

OVERDOSE PREVENTION,
RESPONSE, & POSTVENTION:

Promising Policies and Practices for Organizations

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Health Resources in Action, Inc. (HRiA) is a nonprofit public health and medical research funding organization based in Boston, Massachusetts whose mission is to help people live healthier lives and build healthier communities through prevention, health promotion, policy, and research.

Through HRiA's **Behavioral Health and Racial Equity Initiative**, or BeHERE, we build capacity in opioid overdose prevention, recognition, and response among service providers and support staff in community corrections centers, homeless shelters, family shelters, public libraries, public housing, and other venues. Our BeHERE trainings and technical assistance services are funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Opioid Response grants, administered through the Massachusetts Department of Public Health's Bureau of Substance Addiction Services. Learn more at behereinitiative.org.

The recommendations below aim to reduce fatal opioid overdoses in a variety of settings. This includes but is not limited to community corrections centers, family and individual shelters, and substance use treatment facilities. While these recommendations are focused on addressing opioid overdose, implementing these recommendations may also be helpful in relation to other medical emergencies or traumatic events.

This document provides guidance for the development, implementation, and updating of policies and procedures within an organization. The needs and resources of every organization are different. Many of these recommendations can be implemented on their own or combined with existing policies. Please take these recommendations as a menu of suggestions to implement and integrate into existing organizational policies.

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Addressing Risks and Concerns

Your staff may be concerned about intervening during an overdose due to fear for their own safety or of being held liable should the overdose victim die they intervene. The following information covers legal protections and personal safety for individuals responding to opioid overdose.

GOOD SAMARITAN LAW

40 states and the District of Columbia have enacted some form of a Good Samaritan or 911 **Drug Immunity Law** to encourage individuals to seek out medical attention to treat overdose or for follow-up care once naloxone has been administered. These laws generally protect people when calling 911 or intervening during a medical emergency. More specifically, they often grant immunity from arrest, charge, or prosecution for controlled substance and drug paraphernalia possession when a person overdoses, attempts to rescue another, or seeks help. Some states provide immunity from violations of pretrial, probation, or parole conditions and violations of protection or restraining orders in these circumstances. Bystanders are protected from liability when acting in good faith to respond to a medical emergency such as an opioid-related overdose. In the Commonwealth of Massachusetts, the Good Samaritan Law explicitly provides immunity from criminal prosecution to anyone who seeks medical assistance for themself or another person who is experiencing a drug-related.

Limitations of the Massachusetts Good Samaritan Law

- The Good Samaritan Law does have limitations. You can be arrested for possessing the following, also known as the “3 Ws”:
 - Weapons (The law does not prevent arrest for possession of an unlicensed weapon)
 - Warrants (The law does not prevent arrest if a warrant is issued for that individual)
 - Weights (The law does not prevent arrest for trafficking/distribution, i.e. possession of 50 pounds of marijuana, 18 grams of heroin/cocaine/methamphetamine, or 10 grams of fentanyl)

FENTANYL EXPOSURE :

Staff may be concerned about their personal safety when responding to an overdose due to exposure to fentanyl. Fentanyl, like other opioids, can cause overdose when it is injected, sniffed, or taken by mouth. Fentanyl powder does not cause overdose by touching it alone. If any suspicious powder is present, it is prudent to wear gloves. Further information and recommendations on fentanyl and safety are available here:

- The American College of Medical Toxicology’s statement on fentanyl exposure can be found on their website at <http://bit.ly/acmtfentanyl>.
- Archived White House recommendations on fentanyl can be found [here](#).
- **[Myths and Misinformation About Law Enforcement and Fentanyl Exposure \(from the National Harm Reduction Coalition\)](#)**
- Additional information about fentanyl can be found in **Appendix C** of this document.

Overdose Prevention

The following recommendations are intended to prevent fatal opioid overdoses before they occur.

BATHROOM SAFETY

All public restrooms are places where people may use drugs. The tools below are recommended to make bathrooms safer:

Ensure adequate bathroom monitoring while continuing to respect individuals' dignity and privacy. Options include:

- Assign a staff member to monitor bathrooms with a door knock every 3-5 minutes.
- Lock bathroom doors, requiring bathroom users to request a key or pass code so staff are aware of when the bathroom is occupied and for how long. Using a timer, ensure staff check on individuals using the bathroom every 3-5 minutes.
- Install an intercom (call button) to communicate with someone using the bathroom without having to knock or open the door to ensure the person's safety. Many intercom systems are equipped with call buttons that allow the person in the bathroom to call for help on their own if they are able. Intercom systems are most effective in complement with timers or time limit policies.
- Install a reverse motion detector.
 - A reverse motion detector is a bathroom monitoring system that will sound an alarm if someone who has entered a bathroom does not move for a set amount of time (usually two minutes).
 - Reverse motion detectors can serve as a complement or alternative to timers or time limit policies.
- In single stall or full-door bathrooms, remove the bottom 6 inches from the bathroom door to make it easier to see a patron who is on the ground in distress.

Bathrooms are common locations where fatal overdoses are likely to occur. A strong organizational bathroom policy, including adequate monitoring, naloxone storage, and time limits, can reduce the likelihood of fatal overdose.

Post bathroom policies on or outside the door.

- Indicate the set time that people can use the bathroom before someone checks on them. Clearly communicate to all staff and those using the bathroom how often and in what manner the policies are enforced.
- Indicate access instructions clearly outside the door, in cases when a key or pass code is required for access.

Ensure that staff can easily unlock and access the bathroom if someone were to require emergency assistance inside. This may include:

- Providing the bathroom key/code to multiple staff members to ensure someone on site always has immediate access to the bathroom.
- Designating a location where staff can access the bathroom key in case of emergency.
- Ensuring that bathroom doors open out.
 - When doors open in, a rescuer may have trouble pushing the door open if a body or other object is blocking the way.
 - Outward opening bathroom doors allow rescuers to reach an overdose victim or other unresponsive individual quickly and easily.

Install secure sharps boxes in all bathrooms.

- Sharps boxes can allow for proper and safe disposal of used needles. This has benefits for the broader community as well, as it reduces the likelihood of used needle disposal in trash cans, toilets, or public areas.
- Sharps boxes should be placed in each bathroom, and some sites may choose to include contact information for the nearest **[syringe service program \(SSP\)](#)** on the box. A map of SSPs in Massachusetts can be found at **<https://www.mass.gov/info-details/syringe-service-program-locator>**.
 - Engaging with SSPs can help people who use drugs learn harm reduction strategies and reduce their risk of fatal overdose or other negative outcomes. Providing this information in the bathroom can increase access to these resources for participants.
- For more information on how to properly dispose of used syringes, visit **[SafeNeedleDisposal.org](#)**.

Easy access to naloxone (Narcan®)

- Equip each your bathroom with a naloxone rescue kit. Ensure that each bathroom has a naloxone rescue kit that is easily accessible to anyone who may need it (i.e. not in a locked drawer or desk). Naloxone should be accompanied by other rescue and protective equipment such as pocket masks, gloves, or bag-valve masks, as well as instructions for responding to an overdose.
- If it is not feasible to place a rescue kit in or directly outside each bathroom, post clear signage that indicates the location of naloxone in case of emergency.

Easy access to naloxone is crucial to ensuring an effective response to overdose.

See **Appendix A** for additional information on where and how to obtain naloxone.

MESSAGES TO PROMOTE SAFETY

- Post signs suggesting ways to keep oneself safer if using drugs.
- For example, signs can promote proper syringe disposal or explain risk factors for an overdose (such as using alone) and ways to mitigate those risks.
- Share pamphlets promoting resources including treatment options, harm reduction programs, and where to obtain naloxone.
- Educate staff on overdose and naloxone administration.
- Seek opportunities or formalize a process for discussing overdose prevention with clients, participants, tenants, or residents whenever possible. This may include intake, waitlist review, trauma screening, individual/group counseling, discharge, or post-overdose.

COMBATting DRUG-RELATED STIGMA

- Stigma is defined as the experience of being discredited or marked because of one's undesired differentness or otherness. There is an extensive body of literature documenting stigma associated with drug use. For people who are using drugs, stigma creates barriers to accessing timely, effective, and equitable treatment, recovery, healthcare, or other social services. But there are actions you can take as service provider, family member, friend, or someone who cares about a person using drugs to decrease the stigma they may face. See **Appendix B** for more information.
- For example, using "*Person-First Language*" is more empowering and less stigmatizing than using terms like "*addict*," "*junkie*," or "*druggie*." Studies have shown a strong correlation between the use of person-first language by providers and long-term engagement and retention of individuals in treatment. Person-first language recognizes the whole person, not just the disorder or behavior.
- The use of non-stigmatizing language, in and of itself, is overdose prevention. When we use language that is empowering, that is non-stigmatizing, and that sees people as whole people, it helps to normalize conversations around drugs and drug use. Combatting drug-related stigma is a low-cost overdose prevention strategy that many agencies can easily implement.
- We also honor and acknowledge that language is iterative and constantly changes. The language we use today may shift dramatically in five or ten years. Being open and flexible to new ideas about language, while also respecting how clients, participants, guests, or others you work with want to be referred to is always an effective strategy. Refer to **Appendix B** for more information.

Overdose prevention and other materials can be ordered free through the Massachusetts Health Promotion Clearinghouse:
<https://massclearinghouse.ehs.state.ma.us/category/BSASOVD.html>

Overdose Response

The recommendations below offer guidance on responding to an opioid overdose. This includes steps we recommend taking in advance, as well as the steps for performing a rescue in the event of an opioid overdose.

TRAINING

- Offer staff trainings annually and as part of new employee orientation. Ensure all staff (on all shifts) are trained in overdose response, including security guards, program managers, cleaning and maintenance staff, and all others. Training may be accessed through [Health Resources in Action](#) by emailing Gracie Rolfe at grolfe@hria.org or Mike Leonard at mleonard@hria.org or through local [Overdose Education and Naloxone Distribution \(OEND\) Sites](#).
- Boston Public Health Commission has created short videos in English (<http://bit.ly/2VDIEyP>) and Spanish (<http://bit.ly/2JJJv9N>) that can be used to supplement in-person overdose prevention and response training.
- Practice overdose response drills on a regular basis so staff are prepared in the event of an emergency.

NALOXONE (NARCAN[®])

- Place naloxone rescue kits in easily accessible places. Naloxone should be accompanied by other rescue and protective equipment such as pocket masks, gloves, and bag-valve mask, as well as brief instructions for responding to an overdose. Try to standardize naloxone placement in multiple rooms or floors throughout your site. Following the placement of Automated External Defibrillators (AEDs) and first aid kits may be helpful.
 - Do not lock up naloxone rescue kits.
 - Place clear and prominent signage indicating where kits are located.
- Track the expiration date and availability of the naloxone and replace as necessary.
 - This can be done in a variety of ways depending on organizational and individual needs and preferences. For example, when placing kits, you can set calendar reminders before they expire or check the expiration of kits along with other routine tasks (such as completing a monthly assignment, filling out a weekly timesheet, etc.).
 - If you have placed naloxone rescue kits in busy or public areas of your site, check routinely to ensure they are still there. Replenish as necessary.
- Hang educational posters throughout your site. The posters can alert staff and clients about the use of naloxone as part of an overdose response protocol, where naloxone can be obtained, and where training is offered.
- Develop organizational policies that document all the above decisions about training frequency, naloxone placement, and rescue kit storage, maintenance, and replacement.
 - A sample of the San Francisco Public Library Opioid Overdose Response Procedure can be found in **Appendix D**.

PURCHASING NALOXONE (NARCAN®)

- Through the Massachusetts Department of Public Health's Bureau of Substance Addiction Services, agencies may be eligible to purchase naloxone through the [Community Naloxone Purchasing Program \(CNPP\)](#).
- CNPP allows many eligible programs to purchase naloxone through the State Office of Pharmacy (SOPS). For more information on the CNPP, program requirements and eligibility, and how to apply, please visit the [CNPP information page](#).

IN THE EVENT OF AN OVERDOSE

- Develop an on-site overdose prevention and response plan.
 - This should describe how staff will monitor clients/participants/tenants who appear sedated, and how they will recognize and respond to an overdose emergency.
 - An example of an Opioid Overdose Response Procedure, used by the San Francisco Public Library, can be found in **Appendix D**.
- Designate Roles/Steps
 - With any type of emergency, it is vital that staff and workers have designated roles and responsibilities. It is possible for one person to effectively respond to an overdose, but we recommend the following roles be delineated:
 1. One person who retrieves the naloxone kit(s).
 2. One person who administers the naloxone and performs rescue breathing.
 3. Multiple people may give rescue breaths by taking turns or rotating roles.
 4. One person who calls 911.
 5. One person who stands outside and directs EMTs to the site of the overdose.
 6. One or more people to keep track of how much time has passed, how long the victim has been unconscious, how many doses of naloxone have been given, etc.
 7. One or more people to usher other tenants, clients, or participants away from the emergency if they are not actively helping.
 8. Post-overdose: a manager should check in with staff, lead a debriefing, and make sure that staff take a break if possible (see more in next section).
 - In the event a single person is responding to an overdose, the recommended response steps are (more information on how to reverse an overdose can be found [here](#)):
 1. Recognize overdose ([How to Check for Signs of an Overdose](#))
 2. Call 911.
 3. Administer naloxone as soon as available.
 4. Begin rescue breathing (1 big breath every 5 seconds).
 5. Stay with the person until help arrives.
- Place the individual in the [recovery position](#) (<http://bit.ly/2JGXWvr>) once they regain consciousness or if you need to leave for any length of time.

Overdose Postvention

The following section recommends actions to take after an overdose occurs.

OFFER SUPPORT AND AN OPPORTUNITY TO DEBRIEF WITH STAFF

Take some time to debrief with staff who were present during the overdose. Discuss what happened, how the team responded, how they are feeling, any additional support they may need, and, after enough time has passed, how the team might have responded differently. Check in again later in the day and, if needed, in the days or weeks that follow, while connecting staff to support resources.

- **This debriefing will look different depending on your organization and circumstances. Here are some tips on how to approach a post-overdose conversation:**
 - Be prepared to hold a debrief that could last anywhere from 5 minutes to an hour.
 - A manager, human resources staff member, or an external counselor can lead these debriefs.
 - If possible, allow for the site to close for a short period to give staff time to take a walk, get a coffee, or do another self-care activity.
 - If this is not possible, try to allow staff a quiet space or some time away from the site. This may occur in shifts or on rotation depending on the circumstances.
 - Include discussion of overdose prevention and response in team lunches or half/full day retreats for healing and team building.
 - If clinical supervision is not currently available, arrange for regular group clinical supervision for all staff.
 - If staff need extra support, have a plan in place for individual clinical supervision in addition to group clinical supervision.
 - Allow staff to schedule counseling sessions, attend support groups, or access other care resources during the workday as needed and whenever possible.
- **Revise policies/procedures as needed, based on what was learned from the experience and staff feedback.**

REFRESH STAFF EDUCATION

- Ensure that staff know how to assess overdose risk among those who may have been using with the individual who overdosed.
- Confirm that staff feel confident discussing overdose prevention and/or safer use with clients.
- Find appropriate ways to share vital information about individuals at higher risk for overdose (e.g. clients who have overdosed in the past, clients who have had brief or sustained periods of abstinence, clients who tend to use alone).

- Ensure staff have updated lists of ongoing support groups, naloxone trainings, and other relevant resources to share. The **Massachusetts Substance Use Helpline (helplinema.org)** can be a helpful starting place for anyone seeking substance use treatment or harm reduction services.
- Once staff feel ready, run a skill-building practice session where people review the steps of responding to an overdose through hands-on role playing.



REPLENISH OVERDOSE KITS

- Add new naloxone and other needed supplies like face masks or gloves to rescue kits, even if just one naloxone dose was used.

CREATE SAFETY PLANS WITH CLIENTS AND PARTICIPANTS AT HIGH RISK FOR OVERDOSE

- Both people engaged in treatment and those not engaged are at risk for overdose, so anyone who has used opioids should have an overdose prevention safety plan.
- Staff can work with clients at high risk of overdose to develop a safety plan, which can minimize the risk of overdose and other negative health outcomes.
 - Questions to consider when helping someone plan for safety:
 1. What does the person's overdose prevention plan look like, if they have one?
 - What is the person's plan to avoid using alone?
 - Where will the individual keep their naloxone?
 - What type of setting do they typically use in?
 - How does the person feel about calling 911 if they were to witness an overdose?
 2. Where can the person access sterile injecting equipment?
 3. Are they aware of the risk factors for overdose and fatal overdose (i.e. using alone, periods of abstinence, etc.)?
- Additional information for public health workers on postvention efforts can be found in Franklin Cook's **[Coping with Overdose Fatalities](#)**.

Appendix A

RESOURCES FOR CLIENTS

OEND Sites

- Contact [Overdose Education and Naloxone Distribution \(OEND\) Sites](#) to obtain naloxone and trainings.
- Consumers can obtain free naloxone from all OEND sites in Massachusetts.

Syringe services programs (SSPs)

- [Visit SSPs](#) to obtain sterile (new) needles and syringes free of cost; dispose of used needles and syringes; or get connected to other services such as testing for hepatitis C, HIV and other sexually transmitted infections; overdose education; and naloxone.
- Many SSPs and OEND sites offer both services.
- For more information on proper and safe disposal of used syringes, please visit [SafeNeedleDisposal.org](#).

Boston Public Health Commission - Overdose Prevention and Bystander Training

- [The Overdose Prevention & Bystander Training](#) through the Boston Public Health Commission is free and available to all who are interested and provides information about the opioid epidemic and how to recognize and respond to an opioid overdose.
- The training includes practical, step-by-step guidance for performing rescue breathing and administering naloxone.
- Training participants can receive a Certificate of Training once the course is completed.

Massachusetts Substance Use Helpline

- Free and anonymous resource to find substance use treatment, recovery, and harm reduction resources anywhere in Massachusetts
- Toll-free phone: 800-327-5050
- Website: [HelplineMA.org](#)

Appendix B

COMBATTING DRUG-RELATED STIGMA¹ ²

Language Matters

Language is powerful – especially when talking about addictions. Stigmatizing language perpetuates negative perceptions. "Person first" language focuses on the person, not the disorder.

When Discussing Addictions...

| SAY THIS | NOT THAT |
|--------------------------------------|--------------------------------------|
| Person with a substance use disorder | Addict, Junkie, druggie |
| Person living in recovery | Ex-addict |
| Person living with an addiction | Battling/suffering from an addiction |
| Person arrested for drug violation | Drug offender |
| Chooses not to at this point | Non-compliant/bombed out |
| Medication is a treatment tool | Medication is a crutch |
| Had a setback | Relapsed |
| Maintained recovery | Stayed clean |
| Positive drug screen | Dirty drug screen |

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
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The figures to the left¹ and below² show how providers can shift their language to be more person-centered. Person-centered language is language that puts people first. People are so much more than their substance use disorder, mental illness, or disability. Using person-centered language is about respecting the dignity, worth, and strengths of every individual. Language is iterative and ever-changing. Be flexible with yourself, ask how your clients or participants want to be referred to, and remember that using person-first language is, in and of itself, a low-cost overdose prevention strategy.

| Current Language | Suggested De-Stigmatizing Language | Reason |
|--|---|--|
| Addict, Junkie, Crack-head, User, Abuser, Alcoholic <i>*please don't use "addict"</i> | Individual struggling with the disease of addiction. Individual not yet in recovery. A person with a substance use disorder. | Person-centered language |
| Drug-addicted baby/ Drug-baby | Infant who was neonatally exposed. Infant with pre-natal exposure. Infant experiencing withdrawals. | Person-centered language & infants are not addicted |
| Non-compliant/ Resistant | Struggling with Ambivalence. In the pre-contemplation stage. Choosing not to. | Not-blaming; talking about the stages of change; offers change rather than label |
| Denial | Ambivalent, Pre-contemplation stage | Not-blaming; talking about the stages of change; offers change rather than label |
| Substance Abuse | Substance Use Disorder | Medical diagnosis |
| Drug of Choice | Drug used/ Drug of Use/ Commonly Used Drug | It's not a "choice" |
| Relapse prevention | Recovery management, maintenance | Positive, strength-based, stages of change |
| [AA/Faith-based/MAT/Abstinence] ... is the only way | Each individual takes a different path towards recovery or becoming drug free | Offering opportunities and acknowledging the individual process |
| Drug overdose | Drug poisoning | Medicalize |
| Clean/Sober | In recovery/ Drug free/ Free from illicit drugs or medication | Stigma-free language not associating dirtiness with drug use |
| Chooses to use drugs | Disease of addiction | Medicalize the problem |
| Relapse | Recurrence/ Return to Use | The word relapse brings a lot of baggage |
| Abstinence | Individual in recovery process | Using abstinence language precludes those using medication assisted treatment |
| Replacement drugs | Medication Assisted Treatment | MAT may be part of the process for some |

¹ <https://www.thenationalcouncil.org/surgeon-general-toolkit/language-matters/>

² <https://www.samhsa.gov/sbirt>

Appendix C

FAQs

Where has carfentanil appeared in the US? If not in Massachusetts, what states have been seeing it?

Number and percentage of opioid overdose decedents testing positive for fentanyl analogs and U-47700 — 10 states, July–December 2016. For full table:

<https://www.cdc.gov/mmwr/volumes/66/wr/mm6643e1.htm>

| STATE | TOTAL OPIOID OVERDOSE DEATHS | ANY FENT ANALOG PRESENT, NO. (%) | CARFENTANIL, NO. (%) |
|--------------------------------------|------------------------------|---|----------------------|
| Total | 5,152 | 720 (14.0) | 389 (7.6) |
| Maine | 154 | 44 (28.6) | 0 |
| Massachusetts | 1,071 | 17 (1.6) (reported analogs were furanylfentanyl (10) and acetylfentanyl (est. 5)) | 0 |
| NH | 131 | 16 (12.2) | 0 |
| New Mexico | 166 | 11 (6.6) | 0 |
| Ohio | 2,043 | 531 (26.0) | 354 (17.3) |
| West Virginia | 393 | 79 (20.1) | 35 (8.9) |
| Wisconsin | 413 | 14 (3.4) | 0 |
| MO (22 counties), OK & RI | 781 | 8(1.0) | 0 |

Carfentanil is a fentanyl analog, as is furanylfentanyl, and acetylfentanyl. Unlike carfentanil, which is about 10,000 times more potent than morphine, furanylfentanyl, and acetylfentanyl is estimated to be less potent than fentanyl (these estimates vary).

- From **July-December 2016**, the CDC looked at data from 10 states that are part of the State Unintentional Drug Overdose Reporting System (SUDORS). In this time, there were 5,152 opioid overdose deaths across these states. 720 (14%) had a fentanyl analog present. Carfentanil was present in 389 (7.6%) of the total deaths. Find the report here: <http://bit.ly/2w44IDr>.
- CDC data from 10 states (SUDORS) between July-December 2016 shows carfentanil deaths in Ohio and West Virginia, with Ohio leading as 17.3% of their total opioid overdose deaths involved carfentanil. In all of 2016, Florida reported over 500 carfentanil deaths.
- Ohio is a state to watch. CDC data from SUDORS states is showing a pattern where soon after carfentanil deaths in Ohio peak, other states observe a spike. **CDC information from July 2016-June 2017** shows that when rates of carfentanil related deaths decreased, the number of deaths with any fentanyl analog increased — mainly furanylfentanyl, and acetylfentanyl.³

Have we been seeing carfentanil in Massachusetts?

- While CDC data has not captured any carfentanil related deaths in MA, two deaths involving carfentanil were reported in local news in July of 2017.⁴
Carfentanil has been identified in a lab analysis of samples from MA State Police. Local news reported on three samples containing carfentanil in June of 2017. By September 2017, the lab had identified a dozen samples of carfentanil.⁵

What happens physiologically when someone experiences “*wooden chest*” during a fentanyl overdose? Given that opioids are depressants, what happens in the body that gives way to this seizing of the muscles in the upper body?

³ O’Donnell J, Gladden RM, Mattson CL, Kariisa M. Notes from the Field: Overdose Deaths with Carfentanil and Other Fentanyl Analogs Detected — 10 States, July 2016–June 2017. *MMWR Morb Mortal Wkly Rep* 2018;67:767–768. <https://www.cdc.gov/mmwr/volumes/67/wr/mm6727a4.htm>

⁴ Croteau, S. (2017, July 17). 2 people dead, 1 person hospitalized in suspected drug overdoses in Lawrence. *MassLive*. Retrieved from https://www.masslive.com/news/index.ssf/2017/07/2_people_dead_1_person_hospita.html

⁵ AP. (2017, Sept 26). Mass State Police: Opioid carfentanil found in a dozen samples this year. *Boston News*. Retrieved from <https://www.boston.com/news/local-news/2017/09/26/mass-state-police-opioid-carfentanil-found-in-dozen-samples-this-year>

⁶ Çoruh, B., Tonelli, M.R., & Park, D.R. (2013). Fentanyl-induced chest wall rigidity. *Chest*, 143(4). <https://www.ncbi.nlm.nih.gov/pubmed/23546488>

⁷ Phua, C.K., Wee, A., Lim, A., Abisheganaden, J., & Verma, A. (2017). Fentanyl-induced chest wall rigidity syndrome in a routine bronchoscopy. *Respiratory Medicine Case Reports*, 20, 205-207. <https://www.ncbi.nlm.nih.gov/pubmed/28337407>

Chest wall rigidity risk factors:

1. Dose and rapidity of injection of opioids
2. Extremes of age (newborns and elderly)
3. Critical illness with neurologic or metabolic diseases
4. Use of medications that modify dopamine levels

Helping someone experiencing wooden chest:

- In hospital settings, naloxone has worked to alleviate chest wall rigidity. As this involves a seizing of the muscles, administering a short-acting neuromuscular blockade has been effective in some cases. Additionally, one can continue providing ventilator support and rescue breathing both through the nose and mouth.

Some organizations that are licensed through MA DPH (but not through BSAS) view that having naloxone on site is a liability; these Bureaus within DPH will not allow these organizations to have naloxone on the premises.

Should there be an adverse event, and those involved acted in good faith, responsibility would not fall on those individuals or the site.

- [Title IV Chapter 258C Section 13](#): *"Good Samaritans;"* liability⁶
 - *"No person who, in good faith, provides or obtains, or attempts to provide or obtain, assistance for a victim of a crime as defined in section one, shall be liable in a civil suit for damages as a result of any acts or omissions in providing or obtaining, or attempting to provide or obtain, such assistance unless such acts or omissions constitute willful, wanton or reckless conduct."*
- [Title XVI Chapter 112 Section 12FF](#): Immunity of person administering naloxone or another opioid antagonist to person experiencing opiate-related overdose⁷
 - *"Any person who, in good faith, attempts to render emergency care by administering naloxone or any other opioid antagonist, as defined in section 19B of chapter 94C, to a person reasonably believed to be experiencing an opiate-related overdose, shall not be liable for acts or omissions resulting from the attempt to render this emergency care; provided, however, that this section shall not apply to acts of gross negligence or willful or wanton misconduct."*
- [Title XV Chapter 94C Section 19](#): Prescription; restrictions on issuance⁸

⁸ <https://malegislature.gov/Laws/GeneralLaws/PartIII/TitleIV/Chapter258c/Section13>

⁹ <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXV/Chapter94C/Section34A>

¹⁰ <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXV/Chapter94C/Section19>

- "...The responsibility for the proper prescribing and dispensing of controlled substances shall be upon the prescribing practitioner, but a corresponding responsibility shall rest with the pharmacist who fills the prescription..."
- (d) Naloxone or other opioid antagonist may lawfully be prescribed and dispensed to a person at risk of experiencing an opiate-related overdose or a family member, friend or other person in a position to assist a person at risk of experiencing an opiate-related overdose. For purposes of this chapter and chapter 112, any such prescription shall be regarded as being issued for a legitimate medical purpose in the usual course of professional practice."

What is the possibility of experiencing an overdose from fentanyl becoming "airborne?" Is there a possibility of experiencing an overdose simply from touching fentanyl?

1. The **Safety Recommendations for First Responders** published by the White House states that while the inhalation of airborne fentanyl powder would likely have harmful effects, it is less likely to occur than skin contact, which is already unlikely. Skin contact with fentanyl does not have any expected harmful effects.⁹
 - Additionally, the **American College of Medical Toxicology** and American Academy of Clinical Toxicology released a **position statement** on Preventing Occupational Fentanyl and Fentanyl Analog Exposure to Emergency Responders in July of 2017. In the case of airborne fentanyl, they state that the risk of experiencing an overdose due to fentanyl inhalation is minute. It takes about 200 minutes of exposure to airborne fentanyl to reach a dose of 100 micrograms. Additionally, the vapor pressure of fentanyl is very low, so it is unlikely that it would evaporate into a gaseous phase.^{10,11}
 - Inhalation is only a concern if the drug particles are suspended in the air. An unlikely event that may involve lethal doses of fentanyl or fentanyl analogs is one involving a weaponized aerosol containing the drug.
 - Should one be concerned about significant exposure to airborne fentanyl, a properly fitted respirator or mask should provide sufficient protection.

¹¹⁹ **Safety Recommendations for First Responders (Archived White House Resources)**
<https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/images/Final%20STANDARD%20size%20of%20Fentanyl%20Safety%20Recommendations%20for%20First%20Respond....pdf>

¹² ACMT site; information on fentanyl exposure precautions
https://www.acmt.net/cgi/page.cgi/_zine.html/The_ACMT_Connection/ACMT_Statement_on_Fentanyl_Exposure

¹³ ACMT and AACT Position Statement: Preventing Occupational Fentanyl and Fentanyl Analog Exposure to Emergency Responders. https://www.acmt.net/Library/Positions/Fentanyl_PPE_Emergency_Responders_.pdf

Appendix D

Sample Organizational Policy

San Francisco Public Library

OPIOID OVERDOSE RESPONSE PROCEDURE

APPROVED BY: Office of the City Librarian

Date: August 22, 2017

Staff Responsible for Training Coordination:

SUBJECT: Opioid Overdose Prevention and Response Protocol

POLICY AND PURPOSE:

To prevent fatal opioid overdose and to intervene rapidly and effectively in the event of an opioid overdose to ensure the best possible health outcomes for all library patrons.

GENERAL:

The community served by the San Francisco Public Library (SFPL) includes opioid users who may be at risk for a potential overdose. Whenever a library patron is suspected of overdosing, City emergency services are called. However, there are many interventions to assist during a potential opioid OD that staff can do while waiting for emergency services to arrive.

TRAINING:

SFPL will provide a voluntary overdose response training for all security and library staff once per year and ensure that all new staff members are offered the option of training in overdose prevention and response protocol as part of their orientation.

Training is provided by the Drug Overdose Prevention and Education (DOPE) Project. The DOPE Project is contracted and registered with the San Francisco Department of Public Health to provide overdose response training and naloxone to San Francisco service providers free of charge pursuant to Section 1714.22 of the Civil Code.

PROCEDURE (REVIEWED IN YEARLY TRAINING):

1. If a library patron is unresponsive and/or unconscious and SFPL staff suspects the patron may be suffering from an opioid overdose, staff should try to wake the patron. If staff is unable to wake the patron, staff should check breathing. If the patron is not breathing the staff member should immediately alert another staff member and engage Emergency Medical Services (EMS) by calling 911. Communicate to EMS dispatch: "person is unresponsive and not breathing, possible overdose, please have naloxone/Narcan."
2. Only staff members who have received the training offered by SFPL/DOPE under this policy in overdose recognition, response, and naloxone administration may determine whether the patron's condition requires naloxone and, if so, may administer naloxone to the patron consistent with that training. Naloxone is stored in the First AID kits at the location's information desk(s) on each floor. Staff will administer one dose of naloxone to the patron (naloxone may be administered nasally, which is the type of naloxone available at library locations).
3. If staff is trained in CPR, they may begin standard CPR after the first dose of naloxone has been administered, including rescue breathing (OD is a respiratory emergency, not necessarily a cardiac emergency, please perform rescue breathing in addition to chest compressions if comfortable). If available, an Ambu Bag (artificial breathing) can be used instead.
4. If there is no response to the naloxone from the patient after 2-3 minutes, staff shall administer a second dose of naloxone and continue with CPR/rescue breathing while awaiting EMS.
5. EMS will assess patient and either transport to the hospital or patient will refuse transport. Patients refusing transport will be asked to leave library property for the remainder of the day.

LEGAL/LIABILITY:

Under California law, a prescriber may issue a standing order authorizing the administration of naloxone by any trained layperson to someone who may be experiencing an opioid overdose. If the program does not have an authorized prescriber (anyone who has prescribing privileges in the state of California), then they may work with a program that provides training and naloxone distribution to come provide training to staff.

Pursuant to Section 1714.22 of the California Civil Code:

For purposes of this section, the following definitions shall apply:

1. "*Opioid antagonist*" means naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of an opioid overdose.
2. "*Opioid overdose prevention and treatment training program*" means any program operated by a local health jurisdiction or that is registered by a local health jurisdiction to train individuals to prevent, recognize, and respond to an opiate overdose, and that provides, at a minimum, training in all of the following:

- A. The causes of an opiate overdose.**
 - B. Mouth to mouth resuscitation.**
 - C. How to contact appropriate emergency medical services.**
 - D. How to administer an opioid antagonist.**
3. A licensed health care provider who is authorized by law to prescribe an opioid antagonist may issue standing orders for the administration of an opioid antagonist to a person at risk of an opioid-related overdose by a family member, friend, or other person in a position to assist a person experiencing or reasonably suspected of experiencing an opioid overdose.
- E. A person who is prescribed or possesses an opioid antagonist pursuant to a standing order shall receive the training provided by an opioid overdose prevention and treatment training program.**
 - F. Notwithstanding any other law, a person who possesses or distributes an opioid antagonist pursuant to a prescription or standing order shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for this possession or distribution. Notwithstanding any other law, a person not otherwise licensed to administer an opioid antagonist, but trained as required under paragraph (1) of subdivision (d), who acts with reasonable care in administering an opioid antagonist, in good faith and not for compensation, to a person who is experiencing or is suspected of experiencing an overdose shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for this administration.**

Director:

Date:



Appendix E

Implementing Low-Cost Overdose Prevention Strategies

- ✓ **Put up posters/other safety messages** about preventing overdose and responding to overdose
- ✓ **Provide educational materials** (brochures, fact sheets) for clients/participants on overdose
- ✓ **Develop a policy** for responding to an 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 clients/participants** and screen participants who may be at a higher risk to experience an overdose
- ✓ **Ask clients/participants** if they have witnessed an overdose/survived an overdose
- ✓ **Talk to clients about availability of naloxone**
- ✓ **Offer** referrals to places where clients can get naloxone
- ✓ **Talk with clients about what to do** if they're with someone who is overdosing
- ✓ **Discuss and incorporate overdose prevention** in existing groups
- ✓ **Emphasize a person-centered approach** to language in your work (post the Language Matters handout throughout office spaces, in waiting areas, etc.)