

ENGAGING LAW ENFORCEMENT IN OPIOID OVERDOSE RESPONSE: FREQUENTLY ASKED QUESTIONS

This document is the outcome of the July 31, 2014 U.S. Attorney General's Expert Panel on Law Enforcement and Naloxone. It was prepared by Leo Beletsky, JD, MPH.¹

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INTRODUCTION

Claiming nearly 120 American lives daily, drug overdose is a true national crisis.² The main driver of this epidemic is opioid overdose (OOD), which cuts across class, race, and demographic characteristics. Certain groups, including veterans, residents of rural and tribal areas, recently-released inmates, and people completing drug treatment/detox programs are at an especially high risk of OOD.

The vast majority of OODs are accidental and result from taking inappropriate doses of opioids or mixing opioid drugs with other substances. These drug poisonings typically take 45-90 minutes to turn fatal, creating a critical window of opportunity for lifesaving intervention. Appropriate assistance, including administration of the antidote naloxone, can quickly and effectively reverse the OOD.

Reducing the time between the onset of OOD symptoms and effective intervention is a matter of life and death. Tragically, many victims do not receive timely medical attention. In many cases, witnesses delay calling for help because they do not recognize OOD symptoms or are concerned about getting in trouble with the law. In other cases, emergency medical response may take too long to arrive or the victim may not be discovered until it is too late.

Law enforcement officers (LEOs) have always been on the front lines of the battle against drug-related harm in our communities. The current OOD crisis is no different. Across the US, law enforcement agencies are increasingly initiating programs to stem the tide of overdose fatalities. This document provides an overview of the frequently asked questions (FAQs) that may arise in agencies that are considering or initiating such efforts.

ABOUT NALOXONE

What is naloxone (a.k.a. Narcan)?

Naloxone is an opioid antagonist, designed to reverse an opioid overdose. Also marketed by the trade name Narcan, it is an odorless, clear liquid substance. Opioids cause death by slowing, and eventually stopping the victim's breathing. When administered, naloxone

² Centers for Disease Control and Prevention, *Prescription Drug Overdose in the United States: Fact Sheet*, available at <http://www.cdc.gov/homeandrecreationalafety/overdose/facts.html>. Accessed July 2, 2014

restores respiration within two to five minutes, and may prevent brain injury and death. In some cases, a second dose may be needed to rouse the victim or to prevent them from becoming unconscious again. Naloxone has no potential for abuse. This medication has also been dubbed the “miracle” or “second chance” drug because it can have a transformative effect on both the victim and the rescuer.

How is naloxone administered?

Law enforcement officers have three ways in which to administer naloxone. Currently the most common administration method for LEO overdose rescue programs is **intranasally (IN)**. During this mode of administration, a liquid form of naloxone is sprayed into the victim’s nostrils. Many first responders prefer IN delivery because it does not involve needles, eliminating the risk of an accidental needle stick injury. The drawback is that IN delivery of naloxone has not yet been FDA-cleared; it is only approved as an injectable drug. This does not make IN devices illegal, since IN delivery is a common “off-label” use of the drug. For instance, Boston Basic Life Support medical responders have been using IN naloxone since 2005. In order to make IN doses available, the needleless syringe containing the naloxone vial must first be connected to a separate device called an atomizer that converts the liquid stream of the drug into a fine mist. The different components are typically sold separately, although limited quantities of pre-packaged IN rescue kits may be available from regional compounding pharmacies. A pre-manufactured IN device is under development.

One alternative way to deliver naloxone is through **intramuscular (IM)** injection. This is an FDA-approved delivery process, utilized for decades in medical settings. With IM, naloxone is drawn from a vial into a syringe, and then injected into the victim’s thigh or another large muscle. Many community-based OOD prevention programs distribute IM naloxone to families and other potential OOD bystanders because of its lower cost. Although IN administration is far more common, several law enforcement agencies have opted for injectable administration. The effect of IM administration is typically more rapid than IN, but it does require a level of comfort with hypodermic needles.³

The newest addition to the naloxone arsenal is a naloxone auto-injector product called **EVZIO®**. This device is the first naloxone product specifically FDA approved for administration for suspected opioid overdose outside a medically-supervised setting. It is designed to guide the user through the process of overdose reversal using pre-recorded audio prompts and printed images on the device displaying the administration steps. It injects naloxone utilizing a fully retractable needle system that is designed to eliminate the risk of needle stick injury. EVZIO® has a retail price that is substantially higher than the IN or IM products but the manufacturer, Kaléo, offers a program to make the product available at a discount to law enforcement agencies.

Does naloxone have any side effects?

³ Emergency medical services may also administer naloxone intravenously, which requires professional skill and is not appropriate for non-medical first responders.

Approved by the FDA since the 1970s, naloxone is a very safe medication with the potential side effect of a theoretical risk of allergy that has never been documented. Its administration may result in acute opioid withdrawal (agitation, nausea, vomiting, diarrhea, “goose flesh”, tearing, runny nose, and yawning). When victims experience these symptoms, they may become irritable and anxious. It is uncommon, however, for the revived victim to become violent or combative. Intranasal naloxone delivery is less likely to result in severe withdrawal symptoms than an injection.

On rare occasions, reviving an OOD victim may restart existing health problems or uncover the effect of other drugs the victim had taken. This may result in heart palpitations or seizures. In all cases of overdose, it is critical victims be transferred to the care of medical professionals.

Does naloxone reverse any overdose?

Naloxone only works on overdoses caused by opioids. This family of drugs includes prescription painkillers like OxyContin, fentanyl, methadone, and Vicodin, as well as street drugs like heroin. Naloxone will not reverse overdose resulting from non-opioid drugs, like cocaine, benzodiazepines (“benzos”), or alcohol. Given how safe naloxone is, a victim of a non-opioid overdose, or an overdose caused by a mixture of drugs will not be harmed by naloxone. In multiple drug overdoses, it is still worth administering naloxone as it will remove the effects of the opioid, restoring breathing in many cases.

If a person is unresponsive and it is not known whether opioids are the cause, can naloxone be administered “just in case”?

Yes. This is standard practice among emergency medical personnel.

How should naloxone be stored?

Naloxone is a fairly stable medication, with a shelf life between 18 months and two years. IN and IM naloxone should be stored between 59 and 86 degrees Fahrenheit, and should be kept away from direct sunlight. In most law enforcement settings, naloxone can be stored in the cab of the vehicle. Alternatively, the medication has been stored with automated external defibrillator (AED) units. Naloxone kits can be maintained by the individual officers, or issued at roll call and checked in at the end of the shift. Upon expiration, supplies of the medication should be replaced. EVZIO® maintains stability at temperatures of up to 104 degrees for six months.

[Sample policies and procedures](#) included in this Toolkit list a variety of approaches to naloxone storage.

How can a law enforcement agency procure naloxone?

The easiest way for a law enforcement agency to order naloxone is to partner with a local or state public health agency, or a local health care institution that already has a drug procurement structure. So long as naloxone remains a prescription drug, the ability of law enforcement agencies to order the medication from a distributor will be limited by applicable state laws and regulations. For more information on these provisions, see [How do law enforcement officers become legally authorized to carry and administer naloxone?](#)

ABOUT LAW ENFORCEMENT OVERDOSE REVERSAL PROGRAMS

Should every law enforcement agency get involved in an overdose prevention program?

Whether it is by actually reversing acute overdoses using naloxone, facilitating effective medical response, supporting the availability of opioid addiction treatment in the community, or by undertaking prevention activities like community education, law enforcement agencies have a vital role to play in curbing the overdose epidemic.

Depending on the law enforcement agency's particular role, jurisdiction, and design of emergency medical services, some LEOs may be well-positioned to reverse a substantial number of acute overdoses. Regardless, all law enforcement agencies should weigh overdose rescue as a potential tool that may be appropriate. Efforts to equip LEOs with naloxone (see [What is a law enforcement overdose reversal program?](#)) should prioritize settings where law enforcement personnel may come into contact with OOD victims at least two to four minutes before emergency medical personnel. Law enforcement overdose reversal training and naloxone supply are particularly critical to rural, tribal, and other high-risk settings where professional emergency medical response may be significantly delayed by geographic, resource, and other factors.

Whether or not an agency undertakes an overdose reversal program using naloxone, comprehensive overdose prevention programs often integrate other key elements. This includes community and school education about signs and symptoms of overdose, awareness of local Good Samaritan overdose laws or policies, information about safe drug storage, prescription drug take-backs, and encouraging help-seeking among high-risk groups. (See [Additional Considerations](#) section.)

What is a law enforcement overdose reversal program?

Law enforcement overdose reversal programs are designed to equip LEOs to recognize and reverse an active opioid overdose using naloxone. Providing law enforcement with the knowledge and the tools to reverse overdoses in the field can reduce the time between when an OOD victim is discovered and when they receive lifesaving assistance. Law enforcement overdose rescue programs are similar to the already widespread efforts to train police in first aid and cardiopulmonary resuscitation (CPR). A list of existing law enforcement overdose reversal programs is available [here](#).

Example: The Quincy, MA Police Department (QPD) launched its law enforcement overdose reversal program in 2010. Created in partnership with the Massachusetts Department of Public Health, this initiative consisted of training patrol officers how to recognize and reverse OODs, and equipping them with naloxone. To date, QPD officers have reversed over 280 OODs. This program has been widely recognized for its contribution to the fight against the overdose epidemic⁴ and has served as a model for a growing number of law enforcement overdose reversal initiatives across the United States.

Example: In response to the increase in the number of reported overdose deaths on tribal lands and 20-minute ambulance response times, the Police Department of the Lummi Nation in the Pacific Northwest requested permission to participate in the overdose prevention program sponsored by the Lummi Nation Tribe. Originally focused on training community members in the use of naloxone, the program was expanded to cover 20 officers and command staff. In the first six weeks of the program, Lummi officers successfully reversed three overdoses. In addition to training the remaining Lummi officers, the Lummi Nation PD training is being scaled up to encompass Lummi Housing Security and neighboring First Nations police agencies.

Example: In May 2012, Suffolk County Police Department (SCPD), which serves a wide geographic area began a Narcan Pilot program. A partnership with the New York State Department of Health, this program initially trained 400 officers in several precincts. In the first five months, the program resulted in 32 reversals, leading to a rapid scale-up of the program to all of the patrol and support divisions. Currently, more than 1,200 officers have been certified and have administered naloxone a total of 244 times resulting in 233 successful OOD reversals.

What is behind the growing popularity of law enforcement overdose reversal programs?

Law enforcement officers are often first to arrive at the scene of an OOD, either as a result of an emergency call or in the ordinary course of their patrol or other duties. During an OOD, delaying appropriate first aid by mere minutes can translate into a difference between life and death or permanent brain damage. Being equipped with overdose reversal skills and naloxone gives officers a new critical tool in furthering their mission to protect and serve their communities.

In addition to the lifesaving function, law enforcement overdose reversal activities have gained traction for other reasons. Opioid abuse and the devastation wrought by the overdose epidemic touches some officers on a personal level. Research suggests that

⁴ Recipient of the White House *Advocates for Action* Award, featured in the Office of National Drug Control Policy (ONDCP) 2013 National Drug Control Strategy, and Gary P. Hayes Award, (PERF). See Jack Encarnacao, *White House recognizes Quincy for drug program*, The Patriot Ledger, Apr. 30, 2013, available at <http://www.patriotledger.com/news/x1506802962/White-House-recognizes-Quincy-police-for-drug-program>. Published April 30, 2013. Accessed July 2, 2014.

officers appreciate the opportunity to expand their capacity to respond effectively to overdose emergencies. Learning about and being able to refer at-risk individuals to drug treatment and other public health resources (including naloxone prescription programs) further expands the arsenal available to LEOs in preventing drug overdose in their community. In many instances, OOD reversals by law enforcement personnel have improved internal morale and job satisfaction.

Agencies implementing law enforcement overdose response initiatives have also reported improved community relations, cross-sector information sharing, and better coordination with public health agencies and community groups working on substance abuse problems.

Isn't overdose reversal the responsibility of emergency medical services?

Ideally, each OOD victim can receive timely attention from emergency medical responders; there is an entire range of other accidents during which LEOs routinely step up to provide first aid, including instances of motor vehicle accidents and heart attacks. As always, during overdose events LEOs work in coordination with other first responders. Depending on the design of emergency services in the jurisdiction and the geographical setting, LEOs may be in the position to save lives by providing the initial emergency response. Any follow-up assistance, including medical transport (or refusals of medical attention) is typically handled by emergency medical responders.

Even when emergency medical responders are already present on the scene, those responders may request assistance from LEOs. This may include providing direct first aid, securing the scene, or other types of support. When setting up and executing a law enforcement overdose rescue program, it is important for all three branches of the emergency response system (i.e., police, fire, and EMS) to collaborate at the scene of an overdose. Therefore, it is worthwhile to obtain buy-in from the EMS and fire service to plan for how care of the victim will flow during an overdose response.

The way LEOs conduct themselves during overdose response events is critical to the overall effort to curb the overdose crisis. By treating overdose events first and foremost as health emergencies, officers can foster a culture of trust with members of the public, maximizing the chances bystanders will call 9-1-1 during overdose events. Basic outreach at the scene can help educate families, friends, and other bystanders to be vigilant for signs and symptoms of overdose, since many victims experience more than one such event over their lifetime. Additional outreach, including referral to treatment and community overdose prevention programs may be appropriate.

How do law enforcement officers become legally authorized to carry and administer naloxone?

Naloxone is a prescription medication but it is not a controlled substance. This means authorization is needed to allow possession and administration of the drug by first responders. In most cases, a protocol called a "standing order" can be issued for the entire department by any provider holding a license to write prescriptions. To obtain naloxone,

many law enforcement agencies have collaborated with physicians from the state or local department of health, local EMS agencies, hospitals, or community organizations.⁵ Typically, the agency signs a memorandum of agreement (MOA) or another agreement to formalize the collaboration with authorizing healthcare or public health agencies. A list of [sample MOAs](#) is available as a part of this Toolkit.

In the case of large departments, the agency's medical director or other licensed staff prescribers may be able to authorize field personnel.⁶

Some states have made it easier for LEOs to access naloxone. For example, some Boards of Pharmacy have streamlined the process by which law enforcement agencies can order the medication, allowing these agencies to purchase naloxone directly from a wholesaler instead of receiving it from a retail pharmacy via a prescription from a health care provider.⁷ Other states have supported agreements between law enforcement overdose response programs and EMS agencies to handle purchasing and training.⁸

With proper authorization, law enforcement overdose response programs can access any naloxone product currently available on the market. For the discussion of the differences in these products, see [How is Naloxone Administered?](#)

If something goes wrong during an overdose rescue attempt, could the officer or the officer's employer be held liable?

The risk of liability for a LEOs or their employers resulting from naloxone administration is low. From a legal standpoint, it would be extremely difficult to win a lawsuit against an officer who administers naloxone in good faith and in the course of employment. Overdose response activity is no different from any other good faith effort to provide assistance in an emergency.⁹

In nearly all states, the liability risk is further reduced by laws that provide LEOs, as well as their employers with additional layers of protection from lawsuits. Almost half the states in the United States have passed naloxone access laws that shield "any person" from civil and criminal liability if they administer naloxone.¹⁰ Such immunity applies to LEOs as well as other professional responders who administer naloxone in good faith.¹¹

⁵ Examples include New York and Massachusetts.

⁶ Information on engaging prescribers in such efforts is available at <http://prescribetoprevent.org>. See also the SAHMSA Overdose Prevention Toolkit [http://store.samhsa.gov/shin/content/SMA13-4742/Overdose Toolkit 2014 Jan.pdf](http://store.samhsa.gov/shin/content/SMA13-4742/Overdose_Toolkit_2014_Jan.pdf). Accessed September 1, 2014.

⁷ Examples include New Jersey and New York.

⁸ Example includes North Carolina.

⁹ This analysis assumes that an officer attempting a rescue is acting in good faith. Egregious lapses of judgment, intention to cause harm, or actions that are outside of the officer's scope of training or employment may, in some instances, increase risk of liability.

¹⁰ For an updated list of these laws, see Public Health Law Research Program, *LawAtlas: Naloxone Overdose Prevention Laws*, available at <http://lawatlas.org/query?dataset=laws-regulating-administration-of-naloxone#.U8WQa6gwLYQ>. Accessed July 12, 2014.

¹¹ It is important to distinguish such provisions from Good Samaritan laws, which generally cover volunteers and bystanders acting outside their scope of employment.

Many states also have provisions, commonly referred to as “Tort Claims Acts,” which extend additional liability shields to both state and local governments. Although these rules vary, such laws generally cover discretionary actions made in good faith and are within the scope of an officer’s employment. Related provisions may also cap the maximum liability of the governmental entity and prohibit the payment of punitive or other damages.

In summary, as long as LEOs act in good faith and within the scope of their training and standard operating procedures, the risk of liability to themselves or their employer is extremely low.

Could an officer who is part of a law enforcement overdose reversal program be held legally liable for failing to provide OOD rescue?

Generally, no. In most states, a legal concept called the Public Duty Doctrine blocks such lawsuits. Under this doctrine, officers have no legal duty to assist others, even when they are in a position to do so. These protections do not apply to any administrative discipline directed at the officer for violating standard operating procedures.

Is special training required to engage law enforcement in overdose reversal?

As with any new initiative, officers should be trained in the proper handling and use of the medication. Most states do not require specific training for people who administer naloxone, but some amount of training is mandated for non-medical personnel in several jurisdictions. The length and content of the training are discretionary. The vast majority of LEO overdose reversal programs are administered in collaboration with state or local departments of health, community-based organizations, healthcare organizations, or EMS agencies (see the [MOA section](#) of this Toolkit).

In the case of dual-role officers holding additional medical response certifications (e.g. EMTs), existing training and certification could be sufficient to carry and administer naloxone.

What does the education and training element of a law enforcement overdose reversal program typically cover?

Law enforcement overdose response program trainings typically last from 40 to 90 minutes. At the very least, such trainings include three basic elements: 1) information on how to recognize signs of an opioid overdose, 2) information on how to provide basic life support and proper administration of naloxone, and 3) an applied component providing trainees an opportunity to practice their skills. Trainings also typically include time for the completion of requisite documentations to authorize naloxone possession and administration by LEOs.

Most trainings also cover some combination of the following content elements:

- A. Drug abuse basics, including the chronic nature of addiction and risk factors for overdose
- B. Mechanisms by which opioids can cause overdose and the reversal properties of naloxone
- C. Occupational safety considerations
- D. Legal considerations, including naloxone authorization and applicable Good Samaritan laws or policy provisions covering overdose victims and bystanders
- E. Standard operating procedures, including how to interface with emergency medical personnel
- F. Overdose education and naloxone distribution resources available to community members, including what to expect if a bystander has already administered naloxone

Programs that meet best practices cover information and skills that equip officers to engage in prevention at the scene of the overdose, because overdose reversal is just the first step in helping the victim on the road to recovery. Officers benefit from instruction that covers substance abuse and social services available in their jurisdiction, as well as specific referral protocols. To ensure the accuracy of such content, it is important to consult relevant community partners in key sectors, including drug treatment, behavioral health, and related services. The particular mix of training content and delivery channels depends on local needs and circumstances. Employees who hold existing medical response certifications such as CPR or basic life support may require an abridged training.

There are a number of existing resources to help agencies design their own law enforcement overdose response training. A list of training materials is available in the [Training section](#) of this Toolkit.

Who is responsible for the delivery of the education and training element of a law enforcement overdose response program?

Several options exist for providing training to law enforcement overdose response program participants.

One model is for the training to be provided by the staff of the local hospital, another health facility, health department, or EMS service. In these situations, the same medical organization often acts as a liaison for the naloxone supply. Some law enforcement agencies have an existing emergency response training infrastructure to maintain required first aid and first responder certifications. Depending on the organization's internal capabilities, this training may be provided by a designated training officer, who often has additional medical training, or provided by staff of the external health agencies.¹² OOD response training can be incorporated into this existing training infrastructure.

Another option is for a community-based organization providing naloxone access to members of the public to provide such training.

¹² Example includes the Massachusetts program model.

A third option is for the training to be organized at the state or county level using a distance learning or train-the-trainer model.¹³ E-learning tools may be especially useful for rural and tribal agencies.

Even if the bulk of the training is presented by non-LEO individuals, some participation by the agency's leadership in content delivery is important. Leadership science and documented benefits of peer-to-peer learning suggest that endorsement of the material by trusted LEOs can improve information uptake and retention.

How often do law enforcement overdose response program participants need to be re-trained?

There are currently no legal requirements for retraining in law enforcement overdose response programs. Just like with any other LEO activity, annual or other periodic re-training may be needed to ensure effective and compliant practices. In some jurisdictions, refresher trainings have become part of the annual training programs.¹⁴

Do law enforcement overdose response programs require the creation of specific operating procedures?

While not legally required, it is strongly encouraged. Each agency should establish standard operating procedures (SOPs) for law enforcement overdose response activities. These procedures should be drafted in consultation with the governing laws of the jurisdiction and any applicable collective bargaining units. If applicable, policies should integrate the provisions of relevant 9-1-1 Good Samaritan laws, as well as the department's policy on information gathering, searches, arrests and other activities at the scene of an overdose. Any triage plans developed with EMS and fire agencies can also be reflected in the department's SOP.

A list of sample procedures from a variety of jurisdictions is available in the [Policies and Procedures section](#) of this Toolkit.

What are the typical costs of a law enforcement overdose response program to the agency?

The cost of law enforcement overdose response programs consists of three main components: cost of the naloxone kits, training costs, and personnel costs.

¹³ Office of Ohio Attorney General, *Ohio Peace Officer Training Academy: Naloxone Education Video*, available at <http://www.ohioattorneygeneral.gov/Media/Videos/Naloxone-Educational-Video>. For more information, see *Ohio law enforcement officials offered training to prevent heroin deaths*, WFMJ.com, Jul. 15, 2014, available at <http://www.wfmj.com/story/26022224/ohio-law-enforcement-officials-offered-training-to-prevent-heroin-deaths>. Published July 15, 2014. Accessed July 12, 2014.

¹⁴ Davis CS et al., *Expanded access to naloxone among firefighters, police officers, and emergency medical technicians in Massachusetts*, 104 Am. J. Public Health, e7-e9 (2014).

Cost of naloxone: Depending on the specific form of naloxone used by the department, the cost of a single naloxone rescue kit ranges from approximately \$22 to \$60 for IN kits. A nasal administration kit typically includes a zippered bag, two doses of naloxone, two nasal atomizer, directions on appropriate use, and, in some instances latex gloves. In some departments where street-level personnel always work in pairs, equipping each officer with one dose of naloxone has been deemed sufficient, because two doses are always available at the scene. The EVZIO® auto-injector, new to the market, is now being deployed by law enforcement agencies in several states such as Illinois, Tennessee, and Virginia.

Cost of training: In many cases, law enforcement training for overdose reversal programs is provided at no cost by a sister or a community agency. In some instances, agencies are asked to cover honorariums, costs for transportation and related training expenses, but grants may be available to reimburse these expenditures.¹⁵

Personnel costs: The time for personnel to undergo training as part of law enforcement overdose reversal and prevention varies on a case-by-case basis. Labor unions may consider OOD reversal training a change in work conditions.¹⁶ If trainings are mandatory and do not fall within regular workday hours, overtime coverage may be required. There may also be a cost for retaining a medical supervisor/director to authorize naloxone access.

Who covers law enforcement overdose response costs?

Funds can come from a variety of sources. Some law enforcement overdose response initiatives have been funded directly out of their operational budget. Others have partnered with sister health agencies such as state or county Departments of Public Health to cover naloxone kit supplies and provide training (see the [MOA section](#) of this Toolkit). Naloxone supplies can also be made available through partnerships with local emergency medical services, businesses, or healthcare institutions. Forfeiture funds can be used to fund naloxone rescue kits along with training and limited overtime costs.¹⁷ Federal grants from programs including the Byrne Justice Assistance¹⁸ and High Intensity Drug Trafficking Area (HIDTA) grants may also be used to equip and with naloxone and train them in overdose reversal and prevention.¹⁹ Information about Justice Assistance Grant (JAG) funds can be found by clicking [here](#). Outside funding may be predicated on certain conditions, including reporting requirements to help track overdose problems and program impact (see the [Data Reports section](#) of the Toolkit). Personnel training costs are typically covered from

¹⁵ For example, the New York Attorney General, *Community Overdose Prevention (COP) Program, New York*, available at <http://www.ag.ny.gov/feature/community-overdose-prevention-program-cop-program>.

¹⁶ Rick Pfeiffer, *Deputies set to get overdose training*, Niagara Gazette, Apr. 9, 2014, available at http://www.niagara-gazette.com/news/local_news/article_0943653d-0064-5288-86c5-096fc88ea4b1.html. Published April 9, 2014. Accessed July 14, 2014.

¹⁷ New York Attorney General, *Community Overdose Prevention (COP) Program, New York*, available at <http://www.ag.ny.gov/feature/community-overdose-prevention-program-cop-program>. Accessed July 18, 2014.

¹⁸ Bureau of Justice Assistance, U.S. Dep't of Justice, *Justice Assistance Grant (JAG) Program*, available at https://www.bja.gov/ProgramDetails.aspx?Program_ID=59. Accessed July 1, 2014.

¹⁹ Examples include Ohio and Rhode Island.

departments' operational budgets, but limited funding for overtime expenditures may be available through state and federal grants.²⁰

Are there any collective bargaining issues associated with law enforcement overdose rescue programs?

In most cases, law enforcement overdose rescue programs have been implemented without any collective bargaining disputes. In some cases, labor unions may consider OOD response and associated training a change in work conditions or an additional duty, raising the possibility of contract renegotiation.²¹ Collective bargaining unit representatives should be consulted early in the process of planning LEO overdose rescue efforts and given the opportunity to address personnel and occupational safety concerns. Agencies faced with collective bargaining challenges can proceed by making officer participation in overdose reversal a voluntary activity while disputes are resolved. Additionally, in some instances, union representatives conditioned their agreement on the agency's explicit policy not to discipline officers if their agency-supplied naloxone kit is lost or stolen.

How can agencies benefit from undertaking an overdose response program?

There are a number of benefits to officers, implementing agencies, as well as to the public at large. First and foremost, the implementation of law enforcement overdose response program can lead to the reversal of possibly fatal overdoses in the community. Individual officers express enhanced job satisfaction rooted in improved ability to "do something" at the scene of an overdose.

Implementing departments report improved community relations, leading to better intelligence-gathering capabilities. Similarly, collaboration between law enforcement, public health, drug treatment, fire, and other sectors on overdose response initiatives leads to improved cross-agency communication and helps operationalize a public health approach to drug abuse (See [*Additional Considerations*](#) below).

What are the potential occupational risks of a law enforcement overdose response program?

Providing first aid to an OOD victim carries the same general occupational risk inherent to other first aid activities that are part of policing. Universal precautions should be taken when coming into direct contact with the victim, including moving them into the recovery position, providing rescue breathing, and any other manipulation. Given that a substantial proportion of OOD victims are people who inject drugs, LEOs should be aware of the high

²⁰ New York Attorney General, *Community Overdose Prevention (COP) Program, New York*, available at <http://www.ag.ny.gov/feature/community-overdose-prevention-program-cop-program>. Accessed July 18, 2014.

²¹ Rick Pfeiffer, *Deputies set to get overdose training*, Niagara Gazette, Apr. 9, 2014, available at http://www.niagara-gazette.com/news/local_news/article_0943653d-0064-5288-86c5-096fc88ea4b1.html. Accessed June 29, 2014. See also Oliver Ortega, *Police union, Somerville at odds on Narcan Police say it's a new duty*. Boston Globe, September 22, 2014. Accessed September 22, 2014.

likelihood that hypodermic needles may be present on the victim's person and elsewhere on the scene. Appropriate barrier protection should be deployed.

Administration of IM naloxone carries a remote risk of an accidental needle stick injury (NSI). If the officer experiences an NSI after administering the drug, there is a risk of contracting a blood borne infection, such as Hepatitis C or HIV. Aftermarket atomizers enable intranasal administration of naloxone without using a needle. Most law enforcement agencies have determined that the added expense of purchasing atomizers is worth the occupational safety gains from not having to use needles to administer the drug. The retractable needle system of the EVZIO® naloxone auto-injector is designed to prevent needle stick injury.

Overdose victims rescued by naloxone may experience opioid withdrawal symptoms. In very rare instances when such symptoms are severe, the victim may become combative. This is reported in about one percent of all rescues.²² There are no reported cases of injuries to LEOs or the victim in the context of law enforcement overdose response programs.

ADDITIONAL CONSIDERATIONS

Beyond law enforcement overdose reversal programs, what can law enforcement agencies do in response to the overdose crisis?

There are a number of programs and efforts that LEO agencies can undertake in addition to or in lieu of overdose reversal programs. As described in greater detail below, these include encouraging bystanders to seek timely emergency help during an overdose event, targeting high-risk groups like newly-released inmates with information on how to prevent and recognize an overdose, and forming cross-agency collaborations with public health, drug treatment, and other relevant partners.

How can law enforcement personnel encourage OOD witnesses to seek help?

Many OODs are witnessed, but bystanders often do not call 9-1-1 because they do not recognize the signs and symptoms of an overdose, or because they are concerned about legal repercussions.

To remove barriers for witnesses of OODs to call 9-1-1, a growing number of states have passed overdose Good Samaritan laws. These laws shield those who seek help and witnesses from certain criminal charges for drug or alcohol possession.²³ Even in the absence of Good Samaritan laws, arrests at the scene of an overdose are rare in most jurisdictions. Law enforcement agencies are in a unique position to raise public awareness about these life-saving policies and practices. However, some LEOs and prosecutors may

²² Massachusetts Department of Public Health, Unpublished Data.

²³ Public Health Law Research Program, *LawAtlas: Naloxone Overdose Prevention Laws*, available at <http://lawatlas.org/query?dataset=laws-regulating-administration-of-naloxone#.U8WQa6gwLYQ>. Accessed July 3, 2014.

not be aware of the reforms, especially during the initial implementation period. Failure to follow stated policies about arrest or prosecution as a result of calling 9-1-1 to report an overdose can detrimentally impact the willingness of drug users, their families, and others to seek professional assistance in an emergency.

Example: In Washington State, research suggested that the vast majority of drug users were not aware of the new Good Samaritan law a year after its passage.²⁴ The State Attorney General was featured in a press conference when the law took effect and he and the medical director of the Poison Control Center appeared in a radio public service announcement to share information about the law. The launch of the video was accompanied by a wide-ranging media campaign to educate the public about the provisions and benefits of the Good Samaritan law. The Seattle Police Department also created a video to be shown at roll call to all patrol officers that featured the narcotics captain, a county prosecutor and the medical director of public health. The video addressed what the law does and does not cover, the basics of what naloxone is, and the fact that public health programs would be distributing naloxone. To address their concerns, community members receiving naloxone were informed that police have received education about the Good Samaritan law and naloxone distribution efforts.²⁵

How can law enforcement personnel target education and outreach to high-risk groups?

Veterans, residents of rural and tribal areas, recently-released inmates, people completing drug treatment/detox programs, and some young adults are at an especially high risk of OOD. Law enforcement, community supervision, and correctional officers are uniquely positioned to prevent fatalities by conducting targeted outreach with these high-risk groups. Individuals re-entering society after a period of forced abstinence are especially vulnerable: In the first two weeks, formerly incarcerated individuals are as high as 130 times more likely to die of a drug overdose than members of the general public.²⁶ A number of programs engage law enforcement and correctional staff in educating this population about overdose risk, how to avoid and respond to overdose, and any provisions covering criminal liability of those who seek help.

Example: In Rhode Island’s “Staying Alive on the Outside” program state prisoners are shown a video about overdose risks as part of the pre-release

²⁴ Banta-Green CJ, Beletsky L, Schoeppe JA, Coffin PO, Kuszler PC., *Police officers’ and paramedics’ experiences with overdose and their knowledge and opinions of Washington State’s drug overdose-naloxone-Good Samaritan Law*, 90 J. Urban Health 1102-11, (2013).

²⁵ Additional information about this program, including the police training video is at www.stopoverdose.org.

²⁶ Ingrid A. Binswanger et al., *Release From Prison—A High Risk of Death for Former Inmates*, 356(2) New England Journal of Medicine 157, 170 (2007) (In prisoners released in Washington State, overdose mortality rates were 12-fold higher than what would be expected in similar demographic groups in the general population. In the first two weeks after release, the risk of overdose was even greater, with an adjusted relative risk of 129.);

process.²⁷ Another example is a program at the Allegheny County, PA jail, where public health and corrections officials present overdose prevention trainings to inmates prior to discharge. At the jail in Kent, Washington pharmacists train inmates and naloxone is placed in their possession for pickup upon release.

Example: In Indiana, local law enforcement worked in partnership with the Drug Enforcement Administration to revise the drug education curriculum delivered in schools to include key information about overdose. This includes content covering signs and symptoms of overdose, the substances that are likely to cause overdose, and the considerations involved in calling 9-1-1.

What are some examples of cross-agency coordination to address overdose?

In many communities, law enforcement overdose response programs helped create a united front in the fight against overdose and other drug-related issues. Law enforcement personnel already play a leadership role in cross-agency collaboration and information sharing in the domain of drug abuse. For instance, data sharing can help inform enforcement priorities on the one hand and tailor public health prevention and service delivery on the other. In this realm, medical examiner and EMS data can be used by LEO agencies to focus interdiction efforts on drug sources known to result in overdose events. Using jointly-developed protocols, LEOs may refer individuals with behavioral health problems to local public health and mental health agencies, thus potentially reducing the workload within the criminal justice sector and overall costs to the taxpayers. Multi-agency public education campaigns and drug take-back initiatives are likely to receive heightened media coverage and result in improved awareness about OOD and its prevention.²⁸ Local and regional OOD taskforces effectively integrate criminal justice, public health, drug treatment, judicial, and other partners in creating a comprehensive, systems-level response to this ongoing crisis. Such collaborative efforts can draw on federal or state grants to fund their activities (see **What federal or state grants are available to fund overdose taskforces and collaborations?**).

Example: The High Intensity Drug Trafficking Area (HIDTA) Program in the New England Region has undertaken a leading coordinator role in building bridges between state, local, and special law enforcement agencies as well as other first responders, public health agencies, treatment providers, and community groups.

What federal or state grants are available to fund overdose taskforces and collaborations?

²⁷ Department of Behavioral Healthcare, Developmental Disabilities & Hospitals, State of Rhode Island, *Overdose Materials Videos*, available at <http://www.bhddh.ri.gov/misc/OverdoseMaterialsVideos.php>. Accessed July 13, 2014.

²⁸ For more information about drug disposal and take-back efforts, see http://www.deadiversion.usdoj.gov/drug_disposal/takeback/. Accessed September 21, 2014.

Collaborations and taskforces formed to address overdose and related problems in the community can draw on federal or state grants to fund their activities. One example of a federal funding opportunity is Data-Driven Multi-Disciplinary Approaches to Reducing Rx Grants (Category 3) of the Harold Rogers Prescription Drug Monitoring Program.²⁹

What is a state substance abuse agency and what is their role?

Each state and territory offers information and support regarding substance use disorders through a state substance abuse agency. The role of a state substance abuse agency is to plan, carry out, and evaluate substance use disorder prevention, treatment, and recovery services provided to individuals and families. Specifically, they oversee treatment centers and counselors in their respective states and, in many cases, supply funding to providers, track state trends, and ensure residents receive the services to which they are entitled. More information about the state substance abuse agency in your state can be found at <http://findtreatment.samhsa.gov/locator/stateagencies>.

²⁹ The FY13 solicitation can be found at: <https://www.bja.gov/Funding/14PDMPsol.pdf> Accessed September 21, 2014.