### POLICY AND STANDING ORDER

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<th>SUBJECT:</th>
<th>Naloxone Distribution at Harm Reduction Center</th>
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<td>UNIT:</td>
<td>Harm Reduction Center (HIV Prevention)</td>
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<td>MANAGER:</td>
<td>Pam Dykes</td>
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<td>COPIES DISTRIBUTED TO:</td>
<td>HIV/STD Prevention; Harm Reduction Center; Syringe Exchange Services Staff &amp; Volunteers</td>
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**POLICY:**
In an effort to reduce overdose mortality in Clark County, Clark County Public Health’s syringe exchange program will provide overdose prevention education and distribute naloxone to persons at risk for having or witnessing an opioid overdose. This policy serves as a standing order for Clark County Public Health staff and volunteers who work at the syringe exchange clinic at the Harm Reduction Center to administer naloxone to clients who are experiencing an opioid overdose. It also serves as a standing order to provide overdose prevention education and naloxone kits to syringe exchange clients who are at risk of having or witnessing an opioid overdose.

**OVERVIEW:**
Opioid overdose is the leading cause of accidental death in Washington State. Opioid-related deaths in Washington State and Clark County have significantly increased over the past decade, and are preventable through education and naloxone intervention. Washington State Good Samaritan Law (Revised Code of Washington (RCW) 69.50.315) passed in 2010 legalizes the administering, dispensing, prescribing, purchasing, acquisition, possession, and use of naloxone for persons at risk of experiencing or witnessing an opioid-related overdose. Additionally, the Washington State Board of Pharmacy is supportive of making naloxone available to high-risk populations such as syringe exchange clients, and collaborative drug therapy agreements that allow pharmacists to educate ‘friends’ of potential opioid overdose victims and provide them with naloxone. Naloxone distribution is recommended by the Centers for Disease Control and Washington State Department of Health as a promising strategy to prevent overdose deaths. The American Medical Association and the American Public Health Association both have policies supporting the availability of take-home naloxone. Nationally, naloxone distribution programs have reported over 10,000 overdose reversals, and economic evaluations show that naloxone distribution to heroin users are highly cost-effective.
DEFINITION OF TERMS:

Administer: Direct application of a prescription drug to the body of a patient by a practitioner

CCPH: Clark County Public Health

Dispense: The interpretation of a prescription or order for a legend drug and, pursuant to the prescription or order, the proper selection, labeling, or packaging necessary to prepare that prescription or order for delivery. Practitioners with prescriptive authority such as Physicians and Advanced Registered Nurse Practitioners are authorized to dispense the drugs which they prescribe

Distribute: To deliver medications other than by administering or dispensing a legend drug

Legend: Drugs which are required by state law or regulation of the state board of pharmacy to be dispensed on prescription only or are restricted to use by practitioners only

Naloxone: Prescription medicine that reverses the effect of an opioid overdose

Overdose Prevention Educator: Harm Reduction Center staff and volunteers who have completed the overdose prevention education, under the direction of the Health Officer, and are qualified to deliver the Overdose Prevention and Naloxone Training curriculum to individuals at risk of experiencing or witnessing an opioid overdose

Overdose Responder: Individuals who are at risk of experiencing or witnessing an opioid overdose, have attended the Overdose Prevention and Naloxone Training, and are eligible for possession and administration of take-home naloxone to treat an opioid overdose

RCW: Revised Code of Washington

STANDING ORDER

Naloxone is indicated for reversal of opioid overdose in the setting of respiratory depression or unresponsiveness.

1. Naloxone may be given intramuscularly (IM) by trained Clark County Public Health staff and volunteers (Overdose Prevention Educators) to a person who is experiencing a drug overdose, as described in the “Procedure – Guidelines” section below. Naloxone may be given subcutaneously or intravenously, however, CCPH will teach and use the IM route, unless an urgent situation requires the other routes.

2. Supplies of Naloxone Hydrochloride Injection shall be maintained for distribution as part of the CCPH Overdose Prevention Program for the purpose of reducing opioid-related overdose deaths.

3. Trained Overdose Prevention Educators shall possess and distribute take-home naloxone kits to Overdose Responders who have completed the Overdose Prevention and Naloxone Training.

4. Overdose Responders, trained by Overdose Prevention Educators, who are trained employees and volunteers of CCPH’s Harm Reduction Center, shall be authorized to possess and administer naloxone to a person who is experiencing a drug overdose.

5. Pregnancy & Nursing Mothers: Pregnancy Category B. There are no adequate and well-controlled studies in pregnant women and it is not known whether naloxone is excreted in human milk. Naloxone should only be given to pregnant and nursing mothers if clearly needed.

6. Over-dosage: There is no clinical experience with naloxone over-dosage in humans.
PROCEDURE-GUIDELINES

1. The Harm Reduction Coordinator, under direction of the Health Officer, shall be responsible for training staff and volunteers on overdose prevention and naloxone use. CCPH Staff and volunteers who have completed training shall be qualified as Overdose Prevention Educators.

2. CCPH Harm Reduction Staff shall be responsible for receiving shipments, monitoring inventory, and maintaining log details of dispensed kits and client enrollment forms.

3. All Overdose Prevention Educators (including staff and volunteers) shall be authorized to deliver the Overdose Prevention and Naloxone Training, and distribute take-home naloxone kits.

4. All Overdose Prevention Educators will be eligible for additional training with the Harm Reduction Coordinator to recognize overdose and administer naloxone to clients experiencing overdose at the Harm Reduction Center.

5. Overdose Prevention Educators shall identify syringe exchange clients at least 14 years of age, at risk of experiencing or witnessing opioid overdose as eligible Overdose Responder candidates, who fulfill the following criteria:
   - Current opioid users, individuals with a history of opioid use, or someone with frequent contact with opioid users, age 14 years or older
   - Risk for overdose or likelihood of contact with someone at risk, by report or history
   - Able to understand and willing to learn the essential components of overdose prevention, management, and naloxone administration

6. Overdose Prevention Educators shall be responsible for delivering the “Overdose Prevention and Naloxone Training” educational curriculum to Overdose Responder candidates (Overdose Prevention Guide and Training Appendix D & E – attached). The Overdose Prevention Educator will complete an enrollment form for each participant (Overdose Prevention Program – Participant Form - Appendix F - attached). The training will take from 20 minutes up to 1 hour, depending on questions asked by candidates, and will include:
   - Overdose prevention techniques
   - Recognizing signs and symptoms of overdose
   - Calling 911 and The Good Samaritan Law
   - Rescue breathing
   - Naloxone storage, carrying, and administration
   - Post-overdose follow-up and care

7. Upon completion of the training, the Overdose Prevention Educator will assess the candidates on their understanding of the information and their comfort with the basic components of overdose response. Successful candidates shall be certified as Overdose Responders. A take-home naloxone kit will be dispensed to Overdose Responders who shall be authorized to possess and administer naloxone to any persons (friend, family, partner, etc) experiencing an opioid overdose.
Order to Dispense:
Upon participant completion of Overdose Prevention and Naloxone Training Program and documentation of competency, **dispense for use by a trained program participant:**

- Two 1cc Naloxone Hydrochloride (concentration 0.4mg/ml) vials and two 3ml syringes with 22g 1 1/2” needles.

Naloxone Kit contents:
- Two 1cc vials Naloxone Hydrochloride (concentration 0.4mg/ml)
- Two 3ml syringes with 22g 1 1/2” needles
- Alcohol Pads
- One pair of gloves
- Rescue breathing mask
- Overdose prevention tips & instructions to use Naloxone

Naloxone Administration:
(Please refer to Appendix A, B, & C for detailed instructions):
1. If the person isn’t breathing, call 911
2. Do rescue breathing for a few quick breaths first.
3. Pop off the orange top from the vial of naloxone.
4. Open one intramuscular syringe with needle and twist the needle component to secure it to the syringe.
5. For adolescents and adults, draw up entire contents of the 1cc vial of naloxone (0.4mg) into the syringe. For children less than or equal to 20kg (44 pounds) body weight, please call 911.
6. Inject into a muscle — thighs, upper, outer quadrant of the gluteus, or deltoid 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.
7. After injection, continue rescue breathing 3 minutes.
8. If there is no change in about 3 minutes, administer another dose of naloxone and continue to breathe for the person.
9. Remain with the person until he or she is under care of a medical professional, like a physician, nurse or emergency medical technician.

Naloxone Security & Storage
Syringe Exchange Staff shall ensure that all naloxone kits are securely stored at the Harm Reduction Center under conditions consistent with the manufacture’s guidelines.
Refills
Qualified Overdose Responders will be eligible to receive take-home naloxone refills upon completion of a follow-up assessment. Overdose Prevention Educators will complete the form, “Overdose Prevention Project – Use and Refill” – Appendix F - attached.

Evaluation
The Harm Reduction Coordinator and CCPH staff epidemiologist will review completed enrollment and refill forms (Appendix F) at least every other month.

EMPLOYEE EDUCATION AND TRAINING:
All Harm Reduction Center staff and volunteers shall receive training on this policy, and are recommended to complete Overdose Prevention and Naloxone Training curriculum to qualify as an Overdose Prevention Educator.
References


APPENDIX A. NALOXONE PACKAGE INSERT

Naloxone - Clinical Pharmacology

Complete or Partial Reversal of Opioid Depression

Naloxone prevents or reverses the effects of opioids including respiratory depression, sedation and hypotension. Also, Naloxone can reverse the psychotomimetic and dysphoric effects of agonist-antagonists, such as pentazocine.

Naloxone is an essentially pure opioid antagonist, i.e., it does not possess the “agonistic” or morphine-like properties characteristic of other opioid antagonists. When administered in usual doses and in the absence of opioids or agonistic effects of other opioid antagonists, it exhibits essentially no pharmacologic activity. Naloxone has not been shown to produce tolerance or cause physical or psychological dependence. In the presence of physical dependence on opioids, Naloxone will produce withdrawal symptoms. However, in the presence of opioid dependence, opioid withdrawal symptoms may appear within minutes of Naloxone administration and will subside in about 2 hours. The severity and duration of the withdrawal syndrome are related to the dose of Naloxone and to the degree and type of opioid dependence.

While the mechanism of action of Naloxone is not fully understood, in vitro evidence suggests that Naloxone antagonizes opioid effects by competing for the mu, kappa, and sigma opioid receptor sites in the CNS, with the greatest affinity for the mu receptor.

When Naloxone hydrochloride is administered intravenously, the onset of action is generally apparent within two minutes; the onset of action is slightly less rapid when it is administered subcutaneously or intramuscularly. The duration of action is dependent upon the dose and route of administration of Naloxone hydrochloride. Intramuscular administration produces a more prolonged effect than intravenous administration. Since the duration of action of Naloxone may be shorter than that of some opioids, the effects of the opioid may return as the effects of Naloxone dissipates. The requirement for repeat doses of Naloxone, however, will also be dependent upon the amount, type and route of administration of the opioid being antagonized.

Indications and Usage for Naloxone

Naloxone Hydrochloride Injection is indicated for the complete or partial reversal of opioid depression, including respiratory depression, induced by natural and synthetic opioids including propoxyphene, methadone, and certain mixed agonist-antagonist analgesics: nalbuphine, pentazocine, butorphanol and cyclazocine. Naloxone hydrochloride is also indicated for the diagnosis of suspected or known acute opioid overdosage.

Contraindications

Naloxone hydrochloride injection is contraindicated in patients known to be hypersensitive to Naloxone hydrochloride or to any of the other ingredients contained in the formulation.
**Warnings**

**Drug Dependence**

Naloxone hydrochloride injection should be administered cautiously to persons, including newborns of mothers, who are known or suspected to be physically dependent on opioids. In such cases, an abrupt and complete reversal of opioid effects may precipitate an acute withdrawal syndrome. The signs and symptoms of opioid withdrawal in a patient physically dependent on opioids may include but are not limited to, the following: body aches, diarrhea, tachycardia, fever, runny nose, sneezing, piloerection, sweating, yawning, nausea or vomiting, nervousness, restlessness or irritability, shivering or trembling, abdominal cramps, weakness, and increased blood pressure. In the neonate, opioid withdrawal may also include: convulsions, excessive crying, and hyperactive reflexes.

**Repeat Administration**

The patient who has satisfactorily responded to Naloxone should be kept under continued surveillance and repeated doses of Naloxone should be administered, as necessary, since the duration of action of some opioids may exceed that of Naloxone.

**Respiratory Depression Due to Other Drugs**

Naloxone is not effective against respiratory depression due to non-opioid drugs and in the management of acute toxicity caused by levopropoxyphene. Reversal of respiratory depression by partial agonists or mixed agonist/antagonists, such as buprenorphine and pentazocine, may be incomplete or require higher doses of Naloxone. If an incomplete response occurs, respirations should be mechanically assisted as clinically indicated.

**Precautions**

**General**

In addition to Naloxone, other resuscitative measures such as maintenance of a free airway, artificial ventilation, cardiac massage, and vasopressor agents should be available and employed when necessary to counteract acute opioid poisoning.

**Drug Interactions**

Large doses of Naloxone are required to antagonize buprenorphine since the latter has a long duration of action due to its slow rate of binding and subsequent slow dissociation from the opioid receptor. Buprenorphine antagonism is characterized by a gradual onset of the reversal effects and a decreased duration of action of the normally prolonged respiratory depression. The barbiturate methohexital appears to block the acute onset of withdrawal symptoms induced by Naloxone in opioid addicts.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**

Studies in animals to assess the carcinogenic potential of Naloxone have not been conducted. Naloxone was weakly positive in the Ames mutagenicity and in the *in vitro* human lymphocyte chromosome aberration test but was negative in the *in vitro* Chinese hamster V79 cell HGPRT mutagenicity assay and in the *in vivo* rat bone marrow chromosome aberration study. Reproduction studies conducted in mice and rats at doses 4-times and 8-times, respectively, the dose of a 50 kg human given 10 mg/day (when based on surface area or mg/m²), demonstrated no embryotoxic or teratogenic effects due to Naloxone.
Use in Pregnancy

Teratogenic Effects: Pregnancy Category C
Teratology studies conducted in mice and rats at doses 4-times and 8-times, respectively, the dose of a 50 kg human given 10 mg/day (when based on surface area or mg/m²), demonstrated no embryotoxic or teratogenic effects due to Naloxone. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, Naloxone hydrochloride should be used during pregnancy only if clearly needed.

Non-teratogenic effects
Risk-benefit must be considered before Naloxone is administered to a pregnant woman who is known or suspected to be opioid-dependent since maternal dependence may often be accompanied by fetal dependence. Naloxone crosses the placenta, and may precipitate withdrawal in the fetus as well as in the mother. Patients with mild to moderate hypertension who receive Naloxone during labor should be carefully monitored as severe hypertension may occur.

Nursing Mothers
It is not known whether Naloxone is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Naloxone hydrochloride is administered to a nursing woman.

Geriatric Use
Clinical studies of Naloxone hydrochloride injection did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

Adverse Reactions

Opioid Dependence
Abrupt reversal of opioid effects in persons who are physically dependent on opioids may precipitate an acute withdrawal syndrome which may include, but not limited to the following signs and symptoms: body aches, fever, sweating, runny nose, sneezing, piloerection, yawning, weakness, shivering or trembling, nervousness, restlessness or irritability, diarrhea, nausea or vomiting, abdominal cramps, increased blood pressure, and tachycardia.

Drug Abuse and Dependence
Naloxone hydrochloride injection is an opioid antagonist. Physical dependence associated with the use of Naloxone hydrochloride injection has not been reported. Tolerance to the opioid antagonist effect of Naloxone is not known to occur.

Naloxone Dosage and Administration
Naloxone Hydrochloride Injection, USP may be administered intravenously, intramuscularly, or subcutaneously. The most rapid onset of action is achieved by intravenous administration and it is recommended in emergency situations. Since the duration of action of some opioids may exceed that of Naloxone, the patient should be kept under continued surveillance. Repeated doses of Naloxone should be administered, as necessary.
APPENDIX B: OVERDOSE RECOGNITION

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 ashien
- 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

Adapted from the Harm Reduction Coalition’s ‘Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects’
APPENDIX C: PATIENT INSTRUCTIONS

Are they breathing?
- Slow or shallow breathing
- Gasping for air when sleeping or weird snoring
- Pale or bluish skin
- Slow heartbeat, low blood pressure
- Won’t wake up or respond (sub-nodules on sternum)

Call 911 for help
All you have to say... Someone is unresponsive and not breathing.*
Give clear address and location.

Airway
Make sure nothing is inside the person's mouth.

Rescue breathing
Oxygen saved lives. Breathe for them.
One hand on chin. 45 head back. Pinch nose closed.
Make a seal over mouth & breathe in 1 breath every 5 seconds.
Chest should rise, not stomach.

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

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

Muscular injection
Inject 1cc of naloxone into a big muscle (shoulder or thigh)

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

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

For More Info
PrescribeToPrevent.com

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

Adapted from PrescribeToPrevent.org
APPENDIX D: TRAINING GUIDE

Overdose Prevention Education

- Skills Emphasis- Health Education and Prevention for opiate users
- Priority Population- Harm Reduction Center clients and current PWID (Persons Who Inject Drugs)
- Content Area- Overdose Prevention
- Duration- 20 minutes – 1 hour of materials

Goals and Objectives:

1. By the end of the session clients will be able to recognize a potential overdose.
   a. What are the signs and symptoms of an overdose
   b. What causes an overdose

2. Clients will be able to assist an individual in an event of an overdose using proper technique.
   a. Steps in helping a person who is overdosing
   b. If Naloxone is present how to use it?
   c. What not to do in an event of an overdose
   d. Clients will be able to perform proper Rescue Breathing if necessary to a person who has overdosed.
   e. Demonstrate the proper way to do rescue breathing how this helps save a person’s life even if they haven’t become conscience yet.
   f. Proper placement of recovery position

3. By the end of the session clients will have knowledge of the Good Samaritan Law and how they benefit from it.
   a. Teaching each component of the Good Samaritan Law
   b. What the barriers are from preventing people to call 911
   c. How the Good Samaritan Law protects each individual in the event of an Overdose.

Key Concepts within Lesson:
- Causes of an overdose
- Instruction in rescue breathing
- How to help prevent an overdose

Behavioral Objectives:
Cognitive- clients will be able to recall proper technique for rescue breathing, how to recognize and overdose and how to prevent an overdose. They will also have gained the knowledge of the Good Samaritan Law and how it will help protect them in the case of an overdose.
Affective- during the educational session clients will have the opportunity to discuss knowledge they have or want to know. Clients will discuss information anonymously for protection of themselves and others.
Skills- clients will be trained in proper rescue breathing techniques as well as recovery position. They will be able to recognize a potential overdose and able to assist the individual.

Introduction to educational session:
Welcome, this course will be very informative and structured around the prevention of opiate overdose. Throughout this session you will learn how to recognize a potential overdose, proper technique in assisting an individual who is experiencing and overdose, as well as different situations that increase a one’s risk for overdosing.
Content, Learning and Instructional Strategies:
What causes an overdose?
- An overdose can cause a person’s breathing to decrease, slow or even stop completely.
- Taking too much of a dose at once, mixing different types of opiates, mixing with benzodiazepines, or alcohol increases your risk of experiencing an overdose.

Other opiates may include:
- Oxycontin
- Vicodin
- Heroin
- Methadone
- And many others...

Benzodiazepines are anti-anxiety pills that are usually prescribed by a physician. They include Xanex, Klonopin, and Valium along with many other types. They are used to also treat insomnia and help with anxiety.

How to help prevent an overdose.
- Try not to use alone
- Using a new source make sure you take a smaller dose at first.
- If you haven’t used in a while make sure your dose is less than it usually is. Your tolerance can go down after a short amount of time. (drug treatment, time in jail, detox, etc.)

What to do if someone is experiencing an overdose.

Signs and Symptoms of an overdose:

STEP 1
- Lips and extremities might turn blue or a purple color
- If the person is not responding when you yell their name.
- If the person doesn’t respond after you try rubbing your knuckles on their breast bone.
- If that person’s breathing is slow, abnormal, or if they’re not breathing at all.

STEP 2
- If the individual doesn’t respond to you call 911
- Start Rescue Breathing (we will go over technique for RB shortly).
- One thing you must understand with calling 911 is you not only have a better chance of the individual surviving you are protecting under what’s called the Good Samaritan Law.

Good Samaritan Law:
- If you believe you are witnessing a drug overdose you must seek medical help. The Good Samaritan Law states you will receive immunity from criminal charges of drug possession at the time. The overdose victim you’re helping is protected as well.
- Although, if you already have a outstanding warrant, probation or parole violations, drug manufacturing or any other crime other than drug possession that is not protected.
- If you do call 911 the important thing to do is stay with the victim until EMS or paramedics arrive and if you must leave you can.
**Rescue Breathing:**
Rescue breathing is extremely important and can be the key to saving the victim’s life. It only takes a few minutes without oxygen to the brain for permanent brain damage to occur.

Turn the person over on their back
- Tilt their head back gently to open their airway
- Check their mouth to make sure there is nothing blocking their airway
- Pinch their nose and give 2 slow breaths. You should be able to notice their chest rise and fall.
- Continue to give rescue breaths 1 every 5 seconds until paramedics arrive.

*If there is more than one bystander there take turns breathing for the overdose victim so one person doesn’t get exhausted as quickly. If the victim comes to and starts to breath on their own again do not leave them because it is possible they can slip back into an overdose. Medical attention should still be contacted.*

**Closing Statements/questions:**

“We are here to make sure that you are at minimal risk for overdosing. If there is anything we can do to help you further or if you want more information please ask”
OVERDOSE PREVENTION AND NALOXONE (NARCAN) TRAINING PROGRAM

To be taught by Overdose Prevention Educators (Trained CCPH Harm Reduction Staff & Volunteers)

This training is designed to be taught to opiate users by volunteers of the Clark County Needle Exchange Program about actions to take in case of an overdose of opiates.

This training will help opiate users leave with an understanding of the more common life-saving actions needed to keep someone alive who has overdosed in the hope that quick actions can save a life.

The following information is to be provided to the client by reading or describing what is outlined in text below.

**Background on opiates:**

- All opiates are the same in that they:
  - Come from the opium poppy or are chemically created to be like a drug which comes from the opium poppy;
  - Have their effect on the same part of the brain;
  - Cause overdose in the same ways if too much is used: arrested breathing.

- Opiates are different in that they:
  - Have different concentrations or strengths
  - Produce different speed, length and intensity of withdrawal.
  - Have varying durations of action, such as

<table>
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<th>How long it works</th>
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<tr>
<td>methadone</td>
<td>24 hours</td>
<td>codeine</td>
<td>3-4 hours</td>
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<tr>
<td>heroin</td>
<td>6-8 hours</td>
<td>Demerol</td>
<td>2-4 hours</td>
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<tr>
<td>Dilaudid</td>
<td>4-6 hours</td>
<td>Fentanyl</td>
<td>1-2 hours</td>
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IMPORTANT NOTE: Combining opiates with other drugs, especially alcohol and other downers, is much more likely to lead to an overdose. This training describes opiate overdose management and not overdose with other drugs.

While this training may help you keep a friend alive who overdosed on heroin, it may not work if your friend has also used other drugs.

**About Naloxone (Narcan)**

Respiratory depression may result from overdosage of narcotics, including heroin, morphine, and other opiates. The narcotic antagonist naloxone is a specific antidote against respiratory depression caused by opiate overdose. Therefore, an appropriate dose of naloxone should be administered, preferably intravenously, and simultaneously with efforts at respiratory resuscitation. An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression.

Knowing how to do CPR is one of the best things you can do to keep someone alive no matter why they are not breathing. Training to do CPR well is an important part of being a good overdose manager.

**OD Prevention:**

Some things you can do to prevent OD:

- know your stuff
- testing small amount
- purification
- purity testing
- inject with OD prevention technique
  (tourniquet off after hit, several slow pushes to taste)

**What actually happens in a severe overdose?**

- Cardiac arrest (Heart attack). . . when someone's heart stops
- Apnea . . . when someone can no longer breath
- Circulatory collapse . . . when there is no circulation of blood
Recognizing an OD vs. a Good High:

Some signs of a serious overdose with opiates, which may lead to death, are:

- Respiratory depression . . . very slow and ultimately no breathing
- Cyanosis . . . turning blue on the lips and fingertips first
- Extreme somnolence . . . hard to awaken sleepiness
- Progressing to stupor or coma . . . falling out
- Skeletal muscle flaccidity . . . loose muscles
- Cold or clammy skin
- Bradycardia . . . slow heartbeat &
- Hypotension . . . low blood pressure

Treatment of an opiate overdose:

Once you have determined someone has taken too much:

**First Call 911!**

The more help the better. CPR is hard to keep up for long!

You are protected in Washington State with **Washington State's "911 Good Samaritan" Law:**

If you think you're witnessing a drug overdose and seek medical help, you will receive immunity from criminal charges of drug possession. The overdose victim you're helping is protected, too. **Call 911!**

Then
•••BREATHING IS THE THING•••

Make sure they are breathing.

If they are not breathing, breathing for them will keep them alive.

Maintain the person's airways by gently tilting the patient's head back and lifting their chin.

Put them in a position so that they can breathe.

---- Provide Rescue Breathing training here:

---- Provide CPR training here:

---- The Recovery position:

This recovery position should be used when calling 911 or when drawing up the Narcan. This position will help maintain an airway for the person to breathe and will also avoid aspiration of vomit or any possible blockage to the airway. As soon as you are free to help again position the person on their back and continue CPR until paramedics arrive.
Consider using Naloxone for opiate overdoses only

**Why?** If used correctly, naloxone can reverse the overdose and save the person’s life.

**Why not?** If you get so tied up with the naloxone you don't keep up the breathing the person will die.

### How do you dose Naloxone?

**Dose:**

1 ml/100 units ideally with a prepared syringe
Repeat the dose if necessary after 2-3 minutes*

*A second dose can be given but only if you can quickly resume CPR or there is another person to help out. CPR should be continued until an ambulance arrives.

### How do you deliver Naloxone?

**Method:** Intravenously... Can you get a vein?
If you can get a vein, naloxone will work more quickly.
Consider using veins under the person’s tongue.

Into the muscle? ... the shot might take 3-15 minutes to work.
Also: Can you continue to breathe for them?
Do you have the right syringe (1 - 1 1/2 inch needle)?

Under the skin?
With this method, it might take 30 minutes to work.
Can you continue to breathe for them for that long?
If the naloxone works:

**SUPPORT THE PERSON**

- While the naloxone may have started them breathing again it may also start withdrawal symptoms.
- Using again will likely make the OD worse when it returns in an hour or so.
- If you can support the person in dealing with the discomfort, if any, for an hour the naloxone should wear off and the withdrawal will fade.

Watch for the **return of the overdose.**

- Naloxone will quit working after 30 to 90 minutes.
- If the person still has too much opiate in their system the overdose will return and you'll be faced with the same situation.
- Call for help again, go to the emergency room, prepare another shot of naloxone
- Keep up the CPR if the person is not breathing!

**Spread the word:** Developing a plan with your injection partner(s)

Now that you have had a chance to learn about opiate OD, CPR, and naloxone you need to consider a critical part of OD management:

**TALKING WITH YOUR PARTNERS TO WORK OUT A PLAN.**

Among the questions to consider and things to do for yourself and for your partner(s) are:

- Teach your partner(s) about OD warning signs and be able to recognize them
- Teach your partner(s) how to do rescue breaths and CPR
- Teach your partner(s) how to dose and administer Narcan
- Teach your partner to call 911, do rescue breaths and do CPR when OD is suspected
- Teach your partner(s) to use Narcan every time an OD is suspected after calling 911.
OD Prevention/Management Checklist:
Ask these questions to the opiate user after education session is complete and make sure client is able to answer all questions appropriately.

YES NO

○ ○ Knows OD prevention techniques

○ ○ Knows when to act - color/# breaths in 10 seconds

○ ○ Knows when to call 911

○ ○ Knows if and when to use rescue breathing or CPR

○ ○ Knows how to dose and when to administer naloxone

○ ○ Has agreed to stay with partner to support while naloxone wears off (about an hour after it is given)

○ ○ Notes commitment to not use again while waiting for the naloxone to wear off
# Overdose Prevention Program Participant Form

**Name**

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>_______________</td>
<td>______</td>
<td></td>
</tr>
</tbody>
</table>

**Date of Birth**

______________

**Aliases/other names used**

__________________________

**Client** □ □ □ □

**Professional** □ □ □ □

**Friend/family** □ □ □ □

**Other** □ □ □ □

**Gender**

□ Male

□ Female

□ Transgender

□ FTM

□ MTF

**Race (select all that apply)**

□ White

□ Black/African-American

□ American Indian/AK Native

□ Native Hawaiian/Pacific Is

□ Asian/S Asian

□ Latino/Hispanic

□ Other __________________

**Do you identify as Hispanic or Latino?**

□ Yes

□ No

What best describes your housing situation?

□ Permanent

□ Homeless

□ Temporary/Unstable

**Education**

□ Elementary school or less

□ Some high school

□ High school or GED

□ Some college

□ College or more

**Zip code**

_______________

During the last 12 mos did you?

□ Go to inpatient detox?

□ Get incarcerated or locked up?

□ Have you taken a few days off for any other reasons?

□ Spend the night on the street or in a shelter?

□ Visit the emergency room?

What drugs have you used in the last 3 months? (Read list, check all that apply)

- Speedballs *(heroin & cocaine together)*
- Goofballs *(heroin & methamphetamine together)*
- Heroin by itself
- Powder Cocaine by itself
- Crack Cocaine by itself
- Methamphetamine by itself
- Downers like Valium, Xanax, Klonopin, soma
- Pain Medications like Oxycontin, Vicodin, or Fentanyl
- Methadone
- Buprenorphine or Suboxone
- Alcohol
- Other ____________________________

When you use opioids, how often do you drink *alcohol* within a couple of hours before or after?

□ Never

□ Some of the time

□ Most of the time

□ Always

When you use opioids, how often do you use *sedatives* or *downers* within a couple of hours before or after?

□ Never

□ Some of the time

□ Most of the time

□ Always

How many times have you *overdosed* in your life? ________________

⇒ If any, ask the following questions about the LAST TIME:

- What drugs did you take? ________________
- Did you receive naloxone? □ Yes □ No
- If YES, from whom? ______________________
- Did you receive medical care? □ Yes □ No

How many times have you *witnessed* someone else OD? ________________

⇒ If any, ask the following questions:

- How many times was medical attention received? ________________
- Was naloxone ever used? □ Yes □ No □ DK
- If yes, by whom? ______________________
- Have you ever used naloxone before? □ Yes □ No

How often do you use *heroin* or *other opioids* when you are alone?

□ Never

□ Some of the time

□ Most of the time

□ Always

How often do you use drugs in a **PRIVATE** setting?

(like an apartment or house)

□ Never

□ Some of the time

□ Most of the time

□ Always

How often do you use drugs in a **PUBLIC** setting?

(like a park, alley or bathroom)

□ Never

□ Some of the time

□ Most of the time

□ Always

Appendix F – Participant & Naloxone Refill Form

This material is adapted from materials created by the HIV/STD Program, Public Health - Seattle & King County & Outside In, Portland, OR
Overdose Prevention Program- Naloxone Use & Refill

<table>
<thead>
<tr>
<th><strong>Name</strong></th>
<th><strong>Aliases/other names used</strong></th>
<th><strong>Birth Date</strong></th>
</tr>
</thead>
</table>

**Was naloxone administered to reverse an overdose?**  [ ] Yes  [ ] No

If YES, please ask the questions below for each overdose victim.

**Victim #1**

How many doses of naloxone were administered? _________

Date of use (approximate) ____________

On whom was it used?

[ ] Friend/Acquaint.  [ ] Self  [ ] Family member  [ ] Unknown  [ ] Stranger  [ ] Other___________

**Drugs used by recipient at time of overdose (check all that apply)**

[ ] Speedballs  [ ] Downers/Benzos  [ ] Goofballs  [ ] Rx. Pain Medications  [ ] Heroin by itself  [ ] Methadone  [ ] Powder Cocaine by itself  [ ] Buprenorphine/Suboxone  [ ] Crack Cocaine by itself  [ ] Alcohol  [ ] Methamphetamine by itself  [ ] Other___________

How was naloxone administered?

[ ] Intranasal  [ ] IV  [ ] IM or skin popping  [ ] Other___________

**Was 911 called?**  [ ] Yes  [ ] No  If NO, why?

[ ] No phone avail.  [ ] Afraid of police involvement  [ ] Unknown  [ ] Felt could handle w/o medical help  [ ] Other___________

**Did someone stay with the person until the naloxone wore off and/or they got medical attention?**  [ ] Yes  [ ] No  [ ] DK

Where did the OD take place?

(e.g., zip code, neighborhood, intersection) _______________________

**Was this location:**

[ ] Private residence  [ ] On the street/outside
[ ] Commercial setting  [ ] In a shelter
(e.g., store, bar, restaurant)  [ ] Other___________

What else was done? (check all that apply)

[ ] Rescue breathing  [ ] Ice  [ ] Cold shower
[ ] Walked around  [ ] Slap  [ ] Cocaine shot
[ ] Sternal rub  [ ] Salt shot  [ ] Other___________

**What was the outcome of the incident?** (check all that apply)

[ ] Person OK  [ ] Hospitalization  [ ] Someone arrested
[ ] EMS  [ ] Death  [ ] Police at scene
[ ] ER  [ ] Other___________

If police/EMT were present, was the interaction:

[ ] Positive  [ ] Neutral  [ ] Negative

<table>
<thead>
<tr>
<th><strong>Victim #2</strong></th>
<th><strong>Birth Date</strong></th>
</tr>
</thead>
</table>

How many doses of naloxone were administered? _________

Date of use (approximate) ____________

On whom was it used?

[ ] Friend/Acquaint.  [ ] Self  [ ] Family member  [ ] Unknown  [ ] Stranger  [ ] Other___________

**Drugs used by recipient at time of overdose (check all that apply)**

[ ] Speedballs  [ ] Downers/Benzos  [ ] Goofballs  [ ] Rx. Pain Medications  [ ] Heroin by itself  [ ] Methadone  [ ] Powder Cocaine by itself  [ ] Buprenorphine/Suboxone  [ ] Crack Cocaine by itself  [ ] Alcohol  [ ] Methamphetamine by itself  [ ] Other___________

How was naloxone administered?

[ ] Intranasal  [ ] IV  [ ] IM or skin popping  [ ] Other___________

**Was 911 called?**  [ ] Yes  [ ] No  If NO, why?

[ ] No phone avail.  [ ] Afraid of police involvement  [ ] Unknown  [ ] Felt could handle w/o medical help  [ ] Other___________

**Did someone stay with the person until the naloxone wore off and/or they got medical attention?**  [ ] Yes  [ ] No  [ ] DK

Where did the OD take place?

(e.g., zip code, neighborhood, intersection) _______________________

**Was this location:**

[ ] Private residence  [ ] On the street/outside
[ ] Commercial setting  [ ] In a shelter
(e.g., store, bar, restaurant)  [ ] Other___________

What else was done? (check all that apply)

[ ] Rescue breathing  [ ] Ice  [ ] Cold shower
[ ] Walked around  [ ] Slap  [ ] Cocaine shot
[ ] Sternal rub  [ ] Salt shot  [ ] Other___________

**What was the outcome of the incident?** (check all that apply)

[ ] Person OK  [ ] Hospitalization  [ ] Someone arrested
[ ] EMS  [ ] Death  [ ] Police at scene
[ ] ER  [ ] Other___________

If police/EMT were present, was the interaction:

[ ] Positive  [ ] Neutral  [ ] Negative

Is there anything else you would like to go over or review today?