloxone (Narcan) to reverse an overdose.

You **MUST** be 18 years old to complete the survey. If you are not 18, please exit this survey and don't forget to refill your naloxone.

All responses are anonymous and will remain confidential. Your participation is voluntary and you are free to skip any questions you would rather not answer.

The responses to these questions help us understand the way naloxone is being used in our communities and will help us get more naloxone to the people who need it.

If you have any questions, please feel free to email our team at iprcoverdose@gmail.com

When answering these questions, think about the most recent time you used naloxone. When did you use naloxone? Please click on the day in the calendar below/write the date as MM/DD/YYYY below.

____/____/_____

How did you use the naloxone?

- In the nose (1)
- Injected with a syringe (2)
- Injected using Evzio (talking) auto-injector (3)
- Other (please describe) (4) _____

What happened during the overdose event? Check all that apply. This includes the time shortly before and shortly after you used naloxone.

- Someone did rescue breathing for the person who overdosed (9)
- The person woke up from the overdose (2)
- The person threw up or vomited (3)
- The person went to the hospital (4)
- The person did NOT wake up from the overdose or died (5)
- Someone called 911 (1)
- EMTs or paramedics were there (17)
- Police were there (6)
- Someone was arrested (7)

In which North Carolina county did you use naloxone? If you used the naloxone outside of North Carolina, select the option at the end of the list.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Alamance (2) | <input type="checkbox"/> Dare (29) | <input type="checkbox"/> Lincoln (56) | <input type="checkbox"/> Rowan (81) |
| <input type="checkbox"/> Alexander (3) | <input type="checkbox"/> Davidson (30) | <input type="checkbox"/> Macon (57) | <input type="checkbox"/> Rutherford (82) |
| <input type="checkbox"/> Alleghany (4) | <input type="checkbox"/> Davie (31) | <input type="checkbox"/> Madison (58) | <input type="checkbox"/> Sampson (83) |
| <input type="checkbox"/> Anson (5) | <input type="checkbox"/> Duplin (32) | <input type="checkbox"/> Martin (59) | <input type="checkbox"/> Scotland (84) |
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| <input type="checkbox"/> Chowan (22) | <input type="checkbox"/> Hyde (49) | <input type="checkbox"/> Polk (76) | <input type="checkbox"/> Yancey (101) |
| <input type="checkbox"/> Clay (23) | <input type="checkbox"/> Iredell (50) | <input type="checkbox"/> Randolph (77) | <input type="checkbox"/> Outside North Carolina (103) |
| <input type="checkbox"/> Cleveland (24) | <input type="checkbox"/> Jackson (51) | <input type="checkbox"/> Robeson (79) | <input type="checkbox"/> Unsure (102) |
| <input type="checkbox"/> Columbus (25) | <input type="checkbox"/> Johnston (52) | <input type="checkbox"/> Rockingham (80) | |
| <input type="checkbox"/> Craven (26) | <input type="checkbox"/> Jones (53) | | |
| <input type="checkbox"/> Cumberland (27) | <input type="checkbox"/> Lee (54) | | |
| <input type="checkbox"/> Currituck (28) | <input type="checkbox"/> Lenoir (55) | | |

Please enter the code found on your naloxone kit. The code is found below the Naloxone Saves label, as in the example below.



- Kit Code (1) _____
- Didn't use a Kit (4)
- Don't have the Kit Code (3)

In which county was the naloxone obtained?

- | | | |
|--|--|---|
| <input type="checkbox"/> Alamance (2) | <input type="checkbox"/> Iredell (50) | <input type="checkbox"/> Watauga (96) |
| <input type="checkbox"/> Alexander (3) | <input type="checkbox"/> Jackson (51) | <input type="checkbox"/> Wayne (97) |
| <input type="checkbox"/> Alleghany (4) | <input type="checkbox"/> Johnston (52) | <input type="checkbox"/> Wilkes (98) |
| <input type="checkbox"/> Anson (5) | <input type="checkbox"/> Jones (53) | <input type="checkbox"/> Wilson (99) |
| <input type="checkbox"/> Ashe (6) | <input type="checkbox"/> Lee (54) | <input type="checkbox"/> Yadkin (100) |
| <input type="checkbox"/> Avery (7) | <input type="checkbox"/> Lenoir (55) | <input type="checkbox"/> Yancey (101) |
| <input type="checkbox"/> Beaufort (8) | <input type="checkbox"/> Lincoln (56) | <input type="checkbox"/> Outside North Carolina (103) |
| <input type="checkbox"/> Bertie (9) | <input type="checkbox"/> Macon (57) | <input type="checkbox"/> Unsure (102) |
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| <input type="checkbox"/> Duplin (32) | <input type="checkbox"/> Rockingham (80) | |
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| <input type="checkbox"/> Edgecombe (34) | <input type="checkbox"/> Rutherford (82) | |
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| <input type="checkbox"/> Hertford (47) | <input type="checkbox"/> Washington (95) | |
| <input type="checkbox"/> Hoke (48) | | |
| <input type="checkbox"/> Hyde (49) | | |

How long after the first vial was a second vial of naloxone given?

- Only one vial was given (1)
- Within 5 minutes (2)
- Within 10 minutes (6)
- Within 1 hour (3)
- After 1 hour (4)
- Unsure (5)

How would you describe the gender of person who overdosed?

- Male (1)
- Female (2)
- Transgender (3)
- In another way (please specify if you wish) (4) _____

Which of the following best describes the age of the person who overdosed?

- 17 years or under (1)
- 18 to 30 years (2)
- 31 to 50 years (3)
- 51 years or older (4)

Please feel free to leave any additional comments in the space below. We would especially like to know if you had a good or bad experience with professionals like police, first responders, or hospital staff. If you have any questions about this survey, please contact us at iprcoverdose@gmail.com. Please click the Submit button when you are finished.

Thank you. Don't forget to refill your Naloxone!

To find out more about replacement naloxone, please visit <http://www.nchrc.org/program-and-services/overdose-prevention-project/>.

If you want to talk to a professional about witnessing or being involved in an overdose, please call 211 or visit nc211.org.

DATE (MM/DD/YYYY)	RX NUMBER	PARTICIPANTS'S FULL NAME and DOB	Prescriber/ Dispenser Name	PLEASE COMPLETE THIS SECTION TO HELP US EVALUATE THE PROGAM
				<input type="checkbox"/> 1 st Kit <input type="checkbox"/> Replacement Kit Reason: <input type="checkbox"/> Used <input type="checkbox"/> Expired <input type="checkbox"/> Lost <input type="checkbox"/> Stolen <input type="checkbox"/> Confiscated
				<input type="checkbox"/> 1 st Kit <input type="checkbox"/> Replacement Kit Reason: <input type="checkbox"/> Used <input type="checkbox"/> Expired <input type="checkbox"/> Lost <input type="checkbox"/> Stolen <input type="checkbox"/> Confiscated
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PHARMACIST REVIEW SIGNATURE _____

DATE REVIEWED _____

(Entre nombre y organización)

Ubicación de las clínicas

Richard E. Whitted Human Services Center
300 West Tryon Street
Hillsborough, NC 27278
(919) 245-2400

Southern Human Services Center
2501 Homestead Road
Chapel Hill, NC 27516
(919) 245-2400

A USTED SE LE HA DADO: Naloxone (Naloxona) 0.4 mg / ml (Narcan)

INFORMACIÓN SOBRE ESTE MEDICAMENTO

Naloxona:

- Se usa para tratar una sobredosis de opiáceos o para diagnosticar una adicción a opiáceos.
- Una droga que revierte los efectos de drogas narcóticas (opioides)
- Se usa para revertir los efectos de opioides, utilizados durante cirugías o contra el dolor

CÓMO USAR ESTE MEDICAMENTO:

- A usted se le ha dado 2 ampollitas/viales de Naloxona. Cada ampollita/vial contiene 0.4 mg de naloxona/ 1 mililitro de líquido.
- Para administrar la naloxona, destape el vial y saque todo el líquido con la jeringuilla. Inyéctelo en la parte SUPERIOR DEL BRAZO o EN EL MUSLO formando un ángulo de 90 grados con la piel. Se puede inyectar a través de la ropa (si fuera necesario). Es mejor inyectarlo directamente en la piel.
- Lea la hoja de instrucciones incluida en el equipo para más información sobre cómo inyectar la naloxona.

EFFECTOS SECUNDARIOS POSIBLES

Si el tratamiento es debido a una drogadicción a los opiáceos, los síntomas siguientes pueden ocurrir:

- temblores
- nerviosismo, intranquilidad o irritabilidad
- dolores corporales
- mareos, debilidad
- diarrea, dolor de estómago, náusea leve
- fiebre y sudoración
- bostezos, estornudos, escurrimiento nasal

Esta no es una lista completa de los efectos secundarios ya que otros efectos pueden suceder. Llame a su proveedor de salud para obtener consejo médico acerca de los efectos secundarios. Se puede también reportar esos efectos secundarios a la FDA llamando al 1-800-FDA-1088

Busque atención médica de emergencia si usted tiene cualquier síntoma de reacción alérgica, como: urticaria, dificultad para respirar; hinchazón de la cara, labios, lengua o garganta.

PRECAUCIONES

- **Mantenga su equipo de naloxona fuera del alcance de los niños.**
- La naloxona puede alterar su manera de pensar y sus reacciones. No maneje ni haga cosas que requieren que usted permanezca alerta.
- El alcohol puede aumentar algunos efectos de la naloxona.
- La naloxona atraviesa rápidamente la placenta. El uso de la naloxona sólo se recomienda durante el embarazo cuando no hay otra alternativa, y que el beneficio supera el riesgo.
- En una situación de emergencia puede que no sea posible, antes de que le tratan con naloxona, decirle a sus cuidadores sobre sus condiciones de salud o si usted está embarazada o lactando. Asegúrese de que cualquier médico que le atienda después sepa que le han dado la naloxona.

SOBREDOSIS

- Los síntomas de sobredosis pueden incluir convulsiones, sensación de mareo o desmayo.
- No es probable que ocurran síntomas de sobredosis con la cantidad de naloxona recetada por esta clínica. Si se le da naloxona a alguien a quien este medicamento no le era destinado o recomendado, hay que buscar atención médica de emergencia o llamar a Línea de Ayuda para casos de Envenenamiento al 1-800-222-1222.

ALMACENAMIENTO

Almacenar a temperatura ambiente (que no sea superior a 77 °F.) y alejado de la luz del sol.

(Insert name of organization here)

Clinic Locations

Richard E. Whitted Human Services Center
300 West Tryon Street
Hillsborough, NC 27278
(919) 245-2400

Southern Human Services Center
2501 Homestead Road
Chapel Hill, NC 27516
(919) 245-2400

YOU HAVE BEEN GIVEN: Naloxone 0.4 mg / ml (Narcan)

ABOUT YOUR MEDICINE

Naloxone is:

- Used to treat narcotic drug overdose or to diagnose narcotic drug addiction.
- A drug that reverses the effects of opioid narcotic drugs
- Used to reverse the effects of narcotic drugs used during surgery or to treat pain

HOW TO USE THIS MEDICINE:

- You have been given 2 vials of Naloxone. Each vial has 0.4 mg of naloxone/ 1 milliliter of fluid.
- To give naloxone, remove cap from vial and pull all of the liquid into the syringe. Inject into the UPPER ARM or THIGH at a 90 degree angle to the skin. You can inject through clothing (if needed). It is best to inject directly into skin.
- Read folded instruction sheet included in your kit for more information on how to give naloxone.

POSSIBLE SIDE EFFECTS

If treatment is due to narcotic drug addiction, the following symptoms may include:

- trembling
- feeling nervous, restless, or irritable
- body aches
- dizziness, weakness
- diarrhea, stomach pain, mild nausea
- fever and sweating
- yawning, sneezing, runny nose

This is not a complete list of side effects and others may occur. Call your health care provider for medical advice about side effects. You can also report side effects to FDA at 1-800-FDA-1088

Get emergency medical help if you have any of these signs of an allergic reaction: hives, difficulty breathing; swelling of face, lips, tongue, or throat.

PRECAUTIONS

- **Keep your naloxone kit out of the reach of children.**
- Naloxone may impair your thinking or reactions. Do not drive or do anything that requires you to be alert.
- Drinking alcohol may increase certain effects of naloxone.
- Naloxone quickly crosses the placenta. Naloxone is only recommended for use during pregnancy when there are no alternatives, and the benefit outweighs the risk.
- In an emergency situation it may not be possible before you are treated with naloxone to tell your caregivers about your health conditions or if you are pregnant or breast feeding. Make sure any doctor caring for you afterward knows that you have received naloxone.

OVERDOSE

- Overdose symptoms may include seizure (convulsions), feeling light-headed or fainting.
- Overdose symptoms are not likely to occur with the amount of naloxone prescribed by this clinic. If naloxone is given to anyone for whom this medication was not intended or recommended, seek emergency medical care and/or call the Poison Help Line at 1-800-222-1222.

STORAGE

Store at room temperature (not above 77 °F.) and away from sunlight.

DOPE Project / San Francisco Department of Public Health

Overdose Rescue / Naloxone Training

This is a basic format. Every training is different. Feel free to improvise.

Timing: 70 minutes, in 2 sections, including 5 minute break

Materials Required:

- ⇒ Take home naloxone kit, with demonstration injection-systems for each participant
- ⇒ Demonstration face-mask
- ⇒ 1 Saline or Naloxone demo, for facilitators
- ⇒ Markers, postable blank flip charts
- ⇒ Pre-made graphic flip charts of definition, risk factors, signs, rescue stages, 911-call “tips”
- ⇒ Resuscitation dummies
- ⇒ Thick (1.5-2”) sponges for IM simulation padding
- ⇒ Injection supplies: latex-gloves, alcohol pads
- ⇒ Biohazard bucket / Sharps container
- ⇒ Oranges (optional)

Introductions

FACILITATORS: Introduce yourselves and briefly describe where you come from, why you are here personally doing this OD prevention training. Remember to acknowledge that we are not experts, and if you don’t know the answer to a question, to say so. Offer to find the information and get back to the person after the training. Keep a blank flip-chart titled “QUESTIONS” up on the wall to write these as they come up.

Q: “Say your name, what you would like to learn, and why you want to carry Narcan.”

Section one: Prevention and Recognition of Overdose

~30 minutes

Ground rules (Optional)

< 5 minutes

Q: “What do you think the groundrules should be for this training?”

List responses on flipchart. Make sure to include confidentiality, respect, one person speaking at a time, etc. Ask participants to be responsible for their own “alertness,” that is, to stand up if they feel themselves nodding off, ask their neighbor to nudge them, etc.

What is an overdose?

~5 minutes

Q: “What is an overdose?” Repeat responses back and then clarify, referring to flipchart:

“An overdose happens when a toxic amount of a drug, or a combination of drugs, overwhelms the body and causes it to shut down. With downers like heroin, alcohol and

pills, breathing slows and stops, and then eventually the heart stops. With stimulants, the heart speeds up, the body temperature rises, and the person can go into seizures, have a heart attack or a stroke. No matter what, if someone dies of a heroin overdose it's because they stopped breathing."

"Today you will learn how to save someone's life. Your job if you see someone overdose is going to be to breathe for them, either while the paramedics or on their way, or until the Narcan that you just gave them kicks in. With a stimulant overdose, all you can really do is call 911, and if the person is having seizures, protect their head (there is no need to put a spoon in their mouth. It is NOT possible for someone to swallow their own tongue!)"

Why does an overdose happen and how can it be prevented? ~10 minutes

"Now let's talk about why overdose happens. Generally we break it down into these categories: Mixing, Tolerance, Quality & Using Alone."

Lead discussion and then reveal flipchart as drawn below. Pre-written flipcharts save time. Solicit responses regarding risks, and then brainstorm prevention strategies within each category.

RISKS	PREVENTION
<u>MIXING</u> Uppers Downers ↑speed ↓ alcohol ↑cocaine ↓ heroin ↑ecstasy ↓ pills Upper/Downer Combinations (Heroin & cocaine)	* Use one drug at a time. * Don't mix alcohol with heroin/pills.
<u>TOLERANCE</u> * Exiting jail/detox esp. methadone * Being sick/hospital * New environment	* Use less after getting out of jail, hospital, detox or when sick
<u>QUALITY</u> * Unpredictable	* Tester shots * Release the tourniquet
<u>USING ALONE</u> * Cannot be found. * Behind closed, locked door. * SRO hotel room.	* Fix with a friend * Leave door unlocked * Call a friend

MIXING:

Q: "What are some of the drugs that people use?"

List in two categories, as uppers or downers. Explain the effect that comes with mixing similar drugs, drawing arrows next to an example of each drug.

"One drug takes you down to here, another to here, and the last one makes you hit the floor. This is especially true for mixing alcohol with heroin & pills. Same goes for mixing uppers like speed, cocaine & ecstasy. Together they can speed your heart up & cause a heart attack."

Q: "What drugs are commonly used *together*?" heroin & cocaine (speedball), heroin & speed (goofball).

"People often think that if you use an upper and a downer together that they will cancel each other out but this is not the case. Mixing heroin with cocaine actually increases the likelihood that someone will overdose."

TOLERANCE: "Tolerance is your body's ability to process a drug. Tolerance changes over time so that you need more of a drug to get high. But tolerance can lower quickly."

Q: "What are some examples of times that someone's tolerance would change?"

A: “People’s tolerance goes down after getting out of jail, the hospital or treatment. People coming out of jail are 7 times more likely to overdose in the first two weeks after getting out of jail.”

QUALITY: “Because drugs like heroin, speed and cocaine are illegal, their strength is unregulated and unpredictable. One day you may get a weak batch, the next day one twice as strong.”

Q: “What could you do to test the strength of a new batch?” (Show list.)

Recognizing the signs of an overdose ~10 minutes

“Now that we know why overdose happens, let’s talk about what it looks like. First of all though, let’s talk about what it looks like when someone is really high.”

Q: “What does it look like when someone is high on heroin?” (Reflect back responses).

Q: “Now what would be a warning sign to you that someone might be overdosing? Who here has seen an overdose? What did it look like?” (Reflect responses, refer to flipchart).

“Heroin overdoses often happen slowly, over the course of several hours. If someone seems super high but is still awake and able to walk you want to get them up, walk them around, and keep them talking to you. This may be enough to keep them from going into a full-scale OD. If they do become unconscious then you’ll need to respond right away.”

SIGNS OF OVERDOSE	
OVERDOSE STAGE	
(Signs of High, Heavy Nod)	
➤	Speech slow or slurred
➤	Muscles become slack, difficulty holding ‘self up
➤	Sleepy / nodded, but still responsive
<i>“the line”</i> UNRESPONSIVE	
(Signs of Overdose)	
➤	Unresponsiveness (shouting, pain won’t work)
➤	Unconsciousness
➤	Breathing very slowly or shallowly (Under 12 breaths per minute)
➤	Pale, clammy skin, loss of color
➤	Blue or gray face, especially around the lips or fingernails (caused by lack of oxygen)
➤	Loud, uneven snoring or gurgling noises
➤	Not breathing
Faint or no pulse	

So far we’ve talked about what an overdose is, why it happens, and what it looks like. Now let’s take a break and then practice what to do if we see someone OD.

Break 5 minutes

Section Two: Overdose Rescue and Naloxone Use

30 minutes

During the break, put up pre-prepared flipcharts of response stages. Assemble dummies and prepare practice stations with a dummy and kit available for each participant.

Rescue Training

20 minutes

Have each participant sit next to a dummy and pick a name for it. They can also pick a partner to practice with. Talk participants through the process, doing each step as a group.

Assessment

~5 minutes

“Here’s the scene. You come across someone you’ve seen around before. They were nodding last time you passed them, this time they are passed out. To tell if he is overdosing, the first thing I need to do is try and get a response.

- 1) **STIMULATION:** Check for responsiveness. Start by kicking the foot and yelling “Are you okay?”
- 2) They don’t respond. **Step closer and yell**, “Narcan” or, “I’m calling the cops.” (If this works, get them up and keep them moving, talking and awake. Keep an eye on them for the next several hours.)
- 3) When noise doesn’t work, the next thing you want to do is try **pain**. This does not mean kicking the person in the crotch or putting ice down their pants. What the paramedics do works just fine. Now, everyone make a fist” (Facilitator holds fist out) “this part of your fist (made of middle joints of the fingers, not the knuckles), you use to rake hard across the person’s sternum, or breastbone. Sometimes this is enough to wake a person up. Now try a **sternum rub**.
- 4) **Check for breathing.** “Now, we’ve tried noise, and we’ve tried pain, and our friend here is still not waking up. This is when we know something is definitely wrong. The next thing you want to do is assess whether the person is breathing. An unconscious person’s tongue muscle may be so relaxed that it flops over and blocks their airway. Everyone tuck your chin and look down. (Facilitator demonstrates). Now try to breathe. Look up, now try again. See what a difference it makes? Sometimes just opening the airway is enough to get someone to start breathing again.
- 5) **AIRWAY: To open the airway, use the head tilt chin-lift.** Pressing with one hand on their forehead, and the other lifting under their chin, tilt the head back to open the airway. The next thing we want to do is **look, listen and feel** to see whether they’re breathing. To do this, put your ear above their mouth and LOOK with your eyes towards the chest to see if it is rising and falling, LISTEN with your

ear to hear, and FEEL with your cheek if any breath is coming out. Do this for ten seconds.

- 6) So I've opened the airway, and checked for ten seconds but this person is not breathing. Next I need to tilt the head back again, pinch their nose shut, form a seal with my mouth and give the person **two breaths**, watching the chest rise as the breaths go in.
- 7) **Check for a pulse** (practice on dummy and each other. Circulate and check.) -Slide first 2 fingers (not the thumb because it has its own pulse!) from the Adam's Apple two inches over and into the carotid groove. Count for approximately 10 seconds. A person needs 10-12 heartbeats minimum in this time, or 72 beats per minute to stay alive. Less than six beats in this time would be a warning sign. Studies have found that in an emergency situation, people often get it wrong when they check for a pulse. If are panicked or high and are not sure, err on the side of caution. Do not pump on someone's chest unless you know CPR and are sure that they need it.
- 8) **Recovery Position.** Here you have the option of calling 911 and/or just getting the Narcan if you have it. Either way, you have to act quickly. But before you leave the person for any reason, you have to put the person on their side in the recovery position, so that if they vomit, they will not choke.

“To put him in the recovery position, I need to first lift his left arm above his head, and then lift his right leg up at the knee. Last I put his right hand on his left shoulder. This way, even if he is really big, I can roll him over by pushing at the hip and shoulder without having to muscle it. (Demonstrate). In this position, his airway is open, he's balanced on his side, and if he vomits he won't choke.

Police & Calling 911

~5 minutes

- 9) **CALL FOR HELP** Now that you've put them on their side, it is time to call 911.

“Even if you have Narcan, you don't know if they are also overdosing on alcohol, pills or other drugs. If they don't come back after a shot of Narcan or rescue breathing, the paramedics will be there to take over. If the person does come back, you can both just get up and walk away before the paramedics get there. If it's an upper overdose and they have suffered a heart attack or stroke, all you can do is make sure they get medical attention as soon as possible.”

A lot of people feel afraid to call 911 because they think they will get arrested. When you call 9-1-1 the cops might come but if they do, it is ONLY to backup the paramedics. In San Francisco, the police see overdose as a medical emergency, and are not there to arrest anyone. (This may be different elsewhere.) They will try to make sure the person goes with the paramedics to the Emergency Room for observation so anyone wanting to avoid trouble is best off just cooperating with the paramedics. Saying that, you probably don't want to have piles of drugs lying around when the police get there, so you can use the time before they arrive to stash any drugs, IDs or paraphernalia that are lying around.

There also things you can do when you call to reduce the likelihood that the police will come at all.”

“When you call, stay calm. Try to quiet down anyone that’s in the background. All you need to tell them is where you are, and that someone is unresponsive and NOT BREATHING. You do not have to mention anything about a drug overdose. If someone is not breathing this puts the call to the top of the priority list so that the paramedics will come right away. If you are far from a phone, send someone else to call while you stay with the person. Make sure the person that goes to call knows the address and what to say. If you are alone and have to go call, make sure to explain where the person can be found.”

Hand imaginary phone to a participant to practice, “My friend is overdosing. Call 911”

“When the paramedics arrive, tell them that the person has OD’d on heroin. They don’t care if something illegal has happened, they are in the business of saving lives. The sooner they know that it’s an OD, the sooner your friend will receive naloxone (if you haven’t been able to hit them), which the paramedics always bring on their ambulance. Also tell them if other substances have been taken, if you know, like pills or alcohol. The cops in San Francisco know about this program and cannot arrest you or take your Narcan if you have a prescription.”

Oxygen & Narcan

~10 minutes

“Okay, the paramedics are on their way. While we wait let me ask you a question.”

Q: “How long do you think it takes the brain to start to die without oxygen?”

A: (“5-6 minutes”)

Q: “How long does it take for an ambulance to arrive in your neighborhood?”

A: (Often up to 10 minutes, sometimes more.)

“Do the math: something needs to happen when someone stops breathing to prevent brain damage before the ambulance arrives, like naloxone administration and/or rescue breathing.”

Q: Like we said before, if someone dies, it’s because they stopped breathing. So does putting someone in a bathtub full of ice make them breathe? What about shooting them up with salt water? Speed? Milk?

A: Right. The ONLY things that will help the person are Narcan and rescue breathing. An unconscious person in a bathtub could drown. (Besides, how long does it take to fill a bathtub with ice?) All of this just wastes precious time if not making the person worse.

Narcan is a drug normally given by the paramedics that temporarily blocks the opiates that are telling their brain not to breathe. It will wake the person up in a few minutes. If they are strung out, they will wake up dopesick and mad but alive. If not, they will feel okay. Narcan has no other effects on the body other than blocking opiates.

- 10) If you have it, **get your Narcan and come back to the person.** (If you don't, skip straight to rescue breathing and wait for the paramedics to arrive.) For now we are going to use practice vials that have saline instead of Narcan. After the training you will get kits that include: two boxes of naloxone, (yellow capped syringe and purple capped vial), an alcohol pad, gloves, and a rescue breathing barrier device.
- a) **Pick the injection site** on the upper arm (deltoid-first choice), upper buttocks, close to the hip (gluteus- second choice), or the quadriceps (upper thigh).
 - b) **Clean it** with an alcohol wipe.
 - c) **Take a deep breath** for a second to calm down and focus.
 - d) **Take the purple cap off** the vial and **rotate the vial into the barrel** 1 ½ times or until you begin to feel resistance. Don't push too hard or the Narcan will spill out.
 - e) **Pull the yellow cap off** the **back** of the syringe.
 - f) For the purposes of practicing, put a yellow **sponge** against the person's arm, or pick up an orange and inject it into that if you prefer.
 - g) **Draw the skin tight** with thumb and forefinger, pull the yellow cap off the point of the syringe, then use a dart-motion at a 90-degree angle to **insert the syringe**, and **depress the plunger** fully. This is half the standard dose that paramedics use so that the withdrawal will be less severe.
 - h) **Check for breathing.** We've tried to wake the person up with noise/pain, called 911 and administered Narcan. Now we have to breathe for them until the Narcan kicks in. As long as they have a pulse they should start breathing on their own in a couple of minutes. The slower their circulation, the longer it will take the naloxone to travel to the brain and long it will take to reverse the overdose and get them breathing

Rescue Breathing	5 minutes
-------------------------	------------------

- 11) **Rescue Breathing:**
 One breath every five seconds (count out loud, "One-one-thousand...Two-one-thousand...Three-one-thousand...Four-one-thousand...BREATHE." (Do for one min.)
- 12) If you are worried about touching your mouth to theirs, you can use your shirt or theirs (as long as you can breathe through it), punch a hole in a paper coffee cup or a **rescue breathing barrier device** if you have it. The truth is you cannot get HIV or tuberculosis this way and you could very well save a life. The choice is yours but just know that even if you are afraid of touching someone's mouth, you have options to protect you. (Open and demonstrate sample of barrier device.)

13) Re-check for breathing.

14) Re-check **pulse**. Pulse present, no breathing, continue rescue breathing until paramedics arrive or the Narcan kicks in.

15) If you don't think the Narcan is working give them the **second dose**.

16) When you're done, dispose of your syringe in the red biohazard bucket here, or when you're on your own use the slot in your black fitpacks for **syringe disposal**.

Elicit feedback from the group about any difficulties with the assembly or use of the syringes, any issues that came up for them using the kit.

After Naloxone

5 minutes

1) The person who receives naloxone will wake up and will not remember overdosing or receiving the naloxone.

2) You will need to stay with anyone you give naloxone to and explain that:

a. They were overdosing and received naloxone to save their life.

b. If they are feeling withdrawal symptoms, they will feel better soon. The naloxone will start wearing off in 20-30 minutes and they will start feeling better. Within an hour or two the effects will be gone

c. Once the naloxone wears off, they may overdose again, especially if they do more dope to try to fix the withdrawal symptoms. If they do another shot it will be wasted. They cannot out-shoot the naloxone. They just have to wait.

3) It is *very* important to stay with the person to make sure they don't use more heroin or overdose again when the naloxone wears off, a minimum of two hours, if 911 is not called.

4) You should still call 911 after giving naloxone for 2 main reasons:

a) To keep the person from overdosing when the naloxone wears off.

b) If we can't be 100% sure, the overdose was from opiates alone. Narcan has no effect on overdoses from alcohol, speed, cocaine, or pills.

c) Because there is a small chance of dangerous side effects to the naloxone, including seizures and fluid build-up in the lungs that can cause respiratory distress and/or pneumonia.

The Law

Naloxone/Narcan is not a controlled substance. It is a, however, a prescription drug. As long as you keep the box, where your prescription will be written on a sticker label, and your prescription card, the police do not have the right to take this from you. If you don't have a prescription, they might take it from you and cite you with charges that will most likely be thrown out.

Creating an Overdose Plan with your Injection Partners

This manual hopefully provides you with some basic education on overdose management so that you can begin the process of creating an OD plan for yourself and your injection partners. Use it to encourage your friends to talk about overdose. Figure out what each individual wants done in the event that they OD, and what you're willing and able to do as a caregiver in an overdose situation. These are some questions that will help you formulate an OD plan. You can add to this list. (Refer to flipchart, handout copies.)

- * At what stage do you want 911 called (when not responding, not breathing, blue)?
- * Do you want Narcan used? If so, when? (When breathing stops? As a last resort?)
- * How much Narcan do you want used? One cc, two ccs?
- * After Narcan has brought you back, do you want 911 called? Would you rather go to the Emergency Room or to a city health clinic for follow-up by foot, in a cab, or not at all?
- * If 911 is called, where should stuff be stashed? Should your ID be hidden as well?

Review of logistics

5 minutes

“Now that you've completed the training, you'll be getting a prescription from a Health Department doctor. With your prescription comes a fitpack, two vials of naloxone, gloves, alcohol pads, and a rescue breathing device. Naloxone has an expiration date, and loses its potency past that time. It must also be kept out of sunlight, which is why its best to keep it in the box and or the fitpacks that we're giving out. If it expires, it should be thrown away or traded in for a new vial. If you lose your Narcan, or use it to save a friend, you can get your prescription re-filled at any of the sites listed on this card (distribute.)

“In order to officially prescribe naloxone, the Health Department needs to collect some background information and open a medical chart for everyone. To keep track of how things are going, we'll be asking you some questions now and again when you come back for to replace a lost or used kit. You don't have to answer any questions if you don't want to but we hope you will participate to help us see how things are going and how we can improve the program.”

In case you forget anything we've talked about, there will be information on the kits that will remind you what to do, where to get your kits re-filled, and a contact number to answer any questions that come up.

Thanks so much for coming. Congratulations on being part of a **revolution** in harm reduction, one of the first cities in the US to train users and to distribute Naloxone, aboveground and legally. You are all **lifesavers** now, give yourselves a hand!

OCHD NALOXONE/OVERDOSE PREVENTION PROGRAM TRAINING



ORANGE COUNTY
HEALTH DEPARTMENT

DECEMBER 2013



I HAD a friend who overdosed on oxy.



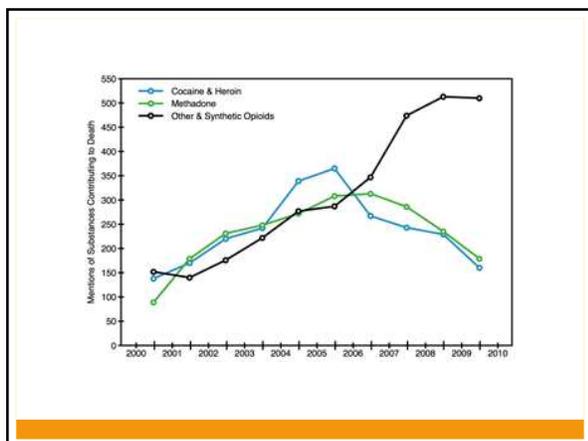
I HAVE a friend who overdosed on oxy.



184% >> 0.5%



1.4

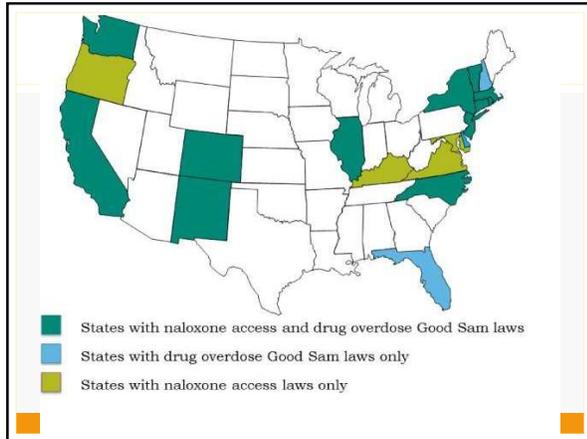


“GOOD SAMARITAN LAW/NALOXONE ACCESS”

- North Carolina, Senate Bill 20
- Passed April 2013
- Naloxone Component
 - ✦ Allows practitioners to prescribe, dispense, or distribute directly, or as a standing order, naloxone to persons at risk of OD or a family member, friend
 - ✦ Permits a person who received an opioid antagonist under the terms outlined above to administer that antagonist to another person
 - ✦ Provides immunity from civil and criminal liability for the practitioner and administrator

“GOOD SAMARITAN LAW/NALOXONE ACCESS”

- 911 Component
 - ✦ Provides limited protection for any person that seeks medical assistance...for a person experiencing a drug-related overdose...if evidence for the prosecution was obtained as a result of the seeking of medical assistance
 - ✦ Underage persons who seek medical assistance for someone experiencing alcohol overdose cannot be prosecuted for possession or consumption of alcohol if evidence for the prosecution was obtained as a result of that person seeking help. The person must give their real name when seeking help and then remain with the victim until help arrives.



OCHD NALOXONE PROGRAM

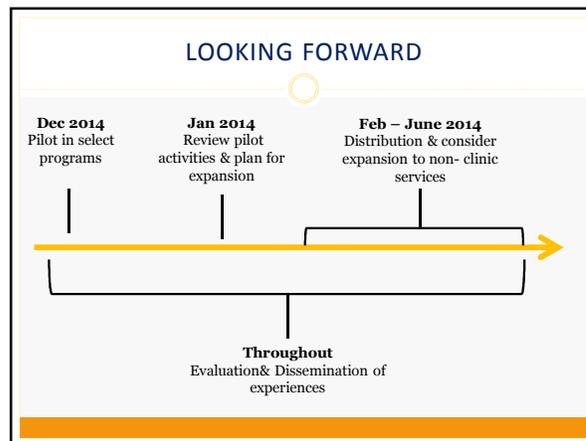


EDUCATION VIDEO



KIT

- 2 vials (0.4 mg/mL) naloxone
- 2 1 in IM syringes
- Alcohol swabs
- Gloves
- CPR mask
- Instructions



Questions

Philosophy of Harm Reduction:

Implementing Harm Reduction into Substance Abuse Treatment



N.C. Harm Reduction Coalition
Prepared May 2014

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 - Eliza Wheeler, D.O.P.E. Project Manager
Harm Reduction Coalition, Oakland, CA
wheeler@harmreduction.org
- And suggestions from many other harm reduction coalitions throughout the US.



2

Goals of Today's Training

- Introduction, Overview of epidemic
 - Fatalities from unintentional poisoning
- Review definitions, goals, and basic principles of Harm Reduction
- Harm Reduction practice in the real world
- Review of behavior change models
- Examples, activities



3



HARM REDUCTION IN EVERYDAY LIFE



What is HARM REDUCTION?

- Doing things other than abstinence to make harmful activities SAFER – not necessarily safe!
 - Cars: Safety glass on windshield, air bags, seat belts
 - Bicycles: Helmets, bike lanes
 - Sex: Condoms, dental dams, medical check-ups
 - Drugs: Careful selection and use of drugs; reversing an overdose



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Why Harm Reduction?

- Nature of man to seek pleasure, substance abuse
 - Historical precedence of sex, drugs and addiction
- Deaths from drug overdoses have reached epidemic proportions
 - More deaths from OD's than from car crashes
- Changes in behavior take a long time for the individual and the community in which we live
- No dead addict ever had the chance to make a better decision tomorrow



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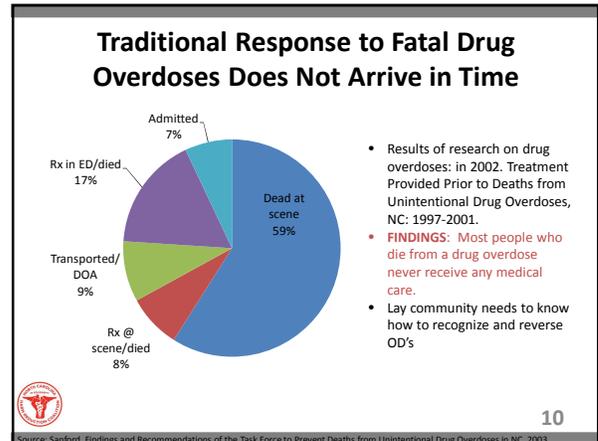
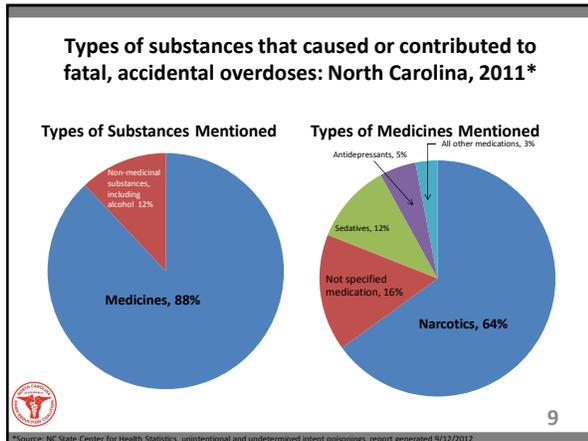
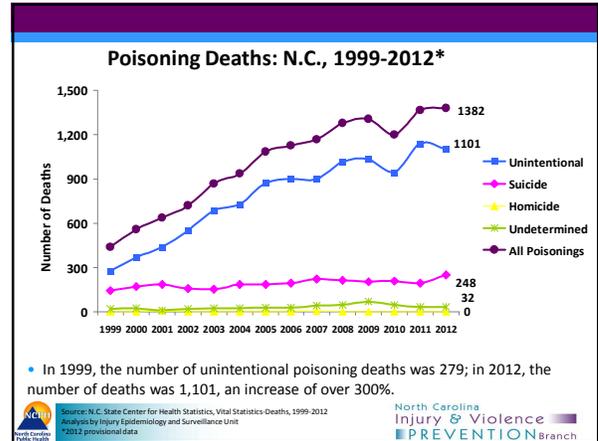
What we are doing...

- Programs and policies
 - Public health
 - Mental health
 - Medical care of chronic pain
 - Drug OD prevention
 - Substance Abuse Treatment
 - Law enforcement
 - Judicial system
 - School

...isn't working fast enough.



7



Medical Precedence

- **DIABETES:** Glucagon
 - Vital first aid for patients with severe/unstable diabetes
 - Often prescribed to patients at risk of severe hypoglycemia
 - Known contraindications and side effects
- **ANAPHYLAXIS:** EpiPens
 - Vital first aid for severe allergic reactions
 - Often prescribed to patients with severe allergies requiring medical rescue
 - Known contraindications and side effects



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Naloxone (Narcan®)

- **OPIOID OVERDOSE:** Naloxone
 - Vital first aid for opioid overdose
 - Not often prescribed to patients at risk for opioid overdose or to those likely to be near them
 - Little to no known contraindications or side effects



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Harm Reduction

DEFINITIONS, GOALS, PRINCIPLES



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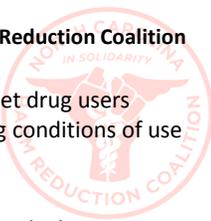
What is Harm Reduction?

- Philosophy
- Service delivery model
- Effective public health (and mental health) strategy
- Social justice and human rights movement
- Way of life



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DEFINITION 1: N.C. Harm Reduction Coalition



- Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself
- Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction



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DEFINITION 2: Chicago Recovery Alliance



- Harm Reduction is a philosophy and practice of respectfully collaborating with people to assist in any positive change as a person defines it for him/herself and begins where the person is at with no biases or condemnation for the person's chosen lifestyle.
- Bottom Line: ANY POSITIVE CHANGE!



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Goals of Harm Reduction

- Increased Health and Well-being
- Increased self-esteem/self-efficacy
- Better living situation
- Reduced isolation and stigma
- Practicing Safer Behaviors
- Reducing Risky or Harmful Behaviors
- Eliminating Harmful Behavior
- REDUCE DEATHS



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Harm Reduction Basic Principles

- Some people engage in behaviors that could be harmful to themselves or others
- People may engage in these behaviors even if they know they're harmful, illegal, or unhealthy



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Harm Reduction Basic Principles

- People may be willing to make some changes to decrease the risk of harm to themselves and their community
- Though abstaining may be the goal, encouraging these behavior changes can reduce harm



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Types of Harm

<ul style="list-style-type: none"> • Physical <ul style="list-style-type: none"> – Violence – Overdose – Disease/infection • Psychological <ul style="list-style-type: none"> – Depression – Isolation – Anxiety • Social <ul style="list-style-type: none"> – Lack of community – Isolation and loss of family support – Stigma 	<ul style="list-style-type: none"> • Spiritual <ul style="list-style-type: none"> – Isolation, apathy – Not finding meaning in life • Economic <ul style="list-style-type: none"> – Loss of housing – Loss job or trouble finding employment • Legal <ul style="list-style-type: none"> – Prohibited from services – Arrest/incarceration – Criminal records
--	--



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Criticisms of Harm Reduction

- Encourages or supports risk behavior
- Supports or endorses options that are not always the least risky options
- Is opposed to the goal of abstinence
- Others?



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What Harm Reduction Is NOT

- “Whatever happens, happens”
- “Anything goes”
- “Helping a person who has gotten off drugs to start using again”
- Condoning, endorsing, or encouraging drug use or other risky behavior



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Implementing Harm Reduction into Substance Abuse Treatment

HARM REDUCTION IN PRACTICE



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Treatment Models: A Comparison

<p style="text-align: center; color: blue;">Traditional Treatment</p> <ul style="list-style-type: none"> • Outcome model • Client needs to be “ready” for treatment • Current use: Eliminate • Relapse reason for discharge • Criticized as punitive 	<p style="text-align: center; color: red;">Harm Reduction</p> <ul style="list-style-type: none"> • Process model • Start where client is • Current use: Reduce harm • Relapse is part of process • Criticized as enabling
--	---



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Effective Harm Reduction Practice

- Safe space to talk
- Relevant and graphic pictures, written information
- Accurate, up-to-date, information
- Hands-on demonstration
- Informal format
- Incentives



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Effective Harm Reduction Practice

- Use language that is reflective of the community
- Staff must to be comfortable discussing sex practices and drug use, along with other potentially risky behaviors
- Use participant experience to discuss risk reduction methods that are realistic and acknowledge barriers
- Ask participants what they already know and validate their knowledge
- Humor
- Patience



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Harm Reduction in Practice

- Work with people to identify all of the harms in their lives
 - Drug use, sexual trauma, violence, mental health, lack of access to health care, housing, etc
- Provide resources, information, and referrals to support people in reducing harm in their lives
- Don't assume that all problems or issues in a person's life are related to drug use
 - Let people identify their needs and issues for themselves



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Harm Reduction in Practice

- Provide accurate and honest information on the possible harms, both general and specific to peoples lives
 - Harm reduction does not mean ignoring or supporting harmful behavior
- Be comfortable and prepared to talk about drugs/sex and all options
- Have a clear policy of respect for all people
- Involve participants/clients in decisions that which affect them



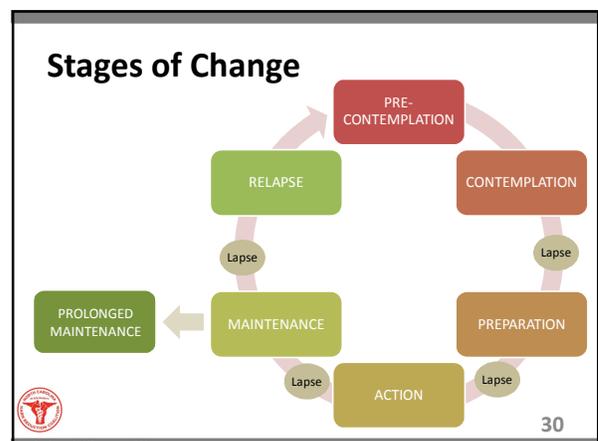
28

Harm Reduction in Practice

- Recognize and address your judgments about drug use and other "risky" behavior
- Work with people practically and non-judgmentally to reduce harm
- Work with people where they are, not where you think they should be



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Maslow's Hierarchy of Needs

A pyramid diagram representing Maslow's Hierarchy of Needs. From top to bottom, the levels are: Self-Actualization (red), Esteem (orange), Love/Belonging (yellow), Safety (light green), and Physiological (dark green).

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Motivation Drives Behavior

- To support behavior change we must understand motivation
- If someone's behavior or decisions seem irrational, it is possible that they simply haven't shared enough information about their priorities and motivation for the provider to understand

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REALITY CHECK: Hierarchy of Needs

- Homeless, HIV+, heroin user

A pyramid diagram illustrating the hierarchy of needs for a homeless, HIV+, heroin user. From top to bottom, the levels are: Self-Actualization (red) with 'Completing Housing applications, Drug treatment, appointments'; Esteem (orange) with 'HIV meds'; Love/Belonging (yellow) with 'Getting new needles, seeing friends, family, significant others'; Safety (light green) with 'Food, water, stashing possessions'; and Physiological (dark green) with 'Heroin, money, shelter, avoiding violence'.

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REALITY CHECK: Hierarchy of Needs

- Prescription drug abuser with chronic pain

A pyramid diagram illustrating the hierarchy of needs for a prescription drug abuser with chronic pain. From top to bottom, the levels are: Self-Actualization (red) with 'Completing job applications'; Esteem (orange) with 'Drug treatment, appointments'; Love/Belonging (yellow) with 'Seeing friends, family, significant others'; Safety (light green) with 'Food, water, stashing possessions'; and Physiological (dark green) with 'Prescription drugs, money, relieving chronic pain'.

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Suspending judgment...

- Focus on what is, not what should be
- *Suspending judgment does not mean that we do not have judgment
 - Providers need and deserve an appropriate outlet for judgments

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How do we handle our judgments?

- Be thoughtful and self-aware about the field you choose to work in and the populations you enjoy working with
- Rely on your team to help with particular people or situations that push your buttons
- Remember that when people are not getting their needs met, they will struggle to get their needs met
- Neutralize judgment, identify the need and the motivation for the behavior

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Reasons practicing Harm Reduction can be difficult

Are you listening??!!



- High, medicated (either self or by a doctor)
- Mental illness
- Attention issues
- Ambivalence
- Transient
- Change of long-time routine/rituals is difficult
- Program staff does not validate experiences shared by participants
- Barriers (police, domestic violence, cultural stigma, chaotic use etc.)



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Risks of Not Practicing Harm Reduction

- Alienate the client
- Contribute to client's need to keep behavior secret
- Perpetuate stigma about risky behavior
- Fail to meet basic prevention needs of clients
- Fail to engage clients in much-needed services
- Disregard the client's ability and willingness to make behavior changes
- Fail to reduce number of people dying from drug overdoses



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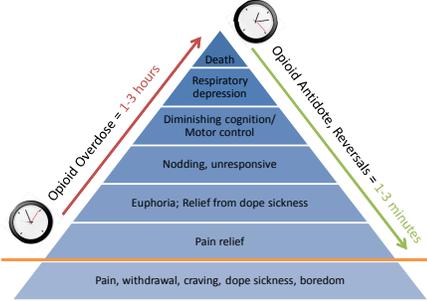
Harm Reduction Method

NALOXONE (NARCAN®)




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Effects of Opioids and Naloxone




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Naloxone (N) in the Brain

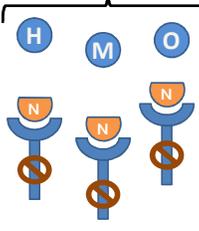
From N. Dasgupta, 2008

opioid receptors activated by heroin and prescription opioids



H=heroin; M=methadone; O=opioids

opioids broken down and excreted




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Naloxone HCL

Antidote to fatal respiratory depression

- Mu-opioid receptor antagonist
- Can NOT get high from it
- Decades of experience
- Uses: Anesthesia, emergency
- Quick acting, works 30-90 minutes
- Generic (cheap?)
- Delivered via injection (IM, SC, IV) or nasal
- NC 911 Good Samaritan Law protects those who prescribe or use naloxone




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SB20: NC's 911 Good Samaritan Law

- **Goal**
 - Save lives by encouraging both seeking medical care for OD's and observer use of naloxone
- Promotes community-based prescribing of naloxone
 - To patients at risk of OD
 - To potential observers of an OD
 - Through direct patient contact and standing orders




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SB20: NC's 911 Good Samaritan Law

- Immunity from prosecution for caller and OD victim
 - Some limitations to immunity from arrest
 - Contrast to provision on underage alcohol poisoning
- Immunity from prosecution for carrying and administering naloxone when used 'in good faith'
- Limited immunity from prosecution for caller of underage drinking toxicity




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Exploring a Harm Reduction Framework

ACTIVITY



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Scenario #1

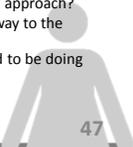
- A male participant comes in to your facility and is high and having trouble staying awake. As the staff on duty, you are concerned for his/her safety. You approach the participant and ask if he is feeling ok. The person denies using any drugs and says "I'm just tired." You tell him if he keeps lying to you about using and keeps coming in high, he'll be barred from the shelter and will probably die out on the streets.
 - What are the outcomes for the client when a staff approaches them like this?
 - What are some alternate ways of dealing with the situation?
 - What if your program requires sobriety or at least that people do not come in looking high?




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Scenario # 2

- You have been working with a female participant for several years that has recently relapsed and is using heroin heavily. She is running the risk of losing her housing. You notice a pretty bad infection on her left arm. You ask her if she feels that her drug use is having any negative effects on her life. She says "Yes". She adds that she is tired of using and want to regain her sobriety. You suggest a few options, including meeting with a substance abuse counselor, methadone, and inpatient treatment. She says thank you for listening and for the suggestions, but she is not ready today. You tell her to come back and talk any time, whether she is ready or not.
 - How does this interaction follow with a harm reduction approach?
 - Do you see any challenges for yourself in reacting this way to the participant?
 - How would you feel if she came back again and seemed to be doing even worse?

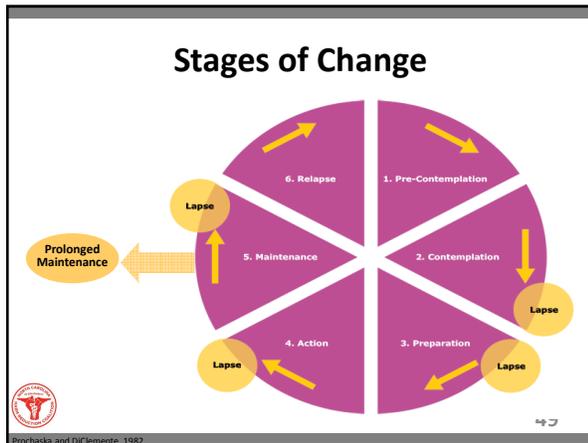



47

BACK POCKET SLIDES



48



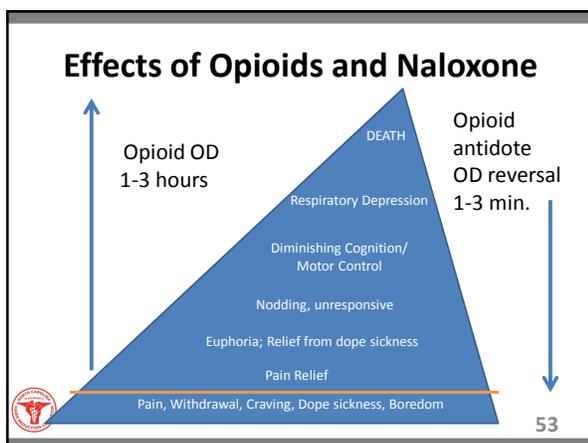
Stage of Change ⇨ Strategy

Stage of Change	Strategy
Precontemplation	Establish rapport, increase client's perception of risks related to current behavior
Contemplation	Elicit reasons for change, risks of not changing, elicit self-motivational statements
Preparation	Offer a menu of options for change or treatment
Action	Support a realistic view of change through small steps
Maintenance	Help the client identify and use strategies to prevent relapse
Relapse	Explore the reality of relapse as a learning opportunity

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- ### Harm Reduction in Practice
- Making contact
 - Meeting survival needs
 - Engaging
 - Holistic needs assessment
 - Focus on participant's own needs and goals
 - Meeting needs to reduce harm
 - Maximizing health and potential
- 51

- ### What triggers YOU?
- Pregnant women using drugs?
 - Someone who refuses treatment for their mental health issues or substance use?
 - Someone who commits crimes to make money?
 - Someone who stays in an abusive relationship?
 - Someone who is the perpetrator of abuse?
 - Someone who leaves their children with family because of their drug use?
 - Someone who is engaging in sex work?
 - Someone who acts aggressively or in an intimidating manner to get their needs met?
 - What else?
- 52



(Insert Name of Organization here) Naloxone (Narcan) Protocol

I. GOAL

- A. To address the growing problem of morbidity and mortality due to overdose of synthetic or natural opioids in North Carolina and Orange County
- B. To provide increased access to naloxone hydrochloride (Narcan), a medication indicated for the reversal of opioid overdose, for individuals at risk of an opioid overdose, or for those in a position to assist individuals at risk of an opioid overdose pursuant to NC SB 20

II. ELIGIBILITY CRITERIA

- A. Clients report being at risk of an opiate-related overdose or in a position to assist a family member, friend, or other person at risk of experiencing an opiate-related overdose.
- B. Client may present in any existing OCHD program during screening by OCHD staff, or may call to make a stand-alone appointment with an available Communicable Disease Nurse for screening, education, and distribution of a naloxone kit.

III. FEES

- A. There is no fee for the client associated with naloxone screening, education, or provision of an OCHD Overdose Rescue Kit, which includes naloxone.
- B. Clients being seen for other services or visits at the OCHD will be charged according to that program's fee policy.
- C. Policies are followed as specified in the agency Administrative Policy and Procedure Manual.

IV. SERVICE PROVIDERS

- A. Clinical providers authorized to dispense naloxone at the OCHD include:
 - Physicians/residents, Nurse Practitioners, and/or Physician's Assistants who function under the supervision of the Medical Director and have obtained approval to practice medical acts by the North Carolina Board of Medical Examiners.
 - Registered Nurses who have been appropriately trained by the NC Board of Pharmacy approved training.
- B. All orders are documented in the client's medical record.
- C. Nursing and allied health providers are authorized to provide screening and education related to the OCHD Overdose Rescue Kit at the OCHD.

V. PHARMACY

- A. OCHD maintains two limited service permits (one for each clinical site) from the N.C. Board of Pharmacy.
- B. Dispensing of pharmaceuticals to OCHD clients is in accordance with North Carolina Pharmacy Laws and the North Carolina Board of Pharmacy.
- C. Naloxone is listed under the OCHD primary care formulary and is maintained in the pharmacy at each clinical site. (See Appendix H of the Primary Care Program Protocol).
 - Authorized dispensers must document on the naloxone dispensing record all dispensed naloxone kits. (See Appendix D of the Pharmacy Program Protocol)
- D. All protocols and procedures related to the pharmacies are found in the OCHD Pharmacy Protocol Manual which is located in each clinical pharmacy.

VI. INTERPRETER SERVICES

- A. Clients who require the assistance of an interpreter are referred to the OCHD Language

Coordinator who advises them of available OCHD services and their right to an interpreter either provided by OCHD or an interpreter or signer of their choosing.

- B. The Health Department uses the certified sign interpreter/translator list provided by the Raleigh Regional Resource Center. This list is kept by the OCHD Language Coordinator, his/her backup and both Clinic Coordinators. The OCHD Language Coordinator is contacted when a signer is needed.
- C. The Waiver of Health Department Interpretive Services form is completed when interpretive Services of a family member or friend are used. (See Appendix N.)
- D. Interpreters are pre-arranged by the OCHD Language Coordinator who screens all contracted interpreters and volunteers for level of proficiency before assigning them to clinic clients.
- E. Non-English speaking clients who walk into clinic can be assisted by using TeleLanguage, access # 1-800-514-9237 or Fluent, 1-877-948-9680 (See Appendix AA). The receptionist may use a Language Identification Card to determine the language a client speaks.
- F. Clients who are seen with interpreter or signer assistance will need the interpreter to witness any informed consents that are required. If TeleLanguage or Fluent is used, the interpreter # and/or name are documented on the consent form.

VII. VISIT PROTOCOL

Client will be screened in one of two ways: 1) Through an existing OCHD appointment or 2) By calling to make a naloxone-only appointment

A. Screening - Existing Appointments

- a. Screen client by asking a question like, *“We have a new program here at the Health Department to protect people from drug overdose. Do you or someone you know take prescription pain medicine such as oxycodone (oxys or roxys), hydrocodone, fentanyl, methadone, or use heroin?”*

- i. If the answer is yes, gauge client's interest with a brief explanation:

1. Prescription opioid painkillers can be an effective pain management tool
2. The number of overdoses and deaths from these medicines has increased across the United States and in North Carolina.
3. Our new program is a way to protect people who use prescription opioid painkillers or other opioids, like heroin, from overdosing.
4. Naloxone (Narcan) can be given to someone experiencing an opioid overdose to re-start their breathing
5. Naloxone (Narcan) is free at OCHD
6. To get the medicine, watch a short video before the end of the visit, ask any questions, and get the medicine for free.

- ii. See Education and Dispensing section below for education and dispensing of kit.
- iii. If the answer is no, let people know that they can participate in the future by asking at their regular appointment or calling to make an appointment.

B. Screening – Naloxone Only Appointment

- a. Client will call to make a naloxone-only appointment.
- b. The MOA will make the appointment for client as “Adult Health – Other” with available CD Nurse.
- c. See Education and Dispensing section below for education and dispensing of kit.

- C. Refills
 - a. For clients needing a refill, the medical office assistant will make an appointment for the client for an “Adult Health – Other” visit with a Communicable Disease Nurse. The Communicable Disease Nurse will work with the clinician to prescribe and dispense another kit according to protocol.

- D. Education and Dispensing
 - a. Regardless of screening method, once client is identified as at-risk or in a position to help someone at-risk for opioid overdose, refer to Naloxone (Narcan) Standing order (Appendix A).

VIII. DOCUMENTATION

- A. For those requesting kit as someone in a position to assist (i.e. not at risk themselves)
 - 1) Record of the screening, education, and dispensing naloxone will be entered into the “Family History” section of the client record according to this protocol and the Naloxone (Narcan) Standing order (Appendix A). Please see Appendix B for an illustrated example of fields to complete.

- B. For those requesting kit as someone at risk themselves
 - 1) Record it in the Problem List as:
 - b. For opioid type dependence that is a result of substance abuse use 304.00
 - c. If opioid dependence is not related to substance abuse, then use V 58.69
 - 2) Prescription should be recorded by authorized dispenser in Patagonia using Med Entry.

- A. Each entry in Patagonia is initialed with the first initial, last name and title (position) of the signer.

- B. Corrections, alterations and inaccuracies in health records follow documentation guidelines specified in the Administrative Policy and Procedure Manual, Section X, Policy 7.0.

- C. All telephone contacts are charted. Documentation is preceded with “PC” or “TC” (phone call, telephone call).

- D. Only approved abbreviations are used in chart documentation. All staff who document in charts have access to the electronic copy of the Approved Abbreviation list which is updated quarterly and is located on S: Approved Abbreviations.

IX. REFERRALS FOR ADDITIONAL SERVICES

- A. Referrals to other medical care providers for identified medical problems:
 - 1. The Clinician/RN documents referral and appointment time (if available) in client’s record.
 - 2. The client is provided with a written Referral/Follow-up Form to take to the provider or the form is faxed to the provider.
 - 3. A copy of the Referral/Follow-up Form is placed in the client’s record until a response is received.

- D. The client is counseled on the availability of all other Health Department services and referred to these programs/services as needed.

Approved by: _____
 Medical Director

Date: _____

Pre and Post Overdose Training Test

A. Naloxone is used for:

1. Helping someone get off drugs
2. Bringing someone back from a methamphetamine overdose
3. Bringing someone back from a heroin overdose
4. None of the above

B. Your risk of overdose increases when you:

1. Mix opiates with other downers like alcohol or benzodiazepines (valium, diazepam, etc.)
2. Use after your tolerance has gone down (because you were in jail or detox, for instance)
3. Use a stronger (more pure) product than usual
4. All of the above

C. You can tell when someone's overdosing (not just really high) when

1. They don't respond to loud calls, shaking their shoulder or grinding a fist hard into their sternum
2. Their lips and nails look blue
3. They emit a deep gurgling sound
4. All of the above

D. Which one of these methods is a good way to deal with a person who is overdosing?

1. Put the person in a cold bath
2. Hit them hard to shock them awake
3. Kick them in the chest
4. Do rescue breathing and call an ambulance
5. Inject them with salt water

E. Naloxone should be injected:

1. Under the skin
2. Into the stomach
3. Into a big muscle like the upper arm, butt, or thigh
4. Into a vein

F. After you inject the naloxone, it is important to:

1. Continue rescue breathing until help arrives or the person revives
2. Call an ambulance or make sure someone does
3. Stay with the person or make sure someone does
4. All of the above

G. If the first dose of Naloxone doesn't work within 3 minutes, you can try another dose

1. True
2. False

H. An overdose can outlast a dose of naloxone, so after the person is revived someone needs to stay with them for at least an hour to make sure they don't slip back into an overdose.

1. True
2. False

I. You can overdose on naloxone

1. True
2. False

Staff Initial: _____

INSTRUCTIONS FOR HEALTHCARE PROFESSIONALS: Prescribing Naloxone

Naloxone is the antidote for an opioid overdose. It has been used for decades to reverse respiratory depression associated with toxic exposure to opioids. Naloxone is not a controlled substance and can be prescribed by anyone with a medical license. Take-home naloxone can be prescribed to patients at risk of an opioid overdose. Some reasons for prescribing naloxone are:

1. Receiving emergency medical care involving opioid intoxication or overdose
2. Suspected history of substance abuse or nonmedical opioid use
3. Starting methadone or buprenorphine for addiction
4. Higher-dose (>50 mg morphine equivalent/day) opioid prescription
5. Receiving any opioid prescription for pain plus:
 - a. Rotated from one opioid to another because of possible incomplete cross-tolerance
 - b. Smoking, COPD, emphysema, asthma, sleep apnea, respiratory infection, other respiratory illness
 - c. Renal dysfunction, hepatic disease, cardiac illness, HIV/AIDS
 - d. Known or suspected concurrent alcohol use
 - e. Concurrent benzodiazepine or other sedative prescription
 - f. Concurrent antidepressant prescription
6. Patients who may have difficulty accessing emergency medical services (distance, remoteness)
7. Voluntary request from patient or caregiver

Two naloxone formulations are available. Intra-muscular injection is cheaper but may be less attractive because it involves using a needle syringe. (IM syringes aren't widely used to inject controlled substances.) Intra-nasal (IN) spray is of comparable effectiveness, but may be more difficult to obtain at a pharmacy. Check with pharmacist to see whether IM or IN is more feasible.

Billing for Clinical Encounter to Prescribe Naloxone

Most private health insurance, Medicare and Medicaid cover naloxone, but it varies by state.

Drug Abuse Screening Test—DAST-10			
These Questions Refer to the Past 12 Months			
1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop using drugs when you want to?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Screening, Brief Intervention & Referral to Treatment

SBIRT can be used to bill time for counseling a patient. Complete the DAST-10 and counsel patient on how to recognize overdose and how to administer naloxone, using the following sheets. Refer to drug treatment program if appropriate.

Billing codes

Commercial insurance: CPT 99408 (15 to 30 mins.)

Medicare: G0396 (15 to 30 mins.)

Medicaid: H0050 (per 15 mins.)

Guidelines for Interpretation of DAST-10		
Interpretation (Each "Yes" response = 1)		
Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior – feedback and advice
3-5	Moderate level	Harmful behavior – feedback and counseling; possible referral for specialized assessment
6-8	Substantial level	Intensive assessment and referral

Pharmacist: Dispensing Naloxone

Many outpatient pharmacies do not stock naloxone but it can be easily ordered from major distributors. The nasal atomizer can be ordered from the manufacturer LMA (1-800-788-7999), but isn't usually covered by insurance (\$3 each). It may take 24 hours to set up an account with LMA, and the minimum order size is 25.

Naloxone for Overdose Prevention

patient name

date of birth

patient address

patient city, state, ZIP code

Rx _____

prescriber name

prescriber address

prescriber city, state, ZIP code

prescriber phone number

Naloxone HCl 0.4 mg/mL (Narcan)
 1 x 10 mL as one fliptop vial (NDC 0409-1219-01) OR
 2 x 1mL single dose vials (NDC 0409-1215-01)

Refills: _____

Intramuscular (IM) syringe, 23 G, 3cc, 1 inch

Qty: _____ Refills: _____

Sig: For suspected opioid overdose,
 inject 1mL IM in shoulder or thigh.
 Repeat after 3 minutes if no or minimal response.

prescriber signature

date

Detach for patient



Are they breathing?

- Signs of an overdose:
- Slow or shallow breathing
 - Gasping for air when sleeping or weird snoring
 - Pale or bluish skin
 - Slow heartbeat, low blood pressure
 - Won't wake up or respond (rub knuckles on sternum)



Call 911 for help

All you have to say:
 "Someone is unresponsive and not breathing."
 Give clear address and location.



Airway

Make sure nothing is inside the person's mouth.



Rescue breathing

Oxygen saves lives. Breathe for them.
 One hand on chin, tilt head back, pinch nose closed.
 Make a seal over mouth & breathe in
 1 breath every 5 seconds
 Chest should rise, not stomach



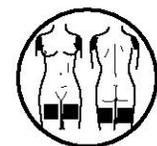
Evaluate

Are they any better? Can you get naloxone
 and prepare it quickly enough that they won't
 go for too long without your breathing assistance?



Prepare naloxone

- Remove cap from naloxone and uncover needle
- Insert needle through rubber plug, with bottle upside down
- Pull back on plunger and take up 1 cc into the syringe
- Don't worry about air bubbles (they aren't dangerous in muscle injections)



Muscular injection

inject 1cc of naloxone into a big muscle (shoulder or thigh)



Evaluate + support

- Continue rescue breathing
- Give another shot of naloxone in 3 minutes if no or minimal breathing or responsiveness
- Naloxone wears off in 30-90 minutes
- Comfort them; withdrawal can be unpleasant
- Get them medical care and help them not use more opiate right away
- Encourage survivors to seek treatment if they feel they have a problem

How to Avoid Overdose

- Only take medicine prescribed to you
- Don't take more than instructed
 - Call a doctor if your pain gets worse
- Never mix pain meds with alcohol
- Avoid sleeping pills when taking pain meds
- Dispose of unused medications
- Store your medicine in a secure place
- Learn how to use naloxone
- Teach your family + friends how to respond to an overdose

For More Info
PrescribeToPrevent.com

Poison Center
 1-800-222-1222
 (free & anonymous)

NAME: _____

DATE: _____

DRUG USE QUESTIONNAIRE (DAST – 20)

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months.

Carefully read each statement and decide if your answer is “Yes” or “No”. Then, circle the appropriate response beside the question. In the statements “drug abuse” refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquillizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions **do not** include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

Adult Version

These questions refer to the past 12 months.

**Circle Your
Response**

- | | | |
|--|-----|----|
| 1. Have you used drugs other than those required for medical reasons? | Yes | No |
| 2. Have you abused prescription drugs? | Yes | No |
| 3. Do you abuse more than one drug at a time? | Yes | No |
| 4. Can you get through the week without using drugs? | Yes | No |
| 5. Are you always able to stop using drugs when you want to? | Yes | No |
| 6. Have you had "blackouts" or "flashbacks" as a result of drug use? | Yes | No |
| 7. Do you ever feel bad or guilty about your drug use? | Yes | No |
| 8. Does your spouse (or parents) ever complain about your involvement with drugs? | Yes | No |
| 9. Has drug abuse created problems between you and your spouse or your parents? | Yes | No |
| 10. Have you lost friends because of your use of drugs? | Yes | No |
| 11. Have you neglected your family because of your use of drugs? | Yes | No |
| 12. Have you been in trouble at work (or school) because of drug abuse? | Yes | No |
| 13. Have you lost your job because of drug abuse? | Yes | No |
| 14. Have you gotten into fights when under the influence of drugs? | Yes | No |
| 15. Have you engaged in illegal activities in order to obtain drugs? | Yes | No |
| 16. Have you been arrested for possession of illegal drugs? | Yes | No |
| 17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | Yes | No |
| 18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)? | Yes | No |
| 19. Have you gone to anyone for help for drug problem? | Yes | No |
| 20. Have you been involved in a treatment program specifically related to drug use? | Yes | No |

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Adolescent Version

These questions refer to the past 12 months.

Circle Your
Response

- | | | |
|--|-----|----|
| 1. Have you used drugs other than those required for medical reasons? | Yes | No |
| 2. Have you abused prescription drugs? | Yes | No |
| 3. Do you abuse more than one drug at a time? | Yes | No |
| 4. Can you get through the week without using drugs? | Yes | No |
| 5. Are you always able to stop using drugs when you want to? | Yes | No |
| 6. Have you had "blackouts" or "flashbacks" as a result of drug use? | Yes | No |
| 7. Do you every feel bad or guilty about your drug use? | Yes | No |
| 8. Do your parents ever complain about your involvement with drugs? | Yes | No |
| 9. Has drug abuse created problems between you and your parents? | Yes | No |
| 10. Have you lost friends because of your use of drugs? | Yes | No |
| 11. Have you neglected your family because of your use of drugs? | Yes | No |
| 12. Have you been in trouble at school because of drug abuse? | Yes | No |
| 13. Have you missed school assignments because of drug abuse? | Yes | No |
| 14. Have you gotten into fights when under the influence of drugs? | Yes | No |
| 15. Have you engaged in illegal activities in order to obtain drugs? | Yes | No |
| 16. Have you been arrested for possession of illegal drugs? | Yes | No |
| 17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | Yes | No |
| 18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)? | Yes | No |
| 19. Have you gone to anyone for help for drug problem? | Yes | No |
| 20. Have you been involved in a treatment program specifically related to drug use? | Yes | No |

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NAME: _____

DATE: _____

DRUG USE QUESTIONNAIRE (DAST – 10)

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is “Yes” or “No”. Then, circle the appropriate response beside the question.

In the statements “drug abuse” refers to (1) the use of prescribed or over the counter drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquillizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions **do not** include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.

Circle Your Response

- | | | |
|--|-----|----|
| 1. Have you used drugs other than those required for medical reasons? | Yes | No |
| 2. Do you abuse more than one drug at a time? | Yes | No |
| 3. Are you always able to stop using drugs when you want to? | Yes | No |
| 4. Have you had “blackouts” or “flashbacks” as a result of drug use? | Yes | No |
| 5. Do you every feel bad or guilty about your drug use? | Yes | No |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs? | Yes | No |
| 7. Have you neglected your family because of your use of drugs? | Yes | No |
| 8. Have you engaged in illegal activities in order to obtain drugs? | Yes | No |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | Yes | No |
| 10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)? | Yes | No |

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GUIDE FOR USING THE
DRUG ABUSE SCREENING TEST (DAST)

Harvey A. Skinner, Ph.D.
York University, Toronto

Email: harvey.skinner@yorku.ca

Why assess Drug Use?

Systematic assessment of drug use and abuse is necessary for ensuring good clinical care. Measures, which are both reliable and valid, provide information to the practitioner, which can be used for identifying problems (early if possible) and for evaluating the effectiveness of treatment. As well, this information is useful for matching patient needs with tailored intervention.

The Drug Abuse Screening Test (DAST) was designed to provide a brief, self-report instrument for population screening, clinical case finding and treatment evaluation research. The DAST yields a *quantitative* index of the degree of consequences related to drug abuse. This instrument takes approximately 5 minutes to administer and may be given in either a self-report or interview format. The DAST may be used in a variety of settings to provide a quick index of drug abuse problems.

DAST-20 and DAST-10 Version

The original DAST contained 28 items that were modeled after the widely used Michigan Alcoholism Screening Test (Selzer, American Journal of Psychiatry, 1971, 127, 1653-1658). Two shortened versions of the DAST were devised using 20-items and 10-items that were good discriminators. The 20-item DAST correlated almost perfectly ($r = .99$) with the original 28-item DAST is measuring the same construct as the longer scale. Moreover, the internal consistency reliability (α) was extremely high (.95 for the total sample, and .86 for a subsample that excluded clients with only alcohol problems). Good discrimination is evident among clients classified by their reason for seeking treatment. Most clients with alcohol related problems scored 5 or below, whereas the majority of clients with drug problems scored 6 or above on the 20-item DAST. The DAST-10 correlated very high ($r = .98$) with the DAST-20 and has excellent internal consistency reliability for such a brief scale (.92 total sample and .74 drug abuse).

Measurement properties of the DAST were initially evaluated using a clinical sample of 256 drug/alcohol abuse clients (Skinner ...Addictive Behaviors, 1982). The internal consistency reliability estimate was substantial at .92. and a factor analysis of item intercorrelations suggested an unidimensional scale. With respect to response style biases, the DAST was only moderately correlated with social desirability and denial. Concurrent validity was examined by correlating the DAST with background variables, frequency of drug use, and psychopathology. A greater range of problems associated with drug abuse (DAST) was related to the more frequent use of cannabis, barbiturates and opiates other than heroin. With respect to psychopathology, the largest correlations were with the sociopathic scales of Impulse Expression and Social Deviation. High scorers on the DAST tended to engage in reckless actions and express attitudes that are markedly different from common social codes.

Furthermore, the DAST was positively related to interpersonal problems, suspiciousness, depressive symptoms and a preoccupation with bodily dysfunction. Thus, drug abuse tended to be manifests in, or covary with, other psychopathological characteristics. Finally, the DAST total score clearly differentiated among clients with (1) drug problems only versus (2) mixed drug/alcohol problems versus (3) alcohol problems only.

Advantages

1. The DAST is brief and inexpensive to administer.
2. It provides a quantitative index of the extent of problems related to drug abuse. Thus, one may move beyond the identification of a drug problem and obtain a reliable estimate of the degree of problem severity.
3. DAST scores could be used to corroborate information gained by other assessment sources (e.g. clinical interview or laboratory tests).
4. The routine administration of the DAST would provide a convenient device of recording the extent of problems associated with drug abuse. It would ensure that relevant questions regarding consequences of drug abuse are asked of all clients.
5. The DAST could provide a reference standard for monitoring changes in client population over time, as well as for comparing clients at different assessment centres.

Limitations

1. Since the content of the DAST items is obvious, clients may fake results.
2. Since any given assessment approach provides an incomplete picture of the client's status, there is a danger that DAST scores may be given too much emphasis. Because the DAST yields a numerical score, this score may be misinterpreted.

Administration and Scoring

The DAST may be administered in either an interview or self-report format. The self-report version is generally preferred since it allows the efficient assessment of large groups. In many circumstances one would expect the interview and self-report formats to give identical results. However, the assessment approaches may differ (1) when a client is particularly defensive or high on social anxiety which may produce under-reporting of problems in a face-to-face interview format, or (2) when a client has difficulty reading and understanding the content of items in the self-report version. The DAST should *not* be administered to clients who are presently under the influence of drugs, or who are undergoing a drug withdrawal reaction. Under these conditions the

reliability and validity of the DAST would be suspect. Thus, one should ensure that clients are drug free (detoxified before the DAST is administered).

The following introduction should be used for either interview or self-report formats: "The following questions concern information about your potential involvement with drugs *not including alcohol beverages*."

"In the statements, 'drug abuse' refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non medical use of drugs. The various classes of drugs may include: cannabis, (e.g. marijuana, hash), solvents or glue, tranquilizers (e.g. valium), barbiturates, cocaine, stimulants, hallucinogens (e.g. LSD), or narcotics (e.g. heroin). Remember that the questions *do not* include alcoholic beverages."

The DAST total score is computed by summing all items that are endorsed in the direction of increased drug problems. Two items: #4 (Can you get through the week without using drugs) and #5 (Are you always able to stop using drugs when you want to), are keyed for a "No" response. The other 18 items are keyed for a "Yes" response. For example, if a client circled "Yes" for item #1 he/she would receive a score of 1, whereas if the client circled "No" for item #1 he/she would receive a score of 0. With items #4 and 5, a score of 1 would be given for a "No" response and a score of 0 for a "Yes" response. When each item has been scored in this fashion, the DAST *total score* is simply the sum of the 20 item scores. This total score can range from 0 to 20.

Interpretation

The DAST total score orders individual along a continuum with respect to their *degree* of problems or consequences related to drug abuse. A score of zero indicates that no evidence of drug related problems were reported. As the DAST score increases there is a corresponding rise in the level of drug problems reported. The maximum score of 20 would indicate substantial problems. Thus, as the DAST total score increases one may interpret that a given individual has accrued an increasingly diverse range of drug-related consequences. Then, one may examine the DAST item responses to identify specific problem areas, such as the family or work. The following tentative guidelines are suggested for interpreting the DAST total score.

DAST Interpretation Guide

	DAST-10	DAST-20	Action	ASAM
None	0	0	Monitor	
Low	1-2	1-5	Brief Counseling	Level I
Intermediate (likely meets DSM criteria)	3-5	6-10	Outpatient (intensive)	Level I or II
Substantial	6-8	11-15	Intensive	Level II or III
Severe	9-10	16-20	Intensive	Level III or IV

ASAM: American Society of Addiction Medicine Placement Criteria

A low score does not necessarily mean that the client is free of drug related problems. One must consider the length of time the client has been using drugs, the client's age, level of consumption and other data collected in the assessment in order to interpret the DAST score. Since most of the alcohol abuse clients scored 5 or below, whereas most of the mixed drug/alcohol clients and drug abuse group scored 6 or above, a DAST score of *6 or greater* is suggested for case finding purposes. Further research is planned to evaluate the diagnostic validity of alternative cutoff points on the DAST.

Availability

Copies of the 20-item and 10-item DAST may be obtained from the author (Harvey Skinner) or by contacting Marketing Services at the Centre for Addiction and Mental Health, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1 Telephone: 1-800-463-6273 or visit the following websites: Harvey Skinner at: www.HealthBehaviorChange.org CAMH: www.camh.net

Key References

Skinner, H.A. (2001). Assessment of substance abuse: Drug Abuse Screening Test. In R. Carson- DeWitt (Ed), Encyclopedia of Drugs, Alcohol & Addictive Behavior. Second Edition. Durham: North Carolina: Macmillan Reference USA p. 147-148.

Skinner, HA: The Drug Abuse Screening Test. Addictive Behavior, 1982, 7, 363-371.

Skinner, HA; and Goldberg, A: Evidence for a drug dependence syndrome among narcotic users. British Journal of Addiction, 1986, 81, 533-538.

Gavin, DR; Ross, HE; and Skinner HA: Diagnostic validity of the DAST in the assessment of DSM-III drug disorders. British Journal of Addiction, 1989, 84, 301-371.

Articles Using the DAST

Cocco, KM; and Carey, KB (1998). Psychometric properties of the Drug Abuse Screening Test in psychiatric outpatients. **Psychological Assessment**, 10, 408-414.

Carey, MP; Carey, KB; Maisto, SA; Gleason, JR; Gordon CM; and Brewer, KK (1999). HIV risk behavior among outpatients at a state psychiatric hospital: Prevalence and risk modeling. **Behavior Therapy**, 30, 389-406.

Maisto, SA; Carey, MP; Carey, KB; Gleason, JG; and Gordon CM (2000). Use of the AUDIT and the DAST-10 to identify alcohol and drug use disorders among adults with a severe and persistent mental illness. **Psychological Assessment**, 12, 186-192.

Carey, MP; Carey, KB; Maisto, SA; Gordon, CM; and Venable, P (2001) Prevalence and correlates of HIV-related risk behavior among psychiatric outpatients. **Journal of Consulting and Clinical Psychology**, 69, 846-850.



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Drug Abuse Screening Test (DAST-20)

Updated April 05, 2006 12:55 PM

This five-minute questionnaire, used in an interview or self-evaluation, can help gauge the severity of addiction to drugs other than alcohol.

- questionnaire • pad of 100 • \$9.95 in Ontario
- \$12.95 outside Ontario • published 1992
- product code PZ075

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DISCLAIMER: Information on this site is not to be used for diagnosis, treatment or referral services and CAMH does not provide diagnostic, treatment or referral services through the Internet. Individuals should contact their personal physician, and/or their local addiction or mental health agency for further information.

ID#P14663 published May 23, 2006 6:07 PM

SBIRT-AUDIT Form

Print Name: _____

Date: __/__/_____

Gender: 5 Female 6 Male

The questions included on this form concern information about the alcoholic beverages you may drink. Please check the box next to each statement that most accurately describes your behavior. The number next to the box will be used for scoring.

1. How often do you have a drink containing alcohol?

- 0 Never 3 2-3 times a week
1 Monthly or less 4 4 or more times a week
2 2-4 times a month

2. How many standard drinks containing alcohol do you have on a typical day when drinking?

- 0 1 or 2 3 7 to 9
1 3 or 4 4 10 or more
2 5 or 6

3. How often do you have six or more drinks on one occasion?

- 0 Never 3 Weekly
1 Less Than Monthly 4 Daily or almost daily
2 Monthly

4. During the past year, how often have you found that you were not able to stop drinking once you had started?

- 0 Never 3 Weekly
1 Less than monthly 4 Daily or almost daily
2 Monthly

5. During the past year, how often have you failed to do what was normally expected of you because of drinking?

- 0 Never 3 Weekly
1 Less than monthly 4 Daily or almost daily
2 Monthly

SBIRT-AUDIT Form

6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?

- 0 Never 3 Weekly
1 Less than monthly 4 Daily or almost daily
2 Monthly

7. During the past year, how often have you had a feeling of guilt or remorse after drinking?

- 0 Never 3 Weekly
1 Less than monthly 4 Daily or almost daily
2 Monthly

8. During the past year, have you been unable to remember what happened the night before because you had been drinking?

- 0 Never 3 Weekly
1 Less than monthly 4 Daily or almost daily
2 Monthly

9. Have you or someone else been injured as a result of your drinking?

- 0 No
2 Yes, but not in the past year
4 Yes, during the past year

10. Has a relative or friend, doctor, or other health worker been concerned about your drinking or suggested you cut down?

- 0 No
2 Yes, but not in the past year
4 Yes, during the past year

SBIRT DAST-10 Form

Print Name: _____

Date: __/__/_____

The questions included in the DAST-10 concern information about possible involvement with drugs not including alcoholic beverages during the past 12 months. Please check the appropriate box for each answer. The number next to box will be used for scoring.

In the statements, “drug use” refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (marijuana, hashish), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD), or narcotics (e.g. heroin).

*In the past 12 months:**Check One Response*

- | | | |
|---|--------------------------------|-------------------------------|
| 1. Have you used drugs other than those required for medical reasons? | 1 <input type="checkbox"/> Yes | 0 <input type="checkbox"/> No |
| 2. Do you abuse more than one drug at a time? | 1 <input type="checkbox"/> Yes | 0 <input type="checkbox"/> No |
| 3. Are you always able to stop using drugs when you want to? | 0 <input type="checkbox"/> Yes | 1 <input type="checkbox"/> No |
| 4. Have you had “blackouts” or “flashbacks” as a result of your drug use? | 1 <input type="checkbox"/> Yes | 0 <input type="checkbox"/> No |
| 5. Do you ever feel bad or guilty about your drug use? | 0 <input type="checkbox"/> Yes | 1 <input type="checkbox"/> No |
| 6. Does your spouse/parents ever complain about your involvement with drugs? | 1 <input type="checkbox"/> Yes | 0 <input type="checkbox"/> No |
| 7. Have you neglected your family because of your use of drugs? | 1 <input type="checkbox"/> Yes | 0 <input type="checkbox"/> No |
| 8. Have you engaged in illegal activities in order to obtain drugs? | 1 <input type="checkbox"/> Yes | 0 <input type="checkbox"/> No |
| 9. Have you ever experienced withdrawal symptoms/felt sick when you stopped taking drugs? | 1 <input type="checkbox"/> Yes | 0 <input type="checkbox"/> No |
| 10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)? | 1 <input type="checkbox"/> Yes | 0 <input type="checkbox"/> No |

Scoring Template

DAST-10 Form

Score: _____

Score 1 point for each question answered “yes,” except for question 3 for which a “no” receives 1 point.

DAST-10 Interpretation

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported.	None at this time.
1-2	Low level.	Monitor, reassess at a later date.
3-5	Moderate level.	Further investigation. Consider Project Lazarus.
6-8	Substantial level.	Intensive assessment. Consider Project Lazarus.
9-10	Severe level.	Intensive assessment. Consider Project Lazarus.

AUDIT Form

Score: _____

Scores for questions 1-8:

1st Response = 0

2nd Response = 1

3rd Response = 2

4th Response = 3

5th Response = 4

Scores for questions 9-10:

1st Response = 0

2nd Response = 2

3rd Response = 4

AUDIT Interpretation

Score	Degree of Problems Related to Alcohol Consumption	Suggested Action
0	No problems reported.	None at this time.
1-7	Low level.	Monitor, reassess at a later date.
Female: 8-12 Male: 8-14	Moderate level. Associated with harmful or hazardous drinking.	Further investigation. Consider Project Lazarus.
Female: >=13	Substantial to Severe level. Likely to indicate alcohol dependence.	Intensive assessment. Consider Project Lazarus.
Male: >=15	Substantial to Severe level. Likely to indicate alcohol dependence.	Intensive assessment. Consider Project Lazarus.

extender registered with the Board of Pharmacy, or community pharmacist partner.

- F. Distributor can be an WCHS employee, outreach staff or other partner in the community.

IV. Applicability/Exceptions:

- A. This standard applies to WCHS staff and other committed partners who dispense or distribute naloxone emergency medication

V. Standard Responsibility and Management:

- A. This standard will be reviewed annually by Pharmacy Director and the Medical Director.
- B. Health Promotions Program manager or designee is responsible for communicating with and/or re-training current employees in the standard and related publications as needed.

VI. Subject Matter Consultant(s):

- A. Medical Director, Kimberly McDonald, MD
- B. Pharmacy Director, Connie Nance, PharmD
- C. Nurse, Nancy Phillips, RN
- D. Public Health Director, Sue Lynn Ledford, RN, PhD
- E. Health Promotions Program Manager, Sonya Reid
- F. DHHS Injury Prevention Consultant, Nidhi Sachdeva
- G. Health Promotion Public Health Educator, Kristen McHugh
- H. Community Care of NC, Robin Reed
- I. NC Harm Reduction, Tessie Castillo

VII. References:

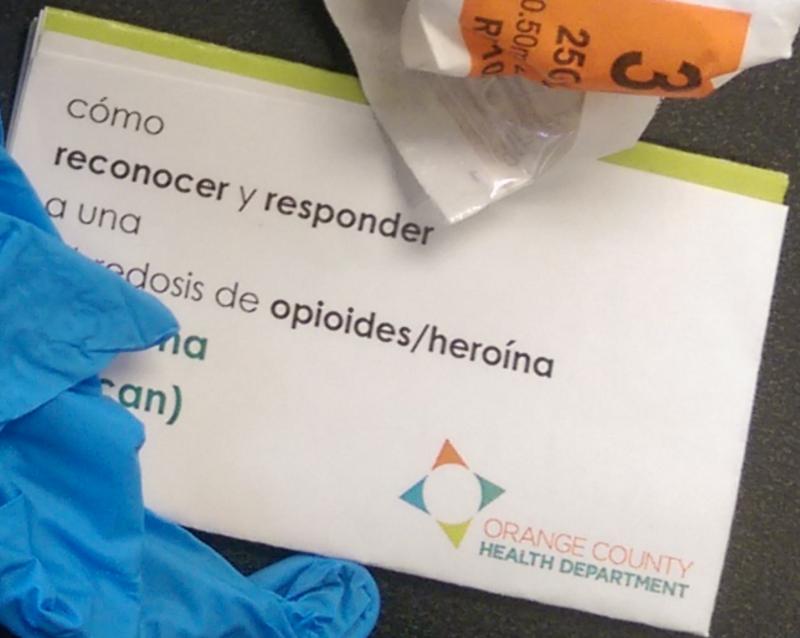
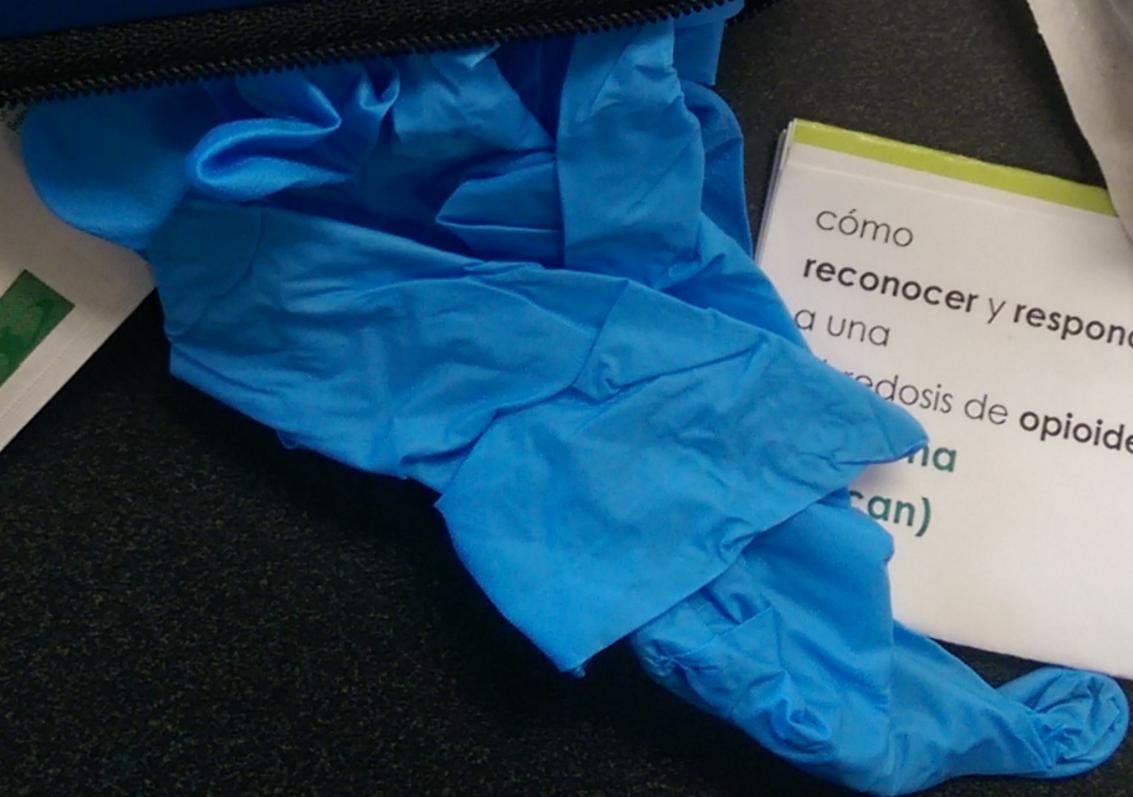
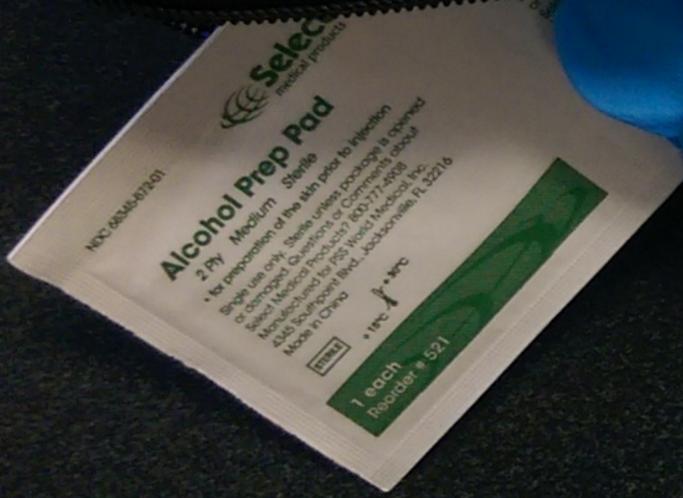
VIII. Related Documents:

- A. Sign out log for dispensing
- B. Distribution log
- C. Tracking number sticker format design
- D. Training materials Patient information leaflet for kit
- E. Post card

IX. Appendices

X. History:

Effective Date	Version	Section(s) Revised	Author/Reviewer
7/2015	1.0	Original	Connie Nance



What is an opioid overdose?



Opioids can cause bad reactions that make your breathing slow or even stop. This can happen if your body can't handle the opioids that you take that day.

TO AVOID AN ACCIDENTAL OPIOID OVERDOSE:

- Try not to mix your opioids with alcohol, benzodiazepines (Xanax, Ativan, Klonopin, Valium), or medicines that make you sleepy.
- Be extra careful if you miss or change doses, feel ill, or start new medications.

Now that you have naloxone...

Tell someone where it is and how to use it.

Common opioids include:

GENERIC	BRAND NAME
Hydrocodone	Vicodin, Lorcet, Lortab, Norco, Zohydro
Oxycodone	Percocet, OxyContin, Roxicodone, Percodan
Morphine	MSContin, Kadian, Embeda, Avinza
Codeine	Tylenol with Codeine, TyCo, Tylenol #3
Fentanyl	Duragesic
Hydromorphone	Dilaudid
Oxymorphone	Opana
Meperidine	Demerol
Methadone	Dolophine, Methadose
Buprenorphine	Suboxone, Subutex, Zubsolv, Bunavail, Butrans

* Heroin is also an opioid.

For patient education, videos and additional materials, please visit www.prescribtoprevent.org



Opioid safety and how to use naloxone



A GUIDE FOR PATIENTS AND CAREGIVERS

How to identify an opioid overdose:

Look for these common signs:

- The person won't wake up even if you shake them or say their name
- Breathing slows or even stops
- Lips and fingernails turn blue or gray
- Skin gets pale, clammy

In case of overdose:

1 Call 911 and give naloxone

If no reaction in 3 minutes, give second naloxone dose

2 Do rescue breathing or chest compressions

Follow 911 dispatcher instructions

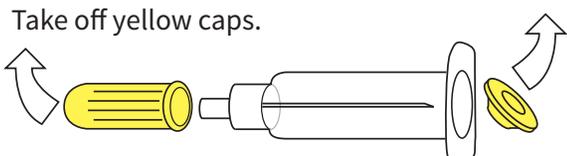
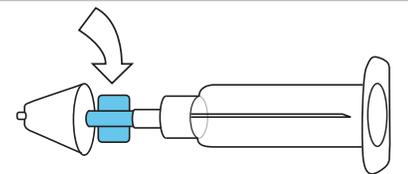
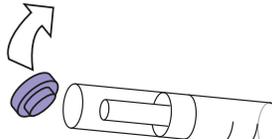
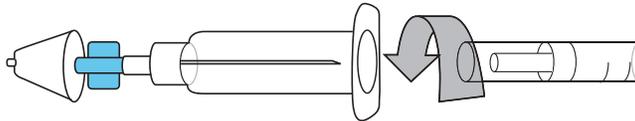
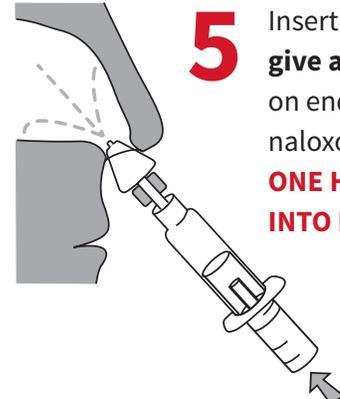
3 After naloxone

Stay with person for at least 3 hours or until help arrives

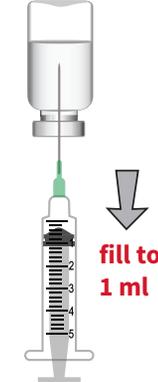
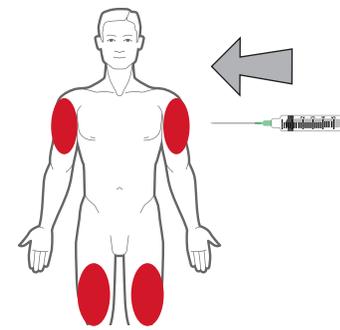
How to give naloxone:

There are 3 ways to give naloxone. Follow the instructions for the type you have.

Nasal spray naloxone

- 1** Take off yellow caps. 
- 2** Screw on white cone. 
- 3** Take purple cap off capsule of naloxone. 
- 4** Gently screw capsule of naloxone into barrel of syringe. 
- 5** Insert white cone into nostril; give a short, strong push on end of capsule to spray naloxone into nose: **ONE HALF OF THE CAPSULE INTO EACH NOSTRIL.**  Push to spray.
- 6** If no reaction in 3 minutes, give second dose.

Injectable naloxone

- 1** Remove cap from naloxone vial and uncover the needle. 
- 2** Insert needle through rubber plug with vial upside down. Pull back on plunger and take up 1 ml.  fill to 1 ml
- 3** Inject 1 ml of naloxone into an upper arm or thigh muscle. 
- 4** If no reaction in 3 minutes, give second dose.

Auto-injector

The naloxone auto-injector is FDA approved for use by anyone in the community. It contains a speaker that provides instructions to inject naloxone into the outer thigh, through clothing if needed.



Intranasal (nasal spray) Naloxone Kit Assembly

Before being given to clients, each blue bag should have 2 doses of naloxone (also known as Narcan) and instructions inside. The blue bags come with gloves, face mask, and alcohol pads already inside them. The alcohol pads are for the intramuscular (injected) version of naloxone and are not needed for these intranasal kits. They can be removed from the blue bags or left in, as you choose. Although the gloves are not needed for these intranasal kits, NY State regulations still require they be included.

Intranasal naloxone Instructions

When making copies of the [instructions](#), print the English on one side of a page and then print the Spanish on the other side. This way, each person will get instructions in both English and Spanish. After making the copies, each page can be cut in half to make two sets of instructions. There are small lines in the center of the page to help you cut it in half (with a scissor or a paper cutter). After cutting the page in half, the instructions are a good size to fold around the blue SKOOP brochure (the one that goes in both the nasal spray and needle version of the kits). After folding the intranasal instruction around the SKOOP brochure, fold them both in half again and put them into the blue bag. It is important to keep the intranasal instructions on the **outside** of the blue brochure when you fold everything up so that they are the first thing seen when the instructions come out of the bag. It could be confusing if someone saw the blue brochure first, because it has only the instructions for the needle version. The blue brochure is part of this kit because it has important general information about overdose.

It works best to print all copies directly from the attached files instead of printing one copy and then photocopying it many times. The reason for this is that when one side is photocopied over and over, and then these pages are turned over for photocopying the other language, the two sides usually don't line up correctly. So, when the page is cut in half, part of the instructions get cut off on one side.

For example: If you need a total of 50 sets of instructions:

- a. Print 25 copies of the English version directly from the attached file (remember, there are two sets on each page).
- b. Put these 25 copies back in the printer where the blank paper goes. (You now want to print the Spanish copy on the blank side of the English copy. Since every printer is different, it is a good idea to print a test copy first so that you know how to put the paper in – with the printed side up or down. For most machines the printed side should be up).
- c. Print 25 copies of the Spanish version directly from the attached file. Nothing is photocopied.
- d. Once both sides are printed, cut the pages in half and you will have 50 copies of instructions, each with English on one side and Spanish on the other. Use the guide lines to help with the cutting.

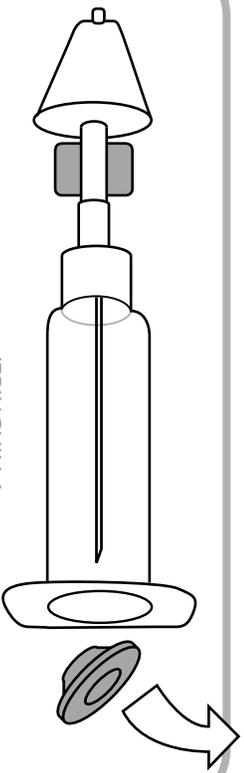
Assembling the nasal spray device (partly)

Each dose of naloxone comes in a tan/orange box that contains a syringe with yellow caps on each end, and a capsule of naloxone with a red cap. Each syringe should be screwed onto a white cone, called a Mucosal Atomization Device (MAD), which turns the liquid naloxone into a spray. With these two pieces screwed together, anyone using the kit does not have to lose time putting them together during an emergency.

Here's how to do it:

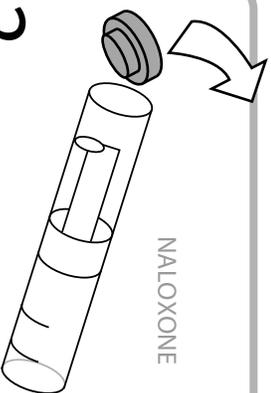
1. Open the tan/orange box at the end that does **not** have the expiration date. This way the date can easily be seen. The expiration date is also printed on the naloxone capsule, but it's hard to read. An easy way to open the undated end of the box is to squeeze the wide sides together so that the sealed end distorts its shape and the flaps are easily grasped to pull apart.
2. Remove the syringe from the box, leaving the naloxone capsule with the red/purple cap inside.
3. Remove the large yellow cap from the tip of the syringe
4. Tear open the plastic wrapping of the MAD without removing it from the bag or touching it. (Look closely at the bag to find where to tear it along the dotted line on one of its long sides.)
5. Hold the MAD through its bag to keep it untouched while screwing the syringe onto it. Grip the clear plastic 'wings' on the MAD through the bag; that will make it easier to hold while screwing. (We are trying not to touch the MAD, because when the kit is used, it will be put into the nose of the person being rescued. Another way of keeping the MAD clean is to wear latex gloves while handling it.)
6. After screwing the MAD onto the syringe, put them into the tan/orange box. The end with the MAD should be put into the box first. This way, the wide part of the syringe keeps the naloxone capsule from falling out, and the MAD squeezed into the box keeps the syringe from sliding out.
7. Put 2 doses into each blue bag, along with one set of instructions.





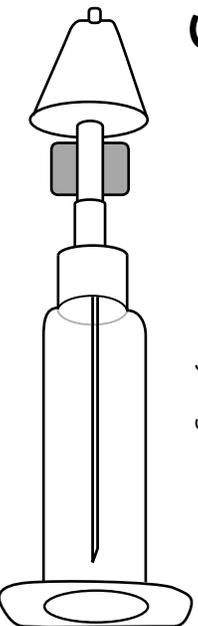
1 Hala o saca las tapas color amarilla

JERINGUILLA

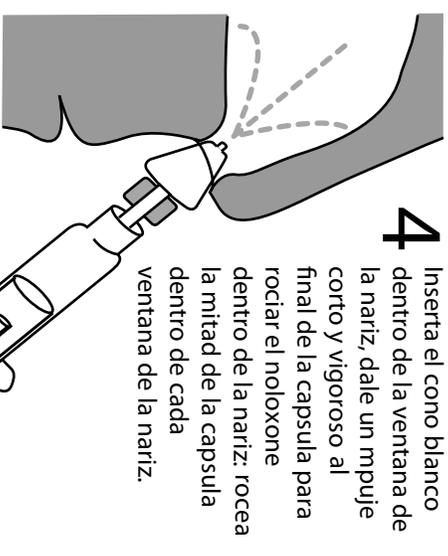
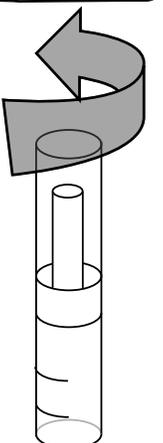


2 Hala o saca la tapa color roja

NALOXONE



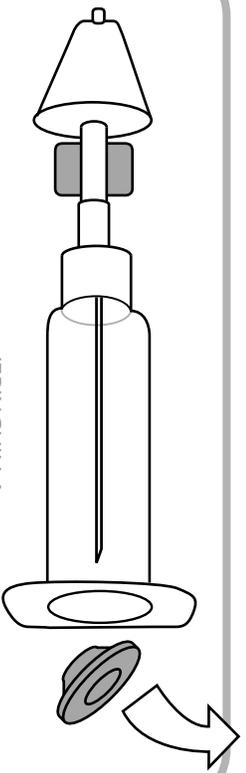
3 Delicadamente, enrosca la capsula de nalozone en el barril de la jeringuilla.



4 Inserta el cono blanco dentro de la ventana de la nariz, dale un mpuje corto y vigoroso al final de la capsula para rociar el nalozone dentro de la nariz: rocea la mitad de la capsula dentro de cada ventana de la nariz.

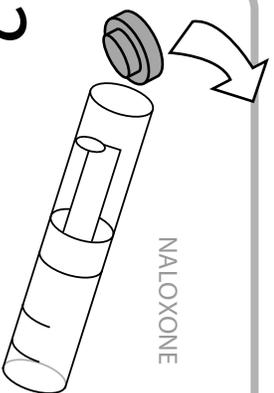
5 Si no reacciona dentro de 2-5 minutos administra una segunda dosis.

Empuje



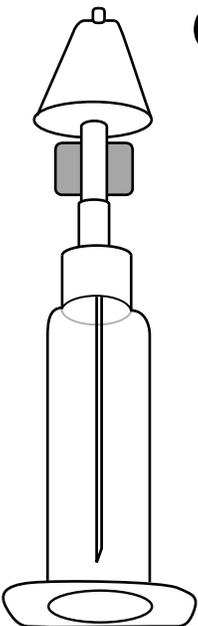
1 Hala o saca las tapas color amarilla

JERINGUILLA

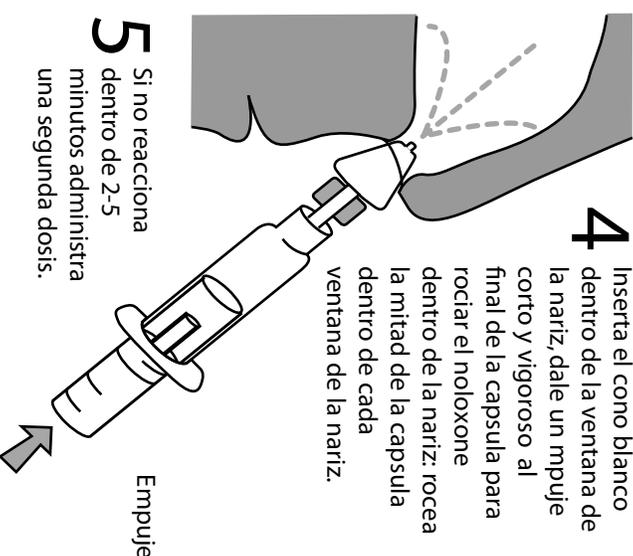
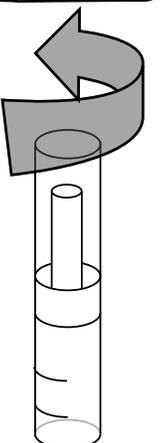


2 Hala o saca la tapa color roja

NALOXONE



3 Delicadamente, enrosca la capsula de nalozone en el barril de la jeringuilla.



4 Inserta el cono blanco dentro de la ventana de la nariz, dale un mpuje corto y vigoroso al final de la capsula para rociar el nalozone dentro de la nariz: rocea la mitad de la capsula dentro de cada ventana de la nariz.

5 Si no reacciona dentro de 2-5 minutos administra una segunda dosis.

Empuje



harm reduction
COALITION

HARM REDUCTION
COALITION

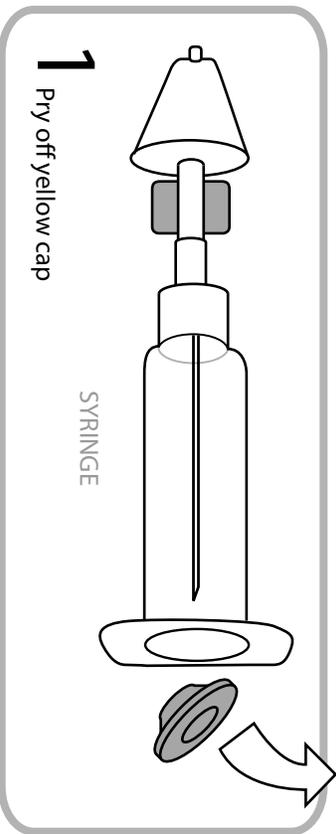
22 WEST 27TH ST, NEW YORK,
NY 10001 (212) 213-6376
www.harmreduction.org



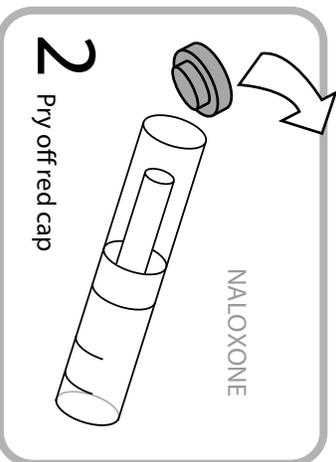
harm reduction
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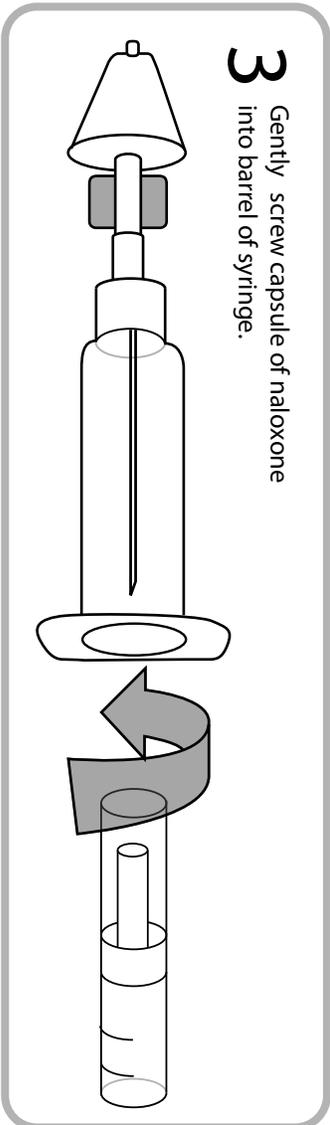
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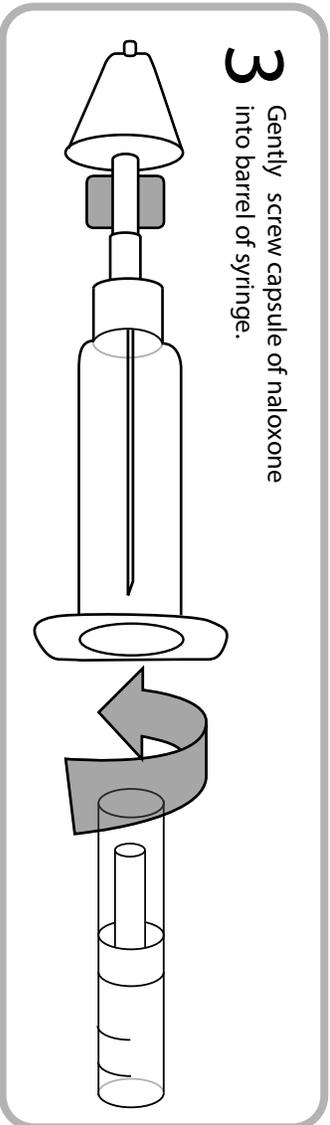
1 Pry off yellow cap



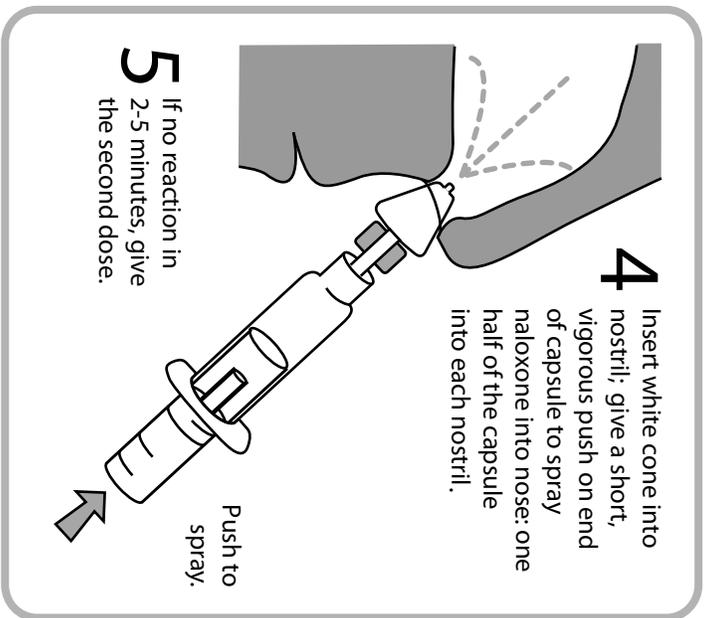
2 Pry off red cap



3 Gently screw capsule of naloxone into barrel of syringe.

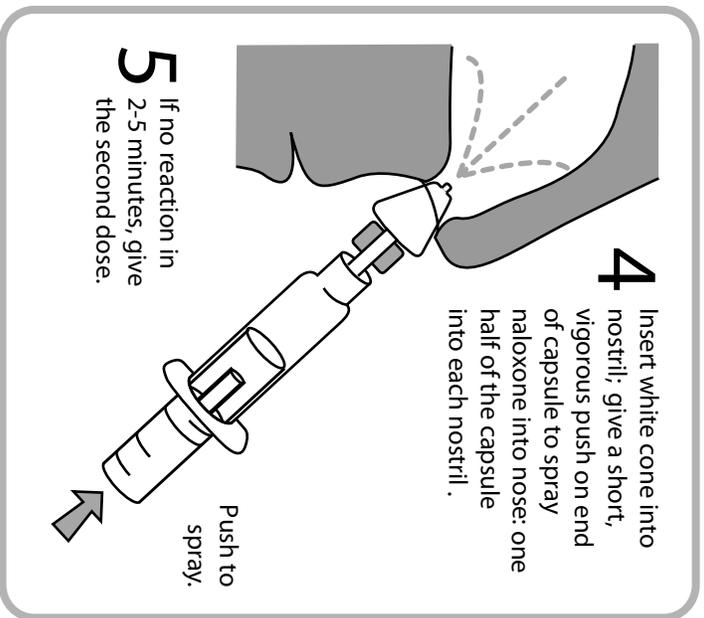


3 Gently screw capsule of naloxone into barrel of syringe.



4 Insert white cone into nostril; give a short, vigorous push on end of capsule to spray naloxone into nose: one half of the capsule into each nostril.

5 If no reaction in 2-5 minutes, give the second dose.



4 Insert white cone into nostril; give a short, vigorous push on end of capsule to spray naloxone into nose: one half of the capsule into each nostril.

5 If no reaction in 2-5 minutes, give the second dose.

Intranasal (nasal spray) Naloxone Kit Assembly



Before being given to clients, each blue bag should have 2 doses of naloxone (also known as Narcan) and instructions inside. The blue bags come with gloves, face mask, and alcohol pads already inside them. The alcohol pads are for the intramuscular (injected) version of naloxone and are not needed for these intranasal kits. They can be removed from the blue bags or left in, as you choose. Although the gloves are not needed for these intranasal kits, NY State regulations still require they be included.

Intranasal naloxone Instructions

When making copies of the [instructions](#), print the English on one side of a page and then print the Spanish on the other side. This way, each person will get instructions in both English and Spanish. After making the copies, each page can be cut in half to make two sets of instructions. There are small lines in the center of the page to help you cut it in half (with a scissor or a paper cutter). After cutting the page in half, the instructions are a good size to fold around the blue SKOOP brochure (the one that goes in both the nasal spray and needle version of the kits). After folding the intranasal instruction around the SKOOP brochure, fold them both in half again and put them into the blue bag. It is important to keep the intranasal instructions on the **outside** of the blue brochure when you fold everything up so that they are the first thing seen when the instructions come out of the bag. It could be confusing if someone saw the blue brochure first, because it has only the instructions for the needle version. The blue brochure is part of this kit because it has important general information about overdose.

It works best to print all copies directly from the attached files instead of printing one copy and then photocopying it many times. The reason for this is that when one side is photocopied over and over, and then these pages are turned over for photocopying the other language, the two sides usually don't line up correctly. So, when the page is cut in half, part of the instructions get cut off on one side.

For example: If you need a total of 50 sets of instructions:

- a. Print 25 copies of the English version directly from the attached file (remember, there are two sets on each page).
- b. Put these 25 copies back in the printer where the blank paper goes. (You now want to print the Spanish copy on the blank side of the English copy. Since every printer is different, it is a good idea to print a test copy first so that you know how to put the paper in – with the printed side up or down. For most machines the printed side should be up).
- c. Print 25 copies of the Spanish version directly from the attached file. Nothing is photocopied.
- d. Once both sides are printed, cut the pages in half and you will have 50 copies of instructions, each with English on one side and Spanish on the other. Use the guide lines to help with the cutting.

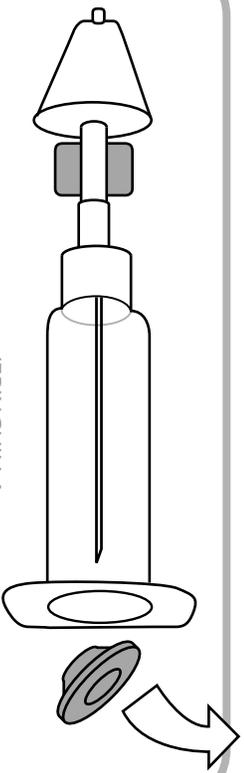
Assembling the nasal spray device (partly)

Each dose of naloxone comes in a tan/orange box that contains a syringe with yellow caps on each end, and a capsule of naloxone with a red cap. Each syringe should be screwed onto a white cone, called a Mucosal Atomization Device (MAD), which turns the liquid naloxone into a spray. With these two pieces screwed together, anyone using the kit does not have to lose time putting them together during an emergency.

Here's how to do it:

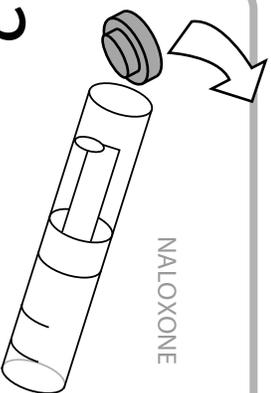
1. Open the tan/orange box at the end that does **not** have the expiration date. This way the date can easily be seen. The expiration date is also printed on the naloxone capsule, but it's hard to read. An easy way to open the undated end of the box is to squeeze the wide sides together so that the sealed end distorts its shape and the flaps are easily grasped to pull apart.
2. Remove the syringe from the box, leaving the naloxone capsule with the red/purple cap inside.
3. Remove the large yellow cap from the tip of the syringe
4. Tear open the plastic wrapping of the MAD without removing it from the bag or touching it. (Look closely at the bag to find where to tear it along the dotted line on one of its long sides.)
5. Hold the MAD through its bag to keep it untouched while screwing the syringe onto it. Grip the clear plastic 'wings' on the MAD through the bag; that will make it easier to hold while screwing. (We are trying not to touch the MAD, because when the kit is used, it will be put into the nose of the person being rescued. Another way of keeping the MAD clean is to wear latex gloves while handling it.)
6. After screwing the MAD onto the syringe, put them into the tan/orange box. The end with the MAD should be put into the box first. This way, the wide part of the syringe keeps the naloxone capsule from falling out, and the MAD squeezed into the box keeps the syringe from sliding out.
7. Put 2 doses into each blue bag, along with one set of instructions.





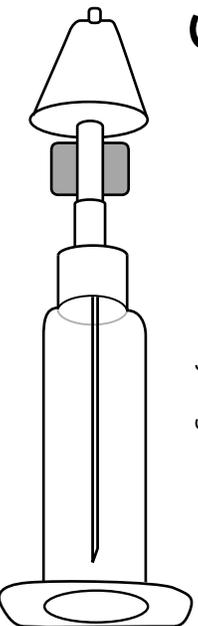
1 Hala o saca las tapas color amarilla

JERINGUILLA

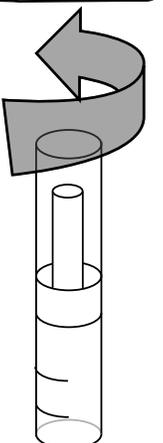


2 Hala o saca la tapa color roja

NALOXONE

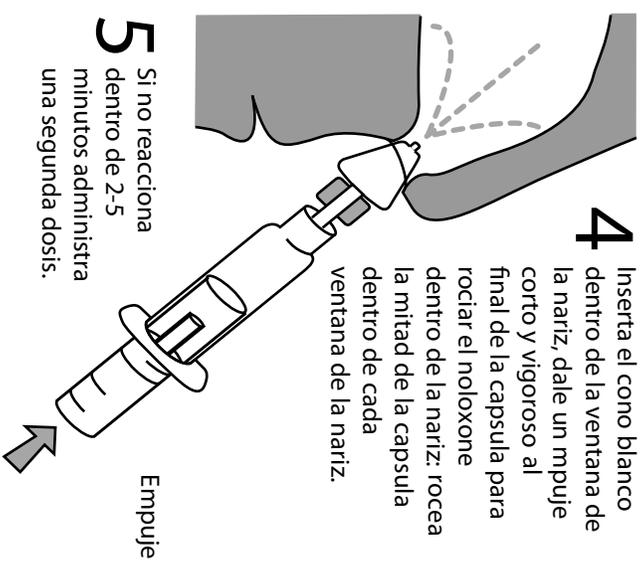


3 Delicadamente, enrosca la capsula de nalozone en el barril de la jeringuilla.

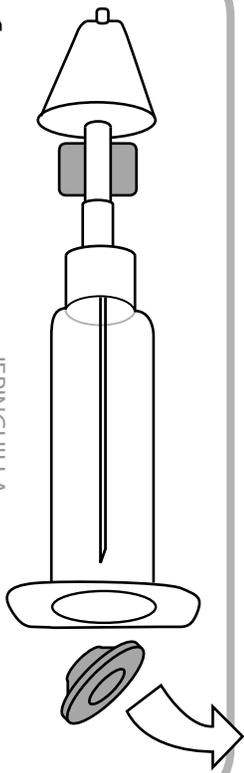


4 Inserta el cono blanco dentro de la ventana de la nariz, dale un mpuje corto y vigoroso al final de la capsula para rociar el nalozone dentro de la nariz: roce la mitad de la capsula dentro de cada ventana de la nariz.

5 Si no reacciona dentro de 2-5 minutos administra una segunda dosis.

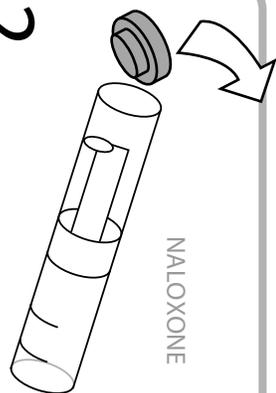


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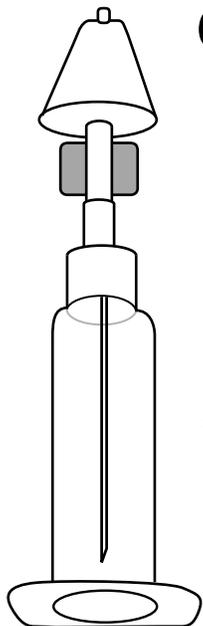
1 Hala o saca las tapas color amarilla

JERINGUILLA

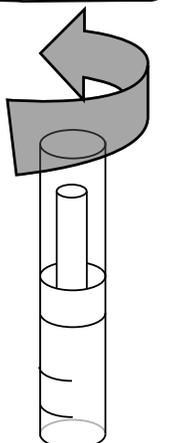


2 Hala o saca la tapa color roja

NALOXONE

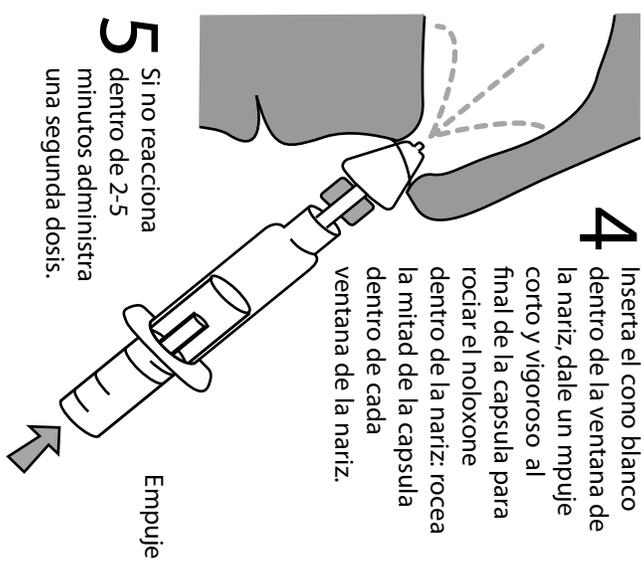


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Empuje



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HARM REDUCTION
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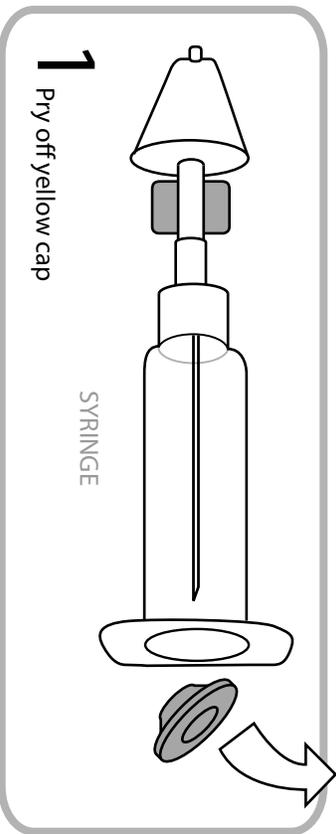
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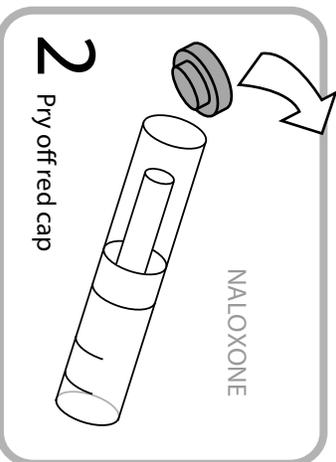
harm reduction
COALITION

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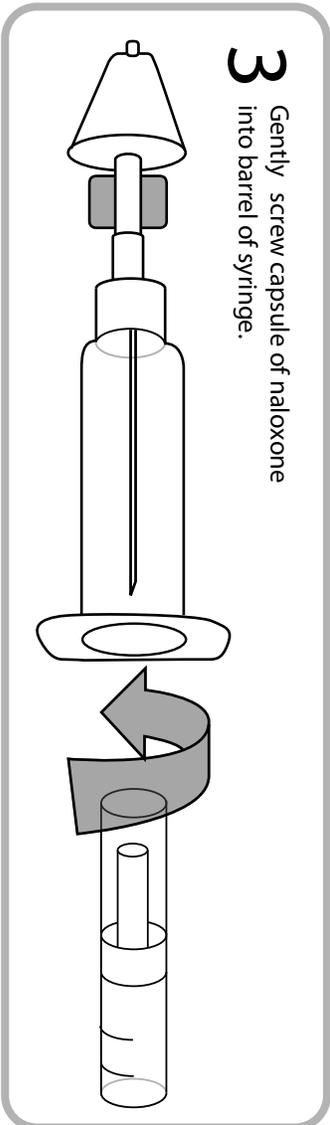
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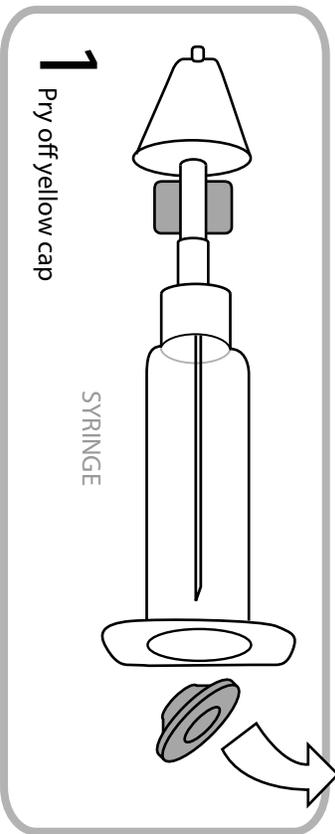
1 Pry off yellow cap



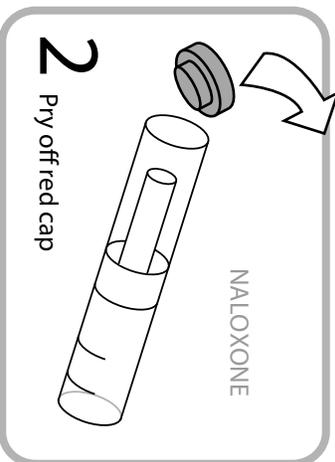
2 Pry off red cap



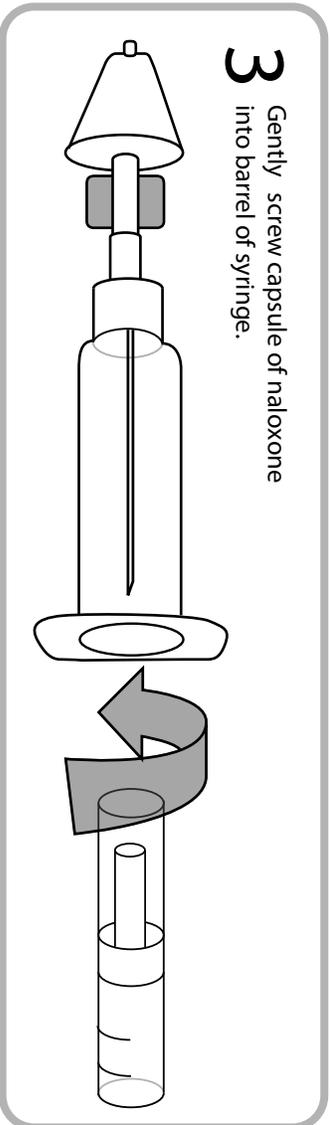
3 Gently screw capsule of naloxone into barrel of syringe.



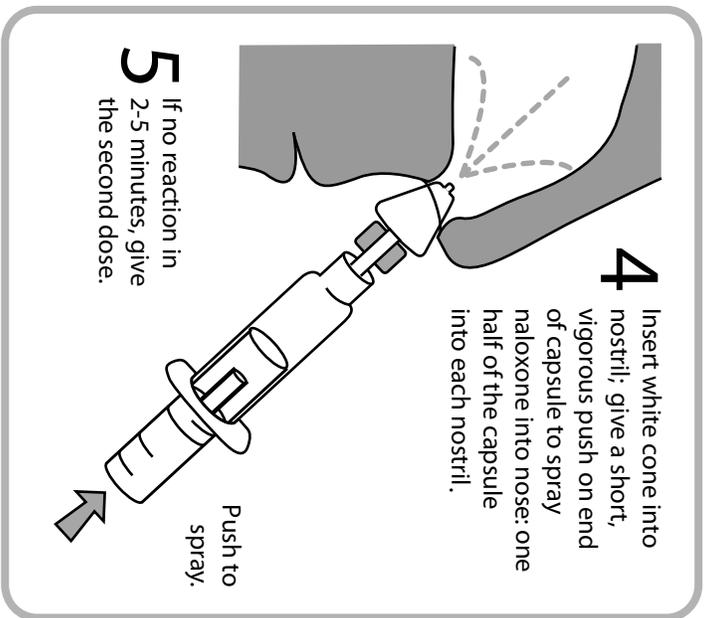
1 Pry off yellow cap



2 Pry off red cap

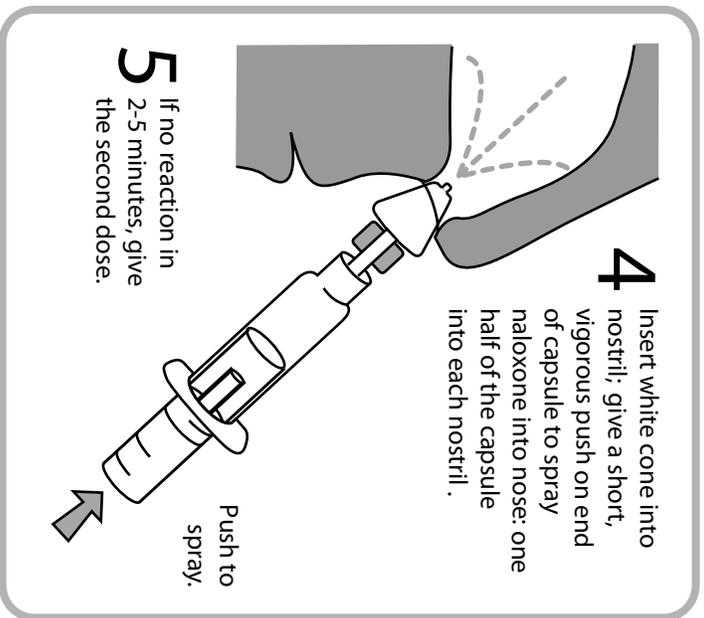


3 Gently screw capsule of naloxone into barrel of syringe.



4 Insert white cone into nostril; give a short, vigorous push on end of capsule to spray naloxone into nose: one half of the capsule into each nostril.

If no reaction in 2-5 minutes, give the second dose.



4 Insert white cone into nostril; give a short, vigorous push on end of capsule to spray naloxone into nose: one half of the capsule into each nostril.

5 If no reaction in 2-5 minutes, give the second dose.

Push to spray.

<p>PATIENT INFORMATION EVZIO™ (EVV-zee-oh) (naloxone hydrochloride injection) Auto-Injector</p>
<p>You and your caregivers should read this Patient Information leaflet before an opioid emergency happens. This information does not take the place of talking with your healthcare provider about your medical condition or your treatment.</p>
<p>What is the most important information I should know about EVZIO?</p> <p>EVZIO is used to temporarily reverse the effects of opioid medicines. The medicine in EVZIO has no effect in people who are not taking opioid medicines. Always carry EVZIO with you in case of an opioid emergency.</p> <ol style="list-style-type: none"> 1. Use EVZIO right away if you or your caregiver think signs or symptoms of an opioid emergency are present because an opioid emergency can cause severe injury or death. Signs and symptoms of an opioid emergency may include: <ul style="list-style-type: none"> • unusual sleepiness and you are not able to awaken the person with a loud voice or rubbing firmly on the middle of their chest (sternum) • breathing problems including slow or shallow breathing in someone difficult to awaken or they look like they are not breathing • the black circle in the center of the colored part of the eye (pupil) is very small, sometimes called “pinpoint pupils” in someone difficult to awaken 2. Family members, caregivers, or other people who may have to use EVZIO in an opioid emergency should know where EVZIO is stored and how to give EVZIO before an opioid emergency happens. 3. Get emergency medical help right away after using the first dose of EVZIO. 4. The signs and symptoms of an opioid emergency can return within several minutes after EVZIO is given. If this happens, give additional injections using a new EVZIO auto-injector every 2 to 3 minutes and continue to closely watch the person until emergency help is received.
<p>What is EVZIO?</p> <ul style="list-style-type: none"> • EVZIO is a prescription medicine used for the treatment of an opioid emergency such as an overdose or a possible opioid overdose with signs of breathing problems and severe sleepiness or not being able to respond. • EVZIO is to be given right away by a caregiver and does not take the place of emergency medical care. Get emergency medical help right away after the first dose of EVZIO, even if the person wakes up.
<p>Who should not use EVZIO?</p> <p>Do not use EVZIO if you are allergic to naloxone hydrochloride or any of the ingredients in EVZIO. See the end of this leaflet for a complete list of ingredients in EVZIO.</p>
<p>What should I tell my healthcare provider before using EVZIO?</p> <p>Before using EVZIO, tell your healthcare provider about all of your medical conditions, including if you:</p> <ul style="list-style-type: none"> • have heart problems • are pregnant or plan to become pregnant. Use of EVZIO may cause withdrawal symptoms in your unborn baby. Your unborn baby should be examined by a healthcare provider right away after you use EVZIO. <p>Tell your healthcare provider about the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements.</p>
<p>How should I use EVZIO?</p> <p>Read the “Instructions for Use” at the end of this Patient Information leaflet for detailed information about the right way to use EVZIO.</p> <ul style="list-style-type: none"> • You should use EVZIO exactly as prescribed by your healthcare provider. • Each EVZIO auto-injector contains only 1 dose of medicine. • EVZIO should be injected into the muscle or skin of the outer thigh. It can be injected through clothing if needed. • Caregivers should pinch the thigh muscle while injecting EVZIO into a child under the

age of one.

- A Trainer for EVZIO with a separate “Trainer Instructions for Use” leaflet is included with EVZIO. For additional training information and video instructions go to www.EVZIO.com or call 1-855-773-8946.
 - Practice with the Trainer for EVZIO before an opioid emergency happens to make sure you are able to safely use the real EVZIO in an emergency.
 - The Trainer for EVZIO does not contain a needle or medicine. It can be reused to practice your injection.
 - The red safety guard can be removed and replaced on the Trainer for EVZIO.

What are the possible side effects of EVZIO?

EVZIO may cause serious side effects, including:

• **Sudden opioid withdrawal symptoms.** In someone who has been using opioids regularly, opioid withdrawal symptoms can happen suddenly after receiving EVZIO and may include: body aches, fever, sweating, runny nose, sneezing, goose bumps, yawning, weakness, shivering or trembling, nervousness, restlessness or irritability, diarrhea, nausea or vomiting, stomach cramping, increased blood pressure, and increased heart rate.

In infants under 4 weeks old who have been receiving opioids regularly, sudden opioid withdrawal may be life-threatening if not treated the right way. Signs and symptoms include: seizures, crying more than usual and increased reflexes.

These are not all of the possible side effects of EVZIO. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store EVZIO?

- Store EVZIO at room temperature between 59°F to 77°F (15°C to 25°C).
- Keep EVZIO in its outer case until ready to use.
- Occasionally check EVZIO through the viewing window of the auto-injector. The solution should be clear. If the EVZIO solution is discolored, cloudy, or contains solid particles, replace it with a new EVZIO.
- Your EVZIO has an expiration date. Replace it before the expiration date.

Keep EVZIO and all medicines out of the reach of children.

General information about the safe and effective use of EVZIO

Medicines are sometimes prescribed for purposes other than those listed in a Patient Information leaflet. Do not use EVZIO for a condition for which it was not prescribed. You can ask your pharmacist or healthcare provider for information about EVZIO that is written for health professionals.

What are the ingredients in EVZIO?

Active ingredient: naloxone hydrochloride

Inactive ingredients: sodium chloride, hydrochloric acid to adjust pH, and water

EVZIO is not made with natural rubber latex.

Manufactured for kaleo, Inc., Richmond, VA, 23219

For more information, go to www.EVZIO.com or call 1-855-773-8946

This Patient Information has been approved by the U.S. Food and Drug Administration. Issued: 4/2014

Instructions for Use EVZIO (EVV-zee-oh) (naloxone hydrochloride injection) Auto-Injector

Read the Instructions for Use that comes with EVZIO before using it. Talk to your healthcare provider if you or your caregivers have any questions about the use of EVZIO.

Automated voice instructions

EVZIO has a speaker that provides voice instructions to help guide you through each step of the injection. See Figure A. If the voice instructions do not work for any reason, EVZIO will still work. If this happens, use EVZIO as instructed below and follow the written instructions on the EVZIO auto-injector label.

Figure A



How to use EVZIO

Step 1. Pull EVZIO from the outer case. See Figure B.

Figure B

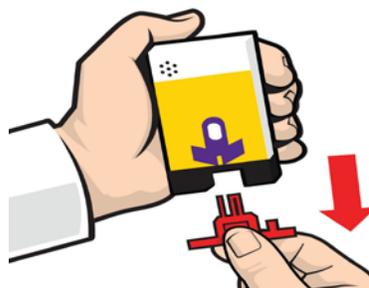


Do not go to Step 2 (Do not remove the **Red** safety guard.) until you are ready to use EVZIO. **If you are not ready to use EVZIO, put it back in the outer case for later use.**

Step 2. Pull off the **Red** safety guard. See Figure C.

To reduce the chance of an accidental injection, do not touch the **Black** base of the auto-injector, which is where the needle comes out.

Figure C



If an accidental injection happens, get medical help right away.

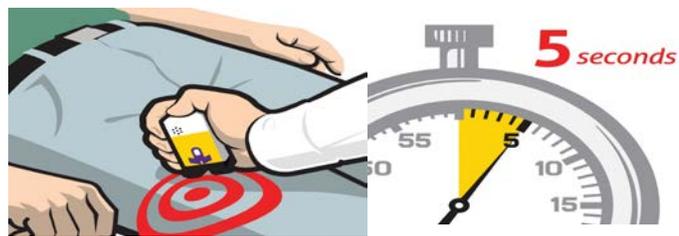
Note: The **Red** safety guard is made to fit tightly. **Pull firmly to remove.**

Do not replace the Red safety guard after it is removed.

Step 3. Place the **Black** end of EVZIO against the outer thigh, through clothing, if needed. **Press firmly** and hold in place for 5 seconds. See Figure D.

If you give EVZIO to an infant less than 1 year old, pinch the middle of the outer thigh before you give EVZIO and continue to pinch while you give EVZIO.

Figure D



Note: EVZIO makes a distinct sound (click and hiss) when it is pressed against the thigh. This is normal and means that EVZIO is working correctly. Keep EVZIO firmly pressed on the thigh for 5 seconds after you hear the click and hiss sound. The needle will inject and then retract back up into the EVZIO auto-injector and is not visible after use.

Step 4. After using EVZIO, get emergency medical help right away.

If symptoms return after an injection with EVZIO, an additional injection using another EVZIO may be needed. Give additional injections using a new EVZIO auto-injector every 2 to 3 minutes and continue to closely watch the person until emergency help is received.

EVZIO cannot be reused. After use, place the auto-injector back into its outer case. Do not replace the **Red** safety guard.

How to know that EVZIO has been used. See Figure E.

- The **Black** base will lock into place.
- The voice instruction system will state that EVZIO has been used and the LED will blink red.
- The **Red** safety guard cannot be replaced.
- The viewing window will no longer be clear. You will see a red indicator.

Figure E



What to do after EVZIO has been used:

- Get emergency medical help right away.
- Put the used EVZIO back into its outer case.
- Do not throw away the EVZIO in household trash. Do not recycle EVZIO.
- Used EVZIO should be taken to a healthcare setting for proper disposal in a sharps container.

There may be local or state laws about how to throw away used auto-injectors.*

*For California Only: This product uses batteries containing Perchlorate Material – special handling may apply. See www.dtsc.ca.gov/hazardouswaste/perchlorate

How should I store EVZIO?

- Store EVZIO at room temperature between 59°F to 77°F (15°C to 25°C).
- Keep EVZIO in its outer case until ready to use.
- Occasionally check EVZIO through the viewing window of the auto-injector. The solution should be clear. If the EVZIO solution is discolored, cloudy, or contains solid particles, replace it with a new EVZIO.
- Your EVZIO has an expiration date. Replace it before the expiration date.

Keep EVZIO and all medicines out of the reach of children.

This Instructions for Use has been approved by the U.S. Food and Drug Administration.

Manufactured for: kaleo, Inc., Richmond, VA 23219

Issued: 4/2014

OPIOID OVERDOSE RESCUE KIT
NORTH CAROLINA HARM REDUCTION
COALITION

Naloxone Hydrochloride (0.4mg/mL)

Directions: In event of opioid overdose with respiratory depression or unresponsiveness, inject 1 mL of naloxone intramuscularly into upper arm, buttock or thigh. If no response in 2 minutes, administer another dose via intramuscular injection as needed for response.

Prescriber: L. Graddy MD 910 Broad Street Durham, NC 27705
 Dispensing Pharmacy: Gurley's Pharmacy, 114 W. Main St., Durham, NC, 27701
 Dispensed by: V. Patel, R.Pharm.
 Date of Prescription: 5/26/2015
 Serial Number: NCHRC-AVL-12-

WARNING: The overdose rescue kit should only be used to save a life. It can stop an opioid overdose. If used, call 911 immediately. **The patient still must go to the hospital** because naloxone will wear off within 30 minutes.

As of 04/09/2013 under NC law SB20, this person has the right to carry this kit, which includes naloxone and supplies to administer.

If kit is used, please report date and city/town of reversal by phone or text to (336) 543-8050. Questions/refills can be directed to same number. Reversals can also be reported at: <http://www.naloxonesaves.org>
No personal data is required to report OD Reversals and data is anonymous.

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No personal data is required to report OD Reversals and data is anonymous.

OPIOID OVERDOSE RESCUE KIT
NORTH CAROLINA HARM REDUCTION
COALITION

Naloxone Hydrochloride (0.4mg/mL)

Directions: In event of opioid overdose with respiratory depression or unresponsiveness, inject 1 mL of naloxone intramuscularly into upper arm, buttock or thigh. If no response in 2 minutes, administer another dose via intramuscular injection as needed for response.

Prescriber: L. Graddy MD 910 Broad Street Durham, NC 27705
 Dispensing Pharmacy: Gurley's Pharmacy, 114 W. Main St., Durham, NC, 27701
 Dispensed by: V. Patel, R.Pharm.
 Date of Prescription: 5/26/2015
 Serial Number: NCHRC-AVL-12-

WARNING: The overdose rescue kit should only be used to save a life. It can stop an opioid overdose. If used, call 911 immediately. **The patient still must go to the hospital** because naloxone will wear off within 30 minutes.

As of 04/09/2013 under NC law SB20, this person has the right to carry this kit, which includes naloxone and supplies to administer.

If kit is used, please report date and city/town of reversal by phone or text to (336) 543-8050. Questions/refills can be directed to same number. Reversals can also be reported at: <http://www.naloxonesaves.org>
No personal data is required to report OD Reversals and data is anonymous.

North Carolina Harm Reduction Coalition

The North Carolina Harm Reduction Coalition (NCHRC) is North Carolina's only comprehensive harm reduction program.

NCHRC engages in grassroots advocacy, resource development, coalition building and direct services for law enforcement and those made vulnerable by drug use, sex work, overdose, immigration status, gender, STIs, HIV and hepatitis.

We believe that the key to bringing sex workers, crack smokers, injection drug users and others who engage in high-risk activities closer to prevention and health services is to treat every person, regardless of their circumstance or condition, with dignity and respect.



NCHRC maintains staff in Fayetteville, Asheville and Durham, NC.

336-543-8050

robert@nchrc.net

Office Location:
904 Broad St
Durham, NC 27705

Mailing Address:
PO BOX 13761,
Durham, NC, 27709

Sternal Rub

Check if they are responsive by rubbing your fist up and down their chest along the sternum. If they don't wake up, call 911.



Call 911

State what you see:

"The person is unconscious and not breathing." Clearly state the address of the overdose.

Give Naloxone

Inject naloxone straight into a muscle (upper arm, butt, or thigh).



Give Rescue Breathing

Tilt their head back slightly, pinch their nose, and give 1 breath every five seconds.



**North Carolina
Harm Reduction
Coalition**

Opiate Overdose Prevention and Survival

If you suspect an overdose,

Call 911

You **cannot** be prosecuted for:

- Small amounts of drugs
- Possession of drug paraphernalia
- Underage possession or consumption of alcohol

Opiate Overdose Prevention and Survival



Signs of an Overdose

The #1 sign of an OD is:
Unresponsiveness

Other signs include:

- Not breathing, turning blue, deep snoring
- Vomiting
- Gasping, gurgling



Risk Factors:

- **Mixing** different types of drugs (opiates with alcohol and/or benzos)
- **Quality** and difference in purity levels based off batch
- **Low Tolerance** due to not using opiates after incarceration, detox, or drug-free drug treatment
- **Using Alone** behind locked door, unable to be found
- **Compromised Health** due to an infection, lack of sleep
- **Stressful or new environments**

Overdose Myths

The following **do not** work to reverse opiate and opioid-based overdoses, but are not limited to:

- Cold shower
- Letting them sleep it off
- Giving someone coffee or making them walk around
- Injecting with anything other than naloxone (salt water, milk, mayonnaise)

The only viable option when someone is experiencing an opiate overdose is to initiate rescue breathing, administer naloxone and seek medical assistance.

To find a drug treatment center near you, visit:

<http://findtreatment.samhsa.gov>

or call

1-800-662-(HELP) 4357

911 Good Samaritan and Naloxone Access Law

Naloxone (Narcan) is an effective, prescription medication that reverses opioid drug overdose.

For Overdoses: As of April 9th, 2013, a person who seeks medical assistance for someone experiencing a drug overdose **cannot** be prosecuted for possession of small amounts of drugs or for possession of drug paraphernalia if evidence for the charge was obtained as a result of the person seeking help. The victim is protected from these charges as well.

For Alcohol Poisoning: As of April 9th, 2013, an underage person who seeks medical assistance for someone experiencing alcohol poisoning **cannot** be prosecuted for possession or consumption of alcohol if evidence for the charge was obtained as a result of the person seeking help. However, the person must give their real name when seeking help and then remain with the victim until help arrives.

Immunity: Doctors and other providers who prescribe naloxone AND the people who administer naloxone in the case of an overdose will be immune from any civil or criminal charges as long as they act in good faith.

APPENDIX 3-D7

The DOPE Project “Quick & Dirty” Narcan Training Checklist

- 1) **Sign-in Sheet:** full name, mother’s name, date of birth (unique identifier code)
- 2) **Mechanism of overdose:** when someone dies it’s because their breathing slows to the point where they stop getting enough oxygen to stay conscious, and without air, eventually the heart stops. With an upper overdose, the heart stops, or person has seizures or stroke.
- 3) **Risk Factors:**
 - a) Mixing: opioids with alcohol/pills, or cocaine → *Prevention:* use one drug at a time, don’t mix highest risk ones.
 - b) Tolerance: exiting jail, hospital, detox, esp. methadone detox → *Prevention:* use less when tolerance at these times.
 - c) Quality: unpredictable → *Prevention:* tester shots, use reliable/consistent dealer.
 - d) Using Alone: behind closed, locked door, where cannot be found, esp. in SROs. → *Prevention:* fix with a friend. Leave door unlocked. Call someone.
 - e) Health: liver, breathing problems (asthma), compromised immune system, active infections, lack of sleep, dehydration, malnourishment all increase risk of OD → eat, drink, sleep, see doctor, carry inhaler, treat infections, etc.
- 4) **Recognition:** The line between high vs. overdosing: **unresponsive**. Other signs to look for: slow, shallow breathing, pale, blue, snoring/gurgling for opiate OD; chest pains, difficulty breathing, dizziness, foaming at the mouth, lots of sweat or NO sweat, racing pulse, puking, seizures, loss of consciousness for stimulant OD.
- 5) **Response (upper/stimulant OD):**
 - a) There is no antidote to a stimulant OD, like Narcan—**call 911** if you see the signs of a seizure, heart attack or stroke.
 - b) If the person is still conscious, have them sit. Loosen any clothing around waist, chest and neck.
 - c) Breathing into a bag can help reduce panic and hyperventilation. Make sure they are getting some air and the room is ventilated (open a window if you have one!) Benzos (like ONE benzo) can help with overamping, similar to a panic attack. This is what they would give you if you went to the ER.
 - d) If they are having a seizure, make sure there is nothing within reach that could harm them (objects that could fall, furniture they could bump themselves on, etc).
 - e) Do not hold the person down, if the person having a seizure thrashes around there is no need for you to restrain them, just make sure objects are out of the way.
 - f) Do not put anything in the person's mouth. Contrary to popular belief, a person having a seizure is incapable of swallowing their tongue so you do not have to stick your fingers or an object into their mouth.
 - g) Do not give the person water, pills, or food until fully alert
 - h) If overheated and/or they have stopped sweating, cool them down with ice packs, mist or fanning.
 - i) If they pass out or become unresponsive, open their airway and immediately **call 911!**
 - j) If the person is unconscious, check for breaths/pulse. Begin rescue-breathing/CPR if needed!
- 6) **Response (downer/opiate OD):**
 - a) Noise: call name, yell “cops, or I’m going to narcan you!”
 - b) Pain: shake, slap, sternum rub.
 - c) Airway: head tilt, chin lift.
 - d) Check breathing and clear airway (check for syringe caps, undissolved pills, cheeked Fentanyl patches, toothpicks, gum, etc.)
- 7) **Recovery Position:** put person on their side if you have to leave them alone to call 911.
- 8) **Calling 911:**
 - a) Say: (location), “someone is unconscious, not breathing.” Not: “overdose.”
 - b) Cops in SF generally do not arrest; there to help paramedics and 1st to respond in medical emergency.
 - c) *Narcan only works on opiates*, not benzos or alcohol. Need 911 as backup.
- 9) **Rescue Breathing**
 - a) If you’re alone with the overdosing person, start rescue breathing and then go get narcan after you’ve given a few breaths. If you’re not alone, start rescue breathing while other person goes to get the narcan.
 - b) Head tilt, chin lift
 - c) Look, listen, feel: to see if chest rises/falls; listen/feel for breath.

- d) Two breaths: normal sized, not quick, not a hurricane!
- e) One breath every five seconds (count one-one thousand, two-one thousand...)
- f) Explain need: brain damage/death after 3-5 min. without oxygen to brain, ambulance may take longer, have to breathe for person until narcan kicks in or paramedics arrive.

10) Administering IM Narcan

- a) Assembling shot: remove cap on vial, draw up 1cc of Narcan into muscling syringe.
- b) Site location: arm (deltoid), thigh, butt. Shoot into muscle, not vein, not abscess.
- c) Administering shot: clean with alcohol wipe (if available). Insert at 90° angle. Push in plunger.

Administering Nasal Narcan

- a) Pull off yellow caps, screw spray device onto syringe
- b) Pull red cap of the vial of Narcan and gently screw into bottom of syringe
- c) Spray half of vial up one nostril, half up the other

11) While you're waiting for the narcan to kick in...

- a) Start rescue breathing again, until you see the person start to breathe on their own.
- b) Wait 2-3 minutes (it seems like forever!) until you give a second dose of narcan. Give it a chance to work, it doesn't always work instantaneously.
- c) If you get no response after 2-3 minutes, give a second dose and start rescue breathing again. If there is still no response, continue breathing until paramedics arrive and let them take over, and if you haven't called 911 yet, do it now! There could be something else wrong, they may have taken different drugs that narcan doesn't work on, or it could be too late for narcan to work.

10) Aftercare:

- a) Takes several minutes to kick in; wears off in 30-45 minutes
- b) Person won't remember overdosing; explain what happened
- c) Don't allow to do more opioids--will be wasting drugs, could OD again
- d) Need to watch person for at least an hour
- e) Could need to administer another dose of Narcan

11) Narcan care:

- a) Keep out of sunlight, and keep at room temperature (not too hot, not too cold—don't put in fridge!)
- b) Expires in about two years—date will be on your narcan itself.

12) Logistics:

- a) IM Narcan Kit contents: 2x 3cc musclers, 2x 1cc vials of narcan, prescription card
- b) Nasal Narcan Kit contents: 2 doses of 2cc Narcan with Atomizer device, prescription card, instructions
- c) Complete Clinical Registration and fill out prescription card and stickers for Narcan.
- d) Legality: cops know about program, should not harass or confiscate, contact DOPE if they do
- e) Follow-up: come back for re-fill if used, lost, or confiscated

updated 7/2011

how to
recognize and respond
 to an
opioid/heroin overdose
naloxone
(narcan)



What should you do?

- 1. DO NOT LEAVE THEM ALONE TO SLEEP IT OFF.**
- 2. TRY TO WAKE THEM.** Call their name. Rub your knuckles on their sternum or upper lip.
- If they don't respond, **CALL 911.**



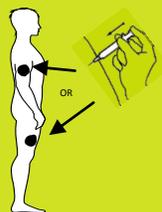
What should you do?

- 4. BREATHE FOR THEM.** (rescue breathing) Make sure nothing is blocking their airway. Tilt their head back, pinch their nose, and give two quick breaths. Continue with one breath every five seconds until paramedics arrive.
- 5. EVALUATE.** Are they any better? Can you get to the naloxone (Narcan) quickly so they won't go too long without you helping them breathe?



What should you do?

- 6. GIVE THEM NALOXONE (NARCAN).** Uncap the bottle and pull all of the liquid into the syringe. Inject straight into their **UPPER ARM** or **THIGH**.
- 7. CONTINUE RESCUE BREATHING** until paramedics arrive. If you need to leave the person, put them in the **RESCUE POSITION** on their left side.



What should you do?

- 8. EVALUATE AND SUPPORT.** If the person doesn't start breathing after 3-5 minutes, give them the **SECOND VIAL OF NALOXONE.**
- 9. WHEN THEY WAKE UP,** they may be very angry and feeling withdrawal symptoms. The effects of naloxone (Narcan) only last 30-90 minutes, so it is important for them to get medical help and not use more drugs.

What Does an Overdose Look Like?

- No breathing or slow breathing?
- Skin looks bluish or gray?
- Fingertips or lips look dark (blue/purple)?
- Unresponsive?
- Slow or no pulse?
- Eyes rolled back?

DON'T BE AFRAID TO CALL 911.

- **GOOD SAMARITAN LAW.** As of April 2013 in North Carolina, if you seek help for someone who is overdosing, you and the victim cannot be prosecuted for possession of small amounts of drugs, or paraphernalia. An underage person reporting alcohol overdose also can't be prosecuted for underage possession or consumption of alcohol.
- **NALOXONE (NARCAN)** is not a substitute for medical care when someone overdoses. **CALL 911.**

About naloxone:

- Is used to reverse overdose from opioids, like RX painkillers (oxycodone, methadone) and heroin
- Has no potential for abuse
- Has no effects of its own—using it without having opiates in you is like injecting water
- Is also called Narcan®
- Can cause withdrawal in someone who uses opioids or heroin regularly
- Does not eliminate heroin or opioids
- Overdose can return when naloxone wears off (30-90 minutes)

How to Prevent Drug Overdose

- If you take opioid pain medications or heroin, try to be with other people who can help you if something goes wrong.
- If you have been drug free for a while, you are more likely to overdose. Take less than you are used to.
- Don't mix opioids with other drugs or alcohol. Make sure your doctor knows all of the medications you take.
- If you or someone you know has problems with alcohol or drugs, **there is help.** Talk to a healthcare provider or visit www.findtreatment.samhsa.gov

Naloxone Kit

This medication is prescribed for the reversal of opioid overdose. The person possessing naloxone has been trained in its safe usage.

Contains: 2 vials naloxone hydrochloride (0.4 mg/mL), gloves, alcohol swabs, syringes, and CPR mask

If your kit expires or you need a new one, call **919-245-2400.**

This kit is made possible by the Orange County Health Dept. and Project Lazarus.



cómo
reconocer y responder
a una
sobredosis de **opioides/heroína**
naloxona
(narcan)



¿Qué debe hacer?

- 1. NO DEJE A LA PERSONA SOLA PARA QUE SE LE PASE EL EFECTO DURMIENDO.**
- 2. TRATE DE DESPERTARLE.** Llámeme por su nombre. Frótle el esternón o el labio superior con sus nudillos.
- 3. Si no responde, LLAME AL 911.**



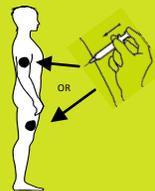
¿Qué debe hacer?

- 4. AYÚDELE A RESPIRAR.** (respiración de rescate/salvamento) Asegúrese de que no hay nada bloqueando las vías respiratorias de la persona. Inclínele la cabeza hacia atrás. Pínchele la nariz y soplele aire en la boca rápidamente dos veces. Continúe dándole un soplo de aire en la boca cada cinco segundos, hasta que lleguen los paramédicos.
- 5. EVALÚE.** ¿Está mejorando la persona? ¿Puede obtener la naloxona (Narcan) rápidamente para que la persona no pase mucho tiempo sin su ayuda para respirar?



¿Qué debe hacer?

- 6. DELE NALOXONA (NARCAN).** Destape el recipiente y saque todo el líquido con la jeringuilla. Inyéctelo directamente en la parte **SUPERIOR DEL BRAZO** o **EN EL MUSLO**.
- 7. CONTINÚE LA RESPIRACIÓN BOCA A BOCA** hasta que lleguen los paramédicos. Si necesita dejar a la persona sola, póngala en **POSICIÓN DE SEGURIDAD**, sobre el lado izquierdo.



¿Qué debe hacer?

- 8. EVALÚE Y DÉ APOYO.** Si la persona no comienza a respirar después de 3 ó 5 minutos, dele **LA SEGUNDA AMPOLLETA/VIAL DE NALOXONA**.
- 9. CUANDO DESPIERTE,** la persona puede estar muy enojada y sintiendo síntomas de abstinencia. Los efectos de la naloxona (narcan) sólo duran de 30 a 90 minutos, por lo tanto es importante que la persona busque asistencia médica y no use más drogas.

¿Qué ocurre durante una sobredosis?

- ¿No respira o la respiración es lenta?
- ¿La piel se ve de un color azulado o gris?
- ¿La punta de los dedos o los labios se ven de un color negro oscuro / morado?
- ¿La persona no responde a los estímulos?
- ¿No hay pulso o el pulso es lento?
- ¿Los ojos están en blanco?

NO TENGA MIEDO DE LLAMAR AL 911

- **LA LEY DEL BUEN SAMARITANO.** A partir de abril del 2013 en Carolina del Norte, si usted busca ayuda para alguien que esté sufriendo una sobredosis, usted y la víctima no pueden ser procesados por poseer pequeñas cantidades de drogas o parafernalia. Lo mismo ocurre en casos donde un menor de edad llama para reportar una sobredosis de alcohol.
- **NALOXONA(NARCAN)** no sustituye la atención médica cuando alguien sufre una sobredosis. **LLAME AL 911.**

Información sobre naloxona:

- se usa para revertir los efectos de sobredosis de opioides, como los medicamentos recetados para el dolor (oxicodona, metadona) y la heroína
- también se llama Narcan®
- no es adictiva
- puede causar síntomas de abstinencia en personas que usan opioides o heroína con regularidad
- no tiene efectos propios - usarla sin tener opiáceos en el cuerpo es como inyectarse agua
- no elimina la heroína o los opioides del cuerpo
- la sobredosis puede regresar cuando se pasa el efecto de la naloxona (de 30 a 90 minutos)

Cómo prevenir una sobredosis de drogas

- Si toma medicamentos para el dolor opiáceos o heroína, trate de estar con otras personas que puedan ayudarte si algo va mal.
- Si ha estado sin consumir drogas durante un tiempo, la probabilidad de sobredosis es mayor. Use una cantidad menor de lo que usted está acostumbrado usar.
- No mezcle opiáceos con otras drogas o alcohol. Asegúrese de que su doctor sabe todas las medicinas que está tomando.
- Si usted, o alguien que usted conozca, tiene problemas con el alcohol o las drogas, **hay ayuda disponible.** Hable con su doctor o visite al sitio de internet www.findtreatment.samhsa.gov.

Equipo de Naloxona

Este medicamento es recetado para revertir los efectos de una sobredosis de opioides. La persona que posee naloxona ha sido entrenada en su uso seguro.

Contiene: 2 ampollas/viales de clorhidrato de naloxona (0.4 mg/mL), guantes, toallitas de alcohol, jeringuillas, y mascarilla de resucitación

Si su equipo caduca o necesita uno nuevo, llame al **919-245-2400**.

Este equipo es auspiciado por el Proyecto Lazarus y el Departamento de Salud del Condado de Orange



DO YOU OR SOMEONE YOU KNOW USE PRESCRIPTION PAIN MEDICINE OR HEROIN?

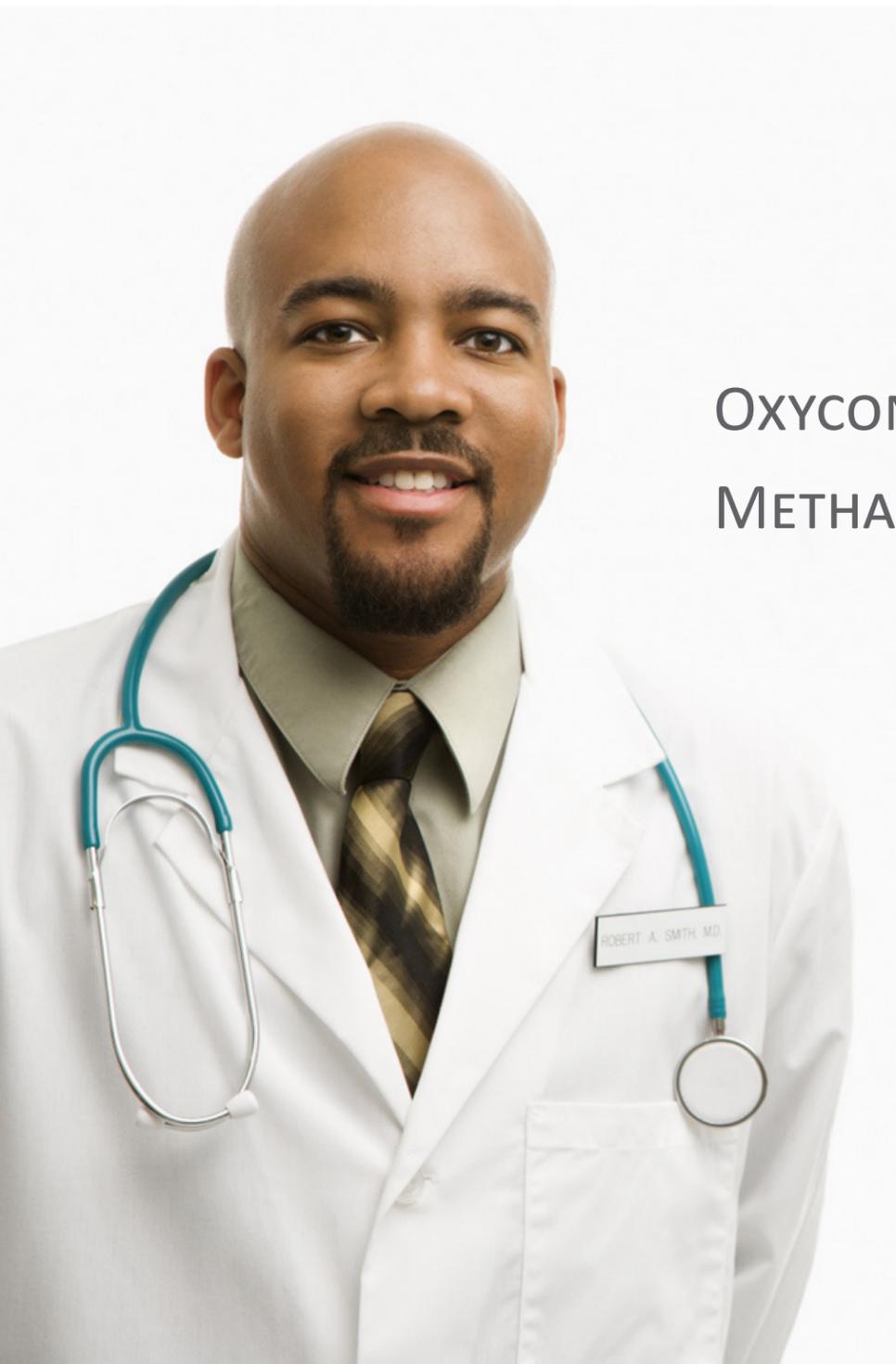


OXYCONTIN, MORPHINE , PERCOCET,
METHADONE, FENTANYL, HYDROCODONE

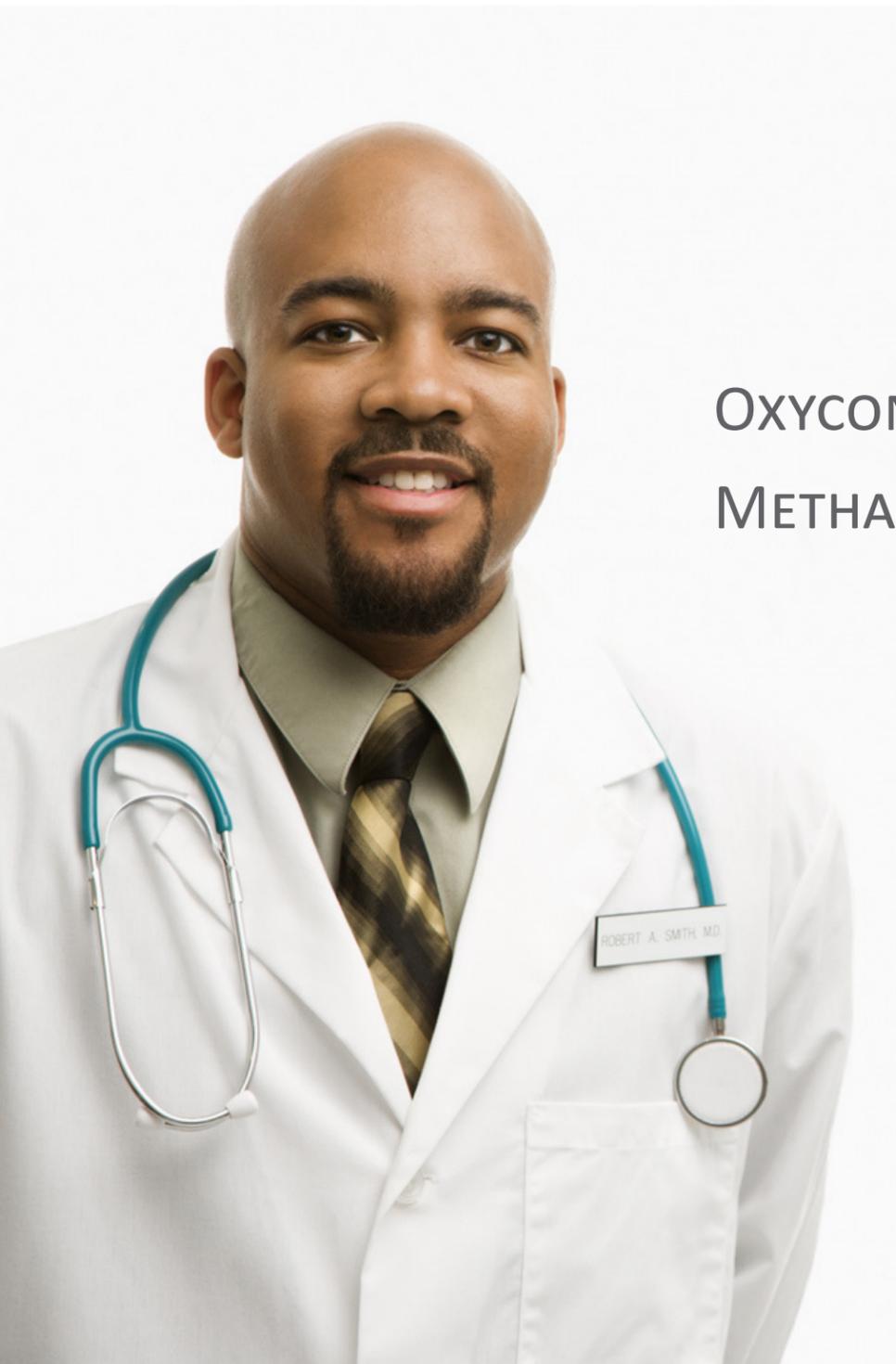


HEROIN

If so, ask your doctor or nurse today about **NALOXONE**,
a prescription medicine that could help *save their lives*
from overdoses on these drugs.



DO YOU OR SOMEONE YOU KNOW USE PRESCRIPTION PAIN MEDICINE OR HEROIN?



OXYCONTIN, MORPHINE , PERCOCET,
METHADONE, FENTANYL, HYDROCODONE



HEROIN

If so, ask your doctor or nurse today about **NALOXONE**,
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Narcotic Overdose and Naloxone Patient Guide

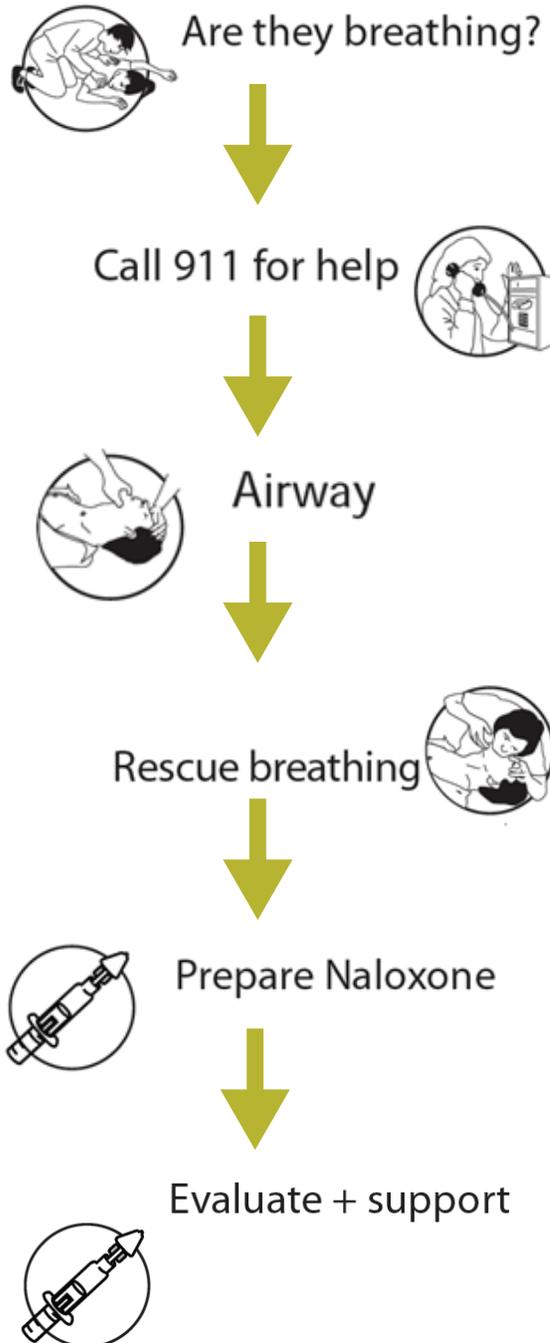


*Brought to you by:
Partnership for Community Care in
collaboration with Project Lazarus*

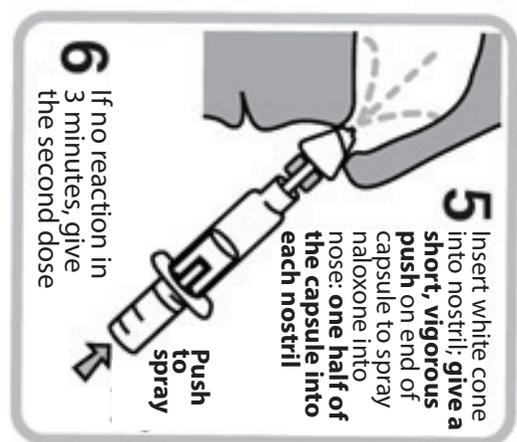
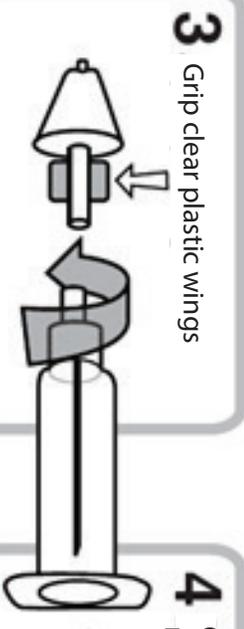
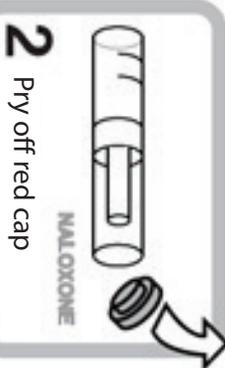
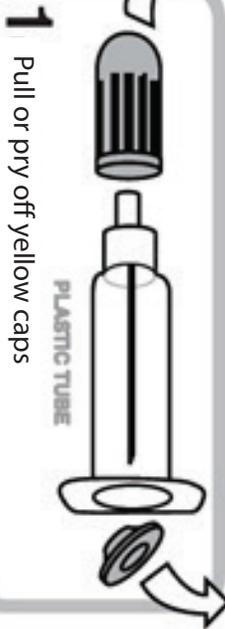
*1050 Revolution Mill Dr. Suite 4,
Greensboro, NC 27405
336-235-0930*

*www.P4CommunityCare.org
www.ProjectLazarus.org*

APPENDIX 3-D10



HOW TO GIVE NALOXONE NASAL SPRAY



Signs of an Overdose:

- *Slow or shallow breathing*
- *Gasping for air when sleeping or odd-sounding snoring*
- *Pale or bluish-grey skin*
- *Slow heartbeat or low blood pressure*
- *Won't wake up or respond*

How to Respond:

1. Are They Breathing?

- Shake them lightly and yell their name
- If no response, perform sternum rub for 10 seconds

2. Call 911 for Help

- All you have to say:
 - "Someone is unresponsive and not breathing"
 - No need to mention drugs on the phone call
- Give clear address and location

3. Check Airway

- Make sure nothing is inside the person's mouth

4. Begin Rescue Breathing

- One hand on chin, tilt head back, pinch nose closed
- Make a seal over mouth and breathe in
- One breath every 5 seconds (chest should rise)

5. Prepare and Give Naloxone Nasal Spray

- Spray of naloxone in each nostril
- Continue rescue breathing if needed
- Give another spray naloxone in each nostril in 3 minutes if still no breathing

6. Evaluate and Support

- Remind the person that naloxone will wear off and they still need to seek medical care
- Comfort them as they may become aggressive; withdrawal symptoms can be unpleasant
- Encourage them to not use more narcotics once they wake up
- Help survivors seek treatment if they feel they have a problem

How to Avoid an Overdose:

- *Only take medicine prescribed to you*
- *Don't take more than instructed by prescriber*
- *Call a doctor if your pain gets worse*
- *Never mix pain meds with alcohol*
- *Avoid sleeping pills when taking pain meds*
- *Dispose of unused medications*
- *Store your medicine in a secure place*
- *Learn how to use naloxone*
- *Teach your family and friends how to respond to an overdose*

Keep your provider informed!

If you or someone else uses the naloxone in your kit, contact your provider right away so they can write you a new prescription.

Poison Center

1-800-222-1222

(free & anonymous)



Partnership *for*
Community Care

A Community Care of North Carolina Network

www.P4CommunityCare.org

Health Center Naloxone Program

Prescription drug overdose is an increasing problem in North Carolina. Health centers can play a role in reducing overdose deaths by educating people and giving them access to the opioid antidote naloxone. With naloxone in hand, bystanders can reverse overdoses and save lives.

Naloxone programs could be useful in any medical clinic, especially community clinics, federally qualified health centers, (FQHC), opioid treatment programs, (OTP), and pain clinics. Clinic naloxone programs can take a variety of shapes: ranging in size, scope, and cost. A program could be as simple as writing prescriptions to patients who ask for naloxone, or as complex as handing out complete naloxone kits and holding training classes. The type of program will depend on feasibility and patients' needs. Here is information to get a program started and ideas to consider when expanding a program further. Please contact Project Lazarus if you would like more information and guidance.

Start Prescribing

The simplest and fastest approach is to encourage providers to prescribe naloxone. Here are the steps to prescribing naloxone:

1. Educate patients on how to recognize an overdose, how to respond with naloxone, and how changes in tolerance can increase the risk of opioid overdose. (See risk factors and signs of an overdose, page 2.)

2. Write a prescription for either nasal or intramuscular naloxone hydrochloride.

Nasal Naloxone: 2x 2mg/2ml pre-filled Luer-Lock ready needleless syringes (NDC 76329-3369-1). The atomization devices (MAD 300) can be purchased by patients through a pharmacy or obtained in a Project Lazarus Rescue Kit. (See below.)

Intramuscular Naloxone: 2x 0.4mg/ml single dose 1 ml vials (NDC 0409-1215-01) and 2x intramuscular syringes (23 gauge, 3cc, 1 inch).

3. Gauge patient's interest in behavioral change. As appropriate, present support services and treatment options.

Liability

Prescribing naloxone to patients at risk of an opioid overdose is legal.¹ Some states, including North Carolina, have passed laws that protect providers who write prescriptions for friends and family members in contact with people at risk of an opioid overdose.² The bill absolves civil liability for providers who write naloxone prescriptions.

Prepare Pharmacies

Most outpatient chain pharmacies do not carry naloxone. Before sending off prescriptions, alert local pharmacies so they can start stocking naloxone and the atomization devices, unless purchasing a Project Lazarus Rescue Kit which contains the nasal atomizers. There might also be some pharmacies that are interested in partnering with the clinic on overdose prevention. Reach out to pharmacies to see if a pharmacy wants to be involved in your effort. The clinic could also order naloxone directly from the manufacturer: nasal at Amphastar or LMA/Teleflex and intramuscular at Hospira.

Cost Considerations

The type of naloxone administration needs to be considered whether it is being paid for by the clinic or patient. Nasal administration is more expensive, about \$25 per dose with atomizer, compared to \$5 per dose for intramuscular. The intramuscular administration requires drawing naloxone from a vial into a syringe and using a needle. Atomizers, which are needed for nasal delivery of naloxone, are not covered by insurance and increases the cost of kits. Educational materials and people's time are also not free. Overdose prevention education could be a part of a Screening, Brief Intervention and Referral to Treatment (SBIRT), which can be billed as CPT 99408, G0396, or H0050.

Develop a Naloxone Policy

A policy should outline how naloxone will be offered to patients, when patient education will take place, what information will be given, how the program will be paid for, and who is responsible for documenting kit distribution and restocking supplies. Here are some options to consider when developing a program.

- *Initiate Conversation or Respond to Patients?*
How will conversations about naloxone begin? The approach can be passive, using signs to let patients know that naloxone is available, or more proactive, where prescriptions could be offered to any patient getting an opioid analgesic prescription. The tactic might vary by physician, but there needs to be some indication that the clinic is willing to talk to patients about naloxone.
- *Patient Education Handouts or Conversations?*
Information about overdose prevention and naloxone use could be conveyed through a conversation, video or handout. The conversation could be with a medical provider or a different health center staff member. The discussion could occur as part of a patient visit, or if there were enough interest, classes could be organized to train people to recognize and respond to an overdose.
- *Educate Patients about what are the risk factors of an overdose?*
Changes in tolerance after a period of abstinence, such as incarceration, hospitalization or outpatient/inpatient treatment, increase the risk of an overdose. Taking other substances such as alcohol, benzodiazepines, anti-depressants and illicit drugs with an opioid may cause overdose. Other risk factors may depend on co-morbid physiological and biological factors such as emphysema, asthma, sleep apnea, COPD, heavy smoking, renal issues and metabolism rate. An overdose occurs when the body consumes more opioids than can be tolerated and the aforementioned factors increase the likelihood of an overdose.
- *Educate Patients about what are the signs of an opioid overdose?*
-Unresponsiveness to stimulation, such as a sternal rub
-Shallow or absent breathing
-Blue or ashen lips
- *Prescriptions or Distribution?*
Naloxone can be offered to patients as a prescription that they fill at a pharmacy or distributed directly from the clinic. Naloxone is covered by most insurance, including North Carolina Medicaid. To make sure that patients get naloxone, the clinic could order naloxone to distribute on its own or as part of a rescue kit.
- *Individual Prescription or Standing Order?*
If a clinic is going to distribute naloxone from the office, a standing order could be used to separate naloxone education from the medical visit. A standing order would enable clinic staff to evaluate a patient's need for naloxone and train them, rather than making it part of the medical provider's visit.
- *How does a Health Center Naloxone Program order Project Lazarus Rescue Kits?*
Kits are available through Project Lazarus and can help simplify bystander naloxone use. The rescue kit keeps all materials together, includes step-by-step instructions for responding to an overdose, and contains 2 nasal atomizers. Patients can order kits for themselves for \$12 or a clinic can order in bulk for distribution. There are three ways to order rescue kits:
 1. Orders can be placed through the Project Lazarus website at this link:
www.projectlazarus.org/naloxone-order-form#overlay-context=overdose-survivors/get-help-addiction
 2. Order forms can be requested by email at rescuekit@projectlazarus.org. Complete form, scan, and email back or fax to 866-400-9915.
 3. Call 336-667-8100 and request by phone.

More information

Prescribe to Prevent: prescribetoprevent.org

Naloxone Program Development Guide: harmreduction.org/issues/overdose-prevention/tools-best-practices/manuals-best-practice/od-manual/

Naloxone Info: naloxoneinfo.org

Project Lazarus: projectlazarus.org

UptoDate: uptodate.com/contents/naloxone-drug-information

1. Davis C, Webb D, Burris S. Changing law from barrier to facilitator of opioid overdose prevention. *The Journal of Law, Medicine and Ethics*. 2013; 41 (s1)33-36.
2. Good Samaritan Law/Naloxone Access, NC [statue on the internet]. c2013 [cited 2013 July 6]. Available from: ncleg.net/Sessions/2013/Bills/Senate/HTML/S20v7.html

Naloxone can reverse an overdose caused by opioids. With a naloxone kit the steps to responding to an overdose become simplified by providing step-by-step picture instructions and keeping necessary materials organized in one location. Educate patients on how to recognize an overdose, how to respond with naloxone, and how changes in tolerance can increase the risk of opioid overdose. Educational materials and people's time are not free. Overdose prevention education could be a part of a Screening, Brief Intervention and Referral to Treatment (SBIRT), which can be billed as CPT 99408, G0396, or H0050.

The Project Lazarus Rescue Kit

Rescue kits are available through Project Lazarus that can help simplify bystander naloxone use. Individuals can order kits for themselves or clinics can order in bulk for distribution. The kit provides everything necessary for a nasal rescue except the naloxone vials.

Kit Contents

Two nasal atomizers, a step-by-step naloxone use guide (English & Spanish), and an overdose prevention DVD are all included in a small durable hard plastic container for just \$12.

How Do I Order a Rescue Kit?

There are three ways to order rescue kits:

- Through the Project Lazarus website at this link:
www.projectlazarus.org/naloxone-order-form#overlay-context=overdose-survivors/get-help-addiction
- By email at: rescuekit@projectlazarus.org. Complete form, scan, and email back or fax to 866-400-9915.
- Call 336-667-8100 and request by phone.

Who Should Have a Project Lazarus Rescue Kit?

Anyone using or in contact with a user of opioids, such as heroin or prescription pain relievers like oxycodone, methadone, or hydrocodone, should have naloxone available.

What are the risk factors of an overdose?

Changes in tolerance after a period of abstinence, such as incarceration, hospitalization or outpatient/inpatient treatment, increase the risk of an overdose. Taking other substances such as alcohol, benzodiazepines, anti-depressants and illicit drugs with an opioid may cause overdose. Other risk factors may depend on co-morbid physiological and biological factors such as emphysema, asthma, sleep apnea, COPD, heavy smoking, renal issues and metabolism rate. An overdose occurs when the body consumes more opioids than can be tolerated and the aforementioned factors increase the likelihood of an overdose.

How Do I Prescribe Naloxone?

Naloxone can be legally prescribed to those at risk of an opioid overdose or the family/friends of someone at risk. To complete a Project Lazarus rescue kit, a prescription should be written for 2x 2mg/2ml pre-filled Luer-Lock ready needleless syringes (NDC 76329-3369-01). Refer to the Prescribe Naloxone Today information sheet to learn more.

Where Can I Learn More About Naloxone?

Prescribe to Prevent: prescribetoprevent.org/

Naloxone Info: naloxoneinfo.org/get-started/about-naloxone

UptoDate: uptodate.com/contents/naloxone-drug-information

Project Lazarus: projectlazarus.org/naloxone-od-antidote

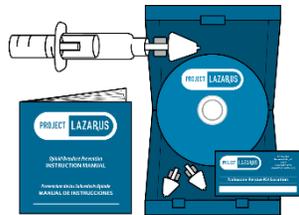
Treatment Options: findtreatment.samhsa.gov/

Steps to Prescribing Nasal Naloxone

1. Educate patients on how to recognize an overdose, how to respond with naloxone, and how changes in tolerance can increase the risk of opioid overdose. (See risk factors and signs of an overdose on right.) Educational materials and people's time are not free. Overdose prevention education could be a part of a Screening, Brief Intervention and Referral to Treatment (SBIRT), which can be billed as CPT 99408, G0396, or H0050.
2. Prepare pharmacies, as most outpatient chain pharmacies do not carry naloxone. Before sending off prescriptions, alert local pharmacies so they can start stocking naloxone and the atomization devices, unless purchasing a Project Lazarus Rescue Kit which contains the nasal atomizers. There might also be some pharmacies that are interested in partnering with the clinic on overdose prevention. Reach out to pharmacies to see if a pharmacy wants to be involved in your effort. The clinic could also order naloxone directly from the manufacturer: nasal at Amphastar or LMA/Teleflex and intramuscular at Hospira.
3. Write a prescription for either nasal or intramuscular naloxone hydrochloride.
 - Nasal Naloxone: 2x 2mg/2ml pre-filled Luer-Lock ready needleless syringes (NDC 76329-3369-1). The atomization devices (MAD 300) can be purchased by patients through a pharmacy or obtained in a Project Lazarus Rescue Kit. (See below.)
 - Intramuscular Naloxone: 2x 0.4mg/ml single dose 1 ml vials (NDC 0409-1215-01) and 2x intramuscular syringes (23 gauge, 3cc, 1 inch).
4. Gauge patient's interest in behavioral change. As appropriate, present support services and treatment options.

The Project Lazarus Rescue Kit

Rescue kits are available through Project Lazarus that can help simplify bystander naloxone use. Individuals can order kits for themselves or clinics can order in bulk for distribution. The kit provides everything necessary for a nasal rescue except the naloxone vials.



Kit Contents

Two nasal atomizers, a step-by-step naloxone use guide (English & Spanish), and an overdose prevention DVD are all included in a small durable hard plastic container for just \$12.

There are three ways to order rescue kits:

- Through the Project Lazarus website at this link: www.projectlazarus.org/naloxone-order-form#overlay-context=overdose-survivors/get-help-addiction
- By email at: rescuekit@projectlazarus.org. Complete form, scan, and email back or fax to 866-400-9915.
- Call 336-667-8100 and request by phone.

Frequently Asked Questions About Naloxone

Is prescribing naloxone legal?

Prescribing naloxone to patients at risk for an opioid overdose is legal.¹ Some states, including North Carolina, have passed laws that protect providers who write prescriptions for friends and family members in contact with people at risk of an opioid overdose.²

What are the benefits and risks in using naloxone?

Naloxone is an effective, non-addictive opioid antagonist that can reliably reverse an overdose and is not a controlled substance. Community-based organizations have been successfully training bystanders to use naloxone for over 15 years.³ The risks lie in the rapid onset of withdrawal symptoms and naloxone's short half-life. When someone is revived by naloxone they can vomit, be agitated, and have diarrhea, body aches, rapid heart rate, and increased blood pressure. Naloxone wears off faster than some extended-release opioids and there is the potential for someone to overdose again, although this is rarely observed in community-based programs. Patients should be encouraged to call 911.

What are the risk factors of an overdose?

Changes in tolerance after a period of abstinence, such as incarceration, hospitalization or outpatient/inpatient treatment, increase the risk of an overdose. Taking other substances such as alcohol, benzodiazepines, anti-depressants and illicit drugs with an opioid may cause overdose. Other risk factors may depend on co-morbid physiological and biological factors such as emphysema, asthma, sleep apnea, COPD, heavy smoking, renal issues and metabolism rate.

An overdose occurs when the body consumes more opioids than can be tolerated and the aforementioned factors increase the likelihood of an overdose.

What are the signs of an opioid overdose?

- Unresponsiveness to stimulation, such as a sternal rub
- Shallow or absent breathing
- Blue or ashen lips

How to respond to an overdose?

- Call 911
- Start rescue breathing
- Administer naloxone
- Put the person in recovery position
- Stay with the person until help arrives

How is nasal naloxone used?

Assemble the vial, syringe, and atomizer. Spray half of the naloxone into each nostril. If the person does not wake up in five minutes, use the second vial of naloxone. There are instructional videos in the links below.

Where to learn more?

Prescribe to Prevent: prescribetoprevent.org/
 Naloxone Info: naloxoneinfo.org/get-started/about-naloxone
 Up-to-date: uptodate.com/contents/naloxone-drug-information
 Project Lazarus: projectlazarus.org/naloxone-od-antidote
 Treatment Options: findtreatment.samhsa.gov/

1. Davis C, Webb D, Burris S. Changing law from barrier to facilitator of opioid overdose prevention. *The Journal of Law, Medicine and Ethics*. 2013; 41 (s1)33-36.

2. Good Samaritan Law/Naloxone Access, NC. c2013 [cited 2013 July 6]. Available from: <http://www.ncleg.net/Sessions/2013/Bills/Senate/HTML/S20v7.html>.

3. Wheeler E, Davidson PJ, Jones TS, Irwin KS. Community-based opioid overdose prevention programs providing naloxone-United States, 2010. *Morbidity and Mortality Weekly Report* 2012; 61(06)101-105.

Dear Prescriber,

Project Lazarus would like to engage the medical community in our efforts to fight prescription opioid overdose. By learning about opioid overdose risk factors and prescribing naloxone to patients with those risk factors, you can help to reduce prescription opioid overdose. Project Lazarus can assist you with educational materials for opioid using patients, their families, and their peers. We advise everyone to “take correctly, store securely, dispose properly, and never share™” with respect to prescription medications.

Project Lazarus has Naloxone Rescue Kits that are available for your practice, health center, and patients. Naloxone Rescue Kits contain two (2) nasal adaptors, an English/Spanish overdose instruction booklet, an educational DVD, a NC SB20 Good Samaritan Law card, and a kit location card. Please be aware that our kits do not come with the naloxone already inside, as the medication requires a prescription from their medical provider. We provide everything that is needed during a rescue, except the actual medication. This part is up to you. We ask that you write the naloxone prescriptions for at-risk patients to place in their Naloxone Rescue Kit. Our kits are \$12 each, tax-free. Most insurance companies will pay for naloxone, so your patients may be covered at no charge for the naloxone. In this folder you will find pages on prescribing naloxone and creating a standing order for naloxone distribution.

We have also included a “Risk Factors” page to help familiarize you with risks that trigger Opioid-Induced Respiratory Depression, including certain high risk medicine combinations. This page is to assist you in assessing your patient’s level of risk when considering prescribing an opioid. Additionally, an SBIRT (Screening, Brief Intervention, and Referral for Treatment) and DAST (Drug Abuse Screening Test) forms are included to provide clear indicators of previous, current, or possible substance abuse issues. If you find that a patient is at-risk while interviewing with these forms, please consider prescribing naloxone and providing the patient with a Naloxone Rescue Kit.

While many patients fear the stigma related to receiving a medication for overdose, you can help make them feel at ease about naloxone. Receiving a naloxone prescription does not label a patient as an addict or abuser, nor does it in any way imply wrong doing. Naloxone simply guarantees safety in an emergency situation where a medication has reached a level that causes respiratory depression for ANY reason. Also, just as prescription records and medical records are kept confidential, Project Lazarus keeps all Naloxone Rescue Kit distributions confidential.

Please remember that we’re here to help. If you have any questions, concerns, or would just like to talk about naloxone, contact our office directly at +1.336.667.8100 or info@projectlazarus.org. Our website can also be a great source of information: www.projectlazarus.org.

Thank you for your efforts to reduce overdose deaths from prescription opioid medications.

Sincerely,

The Project Lazarus Team

PROJECT LAZARUS

Opioid Overdose Prevention
INSTRUCTION MANUAL

NALOXONE INSTRUCTIONS:

1. Watch DVD
2. Read materials
3. Complete Overdose Plan
4. Find safe location for Kit
5. Inform family/friends of Kit location
6. Share DVD

PRESCRIPTIONS:

- Take correctly
- Store Securely
- Dispose Properly
- Never Share

SYMPTOMS OF AN OPIOID OVERDOSE:

1. Awake, but cannot speak
2. Slow heartbeat and pulse
3. Slow breathing, or not breathing
4. Blue lips and/or fingernails
5. Gurgling, snoring or raspy breathing
6. Choking sounds
7. Passing out
8. Throwing up
9. Pale face
10. Limp body

HOW TO RESPOND TO AN OVERDOSE:

1. Check Breathing
2. Call 911
3. Clear Mouth
4. Perform Rescue Breathing
5. Administer Naloxone
6. Recovery Position

STEP BY STEP:

1. See whether person has any symptoms of an opioid overdose.



Call out his or her name loudly.

Check to see if person is breathing. If breathing and responsive, stay with person for at least 2 hours.

2. If person is unresponsive, **call 911**. Tell operator that **the person is not breathing and needs an ambulance**. You do not have to



say the person has overdosed. Tell operator that you cannot stay on the phone, but you will keep it on and nearby. You are going to begin rescue breathing.



3. If person is not breathing or has shallow breathing, open the mouth and check to make sure nothing is in it that could cause choking. Clear the mouth with your fingers.

4. Begin rescue breathing. THIS IS THE MOST IMPORTANT THING THAT YOU CAN DO. Place person on his or her back. Tilt head back and chin up. Pinch nose shut with your fingers. Place your mouth over the person's mouth, making a tight seal with your lips. Gently exhale completely into the person's mouth. Breathe



every 3 to 4 seconds, and repeat at least five times.

5. If person is still unresponsive, administer naloxone.

Assembly instructions are in Naloxone Kit. Locate kit. Once naloxone syringe is assembled, insert nasal adapter in right nostril and push plunger firmly, emptying half of cartridge contents. Repeat in left nostril. Continue rescue breathing until person responds.

6. If no response within 3 minutes, **administer 2nd dose of naloxone.**

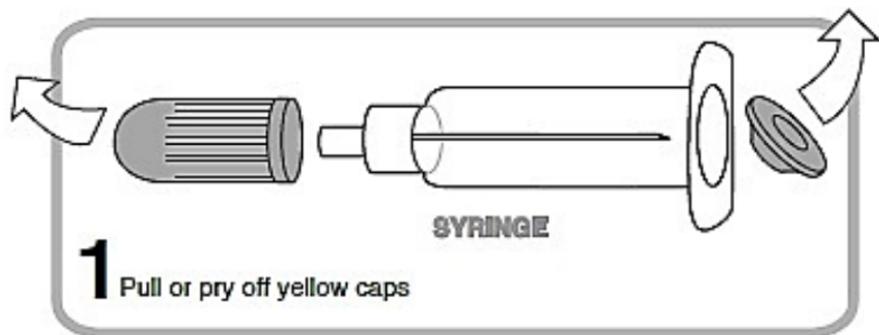
7. Then place person in recovery position (See pictures below).



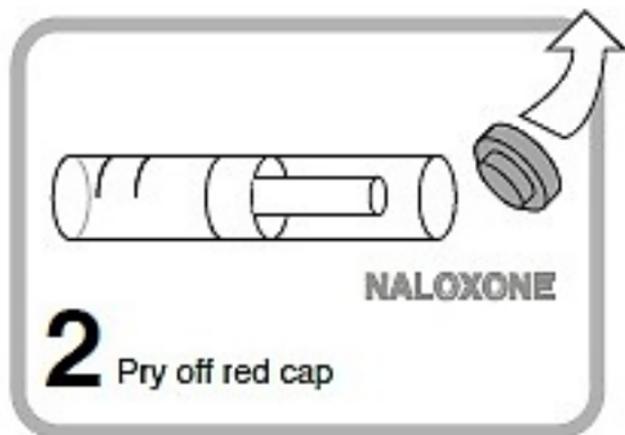
8. Stay with person until help comes.

Pictures used with permission from The Open Society Institute. Excerpted from the Harm Reduction Field Guide: Overdose Prevention and Response. By Curtis, M. and Guteman L., 2009. A Guide for People Who Use Drugs and Harm Reduction Staff in Eastern Europe and Central Asia.

ASSEMBLING MY NALOXONE:

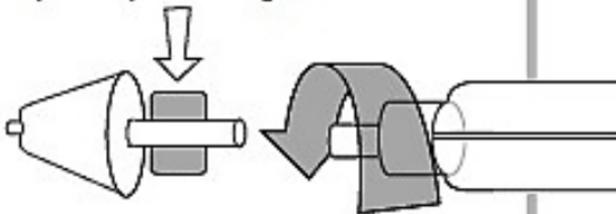


ASSEMBLING MY NALOXONE:



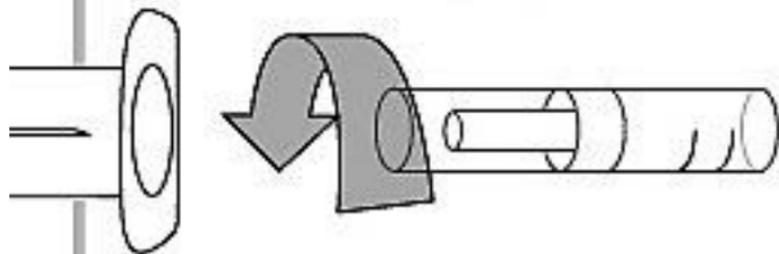
ASSEMBLING MY NALOXONE:

3 Grip clear plastic wings.

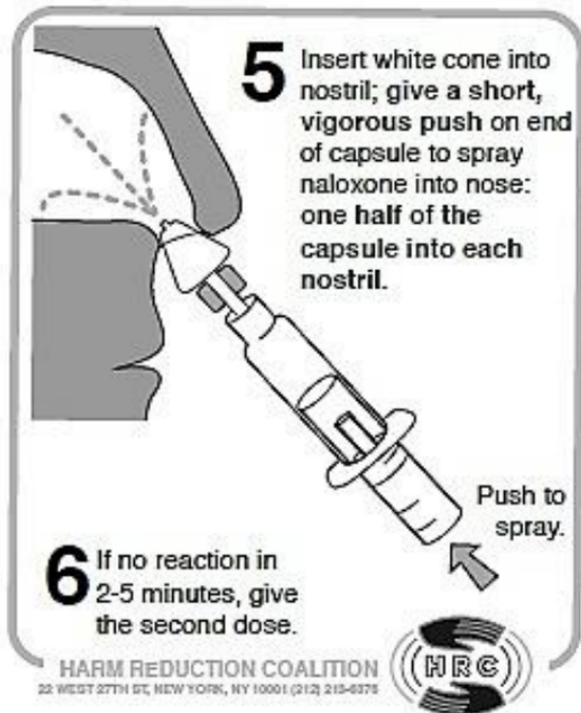


ASSEMBLING MY NALOXONE:

4 Gently screw capsule of naloxone into barrel of syringe.



ASSEMBLING MY NALOXONE:



HOW TO MAKE AN OVERDOSE PLAN:

1. How do you start a conversation about needing a rescue peer?

- “Mistakes can happen when using pain medication.”
- “I need someone to help me stay safe and out of pain. This person can be a family member or friend. We call this person a rescue peer.”
- “Too many pain pills or mixing with other drugs or alcohol can make me stop breathing.”
- “I have received a naloxone rescue kit.”
- “The kit has a DVD that describes what an overdose looks like and what to do.”
- “The kit also has the medicine, Naloxone, you will use to start me breathing again.”
- “The kit location is _____.”

HOW TO MAKE AN OVERDOSE PLAN; CONTINUED:

2. *Who is your rescue peer?* _____

3. *What your peer needs to do:*

- Watch the Project Lazarus DVD.
- Learn signs and symptoms of an overdose and how to rescue.
- Review naloxone rescue kit contents.
- Know location of rescue kit.
- Call Project Lazarus (336-667-8100) for questions about responding to an overdose.

4. *If your prescription is not working, call your doctor. DO NOT SELF MEDICATE.*

HOW TO MAKE AN OVERDOSE PLAN; CONTINUED:

5. What to do if you are taking pain pills not prescribed to you or are not following your doctor's advice:

- Do not mix your pills with other drugs or alcohol.
- Call your peer and ask this person to check on you hourly.
- Make sure someone can get to you if needed.

6. What your peer should NOT do in case of an overdose:

- Put me in a bathtub for a cold shower. I could drown.
- Give me stimulants, like coffee. They don't work.
- Put ice on my body to wake me up. It wastes time and doesn't work.

***IF A RESCUE IS NEEDED, BE SURE TO CALL
911.***

PROJECT LAZARUS

Prevención de las Sobredosis Opiode
MANUAL DE INSTRUCCIONES

NALOXONE INSTRUCCIONES:

1. Ver DVD
2. Lea los materiales
3. Completa el plan de sobredosis
4. Encuentra un ubicación seguro para el botiquín de rescate
5. Informe la familia y amigos de la ubicación del botiquín de rescate
6. Comparta el DVD

PRESCRIPCIONES:

- Toma correctamente
- Puso en la ubicación segura
- Dispone apropiado
- Nunca comparta

SÍNTOMAS DE UNA SOBREDOSIS DE OPIOIDE:

1. Despierto, pero no puede hablar
2. Latido lento de corazón y pulso
3. Respirando despacio, o no respirando
4. Labios y/o uñas azules
5. Borbotando, roncando, o respirando abrasivo
6. Sonidos de estrangulación
7. Desmayándose
8. Vomitando
9. Cara pálida
10. Cuerpo Debilitado

COMO RESPONDER A UNA SOBREDOSIS DE OPIOIDE :

1. Verifique la Respiración
2. Llame al 911
3. Limpie la Boca
4. Realice Respiración de Rescate
5. Administre el Naloxone
6. Posición de Recuperación.

PASO POR PASO:



1. Vea si la persona tiene cualquier síntoma de una sobredosis de opioide. Llámeme por su nombre fuertemente.

Frote el esternón firmemente.

Revise para ver si la persona esta respirando. Si esta respirando y alerta, permanezca con la persona por lo menos 2 horas.

2. Si la persona no responde, **llame al 911**. Dígale al operador que **la persona no esta respirando y necesita una ambulancia**. Usted no tiene que decir que la persona ha sufrido una dosis excesiva. Dígale al operador que usted no puede permanecer en el teléfono, pero que usted lo mantendrá encendido y cerca mientras que empiece la respiración del rescate.



3. Si la persona no está respirando o tiene respiración superficial, abra la boca y revísele para asegurar de que no haya nada causando el estrangulamiento. Limpie la boca con los dedos.



4. Comenzar la respiración del rescate. ESTO ES LO MAS IMPORTANTE QUE PUEDE HACER. Coloque la persona en su espalda. Incline la cabeza hacia atrás y el mentón para arriba. Cierre la nariz con los dedos. Coloque su boca encima la boca de la persona, haciendo un sellado hermético con sus labios. Suavemente, exhale completamente en la boca de la persona. Respire cada 3 a 4 segundos, y repítalo por lo menos cinco veces.



5. Si la persona sigue sin responder, **administre el Naloxone.** El conjunto de instrucciones se encuentran en el Kit de Naloxone. Busca el Kit. Después que la jeringa de Naloxone este lista, inserte el adaptador en la nariz derecha y empuje firmemente, vaciando la mitad del contenido del cartucho. Repita el proceso en la nariz izquierda. Continúe la respiración de rescate hasta que la persona responda.

6. Si no hay respuesta dentro de 3 minutos, **administrar la segunda dosis de Naloxone.**

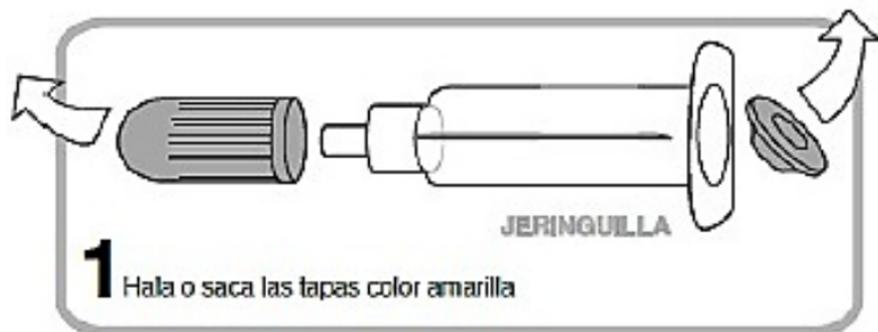
7. Entonces coloque a la persona en posición de recuperación (vea la imagen de abajo).



8. Permanezca con la persona hasta que llegue la ayuda.

Las imágenes son utilizadas con el permiso de "The Open Society Institute." Extractados de la Guía de Campo de Reducción de Daños: Prevención y Respuesta de So-bredosis Excesiva. Por Curtis, M. y Guteman, L., 2009. Una Guía para Personas Que Utilizan las Drogas, y el Personal de Reducción de Daños en Europa del Este y Asia Central.

REUNIR NALOXONE:

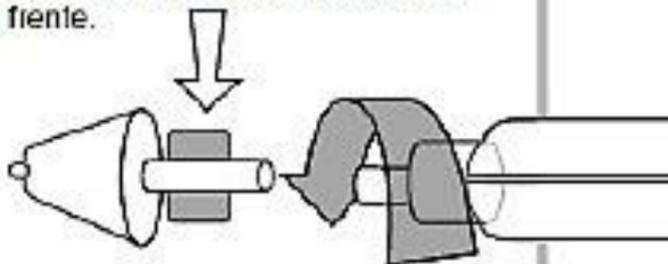


REUNIR NALOXONE:



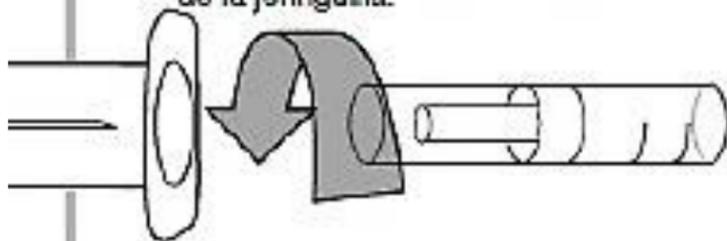
REUNIR NALOXONE:

3 Agarra las alas plasticas en la parte del frente.



REUNIR NALOXONE:

- 4** Delicadamente, enrosca la capsula de naloxone en el barril de la jeringuilla.



REUNIR NALOXONE:



5 Inserta el cono blanco dentro de la ventana de la nariz, dale un empuje corto y vigoroso al final de la capsula para rociar el naloxone dentro de la nariz: roce la mitad de la capsula dentro de cada ventana de la nariz.

6 Si no reacciona dentro de 2-5 minutos administra una segunda dosis.

Empuje



HARM REDUCTION COALITION



CÓMO HACER UN PLAN DE SOBREDOSIS:

1. *¿Cómo iniciar una conversación acerca de la necesidad de un compañero de rescate?*

- “Los errores pueden ocurrir cuando se utilizan medicamentos para el dolor.”
- “Necesito de alguien que me ayude a mantenerme seguro y sin dolor. Esta persona puede ser un familiar o un amigo. Llamamos a esta persona un compañero de rescate.”
- “Demasiadas pastillas para el dolor o mezclándolas con otras drogas o alcohol pueden hacer que yo deje de respirar.”
- “He recibido un botiquín de rescate.”
- “El botiquín tiene un DVD que describe una asimilación de una sobredosis y que hacer.”
- “El botiquín también tiene la medicina, Naloxona, que me ayudara a respirar otra vez.”
- “El lugar de donde se encuentra el botiquín esta _____.”

CÓMO HACER UN PLAN DE SOBREDOSIS; CONTINUADO:

2. *¿Quién es tu compañero de rescate?* _____

3. *Lo que su compañero tiene que hacer.*

- Mirar el DVD de “Project Lazarus.”
- Aprender las señales y síntomas de una sobredosis y cómo rescatar.
- Revisar el contenido del botiquín de rescate de naloxona.
- Conocer la ubicación del botiquín de rescate.
- Llamar a “Project Lazarus” al teléfono (336-667-8100) para preguntas sobre cómo responder a una sobredosis.

4. Si su receta no funcionando, llame a su medico. NO AUTOMEDICARSE.

CÓMO HACER UN PLAN DE SOBREDOSIS; CONTINUADO:

5. ¿Qué hacer si usted está tomando pastillas para el dolor no recetadas para usted o sin seguir los consejos de su médico?

- No mezcle las pastillas con otras drogas o alcohol.
- Llame a su compañero y pídale que este pendiente de usted cada hora.
- Asegúrese de que alguien pueda llegar a usted si es necesario

6. Lo que su compañero no debe hacer en caso de una sobredosis.

- Ponerlo en una ducha para darle un baño con agua fría. Se podría ahogar.
- Darle estimulantes, como café, eso no funciona.
- Ponerle hielo en el cuerpo para despertarlo. Eso es una pérdida de tiempo y no funciona.

SI UN RESCATE ES NECESARIO, LLAME AL 911.

Project Lazarus | P.O. Box 261 Moravian Falls, NC | 336-667-8100
www.projectlazarus.org | info@projectlazarus.org

If you are considering the possibility of prescribing or refilling an opioid prescription, please conduct a medical assessment that includes reviewing all potential risks to determine if the patient is at an increased risk of Opioid-Induced Respiratory Depression or overdose. Please also consider using the SBIRT-AUDIT and DAST-10 forms during the medical assessment. If you determine that your patient is at-risk, yet still needs to receive an opioid prescription, please provide the patient with a Naloxone Rescue Kit and a prescription for naloxone that can be filled at a local pharmacy.

Persons are at risk of Opioid-Induced Respiratory Depression if they have/had a(n):

1. Recent emergency medical situation for opioid poisoning and/or intoxication.
2. Suspected history of illicit or non-medical opioid use.
3. Prescription for a high dose opioid of greater than 100mg of morphine equivalent per day.
4. Methadone prescription (specifically, opioid naïve patients).
5. Recent release from incarceration.
6. Recent release from an opioid detox or mandatory abstinence program.
7. Enrolled in a methadone or buprenorphine detox and/or maintenance program for addiction or pain.
8. Voluntary request from patient or family member.
9. Difficulty accessing EMS due to distance, remoteness, etc.

Persons are at risk of overdose if there is a combination of prescription opioids with any of the following:

1. Smoking, COPD, emphysema, asthma, sleep apnea, or another respiratory diagnosis.
2. Renal dysfunction or hepatic disease.
3. Known or suspected concurrent alcohol use.
4. Concurrent benzodiazepine prescription.
5. Concurrent SSRI or TCA anti-depressant prescription.

NARCAN[®] (naloxone HCl) **NASAL SPRAY**

APPENDIX 3-D12i

QUICK START GUIDE

Opioid Overdose Response Instructions

Use NARCAN Nasal Spray (naloxone hydrochloride) for known or suspected opioid overdose in adults and children.

Important: For use in the nose only.

Do not remove or test the NARCAN Nasal Spray until ready to use.

1

Identify Opioid Overdose and Check for Response

Ask person if he or she is okay and shout name.

Shake shoulders and firmly rub the middle of their chest.

Check for signs of opioid overdose:

- Will not wake up or respond to your voice or touch
- Breathing is very slow, irregular, or has stopped
- Center part of their eye is very small, sometimes called “pinpoint pupils”

Lay the person on their back to receive a dose of NARCAN Nasal Spray.

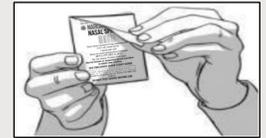


2

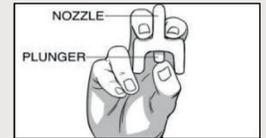
Give NARCAN Nasal Spray

Remove NARCAN Nasal Spray from the box.

Peel back the tab with the circle to open the NARCAN Nasal Spray.



Hold the NARCAN nasal spray with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.



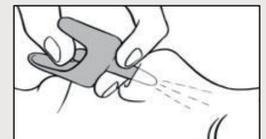
Gently insert the tip of the nozzle into either nostril.

- Tilt the person’s head back and provide support under the neck with your hand. Gently insert the tip of the nozzle into **one nostril**, until your fingers on either side of the nozzle are against the bottom of the person’s nose.



Press the plunger firmly to give the dose of NARCAN Nasal Spray.

- Remove the NARCAN Nasal Spray from the nostril after giving the dose.



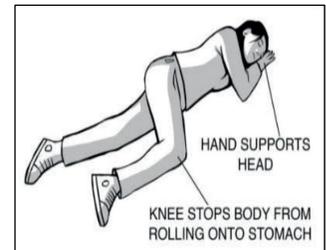
Get emergency medical help right away.

Move the person on their side (recovery position)

after giving NARCAN Nasal Spray.

Watch the person closely.

If the person does not respond by waking up, to voice or touch, or breathing normally another dose may be given. NARCAN Nasal Spray may be dosed every 2 to 3 minutes, if available.



3

Call for emergency medical help, Evaluate, and Support

Repeat Step 2 using a new NARCAN Nasal Spray to

give another dose in the other nostril. If additional NARCAN Nasal Sprays are available, repeat step 2 every 2 to 3 minutes until the person responds or emergency medical help is received.

For more information about NARCAN Nasal Spray, go to www.narcannasalspray.com, or call 1-844-4NARCAN (1-844-462-7226).

APPENDIX 3-D12ii

Client Purchase Order
(For direct purchasers eligible
for Public Interest Pricing)

Customer Name:
Order Date:
Order Number (Adapt use):
Tax ID #

Bill To:
[Name]
[Company name]
[Street Address]
[City, State, Zip Code]
[Phone number]

Ship To:
[Entity Name]
[Attn.]
[Street Address]
[City, State, Zip Code]
[Phone number]

Date Requested		Date Needed				
Pharmacy License <input type="checkbox"/>		Please send a copy of your standing order or pharmacy license along with this purchase order.			E-Mail: Customerservice@adaptpharma.com	
Standing Order <input type="checkbox"/>						
QTY (min 48)	Product	Description	PO#	NDC#	Price	Line Total
	Narcan Nasal Spray	4MG, 2-pack		69547-353-02	\$75	
NOTE: All orders are minimum of 48 units and in increments of 12						

Subtotal	
Sales Tax	
Total	

If tax exempt, please provide proof of exempt status

A valid NARCAN® Nasal Spray (Naloxone Hcl) 4mg prescription, standing order or pharmacy license for the total number of NARCAN® Nasal Spray (Naloxone Hcl) 4mg packs ordered from Adapt Pharma is required to be sent along with a completed purchase order.

Purchasers should email or fax a copy of a valid prescription, standing order or pharmacy license along with a completed purchase order marked for the attention of Adapt Customer Service via email to customerservice@adaptpharma.com or via fax to 484.367.7815.

Purchase orders are subject to acceptance by Adapt Pharma at its sole discretion. Purchase Order Terms and Conditions and other policies of Adapt Pharma apply.

Questions with respect to the Public Interest Pricing program should be sent via email to customerservice@adaptpharma.com marked for the attention of Adapt Customer Service or telephone 844.462.7226.

Name of authorized Representative

Title

Date

Signature

APPENDIX 3-D12iii

CUSTOMER MAINTENANCE

This sheet can be used to add a customer or update customer information

Today's Date:		<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Inactive			
BILL TO					
Customer Acct #:					
Customer DEA # (If Necessary):			SBP License #:		
Customer Standing Order					
Charge To #:			Charge To Address:		
Customer Name:					
Address 1:					
(Street Address)					
Address 2:					
(Street Address)					
Address 3:					
(Department or Attention To)					
Address 4:					
(City/State/Zip)					
Telephone #:	()	S/A Group:	Pricing Group:	Ship Via:	
Fax #	()	Credit Limit:	Terms Code:	Salesman #	Territory Code:
Taxable Entity: <input type="checkbox"/> Yes <input type="checkbox"/> No					
SHIP TO					
Ship To #:		Customer DEA # (If Necessary):		SBP License #:	
Customer Standing Order #					
Charge To:					
Ship To Name:					
Address 1:					
(Street Address)					
Address 2:					
(Department or Attention To)					
Address 3:					
(City/State/Zip)					
Telephone # ()			Fax # ()		
S/A Group:					
Salesman #:					
Territory Code:					
<i>Approved By:</i>				<i>Date:</i>	
<i>Entered By:</i>				<i>Date:</i>	



Credit Application

For internal use only: **APPENDIX 3-D12iv**
 Credit limit approved: \$ _____
 Determination made by _____
 Name: _____ Title: _____
 Date: _____

ORGANIZATION'S CONTACT INFORMATION

Organization's legal name (purchaser): _____
 D/B/A (if different from entity legal name above): _____
 Organization's business address: _____
 City: _____ State: _____ ZIP Code: _____

BILLING CONTACT INFORMATION

Name: _____ Title: _____
 Telephone: _____ Email address: _____

ORGANIZATION TYPE & OWNERSHIP

Organization Type

C – Corporation
 S – Corporation
 Partnership
 LLC
 Trust/estate
 Government org (Federal)
 Government org (State)
 Municipality

Federal Tax ID#: _____ State Tax ID: _____

State of Incorporation: _____

Suits, Liens or judgements

Are there currently any suits, liens, or judgements filed against the organization or its business and has the organization ever filed for bankruptcy: Yes No

If yes, please provide description: _____

Organization Ownership

List the names of the proprietor, partners, or officers of the organization

#	Name	Title	% Ownership	Home Address
1				
2				
3				

ORGANIZATION'S ACTIVITIES

Type of Business

For profit organization:

First responder
 Hospital
 Pharmacy
 Physician
 Rehabilitation org.
 Specialty distributor
 Wholesaler
 Other _____

Not for profit organization:

Federal/state agency
 Foundation
 Harm org.
 Hospital
 Rehabilitation org
 School
 Trust/estate
 University
 Other _____

Is the purchasing organization buying product on behalf of another organization: Yes No

If Yes, please provide the name of the organization: _____

Organization's business address: _____

City: _____ State: _____ ZIP Code: _____

Please indicate the type of the organization for which the purchasing organization is buying product:

Government agency/dept. (Federal)
 Government agency/dept. (State)
 Municipality
 Emergency medical services
 Fire Dept.
 Police/Law Enforcement dept.
 Correction facility
 University
 School
 Other _____



NOT-FOR PROFIT ORGANIZATIONS

Is the purchasing organization a not-for-profit organization and purchasing product using funding provided by a Federal/State/County organization: Yes No

If yes, please provide the name of the Federal/State/County organization providing funding: _____

Has the Federal/State/County organization already provided funding for the purchase of product: Yes No

If no, when does the not-for-profit organization expect to receive funding from the Federal/State/County organization: _____

BUSINESS AND CREDIT INFORMATION

Bank name:

Bank address:

Phone:

City:

State:

ZIP Code:

Type of account:

Account number:

BUSINESS/TRADE REFERENCES

Company name:

Address:

City:

State:

ZIP Code:

Phone:

E-mail:

Max credit limit:

Company name:

Address:

City:

State:

ZIP Code:

Phone:

E-mail:

Max credit limit:

FORECASTED PURCHASES

	Product	Frequency	Units of product	Price (\$) per unit	Total amount (\$)
Forecasted initial purchase	Narcan® Nasal Spray	Once off			
Forecasted recurring purchases (e.g. purchases: semi-monthly, monthly, semi-annually or annually)					

Legal entity name: _____

Printed legal entity name

Authorized signatory

Printed Name of signatory

Title of authorized signatory

Date

Terms and Conditions

Narcan® Nasal Spray at Public Interest Price

(Please email or fax a signed copy of these Terms and Conditions)

Email: customerservice@adaptpharma.com Fax: 484.367.7815

The undersigned ("Customer") hereby acknowledges and agrees that the NARCAN® Nasal Spray (Naloxone Hcl) 4mg (the "Product") made available by Adapt Pharma, Inc. ("Adapt Pharma") to the Customer at the Public Interest Price is conditioned upon the Customer making the following certification. Customer hereby represents and warrants to Adapt Pharma and agrees that:

1. The Customer is a Qualified Purchaser. "Qualified Purchaser" means law enforcement agencies, fire departments, first responders (e.g., emergency medical services), departments of health, local school districts, colleges and universities, and community-based organizations; provided, however, that Customer shall be subject to Adapt Pharma's approval in its sole discretion.
2. The Customer shall only purchase, receive and use the Product purchased at the Public Purchase Price in accordance with all applicable laws, rules and regulations. The Customer has presented to Adapt Pharma a valid pharmacy license or standing order for purchase and use of the Product.
3. The Product purchased at the Public Interest Price may only be used by the Customer, and shall not be subject to submission for reimbursement of any type, including, without limitation, private pay, commercial, government authority, agency or otherwise.
4. The transfer or sale of the Product purchased at the Public Purchase Price to any other party constitutes a material breach of these Terms and Conditions. In such event, Adapt Pharma, among its other rights and remedies, may immediately disqualify the entity in breach from purchasing the Product.
5. The Product purchased at the Public Interest Price is not returnable or refundable.
6. Minimum order quantity is 48 units (4 cases). If Customer notifies Adapt Pharma that its expected volume is less than the minimum order quantity, Adapt Pharma may provide alternative access points.
7. An invoice will be sent to the Customer at its billing address. Unless otherwise specified on the invoice, all invoices are payable in full thirty (30) days after the invoice date. The Customer agrees to review all invoices upon receipt and to notify Adapt Pharma in writing within twenty (20) days of the invoice of any disputes. If such written notice is not received by Adapt Pharma within such time period, the invoice will be deemed to be final and fully payable. Late payments are subject to a late payment charge at the rate of one and one half percent (1.5%) per month of the amount due (but not to exceed the maximum lawful amount).
8. Adapt Pharma shall have the right to request information from the Customer to confirm Qualified Purchaser status and/or credit status prior to accepting an order, and the Customer shall fully cooperate.
9. Adapt Pharma reserves the right to audit purchasing entities to ensure the Product purchased at the Public Purchase Price is used as outlined in these Terms and Conditions and as otherwise required by Adapt Pharma.
10. All orders are subject to acceptance by Adapt Pharma. Adapt Pharma may fulfill or refuse or otherwise limit orders at its sole discretion.
11. All of the information provided to Adapt Pharma by the Customer is true, complete and accurate.
12. The foregoing may be in addition to further terms and conditions by Adapt Pharma and/or its third party vendor related to the sale of the Product.
13. The Customer shall indemnify and hold harmless Adapt Pharma from and against any claims, actions, damages, liabilities and loses, including reasonable attorneys' fees, which may directly or indirectly result from or relate to an act or omission of Customer, or a breach of any representation, warranty, covenant, or obligation of Customer to Adapt Pharma.
14. ADAPT PHARMA MAKES NO EXPRESSED OR IMPLIED WARRANTIES WITH RESPECT TO THE PRODUCT, INCLUDING ANY WARRANTY OF MERCHANTABILITY, NON-INFRINGEMENT OR FITNESS FOR A PARTICULAR PURPOSE.
15. IN NO EVENT SHALL ADAPT PHARMA BE LIABLE WHETHER IN CONTRACT OR TORT OR OTHERWISE, FOR ANY INDIRECT, INCIDENTAL CONSEQUENTIAL, OR SPECIAL DAMAGES OR LOSSES OF ANY NATURE OR FOR LOST REVENUE, LOST PROFITS OR LOST BUSINESS ARISING OUT OF CUSTOMER'S PURCHASES OR THE USE OF THE PRODUCT OR ADAPT PHARMA'S FAILURE TO DELIVER ORDERED PRODUCT. IN NO EVENT SHALL ADAPT PHARMA'S LIABILITY FOR ANY ORDER EXCEED THE AMOUNT ACTUALLY PAID BY THE CUSTOMER FOR SUCH ORDER.
16. These Terms and Conditions and all communications, disputes and performance hereunder shall be governed by the laws of the State of Pennsylvania, without regard to conflict-of-laws principles. The United States District Court for the Eastern District of Pennsylvania and the courts of the Commonwealth of Pennsylvania shall have exclusive jurisdiction over any dispute that arises under these Terms and Conditions.
17. These Terms and Conditions constitute the entire agreement and understanding of the parties with respect to the subject matter hereof. No changes to these Terms and Conditions will be binding upon Adapt Pharma unless made in writing and signed by Adapt Pharma.
18. Failure of Adapt Pharma to enforce a right does not waive it. If a court of competent jurisdiction finds that any provision of these Terms and Conditions is invalid or unenforceable, the other provisions of these Terms and Conditions will remain in full force and effect.

Print Name of Company and Authorized Representative

Title

Date

Signature

APPENDIX 4

SUSTAINABILITY

4-A	List of Federal Resources
4-B	Justification for Grant Applications

Federal Resources

- Centers for Disease Control and Prevention (<http://www.cdc.gov>)
 - Morbidity and Mortality Weekly Report (<http://www.cdc.gov/mmwr/>)
CDC Grand Rounds: Prescription Drug Overdoses – a U.S. Epidemic (MMWR/January 13, 2012/Vol. 61/No. 1)
<http://www.cdc.gov/mmwr/pdf/wk/mm6101.pdf>
 - National Center for Health Statistics
 - Healthy People 2020 Progress Review
Substance Abuse and Mental Disorders: Early Detection, Prevention and Treatment
http://www.cdc.gov/nchs/ppt/hp2020/hp2020_MH_MD_and_SA_progress_review_presentation.pdf
 - National Center on Violence and Injury Prevention and Control
 - Saving Lives and Protecting People: Preventing Prescription Painkiller Overdoses
 - Vital Signs “Prescription Painkiller Overdoses in the US, November 2011”
<http://www.cdc.gov/vitalsigns/painkilleroverdoses/index.html>
 - Vital Signs “Prescription and Painkiller Overdoses: Use and Abuse of Methadone as a Painkiller, July 2012”
<http://www.cdc.gov/vitalsigns/methadoneoverdoses/index.html>
 - Drug Overdose in the United States – Fact Sheet
<http://www.cdc.gov/homeandrecreationalafety/overdose/facts.html>
 - Public Health Law Program (<http://www.cdc.gov/phlp/>)
 - Prescription Drug Overdose: State Laws
<http://www.cdc.gov/HomeandRecreationalSafety/Poisoning/laws/index.html>
 - Office of Communications
 - Division of News and Electronic Media
Opioids drive continued increase drug overdose deaths, February 20, 2013
http://www.cdc.gov/media/releases/2013/p0220_drug_overdose_deaths.html
- Food and Drug Administration
 - Center for Drug Evaluation and Research
 - Division of Drug Information
 - Misuse of Prescription Pain Relievers
<http://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/MisuseofPrescriptionPainRelievers/default.htm>

- National Institutes of Health (<http://www.nih.gov>)
 - National Institute on Drug Abuse (<http://www.drugabuse.gov>)
 - Research Report, “Prescription Drugs: Abuse and Addiction”
<http://www.drugabuse.gov/publications/research-reports/prescription-drugs>
 - NIDAMED
<http://www.drugabuse.gov/nidamed/etools>
- Office of National Drug Control Policy
 - “Epidemic: Responding to America’s Prescription Drug Abuse Crisis”
http://www.whitehouse.gov/sites/degault/files/ondcp/policy-and-research/rx_abuse_plan.pdf
- Substance Abuse and Mental Health Services Administration (<http://www.samhsa.gov>)
 - Center for Behavioral Health Statistics and Quality
 - Division of Surveillance and Data Collection
2012 National Survey on Drug Use and Health (NSDUH)
http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/Index.aspx
The NHSDUH Report: Non-Medical Use of Prescription-Type Drugs, by County Type, April 11, 2013
<http://www.samhsa.gov/data/2k13/NSDUH098/sr098-UrbanRuralRxMisuse.htm>
 - Center for Substance Abuse Treatment
 - Division of Services Improvement
 - Addiction Technology Transfer Center
<http://www.attcnetwork.org>
 - Connect to Fight Prescription Drug Abuse
<http://www.attcnetwork.org/topics/rxabuse/home/htm>
 - Division of Pharmacologic Therapies
 - Opioid Overdose Toolkit
http://store.samhsa.gov/shin/content/SMA13-4742/Overdose_Toolkit_2014_Jan.pdf
- United States Department of Health and Human Services
 - Office of the Secretary
 - Behavioral Health Coordinating Committee Prescription Drug Abuse Subcommittee
“Addressing Prescription Drug Abuse in the United States: Current Activities and Future Opportunities,” September 2013
http://www.cdc.gov/HomeandRecreationalSafety/overdose/hhs_rx_abuse/html

JUSTIFICATION FOR GRANT APPLICATIONS

INFORMATION TO MAKE THE CASE FOR OVERDOSE RESPONSE WITH NALOXONE

Global Fund proposals approved in the past that included support for overdose prevention have not gone into extensive detail to justify why naloxone is needed, or to explain how it will be operationalized. (See previous page.) It is important, however, to give reasons for the inclusion of overdose response with naloxone in your proposal, and to be prepared with the necessary justifications, evidence and costs, in case you are asked for more information. Below are recommendations for what information and supporting materials to gather to make the case for naloxone and to plan an effective overdose response with clear targets.

Include National Data.

- Such as:
 - ✓ Total number of people who use drugs, and the number who use opioids
 - ✓ The number of overdose deaths in your country, and how this ranks compared to other causes of death, especially among young people
 - ✓ Total number of HIV positive people
 - ✓ Proportion of HIV infections related to drug use
 - ✓ What proportion of deaths among people with HIV were the result of an overdose
- If you're missing data, gather information from countries where the drug use and socio-economic situations are similar to yours.¹²

Supply Supporting Information.

- Investigate if surveys or research has been done in your country on overdose experiences. Look for information such as:
 - ✓ What proportion has seen a fatal or nonfatal overdose?
 - ✓ What proportion has experienced a nonfatal overdose themselves?

SOME INDICATORS ON NALOXONE TO INCLUDE IN PROPOSALS

- ✓ Number of naloxone ampoules distributed
- ✓ Number of overdose reversals with naloxone
- ✓ Number of harm reduction staff and clients trained in overdose prevention and response with naloxone

Cost Out Various Components for Budget Calculations.

- Depending on the interventions you decide to include, the proposal may cover:
 - ✓ naloxone (often less than 1USD per dose, but differs significantly from one country to the next)
 - ✓ muscle syringes
 - ✓ costs for developing appropriate overdose prevention and response educational materials (Information, Education and Communication materials)
 - ✓ costs to conduct trainings and develop training materials (Behavioral Change Communication)

¹² See, for example, Eurasian Harm Reduction Network. 2008. *Overdose: A Major Cause of Preventable Death in Central and Eastern Europe and Central Asia*. Available online at http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/overdose_20080801.

APPENDIX 5

BUILDING PARTNERSHIPS

5-A	First Responder Memorandum of Agreement (MOA)
5-B	Orange County Law Enforcement Reporting Form
5-C	Law Enforcement Training Example

FIRST RESPONDER

Memorandum of Agreement: For the Use of Nasal Naloxone by First Responders under Massachusetts Statewide Treatment Protocols

This Agreement is made and entered into on July 30, 2014 and is between **Alexander Y. Walley, MD, MSc**, hereinafter known as “the medical director”; and **Massachusetts State Police Department**, hereinafter known as “the FIRST RESPONDER agency.”

This Agreement is required pursuant to Massachusetts Department of Public Health regulations 105 CMR 171.000 (Office of Emergency Medical Services training regulations) for FIRST RESPONDER agencies that elect to implement a program for the use of Intranasal Naloxone in accordance with 105 CMR 700.003(D) (Drug Control Program regulations). First Responders employed by the FIRST RESPONDER agency will function under the medical control supervision of a physician Medical Director.

This Agreement is in place for the purpose of implementing a Nasal Naloxone Rescue Kit program (“program”).

THEREFORE THE PARTIES NOW MUTUALLY AGREE AS FOLLOWS:

The Medical Director Agrees;

1. To assume responsibility for all medical control aspects of the program and ensure that the administration of the program is in compliance with 105 CMR 171.000, and First Responders are administering Nasal Naloxone in accordance with the applicable Statewide Treatment Protocols, 105 CMR 171.000 (**Treatment protocols, quality assurance**);
2. To approve training programs for the use of Nasal Naloxone which meet the minimum standards established by the Department’s Administrative Requirement 2-100 and are in accordance with applicable Statewide Treatment Protocols, pursuant to 105 CMR 171.000 (**Training**);
3. To establish policies for the proper acquisition, storage, replacement, and disposal of the Nasal Naloxone rescue kits (See Amendment A) (**Acquisition and replacement of devices**);
4. To authorize the purchase of nasal naloxone rescue kits by the FIRST RESPONDER agency under his/her medical license (**Acquisition and replacement of devices**).
5. To complete and file an Application for Massachusetts Controlled Substances Registration (MCSR) for municipalities and non-municipal public agencies for use of naloxone in accordance with the Controlled Substances Act, M.G.L. Chapter 94C. Form available at: <http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/naloxone-nerve-antidote-epi-form.pdf> (**Acquisition and replacement of devices**).

FIRST RESPONDER
Memorandum of Agreement: For the Use of Nasal Naloxone by First Responders under
Massachusetts Statewide Treatment Protocols

The FIRST RESPONDER agency Agrees;

1. To designate one qualified officer to serve as a liaison to the Medical Director and FIRST RESPONDER agency leader of the Nasal Naloxone Rescue Kit Program;
2. To participate in all quality assurance and or remediation procedures established by the Medical Director (**Quality assurance**);
3. To ensure First Responders complete initial and refresher training in cardiopulmonary resuscitation in accordance with the First Responder Training Regulations, at 105 CMR 171.000 (**Training, treatment protocols**);
4. To ensure all First Responders within the agency successfully complete training programs approved by the Medical Director for the use of Nasal Naloxone which meet the minimum standards established by the Department's Administrative Requirement 2-100 and are in accordance with the applicable Statewide Treatment Protocols, pursuant to 105 CMR 171.000 (**Training**);
5. To abide by policies for proper acquisition, storage, replacement, and disposal of the Nasal Naloxone rescue kits approved by the Medical Director and in accordance with the U.S. Food and Drug Administration's approved manufacturer's product label recommendations (see Amendment A) (**acquisition and replacement of devices, shelf life of the medication and proper storage and disposal conditions**);
6. To purchase naloxone rescue kits and equip personnel in a manner consistent with Massachusetts' drug control regulations, including maintaining an active Massachusetts Controlled Substances Registration (MCSR) for municipalities and non-municipal public agencies for use of naloxone in accordance with the Controlled Substances Act, M.G.L. Chapter 94C. Form available at: <http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/naloxone-nerve-antidote-epi-form.pdf> (**Acquisition and replacement of devices**).
7. To work collaboratively with the local ambulance service and fire department to assure continuity of care when transferring overdose victims to the emergency medical service;
8. To provide to the Medical Director, for quality assurance purposes, individual trip record and a summary report of the system-wide database of overdose trip records filed by First Responders, including all First Responder use of Nasal Naloxone; submit summary reports to the Medical Director every quarter (every 3 months) (See Amendment B for sample trip record) (**Quality assurance, record keeping**);
9. To maintain in a manner reasonably safe from water and fire damage, for a period of not less than seven (7) years, at the main office of the FIRST RESPONDER agency, current, accurate records documenting successful completion of first aid training, including the use of Nasal Naloxone and cardiopulmonary resuscitation training for each First Responder (**Record keeping, training**);

FIRST RESPONDER
Memorandum of Agreement: For the Use of Nasal Naloxone by First Responders under
Massachusetts Statewide Treatment Protocols

It is AGREED TO BY ALL PARTIES:

1. That any party may terminate this Agreement within sixty (60) days written notice.
2. That nothing contained in this Agreement is intended to induce, encourage, solicit, or reimburse the referral of any patient or business, including any patient or business funded in whole or in part by a state or federal health care program, to any party hereunder.

Medical Director

____ Alexander Y. Walley, MD, MSc ____
Print name

____ Medical Director ____
Title

Signature

____ July 29, 2014 ____
Date

FIRST RESPONDER agency Director/Chief

Print name

Title

Signature

Date

FIRST RESPONDER
Memorandum of Agreement: For the Use of Nasal Naloxone by First Responders under
Massachusetts Statewide Treatment Protocols

Amendment A

Acquisition, storage, replacement, and disposal of the Nasal Naloxone rescue kits

Acquisition – The components of the nasal naloxone rescue kits will be acquired by the State Police medical unit and assembled into kits that include:

- Two 2 mL Luer-Jet luer-lock syringes prefilled with naloxone (concentration 1mg/mL) [NDC 76329-3369-1]
- Two mucosal atomization devices – Teleflex MAD 300
- One pair of medical gloves
- Information pamphlet with overdose prevention information and step by step instructions for overdose response and naloxone administration.
 - www.mass.gov/eohhs/gov/departments/dph/programs/hcq/dhpl/pharmacy/dis-pensing-of-naloxone-by-standing-order-.html

Storage – The nasal naloxone rescue kits should be stored in first aid kits. During extreme hot or cold temperatures or for extended leave time, kits should be removed from vehicles and maintained at room temperature (59-86 degrees F/ 15-30 degrees C) and away from direct sunlight.

Replacement - Officers issued nasal naloxone rescue kits will notify the naloxone lead officer when a replacement kit is needed. The naloxone lead officer will place an order for the replacement with the pharmacy supplier for delivery of the replacement kit components to the Medical Unit from whom the officer will receive the replacement kit.

Disposal – After use or in the case of breakage, the MAD, syringe, and naloxone vial should be disposed of in a biohazard sharps container.

Orange County Law Enforcement

Overdose Reversal and Naloxone Administration Reporting Form

APPENDIX 5-B

Complete this form after you have responded to an incident that required the use of naloxone.

Today's Report Date

OCA#

Orange County Department (Select one)

Officer First Name

Officer Last Name

Officer E-mail

1. Naloxone Kit ID#

2. Date of Incident (MM/DD/YYYY)

3. Approximate Time Naloxone Used (0000-2359)

4. Location of Incident (Select one)

Private residence

Hotel or motel

Drug treatment center

Shelter

Sidewalk or street

Nursing home or assisted living

Other

5. Physical clues that made you administer naloxone (Select all that apply)

Person looked blue

Person was not breathing or stopped breathing

Person did not respond to sternal rub or painful stimuli

Drugs or drug paraphernalia at scene

Known history of drug use

Other

6. Did someone administer naloxone before you arrived?

Yes

No

7. Were bystanders at the scene when you arrived?

Yes

No

8. How much naloxone was administered?

Half the tube (1 mL)

Whole tube (2 mL)

Other amount

9. What happened after you gave the person naloxone? (Select all that apply)

Person woke up from the overdose

Person threw up or vomited

Person went to the hospital

Person did not wake up from the overdose or died

I am not sure what happened

Other

10. Did you need to use force on the person after you administered naloxone?

No

Yes. Describe the level of force.

11. Was an arrest made?

Yes

No

12. Did you have any problems keeping your kit with you?

No

Yes. Please describe.

13. Other comments, notes, questions? (Optional)

Thank you for providing this important information! Your response will help improve overdose prevention programs in our community.

Once the form is complete, please **click the SUBMIT** button below to send it to the UNC Injury Prevention Research Center and Orange County EMS. Also, **PRINT** a copy to give to your county's EMS Naloxone Program Coordinator listed below:

Carrboro – Chris Atack (catack@townofcarrboro.org)

Chapel Hill – Mike Mineer (mmineer@townofchapelhill.org)

Hillsborough – Robert Whitted (robert.whitted@hpdnc.org)

Don't forget to get a refill of naloxone for your kit!

Opioid Overdose Prevention for Public Safety and Law Enforcement

An educational group curriculum for public safety and law enforcement professionals



Boston Public Health Commission
Bureau of Addiction Prevention, Treatment, and Recovery Support Services
www.bphc.org/overdose

Funded by the Massachusetts Department of Public Health,
Bureau of Substance Abuse Services





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- ✦ Charlestown Substance Abuse Coalition;
- ✦ Jamaica Plain/ Roxbury Substance Use Coalition;
- ✦ South Boston Hope and Recovery Coalition; and the
- ✦ South End Healthy Boston Coalition.

Maya Doe-Simkins and Dharma Cortés authored the curriculum with input from Adam Butler, Devin Larkin, Rita Nieves and countless concerned friends, family members, drug users, social service providers, police officers, firefighters, emergency medical personnel, evaluators, local and national activists, public health and medical professionals, legislators, and recovery community members.

Overview

Synopsis

The goal of this 90-minute curriculum is to assist law enforcement and other public safety workers in responding to opioid overdose emergencies in an informed and timely manner. Through the implementation of this curriculum public safety officials will receive training to better understand the steps involved in addressing an opioid overdose situation and the steps that follow during an opioid overdose reversal. Emphasis is made on communicating the value of understanding and implementing an overdose reversal protocol within your agency.

Agenda

This curriculum session is organized into the following eight topic areas:

1. Introduction/Background Information (10 minutes)
2. Why is it important to focus on overdose prevention? (10 minutes)
3. Myths and facts about opioid overdose and overdose reversal (10 minutes)
4. What are opioids or opiates? (5 minutes)
5. What is an opioid overdose and how can I identify one? (10 minutes)
6. What can I do when an opioid overdose is happening? (20 minutes)
7. Issues of importance to public safety and law enforcement (15 minutes)
8. Questions and Answers (10 minutes)

Time Frame

- 90 minutes

Materials Needed

- Name cards/labels
- Flipcharts and markers
- PowerPoint slides- these are in the back of this curriculum and available electronically at www.bphc.org/overdose

Trainers are strongly encouraged to be very familiar with the content of this curriculum as well as the resources cited in the back of this curriculum. There are many projects that have developed varied and creative approaches to overdose prevention- being knowledgeable about them will be useful in answering questions and supporting brainstorming with people to whom this curriculum is being presented.

Before Participants Arrive

- Set up computer projector and upload PowerPoint slides
- Have attendance sheet ready on a nearby table



Topic 1: Introduction and Background Information

Description

- Welcome: The trainer welcomes participants
- Opening Activity: Introductions

Timeframe

- 10 minutes

Materials needed

- PowerPoint slides
- Flipchart

As participants arrive

- Welcome participants as they enter the meeting room
- Ask participants to sign attendance sheet

Opening activity

- Welcome participants to the session
- Trainer introduces him/herself
- Trainer asks participants to introduce themselves very briefly
 - Name
 - Reason why they are attending training session

Transition to Background Information

Tell participants that you are going to lead today's session and begin presenting the background information that led to the development and implementation of overdose prevention and overdose reversal training.

Tell participants that at the end of the training session they will know what steps to follow if they witness an opioid drug overdose, including the administration of a medication called Narcan that is used to stop or reverse an opioid overdose.



Opioid overdose prevention and reversal: Introduction and background

Ask this question

Based on your experience and observations, to what extent do you think drug overdoses are a big problem?

Write response on flipchart, after participants provide responses review them and provide positive feedback.

Show PowerPoint slides and present the following information

The problem of overdoses nationwide

- ⊕ Drug overdose is the number one cause of death among drug users in the United States. (Latkin, 2004)
- ⊕ More than half of the deaths that occur among heroin injection drug users are related to overdose. Overdoses kill more heroin injection drug users than AIDS, hepatitis, and other conditions that are related to their drug use. (Sporer, 1999)
- ⊕ In recent years, the use of pharmaceutical products combined with alcohol and street drugs have contributed to a significant increase in deaths. (Phillips, 2008)

The problem of drug overdoses in Massachusetts

- ⊕ According to the Centers for Disease Control (CDC), car accidents are the number one cause of accidental death in the country, however, there are 16 states where more people die from drug overdose— due to both legal pharmaceuticals and street drugs— than car accidents. Massachusetts is one of those 16 states. (Stobbe, 2009)
- ⊕ In 2008, 12 Massachusetts residents died every single week from drug overdoses. (MDPH, 2008)
- ⊕ Boston ranks higher than any other metropolitan area in the country for heroin mentions in emergency departments. (DAWN, 2009)

In light of these findings, the Boston Public Health Commission started an overdose prevention program that has since been implemented in other cities in the US. The program involves training individuals who have contact with drug users on reversing a drug overdose using a medication called Narcan.

After you present this information, ask for participants' reaction. Provide positive feedback.

Opioid overdose prevention and reversal: Why is it important?



Topic 2: Why is it important to focus on overdose prevention?

Description

Presentation & discussion: Participants are presented arguments in favor of overdose prevention from different perspectives: societal, service provider, user, and overdose responders.

Topic goal

To provide the philosophical foundation guiding the implementation of this training.

Time frame

- 10 minutes

Materials needed

- PowerPoint slides

Introduce the lesson

Point out that you will be presenting information that speaks to the importance of practicing overdose prevention and management from different perspectives.

Show PowerPoint slides

Societal perspective

- ⊕ Drug overdose is a health problem that affects some individuals directly (i.e., those who use drugs, their loved ones), others more indirectly (i.e., health care providers, law enforcers, emergency personnel), and the society at large (e.g., human and fiscal cost to society and government agencies). The wide-reaching impact that overdose-related deaths have on our society makes it a significant public health problem.
- ⊕ Overdose deaths can be prevented by laypeople.
- ⊕ Lives can be saved.
- ⊕ It is cost effective to reverse a drug overdose.
- ⊕ We all benefit from preventing overdose-related deaths: our clients and/or commu-



Opioid overdose prevention and reversal: Why is it important?

nity member's lives are saved; and we can reduce government costs by providing effective assistance instead of exclusively relying on medically trained personnel to provide first level of intervention.

Service provider perspective

- ⊕ When people begin using drugs again after a tolerance change (e.g., after abstinence-based drug treatment, incarceration, or sickness) they have an increased chance of overdosing.
- ⊕ Overdoses can be reversed.
- ⊕ Conversations about overdose prevention and reversal can provide another way for providers and clients to connect and develop rapport.

User perspective

- ⊕ The fact that overdose prevention and management programs exist send the message that people's lives are worth saving, that their lives are important, that the public health systems and community members do want programs like this around.
- ⊕ Training with drugs users suggests that exposure to overdose (OD) prevention may be a "teachable moment" whereby active injection drug users reflect on their addiction and become motivated to consider or enter detoxification to begin to address their addiction.
- ⊕ Overdoses can be reversed. The intervention works.
- ⊕ According to the Massachusetts Department of Public Health, from 2007 to 2009 4,300 people in Massachusetts were educated on how to recognize and manage an overdose and there were 500 reports of successful overdose reversals. (MDPH)
- ⊕ In all cases, the overdose was correctly diagnosed and managed.
- ⊕ Based on feedback gathered by the Boston Public Health Commission's AHOPE Harm Reduction Services, people reported being satisfied and comfortable with using Narcan. They say that they would use it again, and report that they would want it used on them in the event that they were overdosing.
- ⊕ Trained individuals were proud of their ability to manage the overdose situation and reported that the overdose education received allowed them to act more calm and functional when the OD occurred. Most participants reported that the person who had overdosed was grateful and did not have negative effects. Almost all trained individuals who reversed an overdose emphatically claimed that they "saved someone's life".

Overdose responder perspective

- ⊕ OD responders have reported positive interactions with public safety personnel (i.e., police, EMS, firefighters). For example, they have received praise such as:

Opioid overdose prevention and reversal: Why is it important?



- ⊕ “You definitely saved that person’s life”
- ⊕ “Good work!”
- ⊕ “How did you know what to do so well?”
- ⊕ “Well, this sure makes my job easier”
- ⊕ Overdose responders have also reported being criticized by public safety and law enforcement. Some examples of reported comments are:
 - ⊕ “It’s not worth it, people never learn.”
 - ⊕ “We’ll be better off when the dope fiends die off.”
 - ⊕ “What a waste of time and resources.”
- ⊕ OD responders have been criticized by people in recovery and substance abuse treatment providers
 - ⊕ Overdose prevention programs send the wrong message to people who use drugs or are trying to get clean. Critics believe that providing a safety net, such as the OD prevention program, prevents users from experiencing an event that may lead them to engage in recovery. However, as noted earlier, there are documented cases in which an overdose reversal has turned into a pathway to treatment.
- ⊕ Responders are proud of their involvement in overdose prevention.
 - ⊕ Saving a life makes people feel “like an angel or a doctor or something really important.”
 - ⊕ Drug-using peers perceive them as safe and responsible.
 - ⊕ They are viewed by peers as “experts” and have been able to encourage others to receive OD prevention training.

After you present this information, ask for participants’ reaction, and provide positive feedback.



Topic 3: Myths and facts about opioid overdose and reversal

Description

Presentation & Discussion: Participants are presented popular myths related to drug overdose and overdose reversal in order to correct erroneous information.

Time frame

- 10 minutes

Materials needed

- PowerPoint slides

Introduce the lesson

Explain that you will be presenting misinformed beliefs that the general public has about drug overdoses and overdose reversal and then correct the misinformation.

Show PowerPoint slides

Myths and facts

- ⊕ **Myth:** There is very little you can do when a person is having an opioid overdose since s/he could die instantaneously.

Fact: Death from OD is rarely instantaneous. This means that there is enough time to stop an overdose. A witness to more than one OD said, “ODs happen as a process. Someone slowly stops breathing.”

- ⊕ **Myth:** It is really hard to prevent a person from dying from a drug overdose since people usually use drugs in private.

Fact: The majority of OD occurs in the presence of others. This is why friends, family members, service providers, and medical emergency personnel can help prevent overdose fatalities. Opioid users talking to the Boston Public Health Commission’s needle exchange program indicate that more than 90% of them have seen an OD.

- ⊕ **Myth:** Preventing death due to an overdose is not easy. You have to complete a lengthy, difficult training.

Fact: OD can be reversed by rescue breathing and/or by giving the person a medication called Narcan (naloxone), which is easy to administer. It is a pre-

Opioid overdose prevention and reversal: Myths and facts



measured nasal spray that comes in a simple device. It has no adverse reactions and has no potential for abuse. People cannot overdose from Narcan.

- ⊕ **Myth:** It is a waste of time to give opioid users Narcan, since they are not capable of recognizing and managing an OD with Narcan.

Fact: Opioid users in several cities throughout the United States have been trained about OD prevention using Narcan, and have been able to save many lives.

- ⊕ **Myth:** The person who receives Narcan will react violently when the medication is administered and his/her OD is reversed.

Fact: In the past, some people have witnessed violent reactions to Narcan because of sudden withdrawal symptoms; however, the doses of Narcan are now more regulated by protocols. Also, the nasal administration is gentler on the victim and does not reverse the overdose as abruptly, thereby reducing acute withdrawal symptoms. Of the more than 500 overdoses reversed by non-medical personnel with Narcan in Boston, not one has reported violence or harm by the person overdosing.

- ⊕ **Myth:** The fact that drug users can have access to Narcan will postpone their entry into drug treatment, and it will also encourage riskier drug use.

Fact: After training active users on the use of Narcan, we have observed either consistent or reduced risky drug use. There are reports suggesting that some individuals who have experienced overdose reversal have decided to seek drug treatment. Also, some people who overdose are actually *already* in drug treatment. This is why it is so important to train service providers on the use of Narcan.

- ⊕ **Fact:** A person who received training on overdose reversal said, “It is a normal first thought [to think it is encouraging drug use], but if you take time to talk with someone who thinks this at first and explain that it is about preventing death and diseases, people usually understand.”

- ⊕ **Fact:** The use of Narcan means hope for active users, those in recovery, and users’ loved ones.

- ⊕ **Fact:** For service providers, Narcan provides another tool or opportunity to engage with clients.

After you present this information, ask for participants’ reaction, and provide positive feedback.



Topic 4: What are opioids/opiates?

Description

The goal of this part of the curriculum is to provide basic information for non-medical professionals about opioids, describe how they work and what they are used for, and describe what is *not* an opioid.

Time frame

- 5 minutes

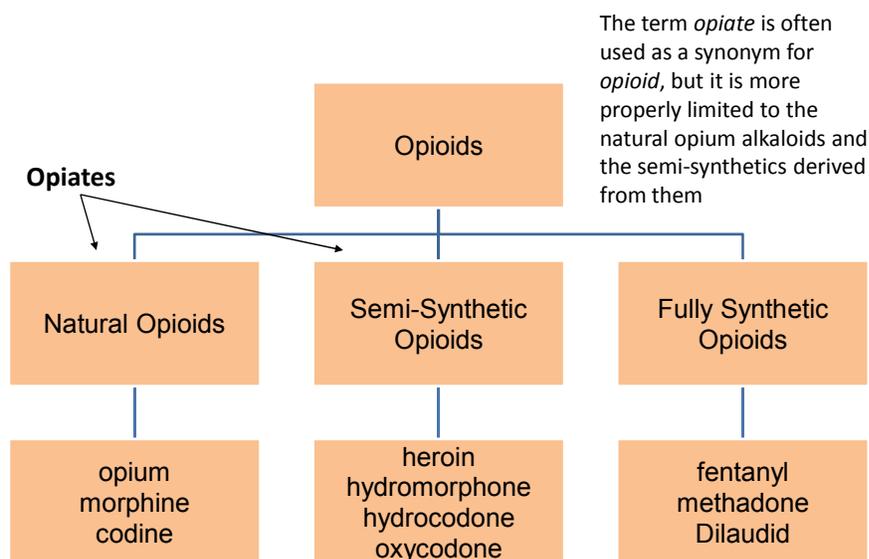
Materials Needed

- PowerPoint slides

Show PowerPoint slides and present the following information

- ⊕ Opioids are sedative narcotics containing opium or one or more of its natural or synthetic derivatives
- ⊕ Sedative narcotics dull the senses and induce relaxation
- ⊕ They are used medically to relieve pain

Take a moment to clarify the similarities and differences between opioids and opiates. Understanding the following graphic, which is also in the slide presentation that accompanies this curriculum, will be helpful:



Substances from all categories of opioids carry risk of overdose!!!

Opioid overdose prevention and reversal: What are opioids?



⊕ Opioids repress the urge to breath – due to a decreased response to carbon dioxide– leading to respiratory depression and death. Thus, when someone is having an opioid overdose, they stop breathing and may die.

⊕ Commonly used opioids are:

Heroin	Dilaudid	OxyContin
Codeine	Methadone	Tylenol 3
Demerol	Opium	Tylox
Morphine	Hydrocodone	Levorphanol
Darvocet	Oxycodone	Percocet
Fentanyl	Vicodin	Percodan

Ask participants if they can think of additional opioids

Ask participants if they can think of pharmaceuticals that are not opioids, but have the potential to be abused or be habit-forming

Provide positive feedback



Topic 5: What is an opioid overdose and how can I identify one?

Description

This section is devoted to describe the signs and symptoms of an opioid overdose and understand what increases and decreases risk .

Time frame

- 10 minutes

Materials Needed

- PowerPoint slides

Show PowerPoint slides and present the following information

What is an opioid OD?

An overdose is when the body has more drugs than it can handle. People can overdose on lots of things, including alcohol, cocaine/crack, opioids or a mixture of drugs. Opioid overdoses happen when there are so many opioids or a combination of opioids and other depressants (downers) in the body that the brain shuts down breathing. This happens because opioids fit into specific receptors on the brain that have an effect on breathing. If someone can't breathe or isn't breathing enough, then oxygen can't get to the brain and after a very short time the heart stops, which leads to unconsciousness, coma, then death. The lack of oxygen from slowed or stopped breathing is the key dangerous aspect to an opioid overdose.

Combining opioids with benzodiazepines or alcohol increases the likelihood of an OD. Benzodiazepines are psychoactive drugs that have sedative, hypnotic, anti-anxiety, anti-convulsant, muscle relaxant, and amnesic actions, which are useful to treat alcohol dependence, seizures, anxiety, panic, agitation and insomnia. The most commonly used benzos are: Klonopin, Valium, Ativan, Librium, and Xanax.

How can you identify an opioid OD?

- ⊕ The person who is overdosing exhibits the following symptoms:
 - ⊕ Blue skin tinge (usually lips and fingertips show first)
 - ⊕ Body very limp
 - ⊕ Face very pale
 - ⊕ Pulse (heartbeat) is slow, erratic, or not there at all

Opioid overdose prevention and reversal: What is an opioid OD and how to identify one?



- ⊕ Throwing up
- ⊕ Passing out
- ⊕ Choking sounds or a gurgling/snoring noise
- ⊕ Breathing is very slow, irregular, or has stopped
- ⊕ Awake, but unable to respond

How to distinguish between being really high and an overdose

REALLY HIGH	versus	OVERDOSE
Muscles become relaxed		Pale, clammy skin
Speech is slowed/slurred		Very infrequent or no breathing
Sleepy looking		Deep snoring or gurgling
Nodding but will respond to stimulation like yelling, sternal rub, pinching, etc.		Heavy nod, not responsive to stimulation
		Slow or no heart beat/pulse

What puts people at risk for an OD?

- ⊕ **Changes in tolerance levels**– When a person uses opioids regularly, the body develops a tolerance to the drug and can tolerate more amount of drug than someone who is not used to taking opioids regularly. A lot of people overdose when they use again after taking a break from using drugs, which lowers their drug tolerance. This usually occurs when the person spends time in drug treatment or jail. People sometimes overdose from using the same amount of drug they were using before their tolerance dropped from not using regularly.
- ⊕ **Mixing drugs**– when people mix opioids with downers like alcohol or benzos. The more alcohol and/or downers someone has in their body, the less heroin needed to overdose. Speedballing- mixing and injecting heroin and cocaine- is a common practice. Some people wrongly assume that doing a speedball will “even the user out” because heroin is a depressant and cocaine is a stimulant. Actually, people who speedball are at higher risk for overdosing than people who use heroin or cocaine alone. This is likely because 1) the body has to process more drugs and 2) people who speedball usually inject more frequently with less time between shots than people who are using only heroin.



- ⊕ **Physical health**– If a person is suffering from other conditions or is ill they could have reduced tolerance to the drug, and thus experience an overdose.
- ⊕ **Previous nonfatal overdose**- people who have overdosed before may have drug use patterns that put them at risk for an overdose in the future. Also important is that experiencing a nonfatal overdose damages the body even if the person survives the overdose. This damage makes any possible future overdoses more risky and more likely to be fatal.
- ⊕ **Variation in strength and content of 'street' drugs**– sometimes the strength of the drug is stronger, the person does not know it, and uses the same amount as before, and then experiences an overdose. Other times, the drug's purity has been altered and that leads to an overdose.

A few words about benzos:

- ◇ They are long acting (at least a day, usually)
- ◇ They impair your short-term memory. So you can actually forget how many benzos or how much heroin you have used in the last 24 hours- this could put someone in danger for an OD!!
- ◇ They are really really common and easy to find on the street
- ◇ They are cheaper than heroin
- ◇ They are frequently necessary for mental health reasons- there is a high comorbidity between substance abuse disorders and mental illness like anxiety, depression, and post-traumatic stress disorder
- ◇ People use benzos to get well- makes people who are in withdrawal feel better
- ◇ People use benzos to get jammed- enhances the effects of heroin (or methadone, etc)

One way to prevent an overdose from becoming fatal is administering Narcan to the person that is exhibiting early signs of an overdose. This is when you can play an important role in the prevention of an overdose!

How can a person avoid an OD?

- ⊕ Being aware of personal tolerance changes
- ⊕ Knowing drug purity
- ⊕ Avoiding mixing drugs or being strategic in how, why, and the order that mixing drug happens
- ⊕ Avoiding using alone
- ⊕ Personal control of the drug preparation and injection process
- ⊕ Using tester shots

**Topic 6: What can I do if an opioid overdose is happening?****Description**

The goal of this part of the curriculum is to teach participants the steps—including overdose reversal—that they should follow when witnessing someone having an opioid overdose.

Time frame

- 20 minutes

Materials Needed

- PowerPoint slides
- Video (embedded in PowerPoint file and available separately at www.bphc.org/overdose)

Show PowerPoint slides and present the following information

If you witness someone having an opioid overdose, follow these steps:

Step 1: Assess the signs to confirm person is experiencing an overdose

- ⊕ Refer to the signs and symptoms described in Topic 5

Step 2: Stimulate the person

- ⊕ Call the person's name loudly. If they respond, they are probably not overdosing, though it is a good idea to watch them closely
- ⊕ Do a sternal rub: rub knuckles hard up and down breast bone

Step 3: Call 911

It is important to call 911. The following issues/beliefs are very common concerns:

- ⊕ Fear of legal risk (outstanding warrants, DCF involvement, loss of public housing)
- ⊕ Embarrassment because the client is supposed to be “clean” to be able to receive treatment or utilize certain services.



Opioid overdose prevention and reversal: What can I do if an overdose occurs?

It is important to know that these concerns rarely play out in reality. It is not the priority of public safety personnel and law enforcement to get people in trouble when there is a medical emergency that needs immediate attention. Also, even though social service programs have rules that their clients should follow, there is always a possibility that someone will not follow them. **Calling 911 and making sure that someone is safe is very important during an overdose.**

When you call 911, say: “A client/person is unconscious/not breathing”; and provide location.

Step 4: Do rescue breathing (mouth-to-mouth)

1. With the person on their back, listen to make sure that the person is not breathing
2. Use the chin-lift method to open the airway– place hand under chin bone and lift
3. Give 2 slow breaths.
4. Blow enough air into their lungs to make their chest rise.
5. Turn your head after each breath to ensure the chest is rising and falling. If it doesn't work, tilt the head back more.
6. Breathe again. Count one-one thousand, two-one thousand, three-one thousand, four-one thousand.
7. Breathe again every 5 seconds.



Continue this pattern until:

- ⊕ The person starts to breathe on their own
- ⊕ An ambulance comes.
- ⊕ Someone else can take over for you.
- ⊕ You are too exhausted to continue.

Step 5: Administer Narcan (naloxone)

What is Narcan?

Narcan (naloxone), is an opioid antagonist (i.e., an agent that binds to the body's opioid receptors thereby blocking the activity of opioid drugs, such as heroin, and endorphins) that is used to reverse the effects of an opioid overdose. A receptor is a specialized cell

Opioid overdose prevention and reversal: What can I do if an overdose occurs?



or group of nerve endings that responds to sensory stimuli. By binding to an opioid receptor, Narcan does not allow the opioid drugs to have an impact on the person's brain. Narcan is the antidote to an opioid overdose.

Narcan is both safe and effective and has no potential for abuse.

It is not a controlled substance but is a scheduled drug that requires a prescription and is currently used by paramedics and emergency medical technicians in ambulances.

- ⊕ In Massachusetts, it is legal for a non-medical person to administer Narcan (naloxone) to someone else in order to treat a potentially fatal overdose.
- ⊕ Federal regulation requires a prescription to obtain Narcan. In Massachusetts, a person who might witness and overdose can get it at any one of eight different pilot programs. For specific information and locations, call the Massachusetts Substance Abuse Information and Education Helpline at 800.327.5050.

How to administer Narcan: (*show video*)

1. Pop off two yellow caps and one red cap
2. Hold spray device and screw it into the top of the delivery device
3. Screw medicine gently into delivery device
4. Spray half of the medicine up one side of the nose and half up the other side

Step 6: Monitor and support

After administering Narcan, continue to provide rescue breathing until reverses the overdose and the person starts to breathe on their own. In 3-5 minutes, if the person doesn't respond, administer the second dose of Narcan that comes in OD kits. **The most important thing is that the person continues to get oxygen, whether through their own efforts or your rescue breathing.**

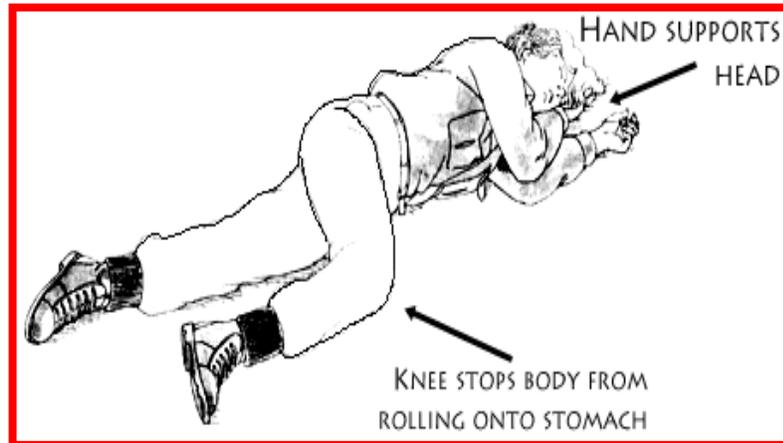
Once the person responds to the Narcan, it is important to monitor and support until the EMTs assume care or the Narcan wears off/ Narcan only lasts between 30 – 90 minutes, but the effects of the opioids may last much longer. A heroin overdose may last several hours and a methadone or another extended release opioid overdose may last for longer. It's possible (though uncommon) that after the Narcan wears off the person could begin overdosing again. It is important that someone stay with the person and wait out the risk period just in case another dose of Narcan is necessary. Narcan can cause uncomfortable withdrawal feelings since it blocks the action of opioids in the brain. Sometimes people want to use again immediately to stop withdrawal feelings. This could result in another overdose. Try to support the person during this time period and encourage them not to use for a couple of hours.



Opioid overdose prevention and reversal: What can I do if an overdose occurs?

The recovery position

If you must leave the person alone— even for a few minutes— put him/her into the recovery position so s/he won't choke. The recovery position puts the person on their side with the top leg bent at the knee, the



bottom arm extended above the head, and the top arm bent at the elbow with the hand under the face as if it were a pillow.

Avoid old school methods of reversing an overdose

While some methods may have worked in certain situations, they won't work for serious overdoses. Instead of trying old school or street methods for reversing an overdose, rescue breathing and Narcan are a proven alternative. Therefore, do NOT do any of the following:

- ⊕ Leave the person alone—they could stop breathing
- ⊕ Put them in a bath—they could drown or get too cold and further slow down breathing
- ⊕ Induce vomiting—they could choke and vomiting won't decrease the amount of opioid in the body
- ⊕ Give them something to drink—they could throw up
- ⊕ Put ice down their pants- it'll make their pants wet! Cooling down the core body temperature of someone who is overdosing is dangerous because it will slow down their body function even more than just the OD.
- ⊕ Try to stimulate them in a way that could cause harm- slapping too hard, kicking in the testicles, burning the bottom of the feet, etc. since it can cause long-term damage.
- ⊕ Inject them with anything (saltwater, cocaine, milk)—it won't work any more than physical stimulation and can waste time or make things worse depending on what you inject. And every injection brings a risk of bacterial infection, abscesses, and other complications.

The fact that old school methods exist means people DO care about responding to overdoses. Usually a person dies from an OD not because people didn't do anything, but because people used methods that were only sometimes effective. Old school street methods of responding to an OD can be thought of as an example of creativity and concern for fellow community members.

After you present this information, ask for participants' reaction or any questions, and provide positive feedback.



Topic 7: Issues of importance to law enforcement and public safety workers

Description

This part of the curriculum provides the opportunity to discuss participants' thoughts and biases toward overdose prevention that emerge from perceived contradictions between job-related duties and overdose prevention related activities.

Time frame

- 15 minutes

Materials Needed

- Flipchart
- PowerPoint slides

Ask participants this question: "What do you think about overdose prevention in light of your work duties?" and write answers on flipchart. Acknowledge that their answers are important and relevant and then cover the topic areas outlined below.

Show PowerPoint slides

Say something like this: "Up until now, we've spent most of our time talking about how important overdose prevention is; why we should all be engaged in doing what we can to prevent overdoses; and how simple and safe it is if we have the right information and materials. Now it is time to talk about the way many of us feel about the work we do and how dealing with issues related to drug addiction could make us feel uncomfortable or resentful."

Acknowledge concerns about workload

Sample response: "People in public safety encounter very difficult topics and situations every day. The thought of adding one more thing to an already long list of duties and responsibilities is hard to imagine. However, feedback received from public service personnel that have undertaken overdose prevention suggests that:



- ⊕ They have been able to engage a wide array of community members by speaking about or engaging in overdose prevention. This has resulted in positive interactions between substance users and police officers responding to an overdose situation, particularly when substance abusers have received training on how to reverse an overdose. Shared knowledge about overdose reversal has led to a less adversarial relationship.
- ⊕ Concerned community members who have come into contact with public safety personnel familiar with OD prevention have been impressed and pleased that public safety personnel have been willing and able to speak knowledgeably about this issue .

Acknowledge perceived interference with job mission

Sample response: “First responders, particularly police officers, have expressed that focusing on overdose prevention could be perceived as “turning a blind eye” to illegal activities. For example, some feel that by not using the opportunity to address the illegal activities leading to an overdose, they are not able to address the factors contributing to drug-related activities. Although this is absolutely true, it is important to remember that when police officers respond to an overdose-related 911 call, the main goal is to secure the scene and to ensure the safety of the other first responders. In addition to this, it is important to make sure that people witnessing an overdose situation not fear calling 911. Arrests and “making examples” at overdose scenes could spread the fear of calling 911 for an overdose.

Ask participants how they understand the mission of their work and draw parallels between their mission and the mission of keeping people safe and alive through overdose prevention

Acknowledge perceived misuse of public resources

Sample response: “Drug addiction is, by definition, recurring. This means that the same people may find themselves in the same situation (e.g., overdosing or requiring public safety resources) repeatedly, and many of us experience a great deal of frustration, sadness, or anger when we witness individuals’ inabilities to break the cycle. Many of us feel that this leads to a disproportionate use of limited available services by a small group of individuals, and makes us wonder if it will ever come to an end.

Acknowledge public service personnel’s commitment to community public safety

Sample response: “Public safety and law enforcement are committed to “protect” com-

Opioid overdose prevention and reversal: Issues important to public safety and law enforcement



munity members from being around or witnessing drug users within a community. Unfortunately, many communities have members that use drugs. This means that, inevitably, some community members will witness the negative impact of substance use such as an overdose. The fact that public service personnel have received overdose prevention training could help turn a negative situation into one that fosters further collaboration between public safety personnel and community members.”

Say: “We are here to contribute to the important goal of saving a person’s life. It is clear that your interaction with people in the community in which you work puts you in contact with individuals who run a chance to experience a drug overdose. For example, during a regular patrol you may witness an overdose.

Ask participants how this information might be supportive on the job, in what contexts, locations, etc. Write responses and support any group conversation that comes out of participant responses

As a result, you are in a position to be able to help save lives and to do it in a way that does not require a great deal of effort or fear. You have what it takes to save someone’s life even if you disagree with their drug use. You also deserve to be safe in situations such as a drug overdose scene. The fact that you are familiar with what to expect in such situations will lead to better management of the situation for all people involved. Remember that even though witnessing a client overdosing may trigger frustration and disappointment, through this training we are focusing on trying to save people’s lives and keep people healthy. We are not enabling drug users to continue using drugs. We are enabling ourselves and the community we serve to save a life and prevent the sorrow and trauma that comes with an avoidable death.”

After you present this information, ask for participants’ reaction. Provide positive feedback.



Topic 8: Questions and answers

Description

The last section of the training session is devoted to answer any questions participants may have, and to distribute educational materials and other relevant information such as safe syringe disposal and pharmaceutical drug disposal services.

Time frame

- 10 minutes

Tell participants that there are several frequently asked questions that you will go over, but ask if they have any specific questions that they would like answered.

After answering participant-generated questions and if time allows, show PowerPoint slides

Is Narcan that stuff that you stick through the heart, like in that movie Pulp Fiction?

- ⊕ No, the movie is likely portraying an adrenaline shot, which is not similar to Narcan. While Narcan does have an injectable form, it is never injected into the heart. The injectable form of Narcan is injected either intravenously or intramuscularly. The mode of administration used in the Massachusetts overdose prevention project is intranasal- a spray that goes up the nose. The dramatic difference between the character overdosing and the character after receiving the medicine is a possible, although uncommon, scenario with Narcan.

What role does your liver play in an overdose?

- ⊕ The liver is extremely important and can affect overdose risk and experience. The liver processes many drugs in a person's body.
- ⊕ If the liver is damaged or not functioning properly, it could cause a back-up of drugs in the body, causing an OD.
- ⊕ A person whose liver isn't functioning properly could have more frequent overdoses.
- ⊕ The most common causes of poorly functioning livers are:
 - ⊕ Viral hepatitis infection (hep A, B, C)

Opioid overdose prevention and reversal: Questions and answers



- ⊕ High consumption of liver damaging substances. Alcohol and acetaminophen (Tylenol) are the most common (remember that Percocet, Vicodin, others contain acetaminophen!)
- ⊕ Fatty diets

How do we get Narcan?

- ⊕ It depends. In Massachusetts, your local overdose prevention program provides free Narcan to substance users and friends and family of users (a list is available by searching the Massachusetts Department of Public Health(MDPH) website for “overdose” www.mass.gov or calling the Massachusetts Substance Abuse Information and Education Helpline at 800-327-5050).
- ⊕ If your local overdose prevention program is unable to provide you with Narcan, contact MDPH: 617-624-5136 or at Sarah.Ruiz@state.ma.us.

Will Narcan work on an alcohol overdose?

- ⊕ Narcan will not work on an alcohol overdose, only opioid overdoses. If it is an alcohol overdose that also involves opioids, it might help by dealing with the opioid part of the OD. If you think that opioids are in any way involved with the overdose, it is worth it to give the person Narcan while you wait for EMS to arrive.

What if it is a crack/coke or speed/methamphetamine overdose?

- ⊕ Narcan will only work with opioid overdoses. If it is a cocaine or speed overdose that also involves opioids, it might help by dealing with the opioid part of the OD. If you think that opioids are in any way involved with the overdose, it is worth it to give the person Narcan while you wait for EMS to arrive
- ⊕ Unfortunately, there isn't a medicine that works on these types of ODs as Narcan works on opioid overdoses. People have developed various ways to manage their own or someone else's speed overdose. Just a few examples include:
 - ⊕ Taking deep calming breaths
 - ⊕ Going for a walk
 - ⊕ Going a cool and/or dark place
 - ⊕ Taking a benzodiazepine or other downer

What is the risk period for an overdose to reoccur after giving Narcan?

- ⊕ It depends on:



Opioid overdose prevention and reversal: Questions and answers

- ⊕ how quickly the person's body processes things
- ⊕ how much drug they used in the first place
- ⊕ how well the liver is working
- ⊕ whether the person is using drugs again
- ⊕ Narcan is active for about 30 – 90 minutes in the body. So if you give someone Narcan to reverse an opioid overdose, the Narcan may wear off before enough of the opioids wear off and the person could go into overdose mode again.
- ⊕ Because Narcan blocks opioids from acting in the brain, it can cause withdrawal symptoms in someone that has a habit. After giving someone Narcan, they may feel dope sick and want to use again right away. It is important that they do not use again for a couple of hours because they could overdose again once the Narcan wears off.

Am I protected against a lawsuit for giving a person who is overdosing Narcan?

- ⊕ According to the legal opinion of the Massachusetts Department of Public Health General Council:
 - ⊕ *Responder means an individual trained in accordance with Department policy in the administration of Narcan to injection drug users experiencing overdose, and authorized by standing order of the Medical Director to administer Narcan to an injection drug user experiencing overdose.*
 - ⊕ *A Responder may possess and administer Narcan to an injection drug user experiencing a drug overdose, as directed by a standing order duly issued by the Medical Director.*
 - ⊕ *Rationale: M.G.L. c.94C, s.7(e) provides that an "ultimate user ...may lawfully possess or administer a controlled substance at the direction of a (physician) in the course of professional practice." In the case of Narcan possession and administration, the Responder shall be regarded as the ultimate user.*

What if the person isn't even overdosing and I give them Narcan? Will it hurt them?

- ⊕ Narcan has no effect on someone who has no opioids in their system
- ⊕ It will not help anyone who is having a different kind of overdose than an opioid overdose (like cocaine, methamphetamine, non-opioid pills, or alcohol), but it will not hurt them either.

Opioid overdose prevention and reversal: Questions and answers



Concluding remarks

- Thank participants for attending the training
- Ask whether they have any questions or comments regarding the topics covered
- Provide handouts and any other informational materials
- Be prepared to make referrals to get Narcan, substance abuse treatment, and family support resources

Additional resources

- The report to the Board of Directors of the Boston Public Health Commission on the Opiate Overdose Prevention and Reversal Pilot Program using Nasal Narcan can be found at www.bphc.org/overdose.
- The Massachusetts Department of Public Health's Bureau of Substance Abuse Services (BSAS) compiled a comprehensive literature review. It can be accessed at: <http://www.hcsm.org/sphere/ODPrevention/research.htm>

Reviewing the available literature has informed the overdose prevention process in Massachusetts, including this curriculum. There are several information sources in particular that are referenced:

- Latkin, C.A., Hua, W., Tobin, K. Social network correlates of a history of non-fatal overdose. *Drug and Alcohol Dependence*, 2004. 73(1):61-67.
- Sporer KA. Acute heroin overdose. *Ann Intern Med*. Apr 6. 1999;130(7):584-590.
- Phillips, D, Barker, G., Eguchi, M. A Steep Increase in Domestic Fatal Medication Errors With Use of Alcohol and/or Street Drugs. *Arch Intern Med*. 2008;168 (14):1561-1566.
- Stobbe M, "CDC: Drug deaths outpace crashes in more states," *The Associated Press*, September 30, 2009.
- United States Department of Justice. "National Drug Threat Assessment 2010." February 2010 <http://www.justice.gov/ndic> (Accessed July 15, 2010).
- 2007: National Estimates of Drug-Related Emergency Department Visits, Office of Applied Studies, Substance Abuse and Mental Health Services Administration, 2010. <https://dawninfo.samhsa.gov/pubs/edpubs/> (Accessed May 15, 2010)
- SPHERE produced a report titled *Overdose Prevention in Drug & Alcohol Treatment in Massachusetts*. It is available at: <http://www.hcsm.org/sphere/ODPrevention>
- An article by Coffin and colleagues (Coffin PO, Fuller C, Vadnai L, Blaney S, Galea S, Vlahov D. Preliminary evidence of health care provider support for naloxone prescription as overdose fatality prevention strategy in New York City. *J Urban Health*. Jun 2003;80(2):288-290.) suggests that there may be support for expanded overdose prevention among healthcare providers:

ABSTRACT Preliminary research suggests that naloxone (Narcan), a short-acting opiate antagonist, could be provided by prescription or distribution to heroin users to reduce the likelihood of fatality from overdose. We conducted a random postal survey of 1,100 prescription-authorized health care providers in New York City to determine willing-

Opioid overdose prevention and reversal: Resources



ness to prescribe naloxone to patients at risk of an opiate overdose. Among 363 nurse practitioners, physicians, and physician assistants responding, 33.4% would consider prescribing naloxone, and 29.4% were unsure. This preliminary study suggests that a substantial number of New York City health care providers would prescribe naloxone for opiate overdose prevention.

- An article by Doe-Simkins, Walley and colleagues (Doe-Simkins M, Walley AY, Epstein A, Moyer P. Saved by the nose: bystander-administered intranasal naloxone hydrochloride for opioid overdose. *Am J Public Health*. May 1, 2009 2009;99(5):788-791.) describes some preliminary success of Boston-based overdose prevention efforts:

ABSTRACT Administering naloxone hydrochloride (naloxone) during an opioid overdose reverses the overdose and can prevent death. Although typically delivered via intramuscular or intravenous injection, naloxone may be delivered via intranasal spray device. In August 2006, the Boston Public Health Commission passed a public health regulation that authorized an opioid overdose prevention program that included intranasal naloxone education and distribution of the spray to potential bystanders. Participants were taught by trained nonmedical needle exchange staff. After 15 months, the program provided training and intranasal naloxone to 385 participants who reported 74 successful overdose reversals. Problems with intranasal naloxone were uncommon. Overdose prevention education with distribution of intranasal naloxone is a feasible public health intervention to address opioid overdose.

- There are many overdose prevention models and pilots in the country. Consider looking into them by using the internet to locate materials, publications, anecdotes, lessons learned, and local resources. Just a few examples are:
 - <http://sites.google.com/site/nomadoverdoseproject/home>
 - <http://www.learn2cope.org/>
 - <http://www.moar-recovery.org/>
 - <http://www.harmreduction.org/>
 - <http://www.projectlazarus.org>
 - <http://www.baltimorehealth.org/stayingalive.html>
 - http://www.nyhealth.gov/diseases/aids/harm_reduction/opioidprevention/
 - <http://www.anypositivechange.org>



Presentation slides



Opioid Overdose Prevention and Reversal Training

For Public Safety Professionals and Law Enforcement

1



Topics To Be Covered

- Introduction & background information
- Why is it important to focus on overdose prevention?
- Myths and facts about drug overdose and overdose reversal
- What are opioids or opiates?
- What is an opioid overdose and how can I identify one?
- What can I do if an opioid overdose is happening?
- Specific concerns for public safety and law enforcement professional
- Questions and answers

2



The problem of drug overdoses nationwide

- Drug overdose is the number one cause of death among drug users in the United States (Latkin, 2004)
- Overdoses kill more heroin injection drug users than AIDS, hepatitis, and other conditions that are related to their drug use (Sporer, 1999)
- Between 1984 and 2004, deaths from mixing pharmaceuticals with alcohol and/or street drugs increased 3196% (Phillips, 2008)

3



The problem of drug overdoses in Massachusetts

- Car accidents is the number one cause of accidental death in the country, except for 16 states where more people die from drug overdose. **Massachusetts is one of those 16 states** (CDC, 2009)
- In 2008, 12 Massachusetts residents died every single week from drug overdoses (MDPH, 2008)

4



National & Regional Drug Threat



Source: National Drug Intelligence Center's National Drug Threat Survey 2009



The problem of fatal and non-fatal drug overdoses in Boston

- Boston ranks higher than any other metropolitan area in the country for heroin mentions in emergency departments (DAWN, 2010)



Why is it important to focus on overdose prevention?

- Overdose affects some individuals directly others more indirectly and the society at large
- Overdose deaths can be prevented by laypeople
- Lives can be saved
- Conversations about overdose prevention and reversal can provide another way for providers and clients to connect and develop rapport

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Why is it important to focus on overdose prevention?

- The fact that overdose prevention programs exist send the message that people's lives *are* worth saving, that their lives *are* important, that the public health systems and community members *do* want programs like this around
- Overdose responders are proud of their involvement in overdose prevention
 - Saving a life makes people feel “*like an angel or a doctor or something really important.*”

8



Myths about overdose and reversal

- There is a very little you can do when a person is having an opioid overdose since he/she could die instantaneously
- It is really hard to prevent someone from dying from a drug overdose since people usually use drugs in private
- Preventing death due to an overdose is not easy and you have to complete a lengthy, difficult training

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Myths about overdose and reversal

- It is a waste of time to give opioid users Narcan, since they are not capable of recognizing and managing an OD
- The person who receives Narcan will react violently when the medication is administered and his/her OD is reversed
- The fact that drug users can have access to Narcan will postpone their entry into drug treatment, and it will also encourage riskier drug use

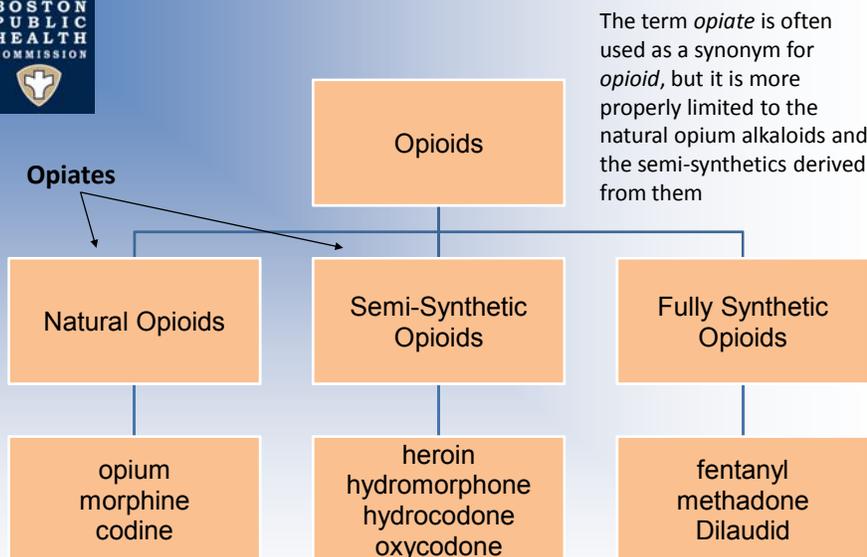
10



What are opioids/opiates?

- Opioids are sedative narcotics
- They are used in medicine mainly to relieve pain
- Opioids repress the urge to breathe- when someone is having an opioid overdose, they stop breathing and could die

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Substances from all categories of opioids carry risk of overdose!!!



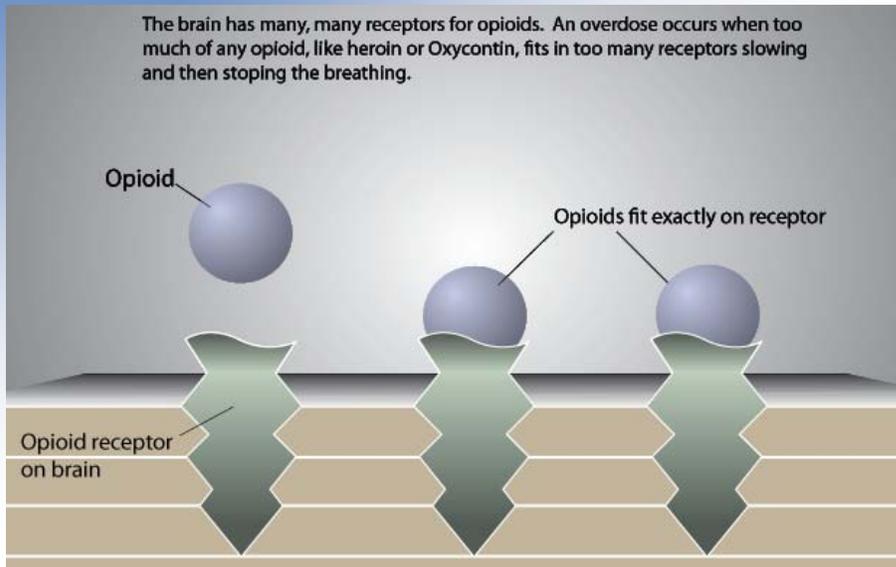
Most commonly used opioids

- Heroin
- Codeine
- Demerol
- Morphine
- Darvocet
- Fentanyl
- Dilaudid
- Methadone
- Opium
- Hydrocodone
- Oxycodone
- Levorphanol
- Vicodin
- OxyContin
- Tylenol 3
- Tylox
- Percocet
- Percodan



What is an opioid OD?

The brain has many, many receptors for opioids. An overdose occurs when too much of any opioid, like heroin or Oxycontin, fits in too many receptors slowing and then stopping the breathing.





What are the signs & symptoms of an OD?

- Blue skin tinge
- Body very limp
- Face very pale
- Pulse (heartbeat) is slow or not there at all
- Throwing up
- Passing out
- Choking sounds or a gurgling/snoring noise
- Breathing is very slow, irregular, or has stopped

REALLY HIGH	OVERDOSE
Muscles become relaxed	Deep snoring or gurgling (death rattle)
Speech is slowed/slurred	Very infrequent or no breathing
Sleepy looking	Pale, clammy skin
Nodding	Heavy nod
Will respond to stimulation like yelling, sternal rub, pinching, etc.	No response to stimulation
	Slow heart beat/pulse ¹⁵



What puts people at risk for ODs?

- Changes in tolerance
- Mixing drugs
- Physical health
- Previous experience of non-fatal overdose
- Variation in strength and content of 'street' drugs



Mixing opioids with benzos

- Combining opioids with benzodiazepines or alcohol leads to a worse outcome
- Benzos are psychoactive drugs that have sedative, hypnotic, anxiolytic, anticonvulsant, muscle relaxant, and amnesic actions
- The most commonly used benzos are: Klonopin, Valium, Ativan, Librium, and Xanax



How can someone avoid an OD?

- Being aware of tolerance changes
- Knowing drug purity
- Avoiding mixing drugs or being strategic in how, why, and the order that mixing drug happens
- Avoiding using alone
- Personal control of the drug preparation and injection process
- Using tester shots



If an OD does happen, what next?

- Call 911 or emergency medical personnel
- Perform rescue breathing
- Administer Narcan

- This is when you can play an important role in the prevention of an overdose!

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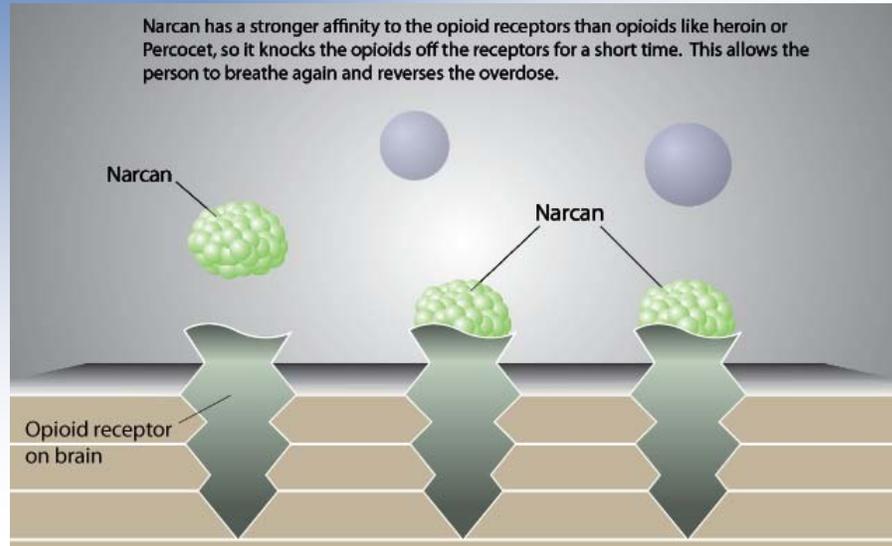


VIDEO

20



Narcan reversing an overdose



The Recovery Position





Avoid old school methods of reversing an overdose

- Do not leave the person alone
- Do not put them in a bath
- Do not induce vomiting
- Do not give them something to drink
- Do not put ice down their pants
- Do not try to stimulate them in a way that could cause harm
- Do not inject them with **anything** (saltwater, cocaine, milk)

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Concerns from people in the field

- Concerns about workload
- Interference with job mission
- Misuse of public resources
- Commitment to community public safety

24



Questions and Answers

- Is Narcan that stuff that you stick through the heart, like in that movie Pulp Fiction?
- What role does the liver play in an overdose?
- How do we get Narcan?
- Will Narcan work on an alcohol OD?
- What if it is a crack/coke OD?

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Questions and Answers

- What is the risk period for an OD to reoccur after giving Narcan?
- Am I protected against a lawsuit for giving a person who is overdosing Narcan?
- What if the person isn't even overdosing and I give them Narcan? Will it hurt them?

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Questions and Answers

- Will using Narcan help someone give a “clean” urine?
- Can someone get arrested for being at an OD scene?
- Are the ambulance and hospitals using the nasal Narcan?
- Others?

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Thank you!

Contact information:

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This project was produced and the work continues with the bittersweet combination of sadness and optimism. Honoring the memories of those who are not with us anymore is an important part of the process, as is the action that comes out of knowing we cannot continue to lose our loved ones, our community.



North Carolina
Injury & Violence 
 PREVENTION Branch