

Guide to Developing
and Managing
**Overdose
Prevention
and Take-Home
Naloxone
Projects**

Guide To Developing and Managing Overdose Prevention and Take-Home Naloxone Projects

Harm Reduction Coalition

For more information on Harm Reduction Coalition's
overdose prevention projects, please visit our website:

<http://harmreduction.org/our-work/overdose-prevention/>

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The Harm Reduction Coalition is a national advocacy and capacity-building organization that promotes the health and dignity of individuals and communities impacted by drug use. Harm Reduction Coalition advances policies and programs that help people address the adverse effects of drug use including overdose, HIV, hepatitis C, addiction, and incarceration. We recognize that the structures of social inequality impact the lives and options of affected communities differently, and work to uphold every individual's right to health and well-being, as well as in their competence to protect themselves, their loved ones, and their communities.

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Contents

Introduction
Using this Guide

Module 1: Understanding the Basics p.9

What is Overdose? p.9
What is Naloxone? p.9
The Need for Take-Home Naloxone Programs p.11

Module 2: Overdose Prevention Strategies without Naloxone p.13

Integrate Overdose Prevention Messages as Standard Practice p.14
Develop an Onsite Overdose Response Policy p.14
Provide Overdose Response Training to Participants p.14

Module 3: Take-Home Naloxone Program Development p.17

Community Assessment, Outreach and Engagement p.17
Legal Considerations p.21
The Role of Medical Professionals p.22
Venues and Tips for Different Settings p.26

Module 4: Program Implementation and Management p.43

Funding p.43
Purchasing and Storing Naloxone p.43
Assembling Kits p.46
Data Collection and Paperwork p.46
Policy and Procedure Manuals p.48
Trainings p.49
Outreach Strategies p.50

Module 5: Overdose Prevention and Response p.53

Risks and Prevention Strategies p.53
Overdose Recognition p.57
Responding to Opioid or Depressant Overdose p.58
Stimulant Overdose: Overamping p.64
Responding to Upper or Stimulant Overdose p.66

Module 6: Frequently Asked Questions p.69

Appendix

Available online at
<http://harmreduction.org>

Overdose Prevention and Response Messages
Sample Documents
Naloxone Kit Materials
Training Materials
Public Policy
Research Bibliography
Additional Resources



Case Studies:

1. Harm Reduction Action Center, Denver, CO p.16
2. Chicago Recovery Alliance, Chicago, IL p.18
3. DOPE Project, San Francisco, CA p.24
4. Clean Works, Grand Rapids, MI p.27
5. Prevention Point, Pittsburgh, PA p.32
6. Learn to COPE and the NOMAD Project, Statewide, MA p.36
7. Duquesne University School of Pharmacy's Center for Pharmacy Services, Pittsburgh, PA p.39
8. Project Lazarus, Wilkes County, NC p.40
9. Massachusetts Overdose Education and Naloxone Distribution, Statewide, MA p.44

Introduction

Drug overdose is the leading cause of injury death in the United States, causing more deaths than motor vehicle crashes. According to the Centers for Disease Control and Prevention (CDC), overdose rates have increased roughly five-fold since 1990. The CDC attributes the rise in drug overdose deaths to a higher use of prescription painkillers and increasing numbers of overdoses from cocaine and prescription sedatives. In 2008, the most recent year for which data is available, the CDC reports 36,500 poisoning deaths in the United States.¹

Providing overdose prevention, recognition, and response education to drug users and their neighbors, friends, families, and the service providers who work with them is a harm reduction intervention that saves lives. Heroin and other opioid overdoses are particularly amenable to intervention because risk factors are well understood and there is a safe antidote — naloxone.

Using this Guide

This manual is designed to outline the process of developing and managing an Overdose Prevention and Education Program, with or without a take-home naloxone component. Overdose prevention work can be easily integrated into existing services and programs that work with people who use or are impacted by drugs, including shelter and supportive housing agencies, substance abuse treatment programs, parent and student groups, and by groups of people who use drugs outside of a program setting. It offers practical suggestions and considerations rooted in harm reduction - an approach to drug use that promotes and honors the competence of drug users to protect themselves, their loved ones, and their communities and the belief that drug users have a right to respect, health and access to life-saving tools and information.

This manual begins with a description of how to integrate overdose prevention education into existing programs. Next, it goes into detail about how to develop and manage a take-home naloxone program. The manual uses case

studies of existing overdose prevention programs to outline main points and provide models. The manual also includes a comprehensive “Overdose Prevention and Response,” section which provides details on overdose and its causes and co-factors; overdose recognition basics; and effective responses. An extensive Appendix is available online and includes annotated citations of existing research studies, examples of data tracking forms, examples of policies and procedures, examples of PowerPoint presentations for overdose prevention trainings/groups, and other overdose materials.

This manual is simply a guide. It is not meant to be exhaustive nor prescriptive, and there are numerous other resources that go into extended detail about many of the topics covered. We have provided links to these resources whenever possible. Take from this manual the parts that are important and meaningful to you, adapt them how you see fit, leave those pieces that may not apply, and pass on to others what you develop.

Introduction Notes

1. Warner M, Chen LH, Makuc DM, et al. Drug poisoning deaths in the United States, 1980-2008. <http://www.cdc.gov/nchs/data/databriefs/db81.htm>. Published December 2011. Accessed September 20, 2012.

Module 1:

Understanding the Basics

What is Overdose?

Overdose (OD) happens when a toxic amount of a drug, or combination of drugs overwhelms the body. People can overdose on lots of things, including alcohol, Tylenol®, opioids or a mixture of drugs. Mixing heroin, prescription opioids (like Oxycotin®, fentanyl, morphine, Vicodin®, Percocet®, etc.) and other downers such as alcohol and benzodiazepines (like Xanax®, Klonopin®, Valium®, Ativan®, etc.) are a particularly dangerous combo, since they all affect the body's central nervous system, which slows breathing, blood pressure, and heart rate, and in turn reduces body temperature. Stimulant drugs like speed, cocaine, and ecstasy raise the heart rate, blood pressure, and body temperature, and speed up breathing. This can lead to a seizure, stroke, overheating, or heart attack. Overamping is the term we have begun using to describe what one might consider an "overdose" on speed. See page 64 for more information.

Opioid overdose occurs when the level of opioids, or combination of opioids and other drugs, in the body render a person unresponsive to stimulation or cause their breathing to become inadequate. This happens because

opioids fit into the same receptors in the brain that signal the body to breathe. If someone cannot breathe or is not breathing enough, oxygen levels in the blood decrease causing the lips and fingers turn blue, a process called cyanosis. Oxygen starvation will eventually stop vital organs like the heart, then the brain, and can lead to unconsciousness, coma, and possibly death. Within 3-5 minutes without oxygen, brain damage starts to occur, soon followed by death.

In the case of opioid overdose, survival or death wholly depends on maintaining the ability to breathe and sustaining oxygen levels. Fortunately, this process is rarely instantaneous; most commonly, people will stop breathing slowly, minutes to hours after the drug or drugs were used. While people have been "found dead with a needle in their arm," in most cases there is time to intervene between when an overdose starts and before a victim dies. Even in cases where a person experiences overdose immediately after taking a drug, proper response can reverse the overdose and keep the person breathing and alive.

What is Naloxone?

Naloxone (also known by the brand name Narcan®) is a medication called an "opioid antagonist" and is used to counter the effects of opioid overdose, for example morphine or heroin overdose. Specifically, naloxone is used in opioid overdose to counteract life-threatening depression of the central nervous system and respiratory system, allowing an overdose victim to breathe normally. Naloxone is not a controlled substance (i.e., non-addictive), prescription medication. Naloxone only works if a person has opioids in their system; the medication has no effect if opioids are absent. Although traditionally administered by emergency response personnel, naloxone can be administered by minimally trained laypeople, which makes it ideal for treating overdose in people who have been prescribed opioid pain medication and in people who use heroin and other opioids. Naloxone has no potential for abuse.

How Naloxone Works

The brain has many receptors for opioids. An overdose occurs when too much of any opioid fits into too many receptors slowing then stopping the

What is an opioid overdose?

The brain has 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.

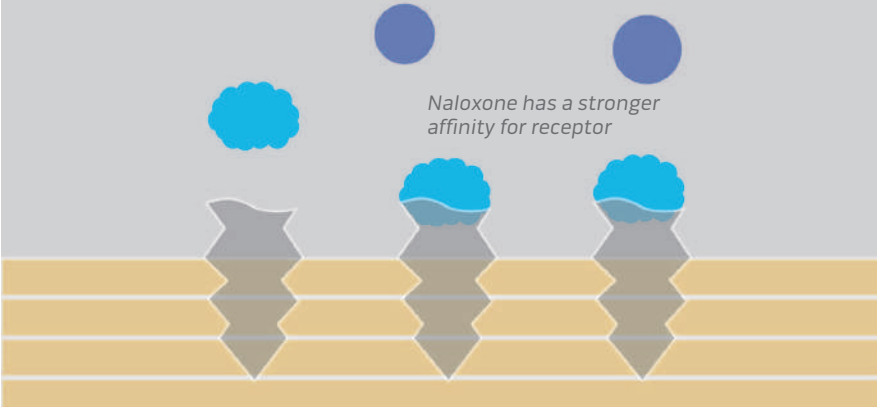
Opioids fit exactly on receptor



Naloxone reversing an overdose

Naloxone has a stronger affinity to the opioid receptors than opioids like heroin or Percocet®, so it knocks the opioids off the receptors for a short time. This allows the person to breathe again and reverses the overdose.

Naloxone has a stronger affinity for receptor



For a comprehensive overview of overdose prevention, recognition and response, please see Module 5: Overdose Prevention and Response. Adapted from graphic by Maya Doe-Simkins

breathing. Naloxone has a stronger affinity to the opioid receptors than many opioids (like heroin, Oxycontin® or Percocet®) so it knocks the opioids off the receptors for a short time. This allows a person to breathe again and reverses the overdose.

Naloxone may be injected in a muscle, vein or under the skin, or sprayed into the nose. Naloxone that is injected comes in a lower concentration (0.4mg/1ml) than naloxone that is sprayed up the nose (1mg/1ml). It is a temporary drug that wears off in 30-90 minutes.

The Need for Take-Home Naloxone Programs

Studies indicate that many people who die from opioid overdose failed to receive proper medical attention because their peers and other witnesses (often other drug users) delay or do not call 911 for fear of police involvement.¹ While not all opioid overdoses are fatal, the provision of naloxone by laypeople to an overdosing person who would otherwise not receive medical intervention saves hundreds of lives each year. Additionally, timely provision of naloxone may help reduce some of the morbidities (i.e. medical complications or conditions) associated with non-fatal overdose. Witnesses who are able to perform rescue breathing and administer naloxone to an overdosing person experiencing respiratory depression will likely prevent brain damage and other harms.

In most jurisdictions naloxone is only used in hospital settings and carried by emergency medical personnel; as a result, it is only available to people experiencing overdose if and when emergency medical services are accessed. However, recognizing that many fatal opioid overdoses are preventable, take-home naloxone programs have been established in approximately 200 communities throughout the United States. These vital programs expand naloxone access to drug users and their loved ones by providing comprehensive training on overdose prevention, recognition, and response (including calling 911 and rescue breathing) in addition to prescribing and dispensing naloxone.

According to a survey conducted in 2010 by the Harm Reduction Coalition of known naloxone distribution programs, between 1996 and June 2010, a total of 53,032 individuals have been trained and given naloxone as a result of the work of programs the US. These 48 take-home naloxone programs, spread over 188 sites in 15 US states and DC, have received reports of 10,071 overdose reversals using naloxone.²

Module 1 Notes

1. Pollini et al, 2005; Tobin et al, 2005; Davidson et al, 2003; Seal et al, 2003; Strang et al, 2000.
Amy S.B. Bohnert, Kathryn Roeder, Mark A. Ilgen, "Unintentional overdose and suicide among substance users: A review of overlap and risk factors." *Drug and Alcohol Dependence*. 110.3 (2010) 183-192. Print.
2. Responses were collected from known naloxone distribution programs between October 5, 2010-November 12, 2010 using a Survey Monkey survey tool by Eliza Wheeler, DOPE Project Manager at the Harm Reduction Coalition. The survey was initiated as a project of the NOPE Working Group (Naloxone Overdose Prevention Education) in order to gather up-to-date data about the impact of US naloxone distribution programs. Published in the *CDC Morbidity and Mortality Weekly Report*, "Community-Based Opioid Overdose Prevention Programs Providing Naloxone — United States, 2010," February 17, 2012 / 61(06):101-105.

Module 2:

Overdose Prevention Strategies without Naloxone

There are important ways you can integrate overdose prevention into your current work at *little to no cost*. Although all of these suggestions may not be relevant to your unique program structure, they are a great starting point to begin brainstorming ways that overdose prevention can fit into your program.

The next section offers guidance for implementing some of these suggestions.

Implementing Low-Cost Overdose Prevention Strategies

- Put up posters about preventing or responding to an overdose
- Provide educational materials (brochures, fact sheets) for program participants on overdose
- Develop a policy for responding to on-site overdose
- Train program staff and volunteers on overdose—including risk factors, signs and symptoms, and response (including rescue breathing and naloxone administration)
- Discuss overdose risks with participants and screen participants for higher risk
- Ask program participants if they have witnessed an overdose
- Ask program participants if they have survived an overdose
- Talk to program participants about the availability of naloxone
- Offer referrals to places where program participants can get naloxone
- Talk with program participants about what to do if they're with someone who is overdosing
- Discuss or incorporate overdose prevention in groups

Notes:



Visit harmreduction.org to download this as a printable worksheet.

Integrate Overdose Prevention Messages as Standard Practice

There are several practical, participant-centered strategies that can be employed to assist staff in promoting overdose prevention messaging. Overdose prevention messages are relevant to anyone who uses drugs, whether they use prescription drugs or “street drugs.” These messages can easily be incorporated into various settings, including primary health care, mental health services, drug treatment programs, shelters, supportive housing or correctional settings.

For example, staff can engage participants around overdose risk during informal conversations by asking if they plan to use alone or if they have friends that know they use. For participants who have recently been released from jail or come out of drug treatment, a conversation reminding them about the increased risk of overdose can be lifesaving.

More formally, staff can add questions about overdose risk to intake/assessment forms, health screenings or include overdose risk reduction as an integral component of treatment planning.

Posting overdose messages on fliers or posters in the agency provides another way of engaging program participants around overdose and sends the message that staff is available to discuss overdose risk and response. Some examples of these types of messages

can be found in the Appendix *Overdose Prevention and Response Messages*, online.

The only costs associated with any of these strategies are staff time for training and printing costs of any materials posted in the agencies.

Develop an Onsite Overdose Response Policy

A simple strategy for integrating overdose prevention into your program is to develop a policy for responding to on-site overdose. Having such a policy in place is not only vital in the event of an overdose, but it has the additional benefits of getting agency staff or volunteers engaged in overdose prevention issues and sends a message to program participants that their lives and safety are valued. This strategy does not require a great deal of resources. The main cost involved in developing a policy is staff time for those involved in the policy development, as well as the time needed to train all staff on the emergency response plan once it is in place.

In order to develop an overdose response plan for your agency, it is important to assess current circumstances related to overdose. See box on page 15.

These considerations are important to take into account when drafting an overdose response policy that is tailored to your agency. Some agencies may opt to incorporate naloxone

training into their protocol, others may rely on calling 911 and doing rescue breathing, while others may train staff to take all these measures. Examples of various overdose response policies can be found online in the Appendix, *Sample Documents*, online.

Provide Overdose Response Training for Participants

Overdose prevention and response education and training can be developed for program participants even if a program is not yet equipped to distribute naloxone. Some of the earliest overdose prevention efforts, such as distributing written materials, posting educational fliers and running groups about overdose, were initiated long before naloxone became available.

Providing education about overdose risk, recognizing overdose, performing rescue breathing, and calling 911 can all be lifesaving interventions. These educational sessions can be incorporated into existing group schedules or done one-on-one with participants. Session length can vary from ten to sixty minutes depending on the setting and trainee experience.

Costs related to participant trainings vary depending on the different supplies you decide to incorporate into your workshop.

Basic costs for implementing overdose prevention training include:

- *Staff time:* For outreach and to conduct or staff the training. See the Appendix, *Training Materials*, online for examples of training guides.
- *Development/printing of materials and handouts:* Educational materials can either be created in-house or there are numerous pamphlets and brochures available from other harm reduction organizations. See the Appendix, *Overdose Prevention and Response Messages*, online.

Optional costs may also include:

- *Rescue breathing dummies (approximately \$70):* A great training tool for practicing rescue breathing.
- *CPR mouth shields (approximately \$180 for a box of 250):* Great for both training and incentives. See the Appendix, *Naloxone Kit Materials*, online for more details.

Develop an Overdose Response Plan

- Has overdose already occurred in your agency? If so, how was it handled? What worked well and what needs improvement?*

- Are there locations within the agency that may present heightened overdose risks or complicate overdose response (such as bathrooms that lock or private rooms in Single Resident Occupancy hotels)?*

- Does your agency have outreach staff or volunteers who work with people off-site, in the street or on home visits? What is the protocol if they witness an off-site overdose while working?*

- Does an existing overdose response policy need to be evaluated or updated?*

- Does your agency have staff on-site with medical and/or CPR training?*



Visit harmreduction.org to download this as a printable worksheet.



CASE STUDY



Harm Reduction Action Center Denver, Colorado

Harm Reduction Action Center finds creative ways to provide overdose prevention services despite their lack of access to naloxone.

Since 2002, the Harm Reduction Action Center (HRAC) has been the only Colorado public health agency providing specific health information and holistic services to injection drug users and their sexual partners. The mission of HRAC is to educate, empower, and advocate for the health and dignity of Metro-Denver's injection drug users and affected partners, in accordance with harm reduction principles. Guided by the principles of compassion, mutual respect and evidence-based solutions, HRAC seeks not only to meet immediate needs but to impart skills, education and behaviors needed to maintain personal health, reduce the harmful effects of marginalized lifestyles, and reduce injection-impacted health risks for the larger public.

According to the Colorado Department of Public Health and Environment, overdoses in Colorado have tripled in the last 10 years. Denver has been experiencing especially frequent fatal overdoses, with 8 fatal overdoses in one 6 week period on Denver's Capitol Hill. Unfortunately, the overdose

memorial in HRAC's front room (where we put framed pictures or handwritten names of program participants that have fatally overdosed) has grown so much in the last couple of years that we've had to expand the memorial.

It is very frustrating that we don't have access to naloxone for our staff or program participants and their drug/social networks. As of 2012, we have been unable to find a prescribing physician to help facilitate a take-home naloxone program. We have approached several doctors and have been met with resistance and a belief that providing take-home naloxone is illegal and we will get in a lot of trouble for doing it. We are continuing to approach different doctors to educate them and discuss the possibility of starting a take-home naloxone program. It is slow going in Colorado. Syringe exchange programs were only made legal in 2010, with legal syringe exchange beginning in Denver in February 2012.

Until we can start a take-home naloxone program, the Harm Reduction Action Center provides overdose prevention messaging in two of our health education classes (Break the Cycle and STRIVE) along with quarterly overdose prevention trainings. We teach folks how to: identify an overdose, call 911 without explicitly telling the operator that it is a drug overdose (an effort to keep law enforcement away), perform rescue breathing, and keep everyone

calm. Also, our overdose messaging dispels common myths such as putting ice up someone's ass, shooting someone up with milk or salt water, and other street myths. HRAC participants consistently ask for one-on-one consultations to cope with past overdose or will come to our agency first thing on the morning after an overdose. We take these opportunities to listen and offer encouragement for efforts taken during such a stressful time.

We honor August 31, International Overdose Awareness Day by organizing events in downtown Denver to speak about overdose and the stigma associated with drug use and overdose. Many mothers come up to us and cry; they have never been able to properly grieve for their child since fatal overdose can be stigmatizing for the entire family. In the event of a fatal overdose of a program participant, HRAC requests an autopsy from the Denver County Coroner and provides a memorial at our next all-IDU Advisory Committee meeting (which meets the 3rd Friday of every month). Harm Reduction Action Center looks forward to the day when we never have to add another person to our overdose memorial.

Program update! As of Spring 2012, HRAC found a physician willing to prescribe naloxone for their program and have started providing naloxone distribution at their sites. ■

Module 3:

Take-Home Naloxone Program Development

As of 2010, there were over 188 sites in 15 US states and Washington DC where someone could obtain take-home naloxone. Most of these programs are run out of syringe access or other harm reduction programs, but take-home naloxone programs are expanding to physician's offices, drug treatment programs and hospital emergency rooms.

Harm reduction programs were a logical first home for take-home naloxone programs because they already work in close collaboration with people using drugs. Harm reduction programs have a direct source of knowledge from drug users who have overdosed or witnessed overdose, including insight into how first responders and emergency rooms are treating overdose victims and changing drug trends that impact overdose risk.

It is also appropriate and necessary to implement take-home naloxone programs in a variety of other settings with access to individuals who are, or could be, at risk for overdose. Take-home naloxone programs are also invaluable for potential bystanders or witnesses to overdose, like family members or loved ones of people who use drugs.

This section will outline important considerations when planning a take-home naloxone program including community engagement, legal considerations, the role of medical professionals and special considerations for implementation within different venues.

Community Assessment, Outreach and Engagement

Engaging in a community planning process is an important step in creating a take-home naloxone program. It is important to tailor your overdose prevention work to the community you work in and, whenever possible, gain community buy-in. One of the first and most important steps is to gather information about overdose in your community. See boxes on pages 20-21.

Some communities are able to collect this information using formal sources, such as the Medical Examiner's office, however in some communities it can be more difficult to get this information. It is helpful to tap into the knowledge of community members who are already somehow engaged with those most at risk of overdose, and also to better understand and assess what is currently known about local overdose trends.

These groups may not only be interested in supporting future work on overdose prevention, but they may also have valuable information about current and past overdose risks in the community. If you do not already work with drug users, familiarizing yourself with service providers who work with drug users can facilitate the linkage of your program to those most at risk for overdose. Reaching out to these stakeholders will help make your take-home naloxone programs more relevant and better integrated within the community.

Reviewing Existing Data

Gathering both qualitative and quantitative data will be helpful in making a case for local take-home naloxone programs and will also help you target your services to those most at risk. Similar to the list of potential community stakeholders, possible sources of local data and information include the following:

- City and State Health Departments
- Community Needs Indexes (where applicable)
- Emergency Medical Services (Ambulance, Fire)
- State or City Offices of Vital Records
- Medical Examiner or Coroner's Offices
- Local emergency rooms



CASE STUDY



Chicago Recovery Alliance Chicago, Illinois

Dan Bigg from CRA talks about how the first take-home naloxone program in the US began.

Chicago Recovery Alliance (CRA) started harm reduction (HR) outreach in January 1992 and, through respectful collaboration with people injecting drugs, has grown to become one of the larger HR programs in the world to date. Starting in a state where it was illegal to purchase or possess a syringe without a prescription, our work's research component exempted CRA and our participants from the laws against syringe and other injection equipment prohibitions. As we've grown, we have met regularly and formally with our participants in what we call Community Advisory Groups (CAG)—composed of a diverse group of people injecting in a geographically limited area—paying people for their expertise and having a good meal at each CAG meeting. CAGs have always informed both the initiation of and ongoing feedback about our work. If CRA owes anything to its successes it is listening to the feedback given by CAGs! As our participants report other needs and interests we respond similarly—such as making viral hepatitis prevention the 'gold-standard' of safer injection, including integrating HAV/HBV vaccination into our work,

and addressing opiate-related overdose prevention. As early as 1995, CRA made our first t-shirt that had a list of HR options on the back, including: "Keep Narcan Around."

It was May 4, 1996 and one of our founders, John Szyler (who had created our philosophical touchstone: "any positive change") died of a heroin overdose. He left us to not only grieve his loss, but also to use his death to motivate—you guessed it—another positive change in helping people prevent overdose by teaching about it and making naloxone, the decades proven opiate overdose antidote available to our participants. In the fall of 1996, after sadness turned to desire for action, some MD friends and myself started naloxone training and distribution to select CRA participants. Overdose was, and is, the number one cause of premature death among our participants and people were delighted about having this resource available to them. For those participants who had heard about naloxone, it was generally regarded as kindly as garlic might be to a vampire. Most experiences with naloxone up to that point were after abuses at the hand of an emergency medical provider who shot 2mg intravenously into a person who had overdosed and subsequently fought with them as they exploded out of the emergency room or ambulance in serious withdrawal. Following HR practice, we sought out medical help that valued and respected life and human rights. Shawn DeLater, an emergency room physician and

Sarz Maxwell, an addictionologist, were our first medical care providers ready and willing to put a healthy, lifesaving touch on reversing opiate-related overdose with effective and humane intervention. From 1997 to 1999, our program expanded slowly and steadily in Chicago, and at our insistence, the Drug Policy Alliance held the first Opiate Overdose Conference in Seattle with international presenters in early 2000.

In January 2001, CRA rolled out its first overdose training for all staff, interested volunteers and participants and incorporated naloxone distribution to all sites and contact points CRA operates. At this time, we also posted materials on our website for any other program to use. Through spreading the word within the HR community about the effectiveness of naloxone distribution, other programs in the US began to start distributing naloxone by the late 1990s and early 2000s.

One consistent hurdle in development of our program was that we first tried to err on the side of caution and provide a lengthy training to participants. After the program had been going for a while we realized that getting good overdose info (focused on maintaining airway and breathing) and naloxone to people in sufficient economy was essential and we slowly distilled the essential information down to a few essential points which we called SCARE ME (see page 19).

In 2010, through collaboration with the AIDS Foundation of Chicago and other HR programs in Illinois we came to enact a new law supporting effective overdose prevention work in our state (20 ILCS 301/5-23) which exempts both prescribers of naloxone and lay persons who try to revive a person with naloxone. Since then, many other programs in Illinois have started providing naloxone.

Our approach is based on forming harm reduction relationships with participants; listening for needs/interests and acting accordingly; and consistently providing as many options for positive change as possible. Through August 2011 we have provided 22,010 overdose prevention encounters and received 2,720 reports of peer opiate-related overdose reversal! ■

SCARE ME is an acronym for:

Stimulation

Call 911

Airway

Rescue Breathing

Evaluate the Situation

Muscular Injection

Evaluate again

- Police reports of drug arrests
- Methadone programs
- Hospital-based and private detoxification programs
- Local drug treatment centers
- Pharmacies and local health-care clinics
- HIV/AIDS service organizations and other community-based organizations
- Syringe exchange programs in other cities and states

You can also consult national data sources if it is proving difficult to get local data. Some great sources of national data on overdose are the Centers for Disease Control (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Please see the Appendix, *Research Bibliography*, online for more information.

Collecting Original Data

Oftentimes, reviewing existing data on overdose trends reveals a lack of information on the subject. For this reason, it is important to collect new data related to the issue.

Methods for collecting original data include:

- Key informant interviews
- Field observation
- Focus groups
- Surveys

During interviews, focus groups, and surveys, it is helpful to ask about:

- Witnessing overdose
- Firsthand experiences of overdose
- Types of drugs commonly available and consumed locally
- Drug purity
- Common modes of administration of these drugs

Understanding Overdose in Your Community

- Who is overdosing? (i.e. age, race/ethnicity, gender, etc.)*

- What drugs are people taking when they overdose?*

- How are people taking drugs when they overdose? (i.e. injecting, snorting, orally)*

- Where is overdose occurring? (i.e. which cities/neighborhoods)*

- In what settings are people overdosing?*



Visit harmreduction.org to download this as a printable worksheet.

Key Elements of a Community Assessment Process

- Reviewing existing data and policies
- Collecting original data
- Identify stakeholders. Stakeholders include, but are not limited to:
 - People who use drugs
 - Friends and families of drug users
 - Syringe access/needle exchange programs
 - First responders (fire departments, EMS, etc.)
 - Homeless shelters
 - Drug treatment providers
 - Jail discharge planners
 - Housing programs
 - HIV prevention programs
 - Health departments
 - Hospital emergency departments
 - Pain clinics
 - Community Health Centers and Health Care for the Homeless Clinics
 - Parent support groups

Who are the stakeholders in your community?



Visit harmreduction.org to download this as a printable worksheet.

Legal Considerations

According to Scott Burris, JD, of Temple University Beasley School of Law, “In the US, naloxone programs fall within the scope of normal medical practice and no specialized legislation is required for them to operate.” Prescribing naloxone to opioid users who are at risk for overdose is a simple and inexpensive harm reduction measure that has the potential to significantly reduce mortality from opioid overdose. Although some physicians in the US may be discouraged from distributing naloxone due to legal concerns, legal analysis conducted by Burris finds that the legal risks are low. Prescribing of naloxone in the US is fully consistent with state and federal laws regulating drug prescribing.¹

Many successful programs have moved forward under the existing legal framework and, further, have advocated with health departments or state legislatures for funding or additional political support. Advocacy has included specific legislation to reduce physicians’ fear of liability, to protect third-party administrators (the actual user of the naloxone), to protect bystanders who call 911 from prosecution, and to provide government funding. See the Appendix, *Public Policy*, online for examples of legislation and policy educational materials.

Protections for Third-Party Administrators

While it is legal anywhere in the US to prescribe naloxone to an at-risk person (i.e. an opioid user) for their personal use, protocols and protections for prescribing naloxone to a “third party”—wherein the person who receives the prescription has the expressed intention of using it on another person—vary. Similar issues have been dealt with regarding use of “EpiPens®” or epinephrine auto-injections, which are prescribed to people with severe allergies. The person who has the allergy is prescribed an EpiPen® for use on his/herself in the advent of an allergic reaction. However, in some states there have been additional protections put in place for someone who is not prescribed the EpiPen® to use it on a person with an allergy. For example, in August 2011 the Illinois General Assembly approved Public Act 097-0361, allowing school personnel, including nurses, to administer certain medications, such as asthma inhalers and EpiPens®, to students.² Another similar precedent concerns expedited partner therapy for sexually transmitted diseases. Expedited partner therapy (EPT) is the practice of treating the sexual partners of people diagnosed with chlamydia or gonorrhea by giving a prescription or dispensing medication to the diagnosed patient on behalf of their

sexual partner(s). EPT has been shown to increase treatment and decrease re-infection. The practice is recommended by CDC as an option for treatment of partners of patients diagnosed with chlamydia or gonorrhea.³ The Center for Law and the Public’s Health and the CDC assessed the legal status of EPT and found that three-fourths of US states either expressly permit EPT or do not expressly prohibit the practice.⁴

There are several ways that US programs have instituted protections for third-party administrators of naloxone. For example, California passed Assembly Bill 2145 in 2010 that explicitly states that third-party administrators of naloxone are protected from liability in participating counties. The Massachusetts Department of Public Health states that third-party administrators are protected in their overdose prevention pilot project guidelines and in the text of the standing orders issued by the medical director that oversees the project. In both of these states, it should be noted that naloxone programs existed without incident long before legislation or public health regulations were passed. That said there are a number of state and federal policy changes that would facilitate greater access to overdose prevention. To read further on the topic, see the Appendix, *Public Policy*, online. See page 42 for additional resources.

The Role of Medical Professionals

Since naloxone is not yet available over-the-counter, and only obtainable by prescription, it is necessary to work with a medical professional who can prescribe the drug for your program. As stated in Scott Burris’ legal analysis, anyone with prescribing authority can legally prescribe naloxone to someone who is at risk for opioid overdose.⁵ Arrangements can be made to provide additional liability protection for the prescriber of naloxone and to third-party administrators of the drug. A “third-party administrator” refers to the person who uses the naloxone to revive an overdosing person.

There are several models for working with medical professionals that allow for different levels of engagement from the prescriber. Some naloxone programs work with a prescriber who is present during naloxone trainings in order to sign off on the prescription for naloxone in person. In this case, the naloxone is typically given to the participant during the training, and is supplied free of charge by the program instead of requiring that it be filled at a pharmacy in the traditional manner. In a variation of this model, some prescribers work with nurse practitioners (NP) and allow the NP to sign off on the prescriptions in their absence.

Other places have adopted a “standing order” model. For example, in Massachusetts, the Department of Public Health has appointed a Medical Director who assumes prescribing authority and clinical oversight for their statewide naloxone distribution pilot program. Massachusetts uses a “standing order” model (see the Appendix, *Sample Documents*, online) that empowers trained non-medical people (i.e. syringe access workers, counselors, outreach workers) to distribute the naloxone (see the Appendix, *Sample Documents*, online). This option is convenient for programs and allows them the most freedom to train and distribute naloxone to participants directly within the community, without the limitation of scheduling a provider to be present at trainings. Other states, such as New Mexico, use a slightly different standing order model that allows Department of Public Health personnel with prescribing authority to prescribe naloxone at overdose prevention programs throughout the state. While prescribing clinicians still sign off on each prescription for naloxone in New Mexico, they have modified their protocol to allow the program to call in a naloxone order over the phone to the clinician. Other states like Illinois and cities like San Francisco and Santa Cruz, California are also using versions of standing orders.

How do you find a prescriber?

The first step in finding a naloxone prescriber is to come up with a list of doctors (psychiatrists, MDs, etc. — anyone with prescribing privileges) that you think may be interested; brainstorm doctors who work with drug users in any capacity, or who are involved in other related work like wound care, methadone or buprenorphine programs, or medical care for homeless individuals. Physicians who work at public health departments, emergency departments, or oversee emergency medical personnel or the fire department may also be interested in becoming prescribers. For example, the first doctor in Boston, Massachusetts to step forward to prescribe naloxone through the Boston Public Health Commission’s syringe access program was the Medical Director of EMS for the city of Boston.

It is important to convey that this project would take very little of the prescriber’s time and effort, but their prescribing authority is important to legitimize and protect the program and its participants. There are doctors in the US that have been prescribing naloxone through harm reduction programs for many years and would gladly speak with someone who was interested in prescribing naloxone. Feel free to contact the Harm Reduction Coalition in order to connect with other take-home naloxone programs and prescribing doctors.

Important Information for Potential Prescribers

If the doctor you are going to approach has little knowledge of naloxone programs, it is a good idea to prepare a packet of information, including:

- A review of the research on overdose and naloxone
- Information on the legality of prescribing naloxone nationally, and in your area
- Summary information from any community planning meetings/initiatives
- Funding plans, if applicable
- Examples of program guidelines

Samples of many of these items can be found throughout this manual and in the Appendix online.

Notes:



DOPE Project San Francisco, California

DOPE Project borrows from their friends, gains the support of the city public health department and secures funding and a doctor to support their existing overdose prevention work.

The DOPE (Drug Overdose Prevention and Education) Project was built on a strong legacy of harm reduction efforts in San Francisco as well as other cities (Santa Cruz, California; Chicago, Illinois), States (New Mexico), and countries (Australia, England, Canada). In 1993, youth outreach workers in San Francisco first distributed overdose prevention education flyers developed by the Santa Cruz Needle Exchange in California. In 1998, in response to increasing fatal overdoses among young IDUs in the Haight Ashbury district, syringe exchange street outreach workers in San Francisco began conducting monthly overdose prevention trainings targeting young IDUs. Education materials were adapted from materials developed in Santa Cruz, California, Chicago, and Australia—early innovators in overdose prevention. Using supplies from peers in the harm reduction community, street-based syringe exchange workers in San Francisco began incorporating training in naloxone into their monthly overdose trainings for young IDUs. What began as a

community-led response among outreach workers and researchers, soon gained institutional support from local public health and substance abuse treatment officials. Research combined with policy advocacy and direct service work made the DOPE Project possible by getting buy-in from the local health department, drug user and HIV researchers, harm reduction organizations and drug users who utilize those services.

Research played a critical role in building the case for overdose prevention interventions in San Francisco. In the early-1990's, empirical evidence among HIV and drug use researchers and prevention workers suggested that IDUs, while targeted for HIV prevention, were instead dying of heroin-related overdose. However, little research had been done to assess the incidence of fatal and nonfatal overdose among IDUs in the U.S. Research and pilot overdose prevention projects conducted in San Francisco by the University of California San Francisco (UCSF)'s Urban Health Study throughout the late 1990s and early 2000s were instrumental in demonstrating the need for overdose prevention, the overdose risk experienced by drug users, and the likelihood that overdose prevention interventions could be successfully adopted by drug users.

In July 1999, the San Francisco Treatment on Demand (TOD) Planning Council tasked a diverse committee with developing recommendations for a response to the city's

"heroin epidemic." The Heroin Committee comprised researchers, clinicians, drug treatment providers, outreach workers, social service providers, drug users and others who developed recommendations for addressing heroin-related issues in San Francisco, including overdose prevention. Several of the Heroin Committee's recommendations were funded and implemented, including a citywide overdose awareness campaign. The campaign featured billboards, bus shelter ads, and free, 20-minute phone cards, which were distributed by programs serving IDUs, with pre-recorded messages encouraging users to "fix with a friend."

As DOPE project founder Rachel McLean noted, "It's about being entrepreneurial. You knock on lots of doors and whichever opens, you walk through." Rachel had written a school paper on the problem of overdose for a public health class, and then written a follow-up paper describing a programmatic response to the problem, which she summarized in a one-pager she gave to the Heroin Committee. Two years later, the public health department had some spend-down money at the end of the fiscal year (as health departments frequently do in June, which can be an excellent source for small and pilot projects), and staff remembered her proposal and asked her to start the overdose prevention project she had recommended.

In December 2001, the TOD planning council allocated \$30,000 in city seed funding to establish a comprehensive overdose prevention program to put the committee's remaining, unfulfilled overdose recommendations into practice and in January 2002, the DOPE Project began with a team of eight overdose trainers conducting trainings on overdose recognition, management, response, and prevention for program participants and workers of syringe exchange programs, homeless shelters, drop-in centers, drug treatment programs, pretrial diversion programs and other venues serving people at risk for drug overdose. The curriculum, which was adapted from materials from the Santa Cruz Needle Exchange, Chicago Recovery Alliance, San Francisco Needle Exchange, and other programs, included rescue breathing, safely calling 911, overdose myths and prevention, but did not include naloxone administration. Trainings typically lasted 30-45 minutes for program participants and 1.5 hours for providers.

In 2003, researchers from the Urban Health Study presented the findings of their naloxone pilot study conducted in 2001 to the Director of the San Francisco Department of Public Health (SFDPH). The findings of the naloxone pilot study, along with an article by Scott Burris on exploring the legal implications for physicians of prescribing take-home naloxone to heroin users, proved instrumental to SFDPH's decision to give the

green light for a citywide take-home naloxone program in San Francisco.

In late 2003, the DOPE Project began providing naloxone by prescription in collaboration with Dr. Josh Bamberger, medical director of the SFDPH's Housing and Urban Health program. DOPE trainers provided the overdose prevention and response education, and the Nurse Practitioner at the site would complete a "clinical registration" form with the person, and sign off on the naloxone prescription. In June 2005, the DOPE Project became a program of the Harm Reduction Coalition, and in 2010, the city changed its policy to allow DOPE trainers to distribute naloxone directly under a standing order without a medical provider present. ■

Venues and Tips for Different Settings

This section adapted from the work of Maya Doe-Simkins, Alex Walley and colleagues for their "Notes from the Field (temporary title)" Overdose Prevention Manual.

Naloxone programs can be implemented effectively wherever they may reach individuals at risk for overdose, or potential bystanders. That being said there are some venues that are particularly well suited to implement take-home naloxone programs, including:

- Syringe access/harm reduction programs
- HIV/AIDS service and prevention organizations
- Drug treatment programs
- Jail and corrections
- Parent and family groups
- Health care settings and pain management clinics

This is not to suggest that these are the only places where overdose prevention programs are needed, but they are good starting points. Overdose prevention and education should be available in a variety of settings, to a variety of different people who may be potential bystanders or witnesses to an overdose. Drug users, their families and friends and staff of programs are all potential lifesavers in an overdose situation. Additionally, some first responders (Fire, EMS) could benefit from a more in-depth discussion about the risk factors that contribute to overdose as well as compassionate

strategies for dealing with overdose in the community.

Syringe Access/Harm Reduction Programs

Chicago Recovery Alliance, a harm reduction and syringe access program (SAP), was the first program in the US to start distributing naloxone to drug users in 1996. Since then, many other SAPs in the US have started take-home naloxone programs while others provide overdose prevention trainings, workshops and educational materials at their exchanges. It should become standard practice to include overdose prevention in syringe access operations since overdose is the single most common cause of death among people who inject drugs (more than HIV and Hepatitis C).

HIV/AIDS Service and Prevention Organizations

Overdose prevention and response are necessary components of quality HIV/AIDS programming for people who use drugs. Some programs that provide services to people living with HIV/AIDS may not have funding to provide syringe access (the most obvious way that drug users are engaged in HIV prevention) but this does not mean they do not serve people who use drugs. HIV case management and housing programs, HIV testing sites and health care clinics that specifically treat people living with HIV/AIDS are all ideal places to provide take-home naloxone and overdose prevention. Even people living with HIV/AIDS who do not have a history of "illicit" drug

use may be on opioid pain medication, which, in combination with other types of medication that are co-prescribed, can be a risk factor for overdose. In the publication, *Why Overdose Matters for HIV*, Curtis and Dasgupta describe seven reasons why it is critical to link HIV services with overdose prevention and education:

- *Overdose is a significant cause of mortality among people living with HIV. Overdose often greatly exceeds HIV and other infectious disease as a cause of death among injection drug users.*
- *HIV infection is associated with an increased risk of fatal overdose, due in part to systemic disease and liver damage associated with HIV infection. HIV care and treatment providers should therefore prioritize providing overdose prevention support to their drug-using patients.*
- *Overdose prevention services connect people who use drugs to HIV prevention, drug treatment, primary health care and other basic services. By expanding the breadth of care and support and addressing the priorities of people who use drugs, HIV prevention services may expand coverage and more effectively fight the HIV epidemic.*
- *Overdose prevention empowers people who use drugs and who have or are at risk of acquiring HIV. Overdose education and naloxone distribution put powerful tools in the hands of people who use drugs, much as syringe exchange enables people to take charge of their health*



The Clean Works Program of The Grand Rapids Red Project Grand Rapids, Michigan

A needle exchange program in Michigan takes action to expand access to naloxone.

In Kent County, Michigan, overdose is currently the leading cause of unintentional injury of all people aged 21-65, yet it is not an issue that is addressed locally by public health. People are dying in Kent County, but they are dying largely silent deaths. At the Clean Works program of the Grand Rapids Red Project, we view this as unacceptable. Overdose fatalities, specifically opiate overdose fatalities, are preventable. We decided that we should do something about this as an organization, and as a group of people concerned with the health of people who use drugs.

In October of 2008, we began partnering with a local doctor to provide participants of our syringe exchange program with access to the life saving medication naloxone and the knowledge and skills to use it to successfully intervene in opiate overdose situations. Prior to this point there had been limited naloxone access within the City of Grand Rapids, but more was needed to make an impact in the rapidly rising death toll from opiate overdose fatality. Michigan does not have specific legislation dealing

with naloxone and overdose programs, so the same laws apply as with any prescription medication. So, in October of 2008, we began providing comprehensive overdose prevention and intervention trainings using the SCARE ME protocol developed by the Chicago Recovery Alliance. A lot of research and work has gone into reducing overdose fatality in other cities and by other organizations; instead of reinventing the wheel in Grand Rapids, we borrowed it from other organizations.

In Grand Rapids, we operate a fixed site syringe exchange program 3 days a week. Overdose trainings are available on a walk in basis for free anytime we are open. We are located in the Heartside neighborhood in downtown Grand Rapids. The overdose mortality rate in the neighborhood in which we operate is 45 times the average rate in Kent County. The neighborhood is dominated by shelters, soup kitchens and low-income residences, and has seen a large rate of gentrification in the past few years. A large proportion of our program participants come from the area in which we operate, but we also receive program participants from many miles away as we are the only syringe exchange program in the Grand Rapids area. Through our overdose prevention program, we talk with our program participants about recognizing overdoses, the importance of rescue breathing, calling 911, and how to intervene in an overdose. Program participants are provided with access to naloxone hydrochloride.

Almost immediately after starting this program, we began receiving reports of people reversing overdoses because of the knowledge and the tools we had the opportunity to put in their hands. Through August of 2011, we have had the opportunity to facilitate 209 trainings, and these trainings have led to 64 reported overdose reversals.

The success of this intervention cannot be denied on an individual level. Anyone who has experienced a friend turning blue, knocking on death's door right next to them, and not knowing what to do—contrasted with having the tools, the knowledge, and the ability to save that friend's life—knows that this intervention works. We have 64 reported reversals to show the strength of this intervention on an individual level. What we also like to see is our interventions working on a community level. Shortly after starting to provide overdose prevention and intervention trainings in Grand Rapids, cumulative overdose fatalities began to stabilize. After increasing almost four-fold in the past fifteen years, overdose fatality stopped increasing, and as of 2010 it actually started decreasing in Kent County.

Training people who use drugs on how to intervene in overdose situations works. Providing people with the knowledge and tools necessary to save lives, saves lives. People who use drugs are the true first responders in most overdose situations, and its past time we treated them as such. ■

- *Overdose may exacerbate HIV-related disease. Nonfatal overdose is associated with a number of disease sequelae, including pneumonia, pulmonary edema, acute renal failure, rhabdomyolysis, immune suppression, physical injury, and other conditions.*
- *Many of the same policies that increase risk of HIV infection among injection drug users also increase the risk of overdose; addressing overdose risk can impact HIV risk. State policies that criminalize and incarcerate people who use drugs or prioritize abstinence-based, often compulsory, drug treatment are well documented to increase the risk of HIV infection and the risk of overdose.*
- *Overdose is a serious concern among people living with HIV who use drugs. Virtually any survey of injection drug users shows that large majorities have both experienced and witnessed overdose, and that a significant proportion have experienced multiple overdoses in their lifetime.*

For full text and references, please see The Eurasian Harm Reduction Network publication.⁶

Drug Treatment Programs

Take-home naloxone programs fit with a variety of types of drug treatment modalities, including opioid replacement therapy programs like methadone and buprenorphine clinics, residential treatment facilities, short-term inpatient detoxes and outpatient

clinics. Drug treatment providers have a unique opportunity to reduce unintentional overdose deaths because they have access to people at risk for overdose and the responsibility of ensuring the health and safety of their participants.

Drug users who are engaged in treatment may have lower risk for overdose while in treatment, but are at extremely high risk of overdosing if they begin using again after a period of abstinence or reduced use. Integrating overdose prevention and education messages into treatment planning, relapse prevention groups and most importantly, discharge planning *does not encourage relapse or drug use*, but instead offers practical, honest information and resources to someone who may begin using again. If it is not realistic to implement a take-home naloxone program at your treatment program, it is important to refer people to their closest take-home naloxone program upon discharge.

In some places in the US, drug treatment programs have embraced this idea and have begun giving participants of inpatient detoxes who are not going on to further treatment a naloxone kit upon discharge. Some methadone maintenance programs include overdose prevention and naloxone prescriptions as part of the intake process. Some residential treatment programs provide overdose prevention, education and response workshops as part of their rotating group schedule. In New York State, the Offices of

Alcohol and Substance Abuse Services offers CASAC/ CPP/ CPS credit hours for addiction medicine professionals who participate in an online course about overdose prevention. To check out their training curriculum, go to <http://www.oasas.ny.gov/AdMed/eshome.cfm>

Methadone and buprenorphine (Suboxone®) programs are ideal places to implement overdose prevention and take-home naloxone programs. According to a 2007 SAMHSA report, the majority of methadone overdose deaths are associated with use of the drug for the *treatment of pain rather than addiction*, but methadone clinics are still great places to implement overdose education as a way of reducing overdose deaths and showing patients that their lives and lives of their family and friends are important to the clinic. Most deaths associated with methadone can be described by one of three scenarios:

- Accumulation of methadone to toxic levels at the start of treatment for pain or addiction (i.e., the induction phase).
- Misuse of diverted methadone at high doses and/or by individuals who had little or no tolerance to the drug.
- Synergistic effects of methadone used in combination with other CNS depressants, such as alcohol, benzodiazepines, or other opioids.

Opioid replacement therapy (ORT) patients who are in the induction phase, who have co-occurring morbidities or polysubstance use are at higher risk for overdose. ORT patients whose treatment ends abruptly, or who begin to decrease their dose of methadone may supplement with other opioids to relieve withdrawal, putting them at high risk for overdose. Finally, ORT patients are important bystanders and potential users of naloxone because they may still know many individuals or family members who are using.

Here are some possible scenarios for incorporating overdose prevention into a treatment setting, in order from simplest to most thorough (see the Appendix, *Sample Documents*, online for more information):

- Clinic staff refer patients to the closest overdose prevention program/take-home naloxone program for training and naloxone as part of their treatment plan;
- Take-home naloxone/overdose prevention program staff regularly visit the treatment clinic to provide on-site training and to distribute naloxone;
- Clinic staff provide overdose prevention training and subsequently refer trainees to the closest take-home naloxone program for naloxone;
- Clinic staff provide both overdose prevention training and distribute naloxone on-site.⁷

Providing Overdose Prevention Training with Drug Treatment Program Staff

If you are hoping to provide overdose education to participants in drug treatment, it is usually a good idea to offer training for program staff first. Typically, once staff are trained and get comfortable with the training and the topic, they become open to having their program participants trained. Sometimes this happens immediately, while other times it requires a prolonged process to build comfort and acceptance and to demonstrate appropriateness. Harm reduction interventions have not always been accepted in more traditional treatment programs, and drug treatment providers may benefit from a discussion about the perceived ethical dilemma of providing overdose prevention, education and naloxone rescue kits to individuals in drug treatment. Questions that are likely to come up include: Will overdose prevention/naloxone training support continued/more use? What kind of message does it send to people in treatment? See box on page 30.

Providing Overdose Prevention Training with People in Drug Treatment

When providing training at another agency, it is vital to be mindful of and respect the confidentiality of participants, including among host agency staff. For example, although a methadone counselor may have arranged for a group or training to take place, patients that attend the group could suffer negative outcomes if their counselor learns about their polydrug use from discussions within the group. It is best to either avoid situations where someone may disclose this kind of information, or have such conversations in private without counselors present.

The trainer should approach groups by first asking what they know about each topic, as opposed to simply telling them about each topic. This allows for a more interactive session and recognizes that all participants come to the session with existing knowledge on the subject; failure to acknowledge this can be both boring and insulting to training participants. Under these circumstances, you're likely to find that groups will generally run themselves.

Tips for Training Drug Treatment Program Staff

- Explain the legal basis for the project and be prepared to field questions.
- Encourage the agency to develop its own internal policy about overdose prevention and naloxone. Bring a copy of an existing agency policy to use as an example.
- Discuss any possible risky environments or situations unique to their program, i.e. are there locking bathrooms, are people in rooms alone?
- Discuss strategies to ensure that residents/guests/program participants feel comfortable and safe reporting overdose or accessing naloxone rescue kits to manage the overdose.
- Describe how overdose prevention conversations enhance therapeutic relationships and build trust with program participants.
- Explain that there is no evidence that discussing overdose prevention and response with individuals in drug treatment results in relapse.
- Explain that while naloxone is provided to treatment program participants, it may also be used to save the life of someone else (i.e. peers or family members). Telling a person in treatment that she or he has the potential to save a life is a very positive message, particularly for those new in treatment that may be struggling to feel good about themselves.
- All groups should be reminded that using naloxone as punishment (i.e.—administering naloxone to someone who *is not* experiencing overdose or administering *too much* naloxone) will be counterproductive.

See the Appendix, *Training Materials*, online for additional resources.



Visit harmreduction.org to download this as a printable worksheet.

If participants (or staff of the treatment program) express discomfort about discussing drug use or relapse, try reframing the training as “how to save a life” and discuss the possibility of being around others, like family or friends, who may continue to use and who may be at risk of overdose. While this may seem insincere or feel like a compromise, it is a legitimate way to discuss overdose prevention and response with participants who may otherwise be unwilling to engage. Either way, they will receive information that they can apply to their own experience if they begin using again at any point after treatment.

Jails and Corrections

Individuals with a history of drug use who are leaving jail or prison have a great likelihood of overdosing in the first 2 weeks following discharge. Correctional settings are great places to provide overdose prevention information and ideally, naloxone prescription at the time of discharge. Overdose prevention groups can be provided to individuals in treatment programs in prison/jail, on open tiers where educational groups are offered or in classrooms. It is also beneficial to work with probation offices, drug courts and pre-trial diversion programs to provide overdose prevention education and when allowed, naloxone prescription.

As a program or individual providing harm reduction services, it can be challenging to get access into the correctional system to provide overdose education, but several programs across the country (in San Francisco, Pittsburgh, New York City, Baltimore, Massachusetts, Rhode Island and several facilities in New Mexico) have made it happen. As of now, none of these programs distribute naloxone to inmates *while* they are incarcerated, or as they are leaving custody, but they do provide vital overdose education and referral to local naloxone programs on the outside.

To gain entrée to the correctional system, it is important to find an ally, someone who is on the inside who you can present the idea to, and who has the power to help move it through the proper channels to gain approval from the facility. Some jails and prisons have public health interventions in place already, like HIV testing or peer-led HIV prevention, or they have a jail health program that could be a good place to start. You can also check to see if the correctional system has an offender re-entry program, or case management program—these are also possible places to find an ally who understands the increased risk of overdose for people leaving prison and re-entering the community. If your local department of public health already works within the prisons, contact them to inquire about proposing an overdose prevention group. Many jails and prisons also have drug treatment components that may be interested in incorporating overdose prevention into their existing workshops and group activities.

Providing Overdose Prevention Training in a Corrections Setting

Respect authority! This might be a tough one, but the correctional system is rigidly hierarchical and there are many rules and policies intended to keep inmates, correctional officers and visitors safe. Some of these policies might seem ridiculous, inappropriate or downright abusive to you, but remember that you are their *guest*; policies must be respected or you won't be allowed in to do the important work that you want to do. So: Follow their rules. Vent later. Your goal is to get information to the individuals who are locked up, and dealing with correctional officers and prison administrators is the only way you'll get to do that. Plus, sometimes they can be great allies, so don't assume the worst from the start.

Similar to the suggestion above, follow the proper channels to get approval to enter the corrections system and keep all relevant parties informed of your intentions, content and actions. Similar to providing overdose prevention in drug treatment settings, if participants (or correctional officers, wardens, etc.) express discomfort about discussing drug use or relapse, it's important to try framing the training as "how to save a life" and to discuss the possibility of witnessing overdose among other people, like family or friends, who may continue to use and who may be at risk.



Prevention Point Pittsburgh Pittsburgh, Pennsylvania

Taking overdose prevention into the jails to reach those at risk.

Prevention Point Pittsburgh (PPP) started the Overdose Prevention Project (ODP) in 2002 in response to the alarming increase in overdose deaths in Allegheny County, Pennsylvania. The ODP Project provides training on overdose prevention and response to individuals at risk of drug overdose, as well as to staff of agencies who work with individuals at risk and other individuals, family and friends, who might be present at the scene of an overdose and might be in a position to save someone's life. Trainings are offered at needle exchange, at methadone and other drug treatment programs, community settings as requested, and the Allegheny County Jail. PPP offers a Naloxone Prescription Program at their Oakland Needle Exchange Site. All participants in the Naloxone Prescription Program receive training on Overdose Prevention and Response, learn how to perform rescue breathing and how to administer naloxone. Individuals who use opiates are also given a prescription for naloxone and receive naloxone to take home at the time of the training. Only individuals who use opiates can be prescribed naloxone, but anyone can take the training.

PPP in the Allegheny County Jail

In 2000, Allegheny County established the Jail Collaborative, a cooperative effort among the Allegheny County Jail, Department of Human Services, Health Department, Court of Common Pleas, and community partners with the purpose of reducing recidivism and increasing success for inmates following incarceration by focusing on treatment and services in the jail as well as intensive support for inmates and ex-offenders. Deb Rock, a staff person for the Collaborative had been an early supporter of harm reduction and had testified at public health hearings resulting in legalization of needle exchange in Allegheny County. In 2002, as Prevention Point Pittsburgh (PPP) was developing the Overdose Prevention Project, Deb suggested that the warden of the Allegheny County Jail (ACJ), Calvin Lightfoot, might be open to PPP implementing Overdose Prevention and Response trainings for inmates in the jail. She facilitated a meeting with Warden Lightfoot who then asked that the PPP training be presented to senior staff of the ACJ.

While we had assumed that trainings in the jail would be open to inmates who asked to participate, with 8-12 in a training group, Warden Lightfoot felt strongly that all inmates should receive the training and asked us to conduct trainings on the "open pods" (housing units) with those who did not wish to participate required to remain in their cells during the training.

PPP began conducting trainings at ACJ in June of 2003. Trainings were conducted 2-3 times a month, rotating between different pods, both male and female. Trainings involved anywhere from 20 inmates, on a pod where many were elsewhere in the jail on work assignments, to 80 inmates on an exceptionally crowded pod.

While we were hesitant about conducting essentially mandated trainings, this actually worked out quite well. Many inmates seemed leery or uninterested in the trainings, some presumably because they expected a "just say no to drugs" message, some because they weren't drug users and some because they felt they knew everything they needed to know about overdose. As we started the trainings, introducing ourselves as "from the needle exchange" and started to get into very practical information on risks and responses, the audience warmed up considerably and by the end of the each training we had lots of great questions and discussion, with particular interest in the demonstration of how to use naloxone and how to do rescue breathing. People often come up, individually, after the training with questions or concerns.

Trainings are conducted by two trainers working together—typically one staff person and one regular PPP volunteer. Permission was granted to bring in a collapsible, aluminum tripod with a paper flip chart pad with pre-printed slides on the chart that were used in lieu of PowerPoint

slides. Trainings are one hour long and at the end, trainers demonstrated how to do rescue breathing by having one trainer lie on a table while the other trainer demonstrated on the “live dummy.” This is generally a major highlight of the presentation and received cheers from the audience. We take in literature on HIV and Hep C, in addition to the regular ODP curriculum and also specific literature on cocaine overdose and prescription opioid overdose.

In the 8 years of conducting the trainings there have been 2 fights witnessed by PPP staff, one of which resulted in cancellation of the training, the other did not. In addition to limitations in PPP staff time, other challenges have involved imperfect communication among jail staff. At times, PPP staff arrives and the correctional officer on the pod has not been informed which sometimes results in trainings being cancelled. To date, we’ve trained over 6,700 inmates and feel the program has been an overwhelming success. We see lots of people at the needle exchange for naloxone who say they learned about us from the “jail trainings.”

A Pre/Post Test Evaluation indicated a 250% increase in knowledge among training participants in the first year of the program. But, more significant are the stories we have heard:

“I think everybody needs this training who is in active addiction or knows someone who is,” said one of the inmates who attended the training. “I learned some things today that may help save a life—maybe my own life, though my goal is to go out of here and stay clean.”

From another training attendee: *“If I would have had this training a year ago, I think my daughter would be alive today.”*

Another said: *“I had this training a year ago when I was in jail. Last week my girlfriend overdosed and I knew just what to do...I saved her and she is alive because of what I learned.”*

Future Directions

The Overdose Prevention Project is building on our success; developing strategies to make Overdose Prevention and Response education and naloxone accessible to prescription opioid users with equal effectiveness, as our efforts to reach heroin users have shown. Prevention Point began working with local physicians and involved in a project with the Schweitzer Fellowship program to develop a model to facilitate naloxone prescribing in a variety of traditional medical settings. This project involves educating physicians and pharmacists and

developing educational materials, printed and video, specifically tailored to this type of practice. In addition to making naloxone more easily accessible to non-injection opioid users who are not reached through needle exchange programs, this practice also serves to reduce the stigma associated with participation in overdose prevention efforts by making the general population aware of the risk of opioid overdose involved in pain management efforts. ■

Parent and Family Groups

All across the country, parents and loved ones of people who use drugs have been organizing in a variety of ways to support each other, advocate for drug policy reform, and expand access to drug treatment. Further, some of these parent groups have embraced overdose prevention and naloxone as a strategy to help keep their loved ones alive. Overdose prevention and harm reduction strategies can be a tough sell at first for some parents and loved ones, who may feel that these strategies are either enabling, or take the focus off getting their loved one into treatment. When responding to these concerns, focus on the life-saving and empowering nature of being prepared to save someone from an overdose; overdose prevention is not meant to be a “solution” to their loved one’s drug use but rather, a way to keep them alive another day.

Be mindful that parents and loved ones who are organized as part of a 12-step program may not be able to invite an outside group to provide overdose education, because this violates some of the traditions of 12-step programs. However, if a member of one of these fellowships wishes to host separate overdose prevention trainings, they can do so. Groups that are not 12-step affiliated have more flexibility to offer educational workshops and to invite guests to their meetings.

Tips for Providing Overdose Prevention Training with Loved Ones, including Parents, Family and Friends

Friends and family of users may need:

- Referrals to support groups and grief counseling.
- Support to address anger that these resources (overdose prevention information and naloxone) were not previously made available.
- Disclosure at the beginning of the group that it will explicitly address overdose, and that it could be emotionally charged and painful.
- Be mindful that discussions about involuntary drug treatment and increased overdose risk are important but also may become heated and lengthy, so plan time accordingly.
- Some loved ones may want to get involved in advocacy or activism—be prepared with suggestions for these opportunities (advocacy opportunities for pending legislation, local coalitions, etc.).
- Discuss ways that family and friends can communicate to their drug using loved one that they have naloxone and are trained to use it, without making that person feel as if they will be punished with the naloxone.
- All groups should be reminded that using naloxone as punishment (i.e.—administering naloxone to someone who *is not* experiencing overdose or administering *too much* naloxone) will be counterproductive.



Visit harmreduction.org to download this as a printable worksheet.

Health Care Settings and Pain Management Clinics

An emerging model for increasing access to naloxone is to work within more traditional health care settings with physicians and pharmacies. Several places in the US have begun piloting this model and details and procedures are still being developed. The first program to develop such a model, Project Lazarus in Wilkes County, North Carolina, was responding to an overdose epidemic in their region that was driven primarily by prescription opioids. Implementing a model within a health care setting requires coordination with multiple players, including health care administrators and pharmacists. For more information on the Project Lazarus model, see the case study on page 40. Contact Project Lazarus (<http://projectlazarus.org>), visit the website <http://prescribetoprevent.org> or contact Harm Reduction Coalition for more information.

Engaging with medical providers about their role in offering overdose education to patients, even if they aren't ready to prescribe naloxone, can be valuable. In some places, overdose education is already being integrated into clinical practice. For example, the New York State Department of Health AIDS Institute's Clinical Education Initiative provides Continuing Medical Education credit for physicians and other medical professionals about overdose prevention and the role of naloxone in the community. Learn more here: <http://www.ceitraining.org/cme/courses/overdose.cfm>

Continues on page 38.

Considerations for Engaging Medical Professionals

- Share information about other overdose prevention initiatives carried out by physicians and medical providers and offer reassurance about the legality of naloxone prescription. Gather information and support documents from other programs doing similar work, such as Project Lazarus. Bring documentation on legality of prescribing naloxone (i.e. Scott Burris' article on naloxone prescription — see page 42).
- Be prepared to provide suggestions about different ways that patients can be educated about overdose. Providers may be resistant to having to squeeze one more thing into their visits with patients. There are creative ways that programs have addressed this, including the use of pamphlets, videos (including the Project Lazarus patient education video: <http://projectlazarus.org/patients-families/videos>), or referrals to health workers, interns or counselors on staff that could provide the overdose education.
- Be prepared to discuss barriers to enacting a traditional prescription model and offer examples of how this has been carried out successfully in other places around the US (North Carolina, Pittsburgh, Massachusetts).
- Clinics and doctors may have questions about how to bill for overdose prevention services and how naloxone can be covered by insurance. Several programs report that they bill for naloxone under opioid abuse/use codes for Medicaid.
- If providers want to differentiate opioid “misusers” from the rest of their opioid using patients, refer to the inclusion criteria for naloxone prescription and reframe the issue as “opioid safety education” or “patient safety.” Anyone taking opioids can benefit from overdose prevention education.
- Remember, there are three major players involved in naloxone prescription: the prescribers, the pharmacists and the payers (insurance, Medicaid, etc.).



Visit harmreduction.org to download this as a printable worksheet.



CASE STUDY



Learn to Cope and the N.O.M.A.D. (Not One More Anonymous Death) Project Statewide, Massachusetts

A life-saving collaboration between parents and a harm reduction program.

Learn to Cope (LTC) is a support group for parents and family members dealing with a loved one addicted to heroin, Oxycotin® and other drugs. Joanne Peterson founded Learn to Cope in 2004 in Massachusetts, with a small group of parents when her own son became addicted to opiates. What started then as a single, peer-to-peer support group in Randolph, Massachusetts, has grown to include nearly 3,000 members registered nationally. There are chapters across Massachusetts in Brockton, Gloucester, Lowell, and Salem. New chapters are planned for Quincy and at Massachusetts General Hospital in Boston. While the cornerstone of LTC remains the weekly support meetings, the non-profit has become a national model for addiction treatment and prevention programming. LTC also maintains a private online message board for parents and other family members, along with a resource guide and other information about substance use at <http://www.learn2cope.org>.

In 2005, outreach workers from a local needle exchange program attended a community forum about opiate use in a Boston suburb, where they heard Joanne speak about LTC. They approached Joanne after the forum and talked, and learned that she was interested in getting information about overdose prevention and other harm reduction programs. Joanne had recently heard about the naloxone distribution pilots in Massachusetts and written an Op-ed in her local newspaper about the huge number of overdose deaths in her community, asking why parents did not have access to this life-saving drug. The fact that a parent was interested in working with harm reduction programs was exciting for the outreach workers and they were very interested in doing what they could with Joanne. The needle exchange workers passed this information on to Mary Wheeler, who was working at the harm reduction program in an area of Massachusetts where LTC held meetings. Mary and Joanne connected, and they have forged a longstanding collaboration that has grown over the years. Mary's program, Healthy Streets (part of CAB Health and Recovery, now Northeast Behavioral Health), provided overdose prevention and naloxone distribution as part of their Not One More Anonymous Death (NOMAD) project. Mary and NOMAD workers first offered support to Learn to Cope families around substance abuse as well as help getting their loved ones into treatment programs.

As the relationship between the program and LTC grew, they began to provide more services and education to the parents' group. Over the last 6 years NOMAD/Healthy Streets has collaborated with the LTC family groups in the following ways:

- Providing education on: Hepatitis C transmission, prevention and treatment; accessing substance abuse treatment and the realities of the process as a non-using family member and; recognizing substance use;
- Providing naloxone training and enrollment at Learn to Cope support group meetings;
- Trained 12 parents from across Eastern MA to become approved Opioid Overdose Trainers. They have since begun distributing naloxone in their respective groups;
- Presented at the "Youth At Risk" conference about working with parents of drug users, presented with 2 LTC group members;
- Provided technical assistance to families who were in LTC but still lost their loved one to a fatal overdose start their own support group called GRASP North Shore. Currently, staff meets to provide TA every 3 months or as needed via email and phone.

- Worked for 6 years with LTC on the Lynn, MA Overdose Vigil. Several parents have spoken and they also conduct outreach for the event.

One of the unique things about this collaboration between a harm reduction program and a parents' group was that Joanne never asked the harm reduction programs to hold back any information from families, no matter how uncomfortable it was for some to hear at first. Harm reduction programs, like needle exchange, can be difficult for some parents to accept at first, but with time and *respectfully* delivered information, many parents have come to accept and even advocate for harm reduction programs.

As Mary states: "From the start, Joanne never requested we keep needle exchange or the realities of drug use a secret. The harm reduction programs that work with Learn to Cope have been very clear that families no longer need palatable information, they need the truth even if it is uncomfortable for some to hear. Joanne was a remarkable advocate for harm reduction. Without her belief in the philosophy we would most likely not be as involved in LTC as we are. Our program is able to bring to the table a lot of the realities of drug use that families are generally shielded from allowing them to have a full spectrum of accurate and useful information. Families often times will call the program and ask us questions about treatment, come to the

program with their loved ones to access treatment or work with us while a loved one is incarcerated to secure treatment upon their release."

While Joanne was supportive of harm reduction programs from the start, other parents continue to struggle with the concepts, especially around needle exchange and safer drug use information. However, parents tend to be extremely supportive of overdose prevention efforts and naloxone distribution. The most important thing for harm reduction programs to remember when working with families is to tailor their information and approach to their audience and to be sensitive to parents' needs. For example, Joanne suggests that overdose prevention trainings focus on overdose risk factors, signs and symptoms, recognizing overdose and responding, including rescue breathing and naloxone administration. In-depth discussion of safer drug use, or overdose prevention strategies for the drug user can be triggering, and not information that parents feel is necessary for them to know. Instead, the trainers could provide information on how their loved one can access this information for themselves from their local harm reduction program.

Joanne suggests that parents that want to learn more about naloxone distribution contact their local department of public health and ask where they can get access to naloxone, and if there are no local programs,

why not? Programs that offer naloxone can reach families by contacting local family groups or by running Op-eds or outreach advertisements in local media. Programs should ensure that the trainings are confidential and they should offer to come to the parents, instead of having parents visit a needle exchange or drop-in center.

To date, there have been countless lives saved by trained family members as a result of this collaboration. In December 2011 alone, a father saved his daughter and a mother saved her son. Other overdoses that have been reversed included a grandmother saving her grandchild and a mom saving her son's friend. ■

Access to Naloxone through Collaboration with Pharmacies

Although it is legal to prescribe naloxone to someone who is at risk for opioid overdose, this does not mean that prescriptions for naloxone can be readily filled at a local pharmacy. This is a particularly relevant concern for naloxone programs being integrated into traditional health care settings. Pharmacies do not typically stock naloxone because it is not a drug that has been prescribed directly to opioid users by physicians in the past. This does not mean that they cannot do so, it just means it's necessary to work with the pharmacy and the physician who may be interested in prescribing naloxone to make sure they include naloxone on their formulary, order the medication and assemble kits (with intranasal, this includes the atomizers, and with injectable, it includes syringes). While it's great to have pharmacists stock naloxone, they can also easily order it as needed. So if a doctor wants to prescribe, they can call the pharmacy and the pharmacy will usually have it by the next day. Many pharmacies will also deliver for free.

When working with medical institutions and pharmacies, it is important to design a protocol that clearly states who will provide patient training as well as the mechanism for obtaining and paying for the prescription naloxone. For example, the Pittsburgh Overdose Prevention Project is currently working with a number of clinics (free clinics, HIV clinics) that have an in-house pharmacy with a pharmacist on staff. According to Alice Bell, who heads up the Pittsburgh OPP, this is has been the easiest way to go, because they can dispense the naloxone right there and it saves the step of sending someone to an independent pharmacy to pick up the naloxone. See the case study on page 39 for more information.

In Wilkes County, North Carolina, Boston, Massachusetts, Seattle, Washington and Pittsburgh, Pennsylvania, protocols have been implemented to prescribe naloxone to opioid users in health care settings in collaboration with pharmacies. Physician prescription and pharmacy access models are developing as we write this, and few have been in operation long enough to gather evidence on effectiveness or to evaluate policies and procedures. However, this is a promising new opportunity to expand access to naloxone to at-risk individuals and their loved ones. For more information, please visit <http://prescribetoprevent.org>



Duquesne University School of Pharmacy's Center for Pharmacy Services Pittsburgh, Pennsylvania

Prevention Point Pittsburgh works with local physicians and pharmacists to increase the accessibility to naloxone for individuals who are legitimately prescribed opioids for pain, in addition to those who may be abusing prescription pain medications.

Drug poisonings are the number one cause of injury death among adults in the U.S. Drug overdose is responsible for over 90% of poisoning deaths, largely opioid overdoses. Naloxone is an opiate antagonist used routinely in emergency medicine to reverse opiate overdose. Distribution of naloxone to lay persons at potential risk of overdose has been demonstrated to be a feasible and effective component to lowering opiate-related mortality.^{i, ii} However, naloxone prescription programs primarily reach injection drug users through syringe exchange and similar programs.ⁱⁱⁱ

Project Lazarus in Wilkes County, North Carolina (see case study on the next page) pioneered the idea of making naloxone available through the regular prescription process in traditional medical settings where opioids are prescribed; the local pharmacist provides education on opioid

safety and naloxone administration. Project Lazarus recently published data indicating a decrease in overdose fatalities achieved by their program in the first year of operation.^{iv}

The Overdose Prevention Project (OPP) of Prevention Point Pittsburgh (PPP) is building on the successful Project Lazarus model in Allegheny County. PPP works with local physicians and pharmacists to increase the accessibility to naloxone for individuals who are legitimately prescribed opioids for pain, in addition to those who may be abusing prescription pain medications. Making naloxone widely accessible when opioids are used may reverse the spiraling rate of poisoning fatalities in Allegheny County.

The Evolution of Community Pharmacy Collaboration

The Duquesne University School of Pharmacy recently opened a community pharmacy, The Center for Pharmacy Services (CPS), in the Hill District of Pittsburgh. OPP and CPS collaborated to develop an evolutionary model for opioid overdose prevention. The model uses pharmacists to educate patients and physicians about opioid safety and the effectiveness of prophylactic prescription of naloxone to prevent fatal overdose. It is now a routine part of opioid safety training for patients prescribed opioids for pain.

Beginning in February 2011, patients presenting at CPS with a prescription for

an opioid analgesic are offered counseling on opioid safety, including potential side effects, how to take opioid pain relievers safely, possible signs of opioid over medication and/or overdose and safe disposal of unused prescription medicines. Patients are provided with opioid safety educational materials. The patient (or caregiver) also receives instruction on how to identify and effectively respond to an overdose and how to administer naloxone.

A patient who receives the opioid safety education can request a prescription for naloxone. The pharmacist facilitates this by fax, sending a simple form to the prescribing physician requesting they sign an order to prescribe naloxone along with the opioids prescribed for an emergency. This would be analogous to the prescription of an EpiPen® as a preventative safety measure for individuals allergic to bee stings.

Once the physician approves the request, the prescription is filled and naloxone is dispensed. The patient is asked to initial a form indicating completion of training on opioid safety and naloxone administration, which is then faxed back to the physician for patient chart inclusion.

CPS is seeking to broaden awareness of the opioid safety education and naloxone service that they offer to physicians and patients in Allegheny County. For further information, contact CPS, 412-246-0963 or PPP 412-247-3404. ■



CASE STUDY



Project Lazarus Wilkes County, North Carolina

In response to some of the highest drug overdose death rates in the country, Project Lazarus developed a community-based overdose prevention program in Wilkes County and western North Carolina that focused on increasing access to naloxone for prescription opioid users.

In 2009, the Wilkes County unintentional poisoning mortality rate was quadruple that of the State of North Carolina's, due almost exclusively to prescription opioid pain relievers, including fentanyl, hydrocodone, methadone, and oxycodone. Earlier data had shown that 80% of overdose decedents did have a prescription for the medication that they died from in the months prior to death, suggesting that an intervention situated in medical practice could make up for this missed opportunity for prevention. In light of this, naloxone distribution is now done through encouraging physicians to prescribe naloxone to patients at highest risk of an overdose. Those entering drug treatment and anyone voluntarily requesting naloxone are also able to receive naloxone for free.

The naloxone is paid for by Project Lazarus, through grants from industry, and is available at a community pharmacy. Patients watch a DVD about overdose prevention and naloxone use in the clinic, go to the pharmacy to pick up the kit, and are also encouraged to watch the video at home with friends and family.

How it Works

The Project Lazarus' take-home naloxone provision model works as follows. A Wilkes County resident sees a physician for routine medical care. The physician, who has been trained by Project Lazarus, identifies the patient as a naloxone priority patient, based on criteria for overdose risk, see box on opposite page. The 15 priority groups and risk factors were derived from a review of the known etiology of opioid-induced respiratory depression and clinical insight. When patients agree to participate in Project Lazarus, they watch a 20-minute DVD in the physician's office. The video covers patient responsibilities in pain management, storage, and disposal of opioid medications, recognizing and responding to an opioid overdose, and options for substance abuse treatment. Project Lazarus participants then go to a pre-arranged community pharmacy and pick up a free naloxone kit.

The messaging in Project Lazarus materials does not dwell on the differences between "legitimate" and "illicit" users of opioids, but rather presents straightforward information that can be used to prevent an overdose fatality.¹

Our efforts over the last two years have prevented overdose deaths in Wilkes County. In a publication in *Pain Medicine*, we report that the overdose death rate dropped 42 percent from 2009 to 2010 and substance abuse related emergency department admissions dropped by 15.3% from 2008 to 2010. In 2010, only 10% of fatal overdoses were the result of a prescription for an opioid analgesic from a Wilkes County prescriber, down from 82% in 2008. The findings show that after our one-on-one education sessions, prescribers increased their use of pain agreements and utilization of the prescription monitoring program (in Wilkes, approximately 70% of eligible physicians are signed up, versus 20% for the rest of the state). Just as importantly, prescribers reported feeling more secure treating pain and increasing doses as needed; patients responded feeling legitimized in having their pain needs addressed and found it worthwhile having explicit rules within which to seek treatment. For more information, visit <http://www.projectlazarus.org/> ■

Naloxone Priority Groups and Risk Factors for Opioid Overdose

- Recent medical care for opioid poisoning/intoxication/overdose
- Suspected or confirmed history of heroin or nonmedical opioid use
- High-dose opioid prescription (≥ 100 mg/day morphine equivalence)
- Any methadone prescription for opioid naive patient
- Recent release from jail or prison
- Recent release from mandatory abstinence program or drug detox program
- Enrolled in methadone or buprenorphine detox/maintenance (for addiction or pain)
- Any opioid prescription and known or suspected:
 - Smoking, COPD, emphysema, asthma, sleep apnea, or other respiratory system disease
 - Renal or hepatic disease
 - Alcohol use
 - Concurrent benzodiazepine use
 - Concurrent antidepressant prescription
- Remoteness from or difficulty accessing medical care
- Voluntary patient request

Module 3 Notes

1. Burris et al. / International Journal of Drug Policy 12 (2001) 237–248
2. <http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=097-0361>
3. <http://www.cdc.gov/std/treatment/EPTFinalReport2006.pdf>
4. <http://www.cdc.gov/std/EPT/legal/default.htm>
5. Burris S, Beletsky L, Castagna C, Casey C, Colin C, McLaughlin, J.M. Stopping An Invisible Epidemic: Legal Issues In The Provision Of Naloxone To Prevent Opioid Overdose. Drexel Law Review; 2009: 1(2):273–339. (<http://ssrn.com/abstract=1434381>)
6. http://harm-reduction.org/images/stories/library/why_overdose_prevention_matters_for_hiv.pdf
7. Treatment models developed by Maya Doe-Simkins, 2011

Case Study References

Dubuque University School of Pharmacy's Center for Pharmacy Services

- i. Sherman SG, Gann DS, Scott G, et al. A qualitative study of overdose responses among Chicago IDUs. Harm Reduction Journal. 2008.
- ii. Green TC, Heimer R, Grau LE. Distinguishing signs of opioid overdose and indication for naloxone: an evaluation of six overdose training and naloxone distribution programs in the United States. Society for the Study of Addiction. 2008.
- iii. Bennett AS, Bell A, Tomedi L, et. al. Characteristics of an overdose prevention, response, and naloxone distribution program in Pittsburgh and Allegheny County Pennsylvania. J Urban Health. 2011.
- iv. Albert S, Brason FW 2nd, Sanford CK, Dasgupta N, Graham J, Lovette B. Project Lazarus: community-based overdose prevention in rural North Carolina. Pain Med. 2011 Jun;12 Suppl 2:S77-85.

Excerpt from the Allegheny County Overdose Prevention Coalition, Fall Issue, October 2011; Written by Terri Kroh, Director of the Center for Pharmacy Services and Alice Bell, Coordinator of the Overdose Prevention Project.

Project Lazarus

- i. Albert S, Brason FW 2nd, Sanford CK, Dasgupta N, Graham J, Lovette B. Project Lazarus: community-based overdose prevention in rural North Carolina. Pain Med. 2011 Jun;12 Suppl 2:S77-85.

Additional Resources

For more information on legal considerations related to naloxone, the following is a good place to start:

Burris S, Beletsky L, Castagna C, Casey C, Colin C, McLaughlin, J.M. *Stopping An Invisible Epidemic: Legal Issues In The Provision Of Naloxone To Prevent Opioid Overdose*. Drexel Law Review; 2009: 1(2):273–339. (<http://ssrn.com/abstract=1434381>)

A few states have created varied regulations and policies around naloxone distribution, so learning if there are any existing state and local policies relevant to naloxone is important. Detailed state-by-state findings and analysis up to 2007 for naloxone distribution programs are available here:

Project on Harm Reduction in the Health Care System:
<http://www.temple.edu/lawschool/phrhcs/Naloxone/Naloxonepolicy.htm>

Module 4:

Program Implementation and Management

So you have a prescribing doctor and you are ready to go! Here are some suggestions for program implementation.

Funding

As of 2012, there are no specific, designated funding streams for overdose prevention or take-home naloxone programs on the federal level. However, existing programs have found creative ways of funding overdose prevention efforts for many years.

In some cases, state, county or city public health departments have found ways to designate money towards overdose prevention activities. As mentioned in the DOPE Project case study on page 24, the City and County of San Francisco's Public Health Department allocated seed money to the DOPE Project out of their general fund. The Massachusetts Department of Public Health, New Mexico Department of Public Health, and New York State Department of Health all supply naloxone for the programs in their states, but do not pay for additional staff at those programs. These states operate under a model wherein individual programs are expected to integrate naloxone distribution into their existing

array of services and therefore do not need additional staff or infrastructure. The state only provides support and naloxone.

Other programs have sought out private donations or foundation grants to purchase naloxone. Still other programs have received support and funding from Medicaid, or used money from existing contracts (like an HIV prevention contract, for example), to support overdose education and take-home naloxone programs. A strong case can be made that overdose prevention should be part of all HIV-related programming. If you need references to make this argument, check out the great document from the Eurasian Harm Reduction Network and the Open Society Foundations, *Why Overdose Matters for HIV*.¹ Also noteworthy, in the early days of take-home naloxone programs, some universities and research groups received funding to conduct studies that included distribution of naloxone and overdose prevention education, and they were paid for out of those grants.

The most important thing to remember is that *take-home naloxone programs do not cost a lot of money*, especially

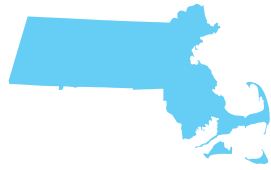
when you are first starting and don't require a large volume of naloxone. If you are folding take-home naloxone and overdose prevention into an existing program, you will not need to hire and train new staff. You will, however, need money for supplies and possibly training for current staff. It is better to start with whatever money you can find than to wait for the day when a funding stream appears.

Purchasing and Storing Naloxone

Naloxone is currently available from two manufacturers in the US: Hospira and International Medication Systems (IMS)-Amphastar. Some secondary distributors of medical products and medications also carry naloxone manufactured by these companies. See the online Appendix, *Naloxone Kit Materials*, for more details. When ordering naloxone, you must work with a licensed physician who has a valid license and DEA number. Generally, when creating an account with the company, they will ask you for a copy of the license and DEA number to keep on file. You then set up an account and order through the company once you've been approved.



CASE STUDY



Massachusetts Overdose Education and Naloxone Distribution

Statewide, Massachusetts

Massachusetts creates a comprehensive statewide naloxone distribution program that is fully supported by the Department of Public Health after years of work by harm reductionists and concerned community members.

Overdose Education and Naloxone Distribution (OEND) in Massachusetts is the result of joint public health system and community advocate efforts fueled by unacceptable levels of death and sorrow. OEND efforts began in the late 1990s by a few committed activists who were working with injection drug users in Massachusetts and were tired of seeing their friends, family members and program participants die from preventable overdoses. They obtained naloxone from some colleagues in the harm reduction movement and began informally distributing it to drug users. They collaborated with needle exchange staff at a Massachusetts AIDS Service Organization to present the need for an OEND program to agency leadership and public health officials at the city and state level. At that time, there was little interest in adopting what was seen as a controversial and untested

intervention, so the activists continued their distribution of naloxone without official approval or oversight from a medical professional. The harm reductionists who were distributing naloxone recognized that while they were putting life saving tools into the hands of drug users, they were also putting programs and participants who distributed or carried naloxone at risk for legal complications. They began collecting basic information about the number of people that they distributed naloxone to and the number of reported overdose reversals and compiled this data into a short report and submitted it to a friend who was working with the Boston Public Health Commission. She used the informal data to create a proposal for the city of Boston to begin providing naloxone distribution at the city needle exchange.

By this time in late 2005, there was a growing number of people and agencies interested in formally incorporating OEND into state-funded HIV prevention programming because of their contacts with injection drug users. This was prompted in part by an intense negative media campaign about drug users—particularly one who was photographed in the process of overdosing and dying—that provided an important spark. Additionally, Massachusetts was experiencing a rise in overdose deaths, beginning in the early 2000s and rising steadily over the years to unacceptable levels.

By 2006, the Board of the Boston Public Health Commission, the City of Boston's Health Department, approved a pilot program, which consisted of training active IDUs on how to avoid, recognize and respond to a drug overdose, and began the distribution of nasal naloxone to enrollees. A year later, the board was presented with the results of this initial work and approved the program unanimously. Thus it became an official program.

This approval for the program was accomplished with support from the Mayor of Boston, community advocates, medical professionals and drug users. The regulation (issued by the City of Boston) named staff "special employees" for whom the City assumed legal liability over for activities related to the overdose prevention pilot program, including naloxone distribution, which was operationalized at the needle exchange program. This order included the medical staff under whose license the naloxone was provided and the nonmedical staff who provided the overdose education and distributed the naloxone. By early 2007, the Cambridge Public Health Department had also begun OEND activities at the Cambridge needle exchange. The Cambridge Public Health Department provided a nurse for several hours per week and who was operating under the orders of the medical director to distribute naloxone to anyone at risk of an overdose who wanted training and a naloxone rescue kit. This design was

considered regular medical care and special public health regulations were deemed unnecessary.

In 2007, the year with the highest ever recorded number of fatal overdoses in MA, the leadership of the Boston Public Health Commission had moved up to the Massachusetts Department of Public Health (MDPH) and brought with them their interest in and experience with OEND. That year, MDPH established a plan to address overdose including expansion of buprenorphine access, community grants to address overdose prevention, and expanding OEND to include four additional agencies beyond the Boston and Cambridge needle exchanges. The OEND project was established based on a written statement from MDPH legal counsel and the Director of the MDPH Drug Control Program that MDPH Drug Control regulations allow DPH to conduct pilot projects to determine whether a change in regulation would be warranted. The model that was outlined includes one statewide medical director who issues a standing order for the naloxone to be distributed by approved overdose prevention trainers in the community.

The MDPH OEND program was implemented as a joint collaboration between the MDPH Commissioner's Office, the Office of HIV/AIDS and the Bureau of Substance Abuse Services. The program started in HIV Prevention programs in the community and

has been expanded to include substance abuse treatment programs and hospital Emergency Departments.

By 2011, there were eight agencies operating in 12 communities with one training organization that works with statewide substance abuse treatment programs providing OEND services. Together, these agencies have trained more than 10,000 drug users, friends and families of drug users, service providers, and first responders about how to prevent and manage overdose—nearly 1,200 reports of the naloxone being used to reverse an overdose have been received so far. There are plans for expansion in FY2012 to new communities and settings in Massachusetts.

Elements of the Massachusetts OEND Program

- Supported and funded by the Massachusetts Department of Public Health (MDPH) Bureau of Substance Abuse Services and in-kind contribution of existing staff time.
- Operating under existing MDPH Drug Control Regulations.
- Medical Director issues standing orders for trained nonmedical public health workers to train and distribute nasal naloxone to potential opioid overdose bystanders.
- Services provided by staff of agencies with existing Office of HIV/AIDS or Bureau of Substance Abuse Services contracts and partner organizations.
- Agencies opt-in and do not receive additional funding.
- MDPH provides nasal naloxone, mucosal atomizers, and educational materials to approved agencies for distribution.
- Potential overdose bystanders are anonymously enrolled using a code based on a memorable formula and able to refill naloxone rescue kits for any reason at any agency location.
- Services are delivered at needle exchange programs, HIV prevention drop-in centers, homeless shelters, methadone clinics, detoxes, office-based medical care, emergency departments, residential drug treatment programs, community meetings, street outreach, home delivery and by other arrangement. ■

Naloxone prices vary and change over time. Between 2010 and 2012, there have consistently been significant price increases to naloxone, which has made it difficult for some take-home naloxone programs to continue operating. Check on the current prices of naloxone as you prepare to order and plan according to your budget.

The shelf life of naloxone is approximately two years. Naloxone should be kept out of direct light, and at room temperature (between 59 and 86 degrees Fahrenheit). It is important to order an accurate amount of naloxone so that you don't run out or have too much (otherwise it might sit around unused and then expire). At first, it might be difficult to estimate supply needs, but if you keep a record of demand over time, you will be able to adjust your orders accordingly.

Assembling Kits

There are different ways you can assemble your naloxone kits. You will need some kind of container, like a bag or a small sharps container, such as a Fitpak (see the Appendix, *Naloxone Kit Materials*, online for examples). For some additional suggestions, see the box on page 47.

Developing Written and Visual Materials

You may want to provide participants with written materials about overdose prevention and using naloxone. Whenever possible, these should be tailored to your community, and produced in the languages that are most common among your participants. Written materials will ideally include easy-to-understand visuals and summarize the training so they can be referenced later.

Written materials should include, but are not limited to, the following:

- Overdose prevention strategies
- Explanation of overdose risks
- How to recognize an overdose
- Overdose response, including: stimulation, calling 911, rescue breathing and naloxone administration
- Aftercare information
- Contact information for getting naloxone refills

Overdose prevention programs have created many great brochures and educational pamphlets. Please feel free to draw inspiration from them to create

your own, or adapt existing materials for your program. (See the Appendix, *Overdose Prevention and Response Messages*, online for samples.)

Data Collection and Paperwork

Data collection requirements are going to be different depending on who is funding your program, and in some cases, who is overseeing it. For example, if your State Public Health Department is supporting your program, they may ask you to collect data during your overdose trainings. Some programs do not collect any data; some collect so much that it becomes a barrier. *Completing paperwork and data collection should never be a barrier to someone receiving naloxone.*

Registration/Enrollment

Some take-home naloxone programs create a registration or enrollment form to document that they have trained someone and prescribed them naloxone; some programs use codes or unique identifiers to document who has received naloxone. It is important to keep a record of who has been given a naloxone prescription so that they can get a refill from your program without going through another training. Registration or enrollment forms can also serve as a medical record, establishing that there was contact between the person receiving the naloxone prescription and a medical provider. Some programs will conduct a brief overdose history or risk assessment with the person being trained, along with collecting basic demographics.



You can put stickers on the naloxone or distribute prescription cards that state that the naloxone belongs to the participant, was obtained from an overdose prevention program and was prescribed by a medical doctor. Some programs put the name of the trained participant on the stickers and cards, along with the name and license number of the physician. While it is extremely rare that someone gets charged with possession of naloxone, having a valid prescription with their name and a doctor's name can minimize the chance of police harassment or arrest.

Assembling Naloxone Kits

- If you are distributing 10ml vials of naloxone, include several muscle syringes so that participants have one syringe per 1ml injection. 3ml, 25g, 1-inch syringes are recommended, but different gauges and point lengths are sometimes used, like 3ml, 22g, 1½-inch . Any option is okay as long as the point is at least 1 inch long so that it can reach the muscle.
- If you are distributing 1ml vials of naloxone, include at least two vials in the kit, with 2 muscle syringes.
- If you are distributing 2ml vials and needleless luer-lock syringes for intranasal administration, include two boxes of naloxone/syringe and use a rubber band to attach an atomizer (Mucosal Atomization Device) to each box.
- Optional items for the kits include: alcohol pads, rescue breathing masks, rubber gloves, prescription cards, and educational inserts.
- You can put your kits in plastic baggies or purchase other containers such as bags with zippers.

 Visit harmreduction.org to download this as a printable worksheet.

Refills

It is *recommended* that participants be able to get unlimited refills, for any reason. It is important to meet the needs of your participants who may have difficulty keeping their naloxone kit with them due to frequent moves, staying outside, theft of their belongings, or confiscations by police or public works. You may have some participants who request refills often, but many others will not need multiple refills, so it does balance out. It is *not recommended* that you require a participant to bring back their old naloxone kit, or put a limit on how many refills they can receive in a given period of time.

A separate contact form can be used for refills, to document whether the person used their naloxone, lost it, had it confiscated or if it was destroyed. *The most important information you can collect is that a participant used his or her naloxone to save a life*; it documents that

Photo credit: Nabarun Dasgupta, hands: Roxanne Saucier

someone who was trained and given naloxone by your program reversed an overdose. Confiscation data is helpful to collect so that you can follow up on repeated incidents of law enforcement or others confiscating naloxone.

Each program should tailor all forms to meet the specific needs of the program, any funders and the prescriber. See the Appendix, *Sample Documents*, online.

Policy and Procedure Manuals

It is a great idea to document how your take-home naloxone program works. Some programs and funders require policy and procedure manuals, so you may have no choice; regardless, it is a good idea to document your work so that it can be sustained over time, despite staff changes.

Developing a Policy and Procedure Manual

A policy and procedure manual can include the following items:

- Background about the effectiveness of overdose prevention
- Community planning data (research and local overdose data)
- Roles and responsibilities (for example, prescribing physician, medical director, program director, outreach counselors, etc.)
- Program logistics (ordering and storing naloxone and other supplies, assembling kits)
- Sites where naloxone prescription/overdose trainings occur
- Sample curricula for short format and longer format trainings and workshops
- Staff training requirements
- Emergency contacts and onsite overdose protocol
- Educational materials

To see some examples of policies and manuals, see the Appendix, *Sample Documents*, online.

Trainings

Overdose training and naloxone distribution can be done on the street, in parking lots, behind cars, in alleys, at syringe access programs, in people's living rooms, in doctor's offices, in hotel rooms, housing programs, at parent support groups, in jails, detoxes, methadone clinics, at universities and just about anywhere people ask for it. You can do either short format trainings (good for needle exchange or outreach) or groups and workshops when you have more time. See the Appendix, *Training Materials*, online for samples.

Tips for Providing Overdose Prevention and Naloxone Trainings

Here are some general tips for doing overdose prevention and naloxone trainings:

- People may only have a short amount of time. Tailor your training to meet the needs of the audience. If they have 10 minutes, make it 10 minutes. If they have 3 minutes, make it 3.
- Respect personal experience. Individuals may have reversed overdose in the past and could be offended if they perceive criticism of their methods. Anything that was tried in the past to revive someone was done in the interest of keeping that person alive, so it was never wrong; it was what the person knew to do in the moment.
- Honor the history of drug user involvement in overdose prevention. Although public health programs are now working to reduce overdose, drug users have been aware of, and trying to curb overdose, for many years. It is vital to acknowledge and honor their contributions, and the loss of so many loved ones.



Visit harmreduction.org to download this as a printable worksheet.

Outreach Strategies

Some programs or individuals who start providing overdose prevention and take-home naloxone are already connected with people who may be at risk for overdose, or their friends, family or loved ones. Others will have to start from scratch finding folks who may need naloxone or information about overdose. The box to the right offers some suggestions that we've gathered from other overdose prevention and take-home naloxone programs for making contact with people who need these services the most. These are just suggestions, and as always, it is important to develop outreach strategies that make the most sense in your community.

Reaching Out to At-Risk Populations

- Partner with agencies that are already working with higher risk groups, such as people recently released from incarceration, hospitals, or drug treatment facilities.
- If direct collaboration with an addiction treatment program, homeless shelter, or medical facility is not possible, find a public place, such as a park or restaurant nearby where you can do education and/or naloxone trainings.
- Ask managers of restaurants, cafes and retail stores in high drug use areas whether overdose has occurred in bathrooms; offer to review safety plans with staff or provide overdose response training. You could also ask to leave outreach materials in their bathrooms.
- To reach homeless encampments, try to find an ambassador who can assist with initiating outreach in a way that promotes trust. Outreach workers working within homeless encampments should behave similarly to being invited into someone's home, even if the space is technically public space.
- Ask participants who are frequent refillers to connect likely bystanders and frequent overdosers with the agency. Consider offering to schedule home visits for groups assembled by frequent refillers.
- Set up a Google Alert for articles, news stories or blog posts related to overdose and post a comment encouraging readers to access overdose prevention and response services.
- Form relationships with local pharmacies that fill prescriptions for opioids and/or sell syringes and ask if you can leave outreach materials with them for their customers.

Strategies specific to your community:



Visit harmreduction.org to download this as a printable worksheet.

Reaching Out to Police and First Responders

It is important to inform your local law enforcement agency and first responders (EMS, Fire) that you will be providing naloxone and training participants to respond to overdose. One way to do this is to send a letter to the agencies introducing your program and explaining what will be happening, including photos of your naloxone kits (see the Appendix, *Sample Documents*, online for examples). You can also request a meeting with responders, and a chance to speak to officers at roll call meetings to explain the program. If you are able to arrange a visit to Fire, EMS or Police to discuss your naloxone program, be prepared for a wide range of reactions from supportive to hostile.

Some programs are supported by state health departments, which provide them with some leverage when communicating with law enforcement. For example, in New York State, the NYS Division of Criminal Justice Services Office of Public Safety in consultation with the NYS Department of Health AIDS Institute, issued a Program Advisory to all NYS Law Enforcement agencies about syringe exchange and opioid overdose programs, along with a podcast that was made available online for law enforcement officers called *Syringe Law and Harm Reduction Programs*. You can see this document and listen to the podcast online (http://www.nychiefs.org/apb_podcast.php Scroll down to APB 035).

Tips When Working with First Responders

- Be prepared to discuss and field questions about perceived ethical dilemmas of providing naloxone to people who use drugs. Common questions include: *Will it support continued or more use? Why help people who are doing illegal activities? Why should we spend taxpayer money on drug users when there are people with "real" emergencies?*
- Offer information and background on the legal basis for the project.
- Be prepared to discuss drug use trends, basic harm reduction and drug-related stigma. While first responders often have a lot of contact with drug users, many also lack information about drug use because they are rarely in a position to form trusting relationships with people who use drugs.
- Some first responders are not able to carry or administer naloxone because of internal policies and regulations. They may be resentful that they are not allowed to administer naloxone, while laypersons can. Suggest that they advocate changing these policies; offer examples of places where such efforts have been successful. For example, Boston, Massachusetts changed policy to allow BLS to administer naloxone and in Quincy, Revere and Gloucester, Massachusetts, , as well as in parts of New York and New Mexico, police and fire are now able to administer naloxone.
- Discuss scenarios in which First Responders arrive after a participant has already used naloxone to revive someone. How will they react?
- Emphasize the importance of not confiscating naloxone kits and reinforce any legal basis for not confiscating if applicable.
- Empower First Responders as allies, highlighting your shared goals and responsibilities to promoting safety and public health.

First responders in your community:



Visit harmreduction.org to download this as a printable worksheet.

Module 4 Notes

1. http://.harm-reduction.org/images/stories/library/why_overdose_prevention_matters_for_hiv.pdf

Module 5:

Overdose Prevention and Response

Risks and Prevention Strategies

The following section highlights common overdose risks and provides prevention tips. We understand that every prevention message might not be applicable or pragmatic in every situation; we hope these tips can provide direction and messages can be shared and adapted as needed.

Risk Factor: Mixing Drugs

Drugs taken together can interact in ways that increase their overall effect. Many overdoses occur when people mix heroin or prescription opioids and/or alcohol with benzodiazepines (such as Klonopin®, Valium®, and Xanax®). *Most fatal overdoses are the result of poly-drug use.*

All sedating medications carry overdose risks when taken on their own. However, when drugs are combined, the risk is substantially increased, because the drugs typically use different mechanisms in the body to create sedation. These mechanisms represent overlapping protection from the brain and respiration shutting down. This overlapping protection is diminished

when multiple substances are combined. For example, the more alcohol and/or downers in someone's system, the less heroin needed to cause an overdose.

“Speedballing”—mixing heroin and cocaine—is a common combination. While it seems intuitive that combining a stimulant and a depressant would counterbalance the drugs' different effects, the combination *does not* cancel out overdose risk. Actually, people who speedball are at higher risk for overdose than people who use heroin or cocaine alone. This is likely because 1) the body has to process more drugs; 2) the stimulant causes vasoconstriction (which reduces blood flow to the brain) and causes the body to use more oxygen, while the depressant reduces the breathing rate, and 3) people who speedball usually inject more frequently with less time between shots than people who are using only heroin.

Prevention Tips: Mixing Drugs

- Use one drug at a time.
- Use less of each drug.
- Try to avoid mixing alcohol with heroin/pills—this is an incredibly dangerous combination.
- If drinking or taking pills with heroin, do the heroin first to better gauge how high you are—alcohol and especially benzos impair judgment so you may not remember or care how much you've used.
- Have a friend with you who knows what drugs you've taken and can respond in case of an emergency



Visit harmreduction.org to download all prevention tips in this Module as a printable worksheet.

Prevention Tips: Tolerance

- Use less after any period of abstinence or decreased use – even a few days away can lower your tolerance.
- If you are using after a period of abstinence, be careful and go slow
- Use less when you are sick and your immune system may be weakened.
- Do a tester shot, or go slow to gauge how the shot is hitting you.
- Use a less risky method (i.e. snort instead of inject).
- Be aware of using in new environments, or with new people—this can change how you experience the effects of the drugs and in some cases, increase the risk of overdose

Prevention Tips: Quality

- Test the strength of the drug before you do the whole amount.
- Try to buy from the same dealer so you have a better idea of what you're getting.
- Talk to others who have copped from the same dealer.
- Know which pills you're taking and try to learn about variations in similar pills.
- Be careful when switching from one type of opioid pill to another since their strengths and dosage will vary.

Prevention Tips: Using Alone

- USE WITH A FRIEND!
- Develop an overdose plan with your friends or partners.
- Leave the door unlocked or slightly ajar whenever possible.
- Call or text someone you trust and have them check on you.
- Some people can sense when they are about to go out. This is rare, but if you are one of the people that can do this, have a loaded syringe or nasal naloxone ready. People have actually given themselves naloxone before!

Risk Factor: Tolerance

Tolerance is your body's ability to process a certain amount of a drug. Low tolerance means that your body can only process a small amount of a drug (i.e., it takes less drugs to feel the effects) and increased tolerance means your body has learned how to process increased amounts of the drug (i.e., it takes more drugs to feel the effects). Tolerance develops over time, so the amount of a drug a long-time user needs to feel the drug's effects is a lot

greater than a newer user. Tolerance also wavers depending on several factors including, weight, size, illness, stress, compromised immune system, and age. Most importantly, tolerance can decrease rapidly when someone has taken a break from using a substance whether intentionally (i.e. while in drug treatment or on methadone detox) or unintentionally (i.e. while in jail or the hospital). Research has also shown that tolerance is affected when a person uses drugs in a new or

unfamiliar environment, and can therefore increase their risk for overdose.¹

Risk Factor: Quality

Quality refers to how pure, or strong, a drug is. The content and purity of street drugs is always unpredictable. They are often "cut" with other drugs or materials that can be dangerous. You can't tell how pure your drugs are from looking at them, and purity levels are always changing, which means you can do a shot that's a lot stronger than what you

are used to and put yourself at risk of an overdose. The same applies to prescription drugs—while we may know the contents of the pill and the dosage, you may not know how strong one type of pill is compared to another of a similar type. For example, an Oxycontin® is not the same as a Vicodin®, even though both are in the opioid family. Understanding strength and dosage when taking pills is as important as knowing the strength and purity of street drugs like heroin.

Risk Factor: Using Alone

While using alone isn't necessarily a cause of overdose, it increases the chance of dying from an overdose because there is no one there to call for help or take care of you if you go out. Many fatal overdoses have occurred behind closed or locked doors where the victims could not be found and no one was there to intervene.

Risk Factor: Age and Physical Health

Your age and physical health impact your body's ability to manage drugs. Older people and those with longer drug using careers are at increased risk for *fatal* overdose. While having more experience with substances is probably protective (and can increase tolerance), the cumulative effects of long-term substance use—which could include illnesses like viral hepatitis or HIV or infections, kidney, heart, lung, or circulation problems, or infections like endocarditis or cellulitis—may hinder resiliency. Older people who overdose are less likely than younger people to survive their overdose.

Prevention Tips: Age and Physical Health

- Stay hydrated! Drink plenty of water or other fluids.
- Eat regularly
- Get enough sleep and rest when you feel worn down.
- Pharmaceuticals (like opioids and benzos)—especially those with Tylenol® (acetaminophen) in them—are harder for your liver to break down. If you have liver damage, stay away from pharmaceuticals with a lot of acetaminophen in them, like Vicodin® and Percocet®.
- Carry your inhaler if you have asthma, tell your friends where you keep it and explain what to do if you have trouble breathing.
- Go slow (use less drugs at first) if you've been sick, lost weight, or have been feeling under the weather or weak—this can affect your tolerance.
- Try to find a good, nonjudgmental doctor and get checked out for any health factors that may increase your risk of overdose, like HIV, viral hepatitis, COPD, high or low blood pressure, high cholesterol, heart disease or other physical issues that could increase your risk for a stroke, seizure, respiratory problems or heart attack

If you have a compromised immune system, you've been sick, or if you have a current infection, like an abscess, this also puts you at higher risk for overdose because your body is weakened. Dehydration and not eating or sleeping enough also puts you at greater risk for overdose. If you are a stimulant user, you are more at risk for a seizure, stroke, or heart attack if you also have other health issues like high blood pressure, heart disease, diabetes, high cholesterol or if you smoke cigarettes.

Liver and lung health, negatively impacted by hepatitis and smoking respectively, play an important role in overdose. The liver filters substances

in the body and is involved in their metabolism; a poorly functioning liver means less capacity to metabolize substances in a timely manner. In other words, when your liver is not working well it can't process drugs and alcohol as easily, leading to "build-up" of drugs in your system; this can be toxic and make the effects of certain drugs last longer than they should.

Since downers cause your breathing to slow down, asthma or other breathing problems can put you at higher risk for overdose. Poor lung function decreases the body's capacity to replenish oxygen supply, which is essential to survive an overdose. Using less when you are

Prevention Tips: Mode of Administration of the Substance

- Be mindful that injecting and smoking can lead to increased risk.
- Consider snorting, especially in cases when you're using alone or may have decreased tolerance.
- If you inject, try and remove the tie after registering and before injecting—this will allow you to better taste your shot and inject less if it feels too strong.
- Be careful when changing modes of administration since you may not be able to handle the same amounts.

Prevention Tips: Previous Nonfatal Overdose

- Always use with a friend or around other people.
- Use less at first, especially if you are using a new product.
- Make an overdose plan with friends or drug partners.

sick or recovering from an illness can reduce the risk of overdose. It is important to rely more on what you know about your own body, tolerance and experience, as opposed to what drug partners or friends may experience because there is substantial variability in how different substances are processed by different people.

Anyone who uses opioids, *including people who take opioids for pain*, should be aware of increased overdose risk if they:

- Smoke or have COPD, emphysema, asthma, sleep apnea, respiratory infection or other respiratory illness
- Have kidney or liver disease or dysfunction, cardiac illness or HIV/AIDS
- Drink alcohol heavily
- Are currently taking benzodiazepines, other sedative prescription or antidepressant medication

Risk Factor: Mode of Administration

There are many ways to use drugs, including swallowing, snorting, plugging (drug-water solution introduced rectally with a needleless syringe—aka booty bumping), intramuscular injection, and intravenous injection. *Regardless of the mode of administration, if someone uses enough drugs in a short enough period of time, overdose is possible.*

Methods that deliver the drug quicker to the brain and are more likely to create a rush (such as intravenous

injection and smoking) are linked to higher risk for overdose. Transition periods (i.e. changing modes of administration) can be dangerous, too. When someone switches the mode of administration that they are used to, it is harder to anticipate the effects. Similarly, when someone migrates to a different drug of preference or temporarily substitutes a different primary drug, there can also be a period of heightened risk. Some examples include: Going from swallowing methadone to injecting methadone; switching from swallowing oxycodone (OxyContin®, Roxicodone®, Percocet®) to swallowing oxymorphone (Opana®); or moving from injecting heroin to injecting Dilaudid®; these are all periods when heightened overdose prevention techniques are important.

Risk Factor: Previous Nonfatal Overdose

People who have had a nonfatal overdose in the past may be at increased risk for overdose in the future. It is believed that this is related to drug use patterns and potentially risky behavior. Experiencing a nonfatal overdose may cause damage to the body, even if the person survives the overdose. One study found that many people who had experienced a non-fatal overdose also experienced other harms, including physical injury sustained when falling at overdose, burns, assault while unconscious, peripheral neuropathy (nerve damage, numbness/tingling), vomiting, temporary paralysis of limbs, chest infections and seizure.²

Overdose Recognition

If someone is using downers, like heroin or pills, and they are very high but not necessarily experiencing overdose, they may exhibit certain symptoms (listed in the box to the right).

If a person seems too high or on the verge of overdose but is still conscious, walk them around, keep them awake, and monitor their breathing.

If a person is experiencing an overdose emergency, their symptoms will be more severe than when they are high (see box to the right).

If someone is making unfamiliar sounds while "sleeping" it is worth trying to wake him or her up. Unfortunately, many loved ones of users have thought a person was snoring, when in fact the person was overdosing. These situations are a missed opportunity to intervene and save a life.

Important: It is rare for someone to die immediately from an overdose. When people survive, it's because someone was there to respond. The most important thing is to act right away!

High vs. Overdose

How do you tell the difference between someone who is really high or overdosing?

High:

- Pupils will contract and appear small
- Muscles are slack and droopy
- They might "nod out" (but remain responsive to stimulus)
- Scratch a lot due to itchy skin
- Speech may be slurred
- They might be out of it, but they *will* respond to outside stimulus like loud noise or a light shake from a concerned friend

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
- Vomiting
- Loss of consciousness
- Unresponsive to outside stimulus

Responding to Opioid or Depressant Overdose

Assess the Signs

- Is the person breathing?
- Is the person responsive?
- Does he or she answer when you shake them and call his or her name?
- Can the person speak? What is the skin color (especially lips and fingertips)?



Above: Sternal Rub: If a person is unconscious, try rubbing your knuckles on their sternum to stimulate them.

Stimulation

If the person is unconscious or in a heavy nod, try and wake them up first by calling their name. You can also say something that they might not want to hear, like "I'm going to call 911" or "I'm going to give you naloxone (Narcan®)."

- If they remain unresponsive, try to stimulate them with mild pain by rubbing your knuckles into the sternum (the place in the middle of your chest where your ribs meet) or

rubbing your knuckles on their upper lip. The sternal rub is preferable over the upper lip because the person may have dental problems, or prosthetic teeth that may cause pain or unnecessary discomfort when rubbed vigorously. However, if the person is in a position where you cannot get to their sternum easily, or if they are wearing multiple layers of heavy clothing, rub the upper lip area.

- If this causes the person to wake up, try to get him or her to focus. Can they speak to you? Check their breathing. Continue to monitor them, especially their breathing and pulse and try to keep them awake and alert. If their breathing is shallow, they tell you that they feel short of breath, or they are experiencing chest tightness—*call 911*.
- If the person *does not* respond to stimulation and remains unconscious or the condition appears to get worse, do *not* try a different or alternative form of stimulation. Treat this as an emergency and call 911 immediately.

Recovery Position

If you have to leave the overdosing person at any time—even for a minute to phone 911—make sure you put them in the Recovery Position: lay the person slightly on their side so that their body is supported by a bent knee, with their face turned to the side. This will help to keep their airway clear and prevent them from choking on their own vomit if they begin to throw-up.



Above: Recovery Position: **1.** Carefully move the person to the ground keeping them on their side. **2.** Placing the arm and leg closest to you at right angles, gently roll the person on their side. **3.** Place one arm under the person's head and tilt the head so that the airway is clear. Photo Credit: N.O.M.A.D. (Not One More Anonymous Death) website <http://sites.google.com/site/nomadoverdoseproject/naloxone>; Life-saver: Mary Wheeler, Overdoser: Joanna Berton Martinez

Call for Help

It is recommended that you call 911 in the case of an overdose because it is important to have trained medical professionals assess the condition of the overdosing person. Even though naloxone can address the overdose, there may be other health problems going on. Also, people who survive any type of overdose are at risk of experiencing other health complications as a result of the overdose, such as pneumonia and heart problems. Getting checked out by a medical professional is an important part of reducing harms associated with overdose.

What to say when calling 911 will depend somewhat on how local responders typically handle overdose emergencies. In every situation, it is important to report certain key information including that the person's breathing has slowed or stopped, that he or she is unresponsive, and to clearly state the exact location. In many communities, the police respond along with the ambulance to *all 911 calls*. In other cases, police are only dispatched in cases where illegal activity is suspected, or if the dispatcher is concerned about the safety of first responders. In some communities, when the police respond they do not routinely arrest bystanders or victims at the scene of an overdose. However, in other places, it is common for police to arrest people at the scene of an overdose, and they have been known to charge people with everything from drug possession, to manslaughter (if the overdosing person dies and the

Tips When Calling 911

It is important to educate participants about the safest and most effective ways to communicate with emergency dispatchers and personnel:

- Tell the paramedics exactly where you and the overdosing person are. Give them as much information as possible so that they can find you quickly (i.e. 3rd floor, or in the bathroom).
- When speaking with the dispatcher on the phone, avoid using words like drugs or overdose—stick to what you see: “The person is not breathing, turning blue, unconscious, non-responsive, etc.” This makes the call a priority because it will be identified as a life-threatening emergency. The dispatcher does not need to know the details of the situation, only that there is an emergency that requires immediate assistance.
- When calling 911, keep loud noise in background to a minimum—if it sounds chaotic, they will surely dispatch police to secure the scene and protect the paramedics.
- When the paramedics arrive, it is important to give them as much information as possible; tell them what you know about what drugs the person may have been using, when they used them, whether naloxone was administered, etc. If the paramedics suspect opioid use, they will give the victim an injection or intranasal dose of naloxone. Remember - paramedics’ main goal is to address the health of the individual and respond to the medical emergency.

Notes:



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bystander is proven to be the supplier of drugs). Fear of arrest and police involvement when calling 911 is substantial. Agencies should talk to participants about perceived and real risks associated with calling 911 and work with police and emergency personnel to address the fear of arrest and police involvement.

If calling 911 is not an option (some people will not call), it is important to make alternate plans in case your rescue attempts are not working. Can someone else in the vicinity call? Can you leave to alert someone else to call (even a passerby) after providing rescue breathing, administering naloxone, and/or putting the person in the recovery position? If you do need to leave the person, do your best to make sure they are in a place where they can be found, with doors unlocked and/or open. Remember, doing something is better than doing nothing.

Poison Control Centers

Poison Control Centers (PCC) (<http://www.aapcc.org/dnn/default.aspx>) are another resource available. Poison centers provide poison expertise and treatment advice by phone. PCC can answer a wide variety of questions about medications and street drugs and can help decide if it is necessary to go to the hospital or if a problem can be managed at home. The centers are completely confidential; specifically they never call law enforcement.

All poison centers can be reached by calling the same telephone number 1-800-222-1222, 24 hours a day. They are staffed by pharmacists, physicians, nurses and poison information providers who are toxicology specialists. They are not only available to the 50 states and Puerto Rico, but also to The Federated States of Micronesia, American Samoa, and Guam.

Perform Rescue Breathing

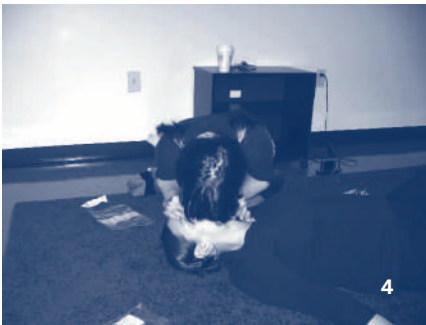
For a person whose breathing is severely impaired, rescue breathing is one of the most important steps in preventing an overdose death.

When someone has extremely shallow and intermittent breathing (around one breath every 5-10 seconds) or has stopped breathing and is unresponsive,

rescue breathing should be done as soon as possible; it is the quickest way of getting oxygen to someone who has stopped breathing. If you are performing rescue breathing, you are getting much needed air into someone's body who will die without it; the difference between survival and death in an opioid overdose depends on how quickly enough oxygen gets into the person's body.

You may have heard that new CPR guidelines recommend "hands-only CPR" or the use of chest compressions only instead of both rescue breathing and chest compressions. *However, these guidelines refer to lay person response to cardiac arrest, and NOT overdose.* Rescue breathing is still recommended when responding to an overdose, where the primary issue is respiratory depression, and not cardiac arrest. For more information, see the Appendix, *Public Policy*, online.

If you are alone with the overdosing person and have naloxone, give the person a few breaths first, then put them in the Recovery Position and go get your naloxone kit. If there is more than one of you there to respond to the overdose, DIVIDE DUTIES—have one person perform rescue breathing while another goes to get the naloxone kit and/or call 911.



Steps for Rescue Breathing

1. Place the person on their back.
2. Tilt their chin up to open the airway.
3. Check to see if there is anything in their mouth blocking their airway—such as gum, toothpick, undissolved pills, syringe cap, cheeked fentanyl patch (these things have ALL been found in the mouths of overdosing people!)—and if so, remove it.
4. Pinch their nose with one hand, place your mouth over the overdosing person's mouth, and give 2 even, regular-sized breaths. Blow enough air into their lungs to make their chest rise. If you don't see their chest rise out of the corner of your eye, tilt the head back more, make sure you're plugging their nose, and also make sure you have a good seal over the victim's mouth.
5. After 5 seconds, breathe again. Give one breath every 5 seconds until the person starts breathing on his or her own or until emergency responders arrive.
6. REPEAT!


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Photo Credit: N.O.M.A.D. (Not One More Anonymous Death) website <http://sites.google.com/site/nomadoverdoseproject/naloxone>; Life-saver: Mary Wheeler, Overdoser: Joanna Berton Martinez

Administer Naloxone (Narcan®)

VERY IMPORTANT:

Remember, naloxone only works if there are opioids involved with the overdose; it will not reverse an overdose resulting solely from cocaine, speed, benzos, alcohol or other non-opioid based drugs.

Administering Nasal Naloxone

1. If the person isn't breathing, do rescue breathing for a few quick breaths *first*.
2. Next, affix the nasal atomizer (the soft white piece) to the needleless syringe and then assemble the glass cartridge of naloxone (see diagram).

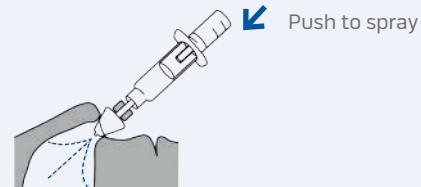


Pry or pull off yellow caps from syringe. Pry off red or purple cap from naloxone.




Grip clear plastic wings of nasal atomizer and screw it onto the tip of the syringe barrel, then gently screw naloxone capsule into barrel of syringe.

3. Tilt the person's head back and spray half of the naloxone up one side of the nose (1cc) and half up the other side of the nose (1cc). Don't worry if it isn't exactly half per side.



4. If the person isn't breathing or breathing continues to be shallow, *continue to perform rescue breathing* for them while waiting for the naloxone to take effect.
5. If there is no change in about 3 minutes, administer another dose of naloxone following the steps above and continue to breathe for the person. If the second dose of naloxone does not revive them, something else is wrong—either it has been too long and the heart has already stopped, there are no opioids in their system, non-opioid drugs are the primary cause of overdose (even if they have also taken opioids), or the opioids are unusually strong and require more naloxone (can happen with fentanyl, for example).
6. Once naloxone has been delivered, it is important to continue rescue breathing until help arrives.

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Administering Injectable Naloxone

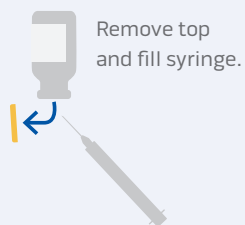
Injectable naloxone comes packaged in several different forms—a multi dose 10 ml vial and single dose 1 ml flip-top vials with a pop off top. With all formulations of naloxone, it is important to check the expiration date and make sure to keep it from light if it is not stored in a box. If someone has an injectable formulation of naloxone, all of the steps in recognizing and responding to an overdose are the same except how to give the naloxone.

These are the steps to use injectable naloxone:

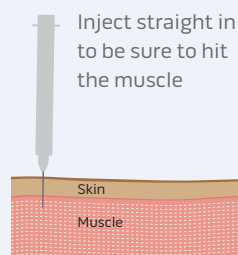
1. If the person isn't breathing, do rescue breathing for a few quick breaths first.

2. Pop off the orange top from the vial.

3. Draw up 1cc of naloxone into the syringe:
1cc = 1ml = 100u. Use a long needle: 1 to 1 ½ inch (called an IM or intramuscular needle)—syringe access programs and pharmacies have these needles.




4. Inject into a muscle—thighs, upper, outer quadrant of the butt, or shoulder are best. If possible, clean the skin where you are going to inject with an alcohol swab first. It is okay to inject directly through clothing if necessary. Inject straight in to make sure to hit the muscle.



5. If there isn't a big needle, a smaller needle is OK to inject under the skin; however, it is better to inject into a muscle whenever possible.

6. After injection, continue rescue breathing 3 minutes.

7. If there is no change in about 3 minutes, administer another dose of naloxone and continue to breathe for the person. If the second dose of naloxone does not revive them, something else may be wrong—either it has been too long and the heart has already stopped, there are no opioids in their system, non-opioid drugs are the primary cause of overdose (even if they have also taken opioids), or the opioids are unusually strong and require more naloxone (can happen with fentanyl, for example).

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Aftercare

Withdrawal and re-overdose risk

Naloxone only lasts between 30–90 minutes, while the effects of the opioids may last much longer. It is possible that after the naloxone wears off the overdose could recur. *It is very important that someone stays with the person and wait out the risk period just in case another dose of naloxone is necessary.*

Further, because naloxone blocks opioids from acting, it is possible that it can cause withdrawal symptoms in someone that has a habit or physical dependence, daily opioid pain medication use or other opioid tolerance. Someone who is taking opioids for daily pain management will go into withdrawal too, and experience the pain that they are treating with the opioids. Therefore, after giving someone naloxone, he or she may feel extremely sick and want to use again right away. It is very important that one does not use again until the naloxone wears off so that a re-overdose does not occur.

Not only that, if the person uses more heroin or opioids when there is still naloxone in the system, he or she may not feel it at all — naloxone will knock it out of the opioid receptors and the person will have wasted their drugs. Try to support the person during this time period and encourage him or her not to use for a couple of hours.

The likelihood of overdosing again depends on several things, including:

- How much drug was used in the first place and the half-life of the drug(s) taken;
- How well the liver works to process drugs;
- If the person uses again.

If the person cannot walk and talk well after waking up, then it is very important that they are taken to the hospital. If possible, stay with the person for several hours keeping them awake. It is safe to administer naloxone again if it is necessary.

Note if a victim is not responsive to stimulation, not breathing, and has no pulse after receiving naloxone and rescue breathing, then the victim needs cardiopulmonary resuscitation (CPR) via a trained bystander and the emergency medical system. Call 911!

Stimulant Overdose: Overamping

What is overamping?

Overamping is the term we have begun using to describe what one might consider an “overdose” on speed. Overamping means a lot of things to a lot of people. Sometimes it is physical, when our bodies don’t feel right. Other times it is psychological, like paranoia, anxiety or psychosis—or a mixture of the two. It’s complicated because sometimes one person will consider something overamping, and the other person actually considers it just part of the high, or maybe even enjoys a feeling that someone else hates. There are many different ways to define overamping, but we’ve tried to simplify it down to some common elements within this document.

Overamping can happen for a lot of different reasons: you’ve been up for too long (sleep deprivation), your body is worn down from not eating or drinking enough water, you’re in a weird or uncomfortable environment or with people that are sketching you out, you did that “one hit too many,” you mixed some other drugs with your speed that have sent you into a bad place — whatever the reason, it can be dangerous and scary to feel overamped.³

Is overamping an overdose?

Most of the time, when we hear the word overdose, we think of heroin, someone in a heavy nod, turning blue, not breathing. A lot of times people say “you can’t overdose on speed or coke,”

but then other people say, "I don't know, I've passed out, or felt like I was gonna have a heart attack...is that an overdose?" The problem is actually with the word itself. "Overdose" isn't really the best word to describe what happens when tweak or coke turn bad...so we call it OVERAMPING.

Even the term "overdose" makes it sound like taking too much is the problem. Speed and coke (unlike some drugs like heroin) are less predictable and overamping might happen regardless of how much or little you use, or how long you've been using. It might happen on the 3rd day of a run when your body is getting run down, or when you get high with some people that make you feel weird.

Since overamping on speed and cocaine (powder) or crack overdose are similar in a lot of ways, we'll refer to them both as "overamping" in this document. With coke, what happens is often similar to the physical and psychological effects of overamping on speed, but coke is much more likely to cause seizures, heart attacks and strokes. In a recent study of heart damage in cocaine users, 83% had heart damage, and 73% had scarring on their heart (fibrosis) from silent heart attacks.⁴ Cocaine is the second most common drug that causes overdose deaths in the US (after prescription opioids, which cause the most deaths and more than heroin, which is the third most common drug in overdose deaths).

Overamping Prevention

When it comes to stimulants like speed or coke, a healthy body is often the best prevention for overamping. Since it's not always about how much you do, we need to look at other ways to help prevent having heart attacks or other complications from stimulants:

- Get checked out a local clinic that you trust, where you can be honest about drug use. We know these can be hard to find, but being able to speak honestly with a provider may help you come up with some great ways to stay safe. Ask around to see if friends can refer you to medical providers that they trust.
- Make sure you get your heart checked out, your blood pressure, cholesterol, circulation and all that other good stuff. Having high blood pressure or an irregular heart beat or other types of heart disease can put you at really high risk for a heart attack when you smoke, shoot or snort stimulants.
- In general, try and take good care of your body. If you're on medication for high blood pressure, make sure you take it; if you're diabetic, make sure you try to manage your diabetes; consistently try to eat, sleep and drink fluids, even when you're on a run.

What does a Stimulant Overdose look like?

Physical symptoms of overamping could include:

- Nausea and/or vomiting
- Falling asleep/passing out (but still breathing)
- Chest pain/tightening in the chest
- High temperature/sweating profusely, often with chills
- Fast heart rate, racing pulse
- Irregular breathing or shortness of breath
- Convulsions or tremors
- Stroke
- Limb jerking or rigidity
- Feeling paralyzed while you're awake
- Severe headache
- Hypertension (elevated blood pressure)
- Teeth grinding
- Insomnia or decreased need for sleep

These symptoms can lead to heart attack, stroke, seizure, or overheating— it is important to take them seriously!

Psychological symptoms of overamping or "mental distress" could include:

- Extreme anxiety
- Panic
- Extreme paranoia
- Hallucinations
- Extreme agitation
- Increased aggressiveness
- Restlessness or irritability
- Hyper vigilance (being super aware of your environment, sounds, etc.)
- Enhanced sensory awareness
- Suspiciousness

Responding to Upper or Stimulant Overamping

The first step in responding to stimulant overamping is to figure out what kind of response is needed: medical assistance or support and rest?

Responding to Physical Concerns

Overheating

Overheating or “hyperthermia” can be deadly. If you notice someone overheating, help them to slow down, stop agitated movements and try to cool down with ice packs, mist and fan techniques. Placing cool, wet cloths under their armpits, on the back of their knees, or on the forehead can also help. Open a window for fresh air. Encourage them to drink water or a sports drink with electrolytes so they don’t dehydrate. Dehydration associated with overheating can produce nausea, vomiting, headaches, and low blood pressure. This can lead to fainting or dizziness, especially if the person stands suddenly.

Hot, dry skin is a typical sign of hyperthermia. The skin may become red and hot as blood vessels dilate in an attempt to get rid of excess heat, sometimes leading to swollen lips. An inability to cool the body through perspiration causes the skin to feel dry.

Other signs and symptoms vary depending on the cause. In the case of severe heat stroke, the person may become confused or hostile, and may seem intoxicated. Heart rate and

breathing will increase as blood pressure drops and the heart attempts to supply enough oxygen to the body. The decrease in blood pressure can then cause blood vessels to contract, resulting in a pale or bluish skin color in advanced cases of heat stroke. Eventually, as body organs begin to fail, unconsciousness and death will result.

When body temperature reaches about 40 C/104 F or if the person is unconscious or showing signs of confusion, hyperthermia is considered a medical emergency that requires treatment in a proper medical facility. Call 911. In a hospital, more aggressive cooling measures are available, including intravenous hydration, gastric lavage (pumping the stomach) with iced saline, and even hemodialysis to cool the blood.

Stroke

Strokes occur when a blood clot blocks or plugs a blood vessel or artery in the brain or when a blood vessel breaks and bleeds into the brain.

The symptoms of stroke are distinct because they happen quickly:

- Sudden numbness or weakness of the face, arm, or leg (especially on one side of the body)
- Sudden confusion, trouble speaking or understanding speech
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden severe headache with no known cause

If you believe someone is having a stroke — if he or she suddenly loses the ability to speak or move an arm or leg on one side, or experiences facial paralysis on one side — call 911 immediately.

Seizure

The brain is full of electrical activity. It is how the brain “talks” to the rest of the body. If there is abnormal or excess electrical activity in a part of the brain it can cause a misfire and result in a seizure or convulsion.

Seizures fall into two general groups: partial and general. A *partial seizure* affects small parts of the brain. A *general seizure* affects the whole brain and can cause loss of consciousness and/or convulsions. General seizures are the type that most people think of when the word “seizure” is mentioned.

Typical symptoms of a general seizure include:

- Drooling or frothing at the mouth
- Grunting and snorting
- Tingling or twitching in one part of the body
- Loss of bladder or bowel control
- Sudden falling
- Loss of consciousness
- Temporary absence of breathing
- Entire body stiffening
- Uncontrollable muscle spasms with twitching and jerking limbs
- Head or eye deviation (fixed in one direction)
- Aura before the seizure that may be described as sudden fear or anxiety, a feeling of nausea, change in vision,

What to Do When Someone Has a Seizure

- Remain calm, be a good observer. Speak calmly and softly to the person.
- Help the person into a lying position and put something soft under the head.
- Turn the person to one side (if possible) to allow saliva to drain from the mouth. (If not possible during the seizure, do so once the seizure has stopped).
- Remove glasses; loosen ties, collars and tight clothing.
- Protect the head and body by clearing the area of hard or sharp objects.
- **Do not** force anything into the person's mouth or between their teeth. This is an old myth—people cannot swallow their own tongues. You can harm yourself trying to put things in their mouth, and you can also break their teeth or cause other harms to the person.
- **Do not** try to restrain the person. You cannot stop the seizure.

What to Do After Someone Has a Seizure

- Have someone stay nearby until the person is fully awake.
- Clear the airway of saliva and /or vomit.
- Allow the person to rest. Most people will sleep soundly for a period of time following the seizure.
- **Do not** offer any food or drink until the person is fully awake.
- Seizures can be a big deal and calling 911 is important under most circumstances, but especially when:
 - The seizure lasts for more than 5 minutes.
 - The person has one seizure right after another.
 - The person appears to be injured.
 - The person does not regain consciousness.
 - This is a first time seizure.
 - The person's color remains poor.
 - The person does not start breathing within one minute after the seizure has stopped (in which case, it is also important to start CPR if possible).

dizziness, or an obnoxious smell (not as common with drug-related seizures).

- Skin color may be very red or bluish.

Heart Attack/Cardiac Arrest

Heart attacks that may be related to drugs will look similar to those that might not be drug-related. It can sometimes be difficult to distinguish between side effects from taking drugs (i.e. sweating) and signs of a heart attack. Things to look out for include:

- Uncomfortable pressure, fullness, squeezing, or pain in the center of the chest. These symptoms can range from mild to severe, and they may come and go.
- Discomfort in other areas, such as the neck, arms, jaw, back, or stomach.
- Shortness of breath, lightheadedness, nausea, or breaking out in a cold sweat.

Women may get chest pain or discomfort, but in many cases, it's not the most obvious symptom. Instead, women are more likely than men to have these symptoms:

- Unusual fatigue
- Nausea or indigestion
- Dizziness or lightheadedness
- Abdominal discomfort that may feel like indigestion
- Discomfort described as pressure/tightness or an ache in the neck, shoulder, or upper back

If the person has lost consciousness and you notice that they are not breathing, call 911 and begin CPR if you are trained. Time is very important with heart attacks, so help your buddy!

Reminder: When calling 911, give the dispatcher basic info about the physical concerns that need to be addressed. It is unnecessary to mention drugs or overdose to the 911 dispatcher; more specific information can be given directly to EMS once they are onsite.

Responding to Psychological Concerns

If you are confident that the problem is not medical in nature (seizure, stroke, heart attack, overheating), but you or your friend is experiencing anxiety or other psychological symptoms of overamping the following suggestions may offer some relief:

- Drink water or sports drink and eat some food.
- Try to sleep or rest.
- Switch how you're doing your speed or coke; for example, if you've been shooting, switching to smoking may help.
- Change your environment or the people you're with.
- Take a benzo or other mild sedative that works for you (a small dose, like an Ativan® or some people have even taken an antihistamine, like Benadryl® and that has helped calm them down.)
- Breathing or meditation exercises.
- Physical contact, such as massaging yourself or having someone else do it for you.
- Walking, walking, walking—walk it off!
- Take a warm shower.
- Get some fresh air.

Module 5 Notes

1. Gerevich J, Bácskai E, Farkas L, Danics Z. (2005). A case report: Pavlovian conditioning as a risk factor of heroin 'overdose' death. *Harm Reduct J.* 2, 11.
2. Warner-Smith M, Darke S, Day C. Morbidity associated with non-fatal heroin overdose. *Addiction.* 2002 Aug; 97(8):963-7.
3. Overamping section was written with the input from participants of the Speed Project, San Francisco: <http://new.sfaf.org/tspsf/>
4. Aquaro GD, Gabutti A, Maini M, et al. *Silent myocardial damage in cocaine addicts.* *Heart.* 2011;97(24):2056-2062

Module 6:

Frequently Asked Questions

This section adapted from the work of Maya Doe Simkins, Alex Walley and colleagues for their "Notes from the Field (temporary title)" Overdose Prevention Manual.

This is a list of questions and responses that overdose education and naloxone distribution trainers have gathered.

*Naloxone is that stuff that you stick through the heart, like in that movie **Pulp Fiction**, right?*

No. While naloxone does have an injectable form, it is never injected into the heart. The injectable form of naloxone is injected either intravenous or intramuscularly.

What role does your liver play in an overdose?

The liver processes all drugs in a person's body. If the liver is damaged or not functioning properly, it causes a back up of drugs in the body, which can contribute to overdose. A person whose liver isn't functioning properly may overdose more frequently and overdose may last longer.

Hey, isn't there naloxone in Suboxone®? What's up with that?

Buprenorphine (brand name Suboxone®) is used in opioid substitution therapy. Buprenorphine diminishes cravings for opioids such as heroin; naloxone is added to Suboxone® as a way to counter "potential abuse" (i.e. injection) of Suboxone®. If the Suboxone® is taken under the tongue as prescribed, the small amount of naloxone will not get absorbed into the body and does nothing. However, if Suboxone® is injected, the naloxone will beat the buprenorphine to the opioid receptors, delaying and lessening the high.

OK, so there IS naloxone in Suboxone®...then, will Suboxone® reverse an overdose?

Using buprenorphine to reverse an overdose is not something that has been studied scientifically, however there are anecdotal reports of this approach having worked. Buprenorphine has a stronger affinity or attraction to opioid receptors than heroin or other opioids and can

therefore displace the opioids that are causing the overdose. However, it is unlikely that the naloxone is the reason that Suboxone® can reverse an overdose since it is such a small amount. Rather the buprenorphine displaces the opioids, which then causes the person to wake up. But remember: successful overdose response is all about time and oxygen. Preparing Suboxone® for injection takes precious time, and waiting for the pill to dissolve in the mouth takes even longer; these actions may also keep you from being able to perform consistent rescue breathing.

Will Naloxone work on an alcohol overdose?

No. Naloxone will not work on an alcohol overdose, only opioid overdose. If the overdose is a result of using both alcohol and opioids, administering naloxone might help by addressing the opioid part of the overdose.

Can I give someone who is overdosing a shot of coke or speed OR does speedballing balance you out?

No. Speedballing does not cancel out overdose risk and in fact, it actually increases risk. Speedballing is any combination of a stimulant (upper) and a depressant (downer) taken together; common speedballs include a mixture of heroin and cocaine or heroin and methamphetamine injected into the bloodstream. Stimulants actually constrict blood vessels, and cause the heart to beat faster, which can deplete the body of much-needed oxygen and makes the overdose *worse*. The more different drugs someone's body has to process, the harder it is on their body. Also, people who speedball usually use more frequently than people who only use heroin, which increases overdose risk.

Can I give someone naloxone for a crack/coke overdose?

Naloxone will not work on a cocaine overdose, only opioid overdose. If it is a cocaine overdose that also involves opioids, naloxone might help by addressing the opioid part of the overdose. Cocaine overdose is dangerous because it is not dose-dependent and is a complicated medical emergency—call 911.

Clonidine: Is it an opioid or a benzo?

Neither. (Do not confuse *clonidine* with *Klonopin®*, which *is* a benzo). Clonidine is traditionally a medication used to treat high blood pressure, however

it can be used to relieve withdrawal symptoms from opioids, alcohol and nicotine. When combined with opioids it increases one's high; it lowers blood pressure, heart rate, causes dizziness and drowsiness. There is a higher risk of overdose with a clonidine/opioid combo than with opioids alone, but less than with a benzodiazepine/opioid combination. Clonidine is not as long lasting as benzos are and it doesn't have amnesiac effects (short-term memory loss). Lowering the blood pressure also raises the risk of dizziness and falling down, which can result in injury. Stopping *regular use* of clonidine does result in mild *physical* withdrawal symptoms and in cases where it was being used to treat high blood pressure, stopping result in very high blood pressure.

What about Phenergan® (Finnegan, Promethazine)?

Phenergan® is used to combat nausea, as a sedative, as an allergy medication, to treat motion and morning sickness, and to *increase the activity of opioids*. For example, someone on high doses of opioid pain medication could take Phenergan® and lower their dose of pain medication to get the same effects. Similarly, the effects of heroin or methadone would also be increased when taken with take Phenergan®. There is a higher risk of overdose with a Phenergan®/opioid combo than with opioids alone, but less than with a benzodiazepine/opioid combination. Phenergan® is not considered to be habit-forming or cause withdrawal.

What's the deal with fentanyl and overdose?

Fentanyl is an extremely concentrated and potent opioid. Some heroin dealers mix fentanyl powder with larger amounts of heroin in order to increase potency or compensate for low-quality heroin. If it is not well mixed a small bit of highly potent fentanyl could cause an overdose in a user that is expecting just heroin or whose tolerance isn't high enough. Fentanyl patches can also be used by: putting them on the skin to get the time released medication and using other drugs on top of that; placing the patch inside the cheek, which allows the medication to release quicker; or shooting or snorting the gel inside the patch (there is a process required to get fentanyl into injectable form, but it can be done). Fentanyl carries a lot of risk in terms of overdose because it is extremely potent and short acting and can flood the receptors in the brain very quickly. Fentanyl is designed to treat pain for people who are already dependent on opioids for pain management, so it is designed to be very strong to handle the pain someone experiences despite already taking sometimes high doses of opioids.

What about giving someone a salt shot when they overdose?

A salt shot will cause pain—both because of the injection and because saltwater will sting/burn—so if the person can respond to *pain*, they will (i.e., if the overdose isn't as serious and pain will rouse them). That said, fixing a salt

shot wastes precious time that could be spent on calling 911, performing rescue breathing and giving naloxone. While salt shots may have appeared to work in some cases, salt shots do not address the need for oxygen and can also cause damage. Naloxone is a safer and more effective alternative.

Will hitting or slapping someone bring them out of an overdose?

You really do not want to kick, slap, punch, drag anyone...you might hurt them. The sternal rub basically does the same thing as hitting—the point is to cause pain *without* causing harm. If someone doesn't respond to a sternal rub, move on! Call 911, do rescue breathing and give naloxone.

What about ice or cold showers?

Ice down the pants or a cold shower is not an appropriate response to overdose. While it might rouse someone who would also respond to pain stimulus, ice down the pants or cold showers can slow down the respiratory system and send someone into shock or hypothermia. A safer, quicker, more effective action is to call 911, do rescue breathing and give naloxone.

Will using naloxone help someone give a clean urine?

No. Naloxone knocks opioids off the opioid receptors, but the drug is still floating around in the body (and urine!)

Are police, probation officers or program staff allowed to confiscate my naloxone rescue kit?

Your naloxone rescue kit is yours like any other possession. It should not be confiscated. It is a prescription medication. If it does get confiscated, please tell someone at the naloxone distribution program where you got it. Some programs and shelters have policies about needing to check prescription medications—you can expect to have to follow individual program guidelines, as naloxone is a prescription medicine. Sometimes people like police or probation officers might assume that the only people who have naloxone rescue kits are people who might overdose themselves, so they might assume that it is a flag for illegal activity.

Can someone get arrested for being present at an overdose?

Unfortunately, there is no easy answer to this question, because it depends on the policies and culture of your local police department and community. For example some departments have unwritten policies that people at the scene of an overdose will never be arrested after for calling for help. Other regions, cities and communities take a much more punitive stance, and the chance of getting searched and arrested at the scene of an overdose is higher. Some states have passed laws (or are trying to) that are called 911 Amnesty or Good Samaritan bills that make it extremely unlikely for police to arrest you or at least to charge and

prosecute someone who called for help for an overdose. The following considerations may be important: Are you on probation? Do you have warrants/open cases? Could the incident impact your housing situation? For example, could you lose your housing because of drug use or drug possession? Do you live with your mom, whose landlord may evict her if there is an incident involving drugs?

What if the police come after calling 911 and question us?

It is important to plan as if police will respond in advance. Remove all drugs and paraphernalia from view to reduce the likelihood of search or arrest. The first priority for police is safety at the scene—the smoothest interactions will happen when it is calm and under control.

What's with the intranasal naloxone, does it work?

Yes. The intranasal naloxone device has a stronger concentration of naloxone (2mg/2ml versus the standard injectable naloxone concentration, .4mg/1ml) to compensate for the different mode of absorption into the body. EMS services across the country are now using intranasal naloxone (Boston and San Francisco, for example) as well as some hospital emergency, police and fire departments. Nasal naloxone is also distributed at several overdose prevention programs, including the DOPE Project in San Francisco, Project Lazarus in North Carolina, naloxone

distribution programs throughout New York City, and statewide in Massachusetts and New Mexico. There has been some formal research done on the effectiveness of intranasal naloxone and 1000s of lives have been saved using nasal naloxone in the 5 programs that are currently distributing it. Intranasal naloxone is more expensive, but has the advantage of having no needle.

What if someone injects intranasal naloxone?

The intranasal naloxone device has a stronger concentration of naloxone (2mg/2ml versus the standard injectable naloxone concentration, .4mg/1ml) to compensate for the different mode of absorption into the body. If this dose were to be injected, it may be a higher dose than therapeutically necessary and the person may experience more severe withdrawal symptoms. Injecting about one quarter of the naloxone in the vial is a good amount to start. That said, injecting intranasal naloxone would work to reverse an overdose.

What happens if the MAD nasal adapter gets lost for the nasal naloxone?

Two things have been done successfully (but should only be done in an emergency): Either inject the naloxone from the vial or squirt it up the person's nose anyway without the nasal adapter. If you squirt it without the adapter it will be more of a stream than a spray—make sure the head is tilted

way back so it doesn't all run out the nose! When making a decision about which to do, remember time and oxygen! Try to keep the nasal spray piece attached to the naloxone box with a rubber band or attach it ahead of time so it's ready to go.

What if I lose the muscle syringe for my injectable naloxone and only have a regular syringe?

Regular insulin syringes have shorter points than muscle syringes, so you're not getting the naloxone all the way into the muscle, but they are better than nothing! Some studies have shown that subcutaneous injections (under the skin, but not all the way into the muscle) are just as effective as shooting it into the muscle. But make sure to pay attention to the measurements—you want to inject 1cc of naloxone to start, which will be a FULL syringe if you are using a 1cc syringe, and it will be TWO full syringes if you are using a ½ cc syringe.

What is the risk period for an overdose to reoccur after giving naloxone?

The risk that someone will overdose again, after giving naloxone, depends on several factors: the person's metabolism (how quickly the body processes things); how much drug they used in the first place; the half-life of the drug they used (i.e. methadone has a much longer half-life than heroin); how well the liver is working; and if they use again. Naloxone is active for about 30—90 minutes in the body. So if

you give someone naloxone to reverse an opioid overdose, the naloxone may wear off before the opioids wear off and the person could go into overdose mode again. Because naloxone blocks opioids from acting in the brain, it can cause withdrawal symptoms in someone that has a habit. After giving someone naloxone, they may feel sick and want to use again right away. It is very important that they do not use again for a couple of hours because they could overdose again once the naloxone wears off. Ideally people should receive medical attention but if they are able to speak clearly and walk after the naloxone they will *probably* be ok; if not, they must get medical attention.

Why do the new CPR guidelines for lay people suggest hands-only CPR instead of rescue breathing and chest compressions, when we still advocate for rescue breathing for overdose?

The new guidelines are aimed primarily at response to cardiac arrest, not respiratory arrest. In cardiac arrest, respirations are not as important as compressions—particularly in first few minutes. In respiratory arrests (like overdose), respirations are the key. If the respiratory arrest progresses to a full cardiac arrest the patient should get both chest compressions and rescue breathing. Opioid overdose, where the primary problem is lack of oxygen because of decreased breathing, affects the body differently than a heart attack. The newest AHA guidelines for trained Basic Life Support do actually include instructions to do rescue breathing for

opioid toxicity prior to cardiac arrest, but this has not been publicized as widely as the new recommendations for cardiac arrest.

What if the person is not even overdosing and I give them naloxone? Will it hurt them?

Naloxone has no effect on someone who has no opioids in their system. It will not hurt or help anyone who is not experiencing an overdose. For someone who is opioid dependent, naloxone will likely cause uncomfortable withdrawal symptoms.

Can someone overdose on naloxone or what if I give too much naloxone?

It is not possible to give too much naloxone in the sense that it is dangerous. However, if a person is dependent on opioids or has a habit (including people on chronic pain medication), the more naloxone they get, the more uncomfortable they will be because of withdrawal symptoms. Vomiting is a possibility—be sure they don't aspirate (inhale) the vomit—that is very dangerous. If the person gets too much naloxone, try to explain to them that the withdrawals will fade in a half hour or so.

Can you develop immunity to naloxone?

No, people do not develop immunity to naloxone—it can be used as effectively on the first overdose as on the 8th overdose, for example. However,

someone who overdoses a lot might want to explore why they are overdosing repeatedly; a good trainer can help brainstorm some of the reasons. Some potential reasons include:

- Untreated asthma
- Seasonal allergies
- Changes in medications for depression, anxiety, sleep, HIV
- Disassociation because of trauma= not remembering amount of drugs used
- New environment, new friends, new practices
- Infrequent use (which can lead to low/inconsistent tolerance)
- Suicidality

What if my kids (or any small children) find and use the naloxone—can it hurt them?

No. Naloxone acts as an opioid antagonist and has no adverse effects in persons that do not have opioids in their system. Its only effect is to kick opioids off brain receptors temporarily to reverse an overdose. However, there are certain risks associated with the naloxone applicator itself—the small parts may pose a choking hazard, the vial is made of very thin glass which can be easily broken, and there is a sharp needle inside the plastic tubing of the applicator. It is a good idea to keep this and other medicines out of reach of children.

My naloxone expired—what should I do?

Get a new kit! Simply go to the place where you got the first one and get one that is unexpired. If you bring in the expired kit, the program can use it as a sample for demonstrations. If you forget, it is not a big deal. If you witness an overdose emergency and all you have is your expired naloxone, it is better than nothing and may work. See the next question for more details.

My naloxone expired—can I still use it?

If all you have is an expired naloxone kit—yes—use it. Like most other medication, naloxone will start to lose its effectiveness after its expiration date. However, it may be strong enough to reverse an overdose if that is the only kit that is available. It is not toxic, so use it and continue to perform rescue breathing.

Our clinic/program policy doesn't even allow us to give people over the counter medication—how is it possible that we are now allowed to give people naloxone?

This will vary from one program to another. It is important for overdose prevention trainers to ask these specific types of questions to programs (example: detox, shelter) before doing group trainings. Some programs are simply unable to get around this internal policy and are not allowed to have naloxone on-site to respond to overdose or to give out naloxone for program participant use. In cases like

this, focus on helping the program create a policy for on-site overdose that includes identifying the overdose, calling 911, rescue breathing and recovery position and to help them think of ways they can still train program participants about overdose prevention and response while providing referrals to obtain naloxone. In some cities and states, there are regulations or laws that have passed to allow “3rd party administrators” of naloxone, thus providing protection for staff persons to have and use naloxone at their programs. Learn about your local regulations before the training.

Naloxone makes people violent, right?

No. Naloxone itself does not evoke ‘violent’ reactions in folks—rather, having too much naloxone administered to them (if you are opioid dependent, or have a habit, the more naloxone that is given, the sicker you will feel), or their environment at the time of them ‘coming to’ may be a vitriolic one... imagine waking up, feeling sick, not knowing what happened, maybe you are in a strange place or en route to a hospital, and people are yelling at you to wake up, or perhaps you are restrained. This can be a scary experience. Also, people may be angry to have their high ruined or taken away or be in withdrawals especially if they do not know that they were overdosing (which happens sometimes). Being uncomfortable and

disoriented is certainly a combination that could cause someone to act like a jerk, even if you or another bystander may have just saved his or her life. The person may feel better if they are told that the naloxone will only last about a half hour and then they will go back to feeling how they did before. Even if they are angry at the time, some may return later to thank you. The overdose reverser may feel better later by venting to a staff person at a naloxone program.

Shouldn't people just go into drug treatment?

There are multiple barriers to people going into treatment for substance use: Sometimes people are not interested, willing, ready or able to go to treatment; there can be financial barriers; there are often waiting lists/availability barriers; fear and stigma; untreated underlying mental health or trauma issues; acceptability of treatment models; hours of operation; staff; requirements (such as proper ID, etc.). Overdose response and naloxone trainings are a practical strategy that focus on what *is*, as opposed to what *should be*. If this question is raised in a group setting, one successful strategy is to turn this question around to the group. Usually group members elucidate the reasons why treatment is only sometimes a viable option for some substance users.

If we help people avoid overdose, how will they ever learn how dangerous drug use is/hit “rock bottom”/get a “wake up call”?

The death of a peer or a near death experience does not “teach” drug users a “lesson”. Increased psychological distress or trauma can actually increase substance use. The actual definition of addiction (called “dependence” or “abuse” by the American Psychological Association’s DSM V) includes one important criteria that relates to this issue: Use continues despite knowledge of adverse consequences (e.g., failure to fulfill role obligation, use when physically hazardous). This means that someone who is addicted *by definition* may not modify behaviors based on bad outcomes such as overdose.



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