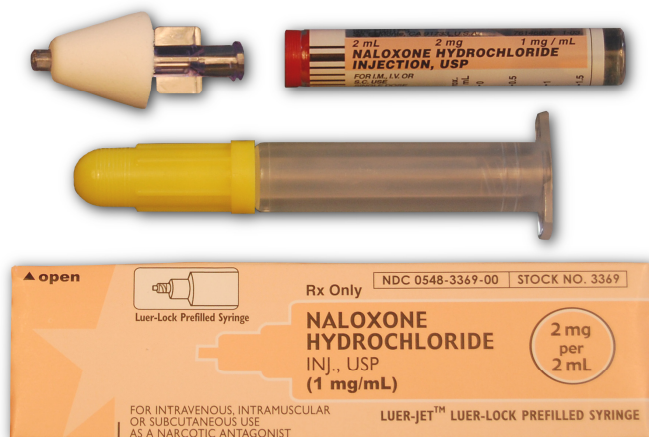




Massachusetts Department of Public Health

Opioid Overdose Education and Naloxone Distribution

MDPH Naloxone pilot project Core Competencies



Acknowledgements:

Thank you to the Boston Public Health Commission and to all of the MDPH partners who are working to save lives as participants in this overdose prevention pilot program.

We would also like to thank Maya Doe-Simkins, MPH and Alexander Y. Walley, MD, MSc. for their significant contributions to this guide.

Table of Contents

About this Document	4
Introduction: the need and response	4
What are opioids?	5
What is an opioid overdose?	5
How to recognize an opioid overdose	6
How to respond to an opioid overdose	7
Risk Factors for Overdose and Overdose Prevention	13
Summary	15
Contacts.....	15
Appendix I: Other Resources.....	16
Appendix II: Legal Opinion & Standing Order	17

About this Document

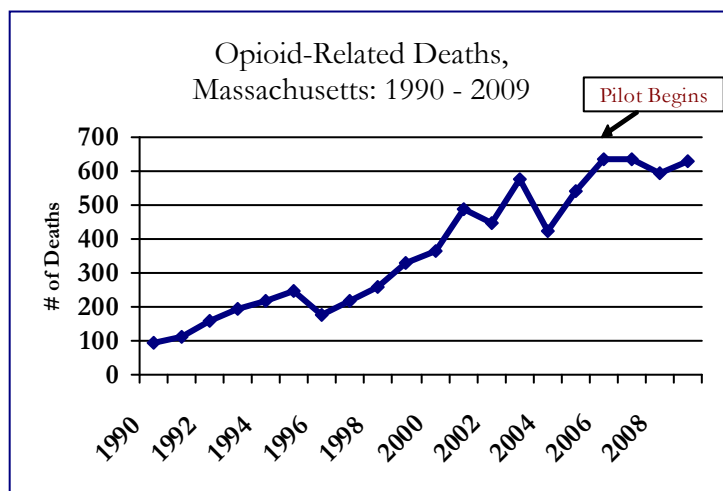
This guide is intended to describe the knowledge and core competencies necessary for potential overdose responders trained as part of the MDPH opioid overdose prevention pilot program to respond to an opioid overdose event. Potential overdose responders are other opioid users, parents, relatives, and friends of opioid users; first responders such as police and fire departments; and staff of agencies that serve high-risk individuals. The guide provides information on recognition and response to an opioid overdose and is accompanied with important contextual information.

The MDPH opioid overdose prevention pilot is part of a broader effort to prevent/decrease opioid use that includes prevention, intervention, treatment, and recovery support strategies. A more detailed overview of these strategies can be found on the [MDPH-BSAS website](#).

Introduction: the need and response

Recognizing that fatal and non-fatal overdoses from opioids play an increasing role in the mortality and morbidity of Massachusetts residents, the Massachusetts Department of Public Health launched the Overdose Education and Naloxone Distribution (OEND) prevention program using intra-nasal Narcan (naloxone) in an attempt to reverse this trend.

Naloxone is an opioid antagonist which means it displaces the opioid from receptors in the brain. An overdose occurs because the opioid is on the same receptor site in the brain that is responsible for breathing. Naloxone usually acts dramatically, allowing slowed or absent breathing to resume. It is both safe and effective and has no potential for abuse. Naloxone has been used by paramedics in ambulances and by emergency room clinicians for decades. While not a controlled substance, naloxone is what is known as a “scheduled” drug and therefore does require a prescription.



The Department of Public Health is operating this naloxone distribution program as a pilot program in accordance with M.G.L. c. 94C and DPH/Drug Control Program regulations at 105 CMR 700.000. The distribution of naloxone by approved trainers is authorized by the Department of Public Health and by [the standing order](#) issued by the Medical Director of the naloxone pilot.

In 2012 a new law (Chapter 192 of the Acts of 2012) passed in Massachusetts that includes the following related to naloxone:

- A person acting in good faith may receive a naloxone prescription, possess naloxone and administer naloxone to an individual appearing to experience an opiate-related overdose.
- Naloxone 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

As part of the Department’s comprehensive approach to addressing opioid overdose, the Overdose Education and Naloxone Distribution (OEND) programs are targeted toward areas in the state with the highest numbers of fatal and non-fatal overdoses. Massachusetts has been particularly successful in expanding overdose prevention services to thousands of state residents due to the support from MDPH combined with the committed efforts of several community based harm reduction and substance abuse treatment and prevention agencies.

What are opioids?

Opioids are chemicals that are either derived from the opium poppy or are synthetically manufactured by pharmaceutical companies. Whether synthetic or naturally occurring, opioids all act in similar ways at specific sites in the body. They are depressants, and slow down the central nervous system. At high levels, opioids reduce consciousness and decrease breathing (respiratory depression). Opioids attach to specific receptors in the brain, spinal cord, and gastrointestinal tract and block the transmission of pain messages. They induce euphoria and users generally report feeling warm, drowsy, and content. Opioids relieve stress and discomfort by creating a relaxed detachment from pain, desires, and activity. They also cause slow heart rate, constipation, a widening of blood vessels, and decrease the natural drive to breathe.

Opioids differ in both strength and how long they remain active. At least three factors are important to consider when judging the strength of an opioid and therefore it’s risk for causing an overdose:

1. Prescription opioids come in short-acting and long-acting formulations. Short-acting and long acting opioids contribute to overdoses in different ways. For example, oral methadone usually stays in the body for more than 24 hours and therefore can contribute to overdose risk over a long period of time, whereas intravenous fentanyl only lasts for a few minutes.
2. Tampering with how an opioid medication is manufactured can turn a long-acting, less potent medication, into a more potent, rapid acting one. If an extended release tablet is crushed, the medication becomes short-acting and more potent.
3. Rapid delivery of opioids via injection and smoking increases overdose risk. The faster the opioid is delivered, the more intense the high, but also the greater risk of overdose. Injecting heroin delivers more opioid to the brain faster than sniffing. **However, no delivery method protects an opioid user completely from overdose.**

Key Points: What are Opioids?

- There are “street” opioids such as heroin, and prescription opioids
- Opioids vary in how long they last in the body
- How you take different opioids affects how long it lasts in the body and how potent it is

What is an opioid overdose?

An overdose occurs when the body has more drugs in its system than it can handle, resulting in potentially life threatening dysfunction. People can overdose on many different substances including other drugs or

alcohol. During an opioid overdose there are so many opioids or a combination of opioids and other drugs in the body that the victim becomes unresponsive to stimulation and/or breathing becomes inadequate.

Those experiencing an overdose become unresponsive, or unconscious, because opioids fit into specific brain receptors that are responsible for breathing. When the body does not get enough oxygen, lips and fingers turn blue. These are the signs that an overdose is taking place. A lack of oxygen eventually affects other vital organs including the heart and brain, leading to unconsciousness, coma, and then death.

With opioid overdoses, the difference between surviving and dying depends on breathing and oxygen. Fortunately, opioid overdose is rarely instantaneous; people slowly stop breathing after the drug was used. There is usually time to intervene between when an overdose starts and a victim dies. Furthermore, not all overdoses are fatal. Without any intervention, some overdose victims may become unresponsive with slowed breathing, but will still take in enough oxygen to survive and wake up.

Key Points:

- A lack of oxygen is the greatest risk during an overdose
- Due to the lack of oxygen a person's lips and fingers might turn blue
- There is usually time to intervene between when an overdose starts and a victim dies.

How to recognize an opioid overdose

The signs of an opioid overdose (what to look for):

- Blue skin tinge- usually lips and fingertips show first
- Body very limp
- Face very pale
- Pulse (heartbeat) slow, erratic, or not there at all
- Throwing up
- Passing out
- Choking sounds or a gurgling/snoring noise
- Breathing is very slow, irregular, or has stopped
- Unable to respond

TIP: If someone is making unfamiliar sounds while “sleeping” it is worth trying to wake him or her up. Many bystanders think a person is snoring, when in fact the person could be overdosing.

Differentiating between overdose and an opioid high

Sometimes it is difficult to tell if someone is overdosing or if he or she is just really high. The table below offers clues on how a responder might be able to tell the difference.

REALLY HIGH	OVERDOSE
Muscles become relaxed	Pale, clammy skin
Speech is slowed/slurred	Very infrequent or no breathing
Sleepy looking	Deep snoring or gurgling (death rattle)
Responsive to stimuli (such as shaking, yelling, sternal rub, etc.)	Not responsive to stimuli (such as shaking, yelling, sternal rub, etc.)
Normal heart beat/pulse	Slow heart beat/pulse
Normal skin tone	Blue lips and/or fingertips

Assessing for Responsiveness and Breathing

In order to determine if the individual is experiencing an overdose, the most important things to consider are presence of breathing and responsiveness to stimulation. There are some relatively harmless ways to stimulate a person. These strategies are:

- yelling their name, and if they do not respond,
- rubbing knuckles over either the upper lip or up and down the front of the rib cage (called a sternal rub).

If an individual responds to these stimuli, they may not be experiencing an overdose at that time. It is best to stay with the person, to make sure the person wakes up. It is possible that the person could become unresponsive and would need help.

How to respond to an opioid overdose

If an individual does not respond to stimulation, it is important to:

- call 911 to get help
- perform rescue breathing to provide oxygen
- administer naloxone
- stay with the person until help arrives

Continued attempts at stimulation will waste valuable time in helping the individual breathe.



1. CALL 911

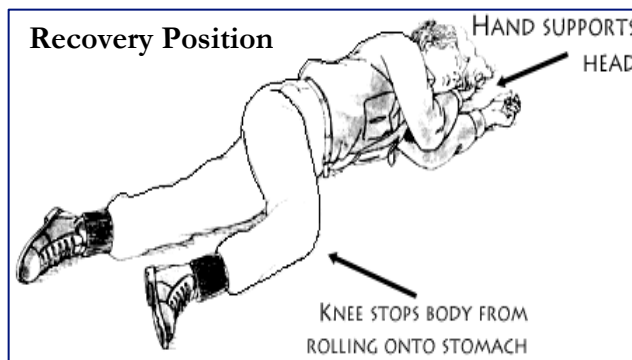
Call for Help – Dial 911

All participants in this DPH-approved program are expected to call 911 in the case of an overdose. An overdose is a medical emergency and it is important to have trained medical professionals assess the condition of the overdose victim. Even though naloxone can reverse the overdose, there may be other health problems of which the responder may not be aware. In addition, people who survive any type of overdose are at risk of experiencing other health complications as a result of the overdose, such as pneumonia and

heart problems. Getting someone examined by a medical professional is an important part of reducing the harms associated with overdosing. It is important for responders to remember that naloxone only works

if there are opioids involved with the overdose. It cannot reverse an overdose on benzodiazepines, cocaine, or alcohol.

Individuals who overdose can die because they choke on their own vomit (aspiration). This can be avoided by putting the individual in the recovery position. The recovery position is when you lay the person on his or her side, his or her body supported by a bent knee, with his or her face turned to the side. This position decreases the chances of the individual choking on his or her vomit. If you have to leave the person at all, even for a minute to phone 911, make sure you put them in the recovery position.



In 2012, a new Massachusetts law passed that states that a bystander or a victim of an overdose cannot be charged with “possession of a controlled substance” if they seek medical attention during an overdose. This new law is intended to reduce the fear of calling 911. It does not protect individuals who are present at the overdose from being charged with other crimes or being picked up on a warrant.

If a responder cannot stay with the victim until help arrives, it is important to leave the person in the recovery position and direct those coming to help where to find the victim.

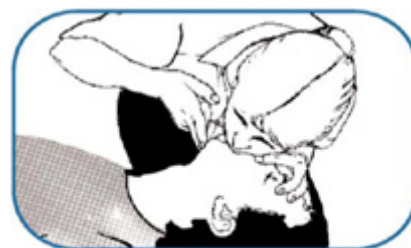
What to say when 911 is called

It is important to report the victim’s breathing has slowed or stopped, he or she is unresponsive, and the exact location of the individual. If naloxone was given and it did not work, this is important information to tell the dispatcher. In many communities, the police respond along with the ambulance to 911 calls.

Perform rescue breathing

For a person who is *not breathing*, rescue breathing is an important step in preventing an overdose death. When someone has stopped breathing and is unresponsive, rescue breathing should be done as soon as possible because it is the quickest way to get oxygen into the body. Steps for rescue breathing are:

1. Place the person on his or her back and pinch their nose
2. Tilt chin up to open the airway. Check to see if there is anything in the mouth blocking the airway. If so, remove it.
3. Give 2 slow breaths.
4. Blow enough air into the lungs to make the chest rise.
5. Turn your head after each breath to ensure the chest is rising and falling. If it doesn’t work, tilt the head back more.
6. Breathe again every 5 seconds.



2. RESCUE BREATHING

Administer naloxone (Narcan)

Naloxone is a medication that reverses overdose from heroin or other opioids (more information about naloxone can be found in the [introduction of this guide](#)). Naloxone is the generic name for Narcan. These names are often used interchangeably.

There are multiple routes of administration for Naloxone. It may be injected in the muscle, vein, under the skin, or sprayed into the nose (intra-nasal). The formulation used for bystander naloxone rescue kits in Massachusetts is for intra-nasal use. The benefits of this formulation are acceptability, safety, and ease of administration.

Naloxone may work immediately, but can take up to 8 minutes to have an effect. The effect of the naloxone will last for about 30 to 90 minutes in the body. **Because most opioids last longer than 30 to 90 minutes, the naloxone may wear off before the effects of the opioids wear off and the person could go into an overdose again.** This depends on several things, including:

- the quantity and purity of opioids used
- the presence of other drugs, like alcohol or other drugs
- how well the liver works to filter out the drugs
- if the victim uses again once the naloxone is administered

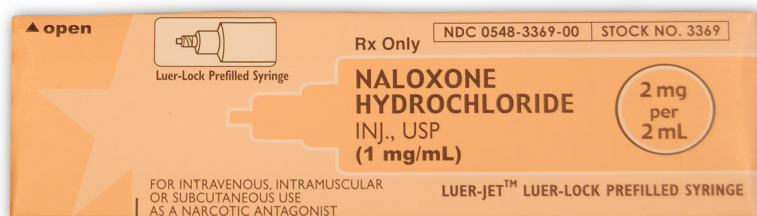
In response to these issues, the naloxone rescue kits include 2 doses. Naloxone administration may be repeated without harm if the person overdoses after the first dose wears off. **Due to the complex nature of each of these medical emergencies, it further highlights the necessity of calling 911.**

How to assemble naloxone device and administer naloxone

It is strongly recommended that you visit the [Boston Public Health Commission's YouTube page](#) for a video description of how to assemble and administer naloxone.



1. Pop off two yellow caps and one red (or purple) cap.
2. Hold spray device and screw it onto the top of the plastic delivery device.
3. Screw medicine *gently* into delivery device
4. Spray half of the medicine up one side of the nose and half up the other side.



3. GIVE NARCAN

Assemble the pre-filled vial and screw the nasal atomizer piece on the top (as described above). Spray half of the naloxone (1 ml) up one side of the nose and half (1 ml) up the other side of the nose. If there is no breathing or breathing continues to be shallow, continue to perform rescue breathing while waiting for the naloxone to take effect.

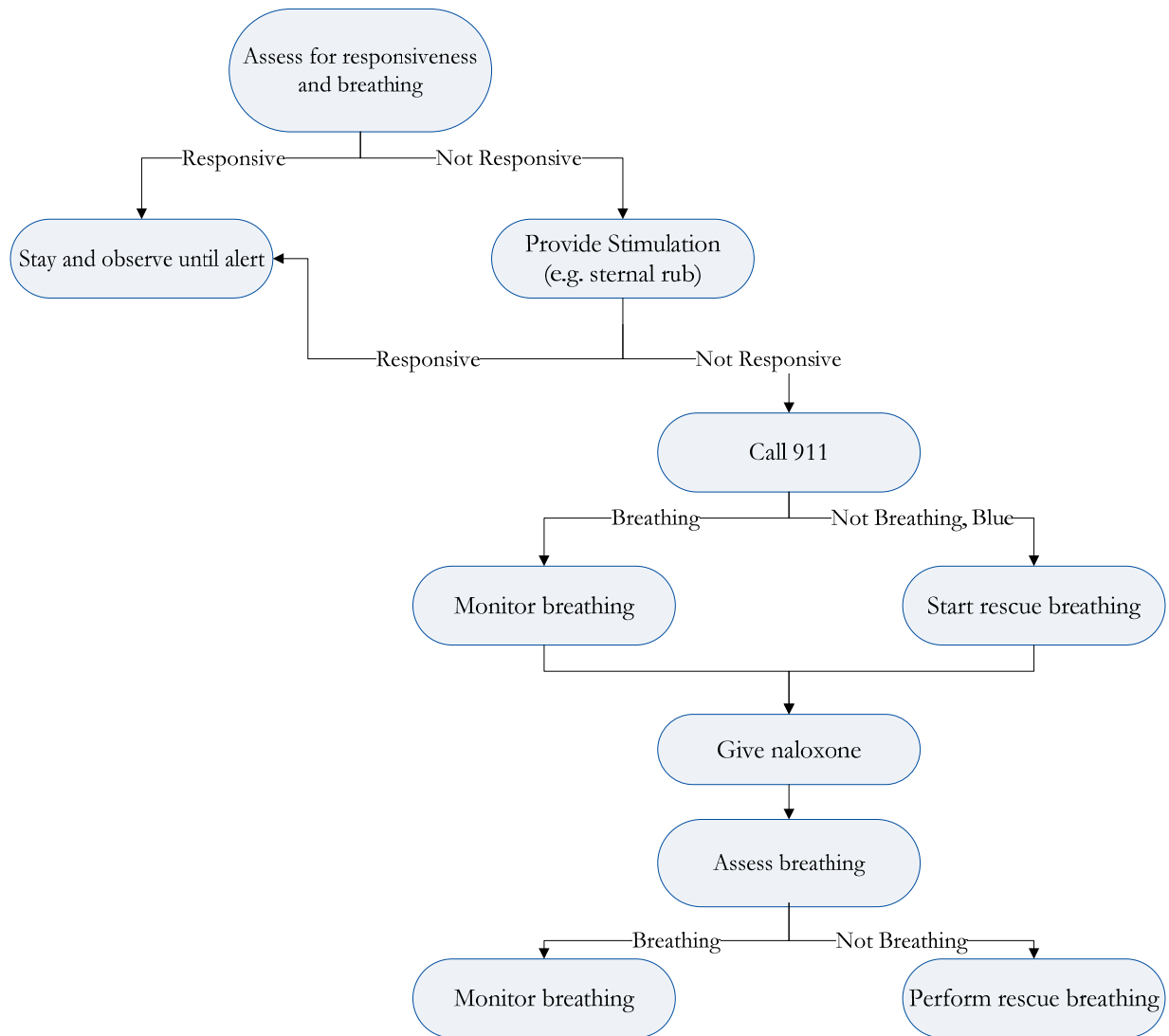
If there is no change in 3-5 minutes, administer another dose of naloxone (use another box) and continue rescue breathing until they breathe for themselves or help arrives.

Monitor the victim

Naloxone blocks opioids from acting so it can cause withdrawal symptoms in someone with opioid tolerance. Therefore, after giving someone naloxone, he or she may feel withdrawal symptoms and may want to use again. It is important that the victim does not use opioids again after receiving naloxone so that an overdose does not re-occur. If possible, the bystander who administered the naloxone should stay with the person who overdosed.

Flow Chart

The following flow-chart illustrates the steps that are taken depending on the victim's responsiveness.



Key Points: View the Video

[For a video description of how to assemble and administer naloxone, visit the Boston Public Health Commission's YouTube Page.](#)

Troubleshooting naloxone

Lost or broken nasal atomizer

Sometimes the nasal atomizer gets lost or broken. People have reported success by squirting the naloxone in the person's nose without the spray adapter.

Bleeding from the nose

If the person overdosing has substantial nasal bleeding, naloxone may not work because the blood will interfere with absorption of the naloxone. Call for help and rescue breathe.

Injectable naloxone – distributed in other states

Some people might have a different formulation of injectable naloxone, which is common in many other states. This formulation of naloxone comes packaged in three different forms- a multi dose 10 mL vial, single dose 1 mL ampoules with a crack off top and single dose 1 mL vials.

If someone has an injectable formulation of naloxone, all of the steps in recognizing and responding to an overdose are the same except how to give the naloxone.



What NOT to do during an overdose:

There is a lot of street knowledge, experience and expertise about how to treat an overdose and many people have seen these techniques work. While it is important to validate people's experience, these strategies are not as consistently successful as naloxone and rescue breathing and may distract responders from keeping the victim breathing.

The following are some traditional methods for managing an overdose and why they are not as effective as naloxone and rescue breathing:

- Do not put the victim in a bath. He or she could drown.
- Do not induce vomiting. He or she could choke.
- Do not give the victim something to drink. He or she could throw up or choke.
- Do not put ice down the victim's pants. It will just make his or her pants wet. Cooling down the core body temperature of someone who is overdosing is dangerous because it will slow down his or her heart rate and can increase the risk of a heart arrhythmia.
- Do not try to stimulate the victim in a way that could cause harm. Slapping too hard, kicking in the testicles, burning the bottom of the feet, etc. can cause long-term damage.
- Do not inject the victim with anything (saltwater, cocaine, milk). It will not work any more than physical stimulation and can waste time. Also, every injection brings a risk of bacterial and viral infection, abscesses, endocarditis, cellulitis, etc.

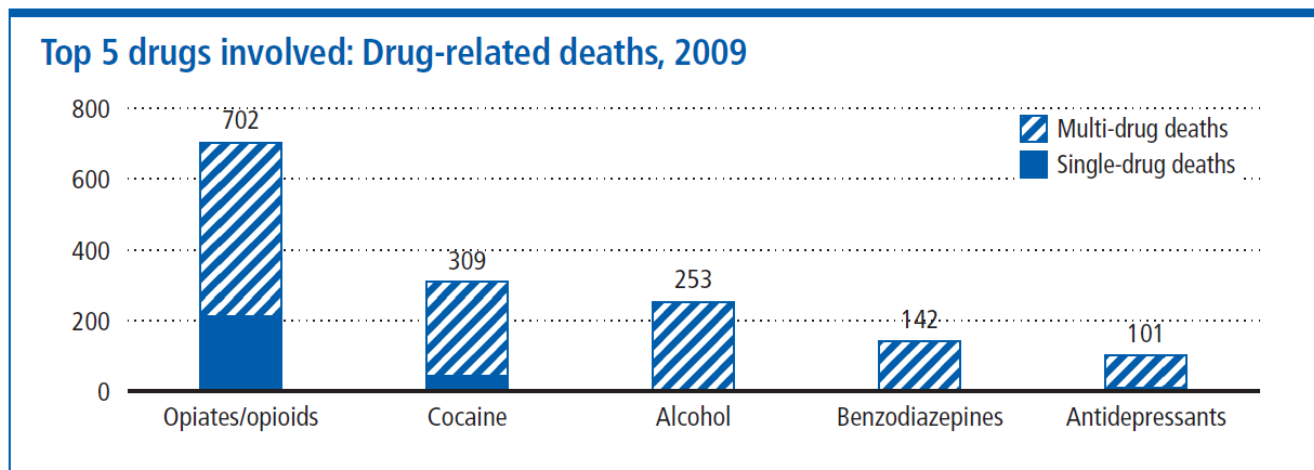
Key Points: How to respond to an opioid overdose

- Call 911
- Perform rescue breathing
- Administer naloxone
- Place the person in the recovery position
- Stay with the victim

Other types of “overdose”

Naloxone is only effective when opioids are contributing to an overdose. The more non-opioid substances contribute to the overdose, the less effective naloxone is. However, overdose prevention and management techniques, such as understanding that periods of abstinence come with reduced tolerance, avoiding mixing substances, not using alone, storing substances securely, calling 911 for help, and placing the victim in the recovery position, are all useful for preventing and managing any overdose.

While opioid overdose is the main type of drug overdose in Massachusetts, other types of overdose including alcohol and cocaine overdoses are major causes of fatalities. The figure below is from the Drug Abuse Warning Network for Massachusetts.



Overdoses from non-opioids may have effects other than depressed consciousness and breathing, such as seizures, stroke (manifested as numbness or weakness or difficulty speaking), heart attack, or recurrent vomiting. Naloxone will not correct these symptoms, but responders can help by staying with the victim and seeking emergency help by calling 911.

Participants who have questions about other types of overdose can be referred to other resources such as the Harm Reduction Coalition website: harmreduction.org.

Risk Factors for Overdose and Overdose Prevention

The goals of MDPH's naloxone pilot project include both preventing overdoses from occurring and saving lives when they do. This section describes common risk factors, that is, something that is likely to increase the chances that an overdose might occur. For that reason, familiarity with the following is essential.

Tolerance

With daily use of opioids, the body develops tolerance; which means individuals have to use an increasing amount of drug to get the same effect. Because of tolerance, a daily opioid user can use a quantity of opioids that would overdose an opioid-naïve individual or someone without the same level of tolerance. However, with just a few days of opioid abstinence, tolerance is reduced. Reduced tolerance increases the risk of overdose if an individual tries to use the same amount of drug he or she used before the period of abstinence.

Risk of Overdose increases after a period of abstinence such as:

- Incarceration
- Hospitalization
- Detoxification or Drug Treatment
- Stopping on their own

Tolerance and opioid prescriptions

People who take opioids for pain are at heightened risk for opioid overdose when they are rotated from one medication to another. Similarly, the induction period for new methadone patients (the first 2-4 weeks) is a potentially risky time period because a person's illicit opioid use is not necessarily easily converted into a safe and comfortable methadone dose. People in both situations should remain in close communication with their medical provider about symptoms during this period.

Tolerance and intermittent use

People who use opioids intermittently may also be uniquely vulnerable because they do not have an opioid tolerance. This tolerance-free group of opioid users is also at a considerably higher risk when opioids are mixed with other substances.

Mixing Opioids with other drugs

All sedating medications carry overdose risks of their own; however, when drugs are combined, the risk is substantially increased because the drugs typically use different mechanisms in the body to create sedation.

Mixing with Benzodiazepines

Benzodiazepines (benzos) are sedating drugs that include alprazolam (Xanax), chlordiazepoxide (Librium), lorazepam (Ativan), clonazepam (Klonopin), and diazepam (Valium). These medications are typically prescribed to treat anxiety disorders, insomnia, tremors, and alcohol withdrawal. In Massachusetts, benzodiazepines are the most common type of drug mixed with heroin resulting in multi-drug overdoses. Benzodiazepines are a particular risk factor for overdoses for two reasons: they are long acting, and they impair short-term memory.

While benzodiazepine use contributes to overdose risk, doctors may still prescribe them to patients using opioids because sometimes the benefits of treating an anxiety disorder or insomnia outweigh

these risks. Generally, prescribers will keep the benzodiazepine doses low and monitor the patient for overmedication.

Mixing with other sedating medications and/or alcohol

There are many other sedating medications besides benzodiazepines that also present a risk of overdose when mixed with opioids. A few examples include clonidine (Catapres), gabapentin (Neurontin), quetiapine (Seroquel), and promethazine (Phenergan). While these medications have different clinical uses they are all sedating which means they slow down the body's processes, including breathing and/or heart rate. For this reason, all of these mixed with an opioid increase the risk of overdose compared to use of the opioid alone.

Alcohol is also a sedative. Combining alcohol with opioids increases the risk for overdose in the same manner as other sedating drugs or medications.

Mixing with Cocaine or other stimulants

Cocaine and other stimulants like methamphetamine also increase overdose risk when mixed with opioids. Stimulants combined with opioids can create a cycle of trying to treat the sedating effects of one medication with the stimulating effects of the other and vice versa. In this setting, the dangerous side effects of each of these medications can accumulate to increase the risk of overdose. For example, stimulants increase heart activity which uses up oxygen faster than the supply can be replenished because opioids slow down breathing.

Overdose risk and chronic medical conditions

People with longer drug using histories are at increased risk for fatal overdose due to the cumulative effects of long term substance use, including viral hepatitis, HIV or infections like endocarditis or cellulites. In addition, liver and lung health are often negatively impacted by hepatitis and smoking. The liver and lungs play important roles in an overdose because the liver filters substances from the body and the lungs replenish the oxygen supply, which are essential for a person to survive an overdose.

Anyone who uses opioids, including people who take opioids for pain, should be aware that they are at higher risk for overdose if they:

- Smoke or have chronic bronchitis, emphysema, asthma, sleep apnea, respiratory infection, or other respiratory illness
- Have kidney or liver disease or dysfunction, cardiac illness or HIV/AIDS
- Drink alcohol
- Currently take benzodiazepines or other sedative prescription or antidepressant medication

Mode of administration of the substance

There are many ways to use drugs, including swallowing, snorting, smoking, and intramuscular or intravenous injection. Regardless the mode of administration, if someone uses enough of a drug in a short enough period of time, overdose is possible. However, those methods that deliver the drug more quickly to the brain, such as smoking and intravenous injection, create a higher risk for overdose. Furthermore, when a person changes what they use or how they use it, they can be putting themselves at higher risk for overdose. For example, if a person migrates from swallowing methadone to injecting methadone, switches from swallowing oxycodone (OxyContin, Roxicet) to swallowing oxymorphone (Opana), or injecting heroin to injecting Demerol, a person should employ heightened overdose prevention techniques.

Previous nonfatal overdose

Previously experiencing an overdose increases the risk of dying from an overdose in the future. This is because people who have previously overdosed may have drug use patterns that continue to put them at

risk for an overdose in the future. In addition, experiencing a nonfatal overdose may cause damage to the brain or lungs even if the person survives. This damage may make possible future overdoses more risky and more likely to be fatal.

Variation in strength and content of ‘street’ drugs

There is no regulation on the quality or strength of opioids bought on the street. A bag of heroin, for instance, can vary a lot in purity. If someone is used to street heroin that is only 18% heroin and then buys a bag that is 44% heroin, using one bag of the new heroin is like doing more than two bags of the previous heroin. Drug sellers may enhance the strength of weak heroin by cutting it with pills or fentanyl, which means an individual is mixing drugs without knowing it.

Using alone

When an individual uses opioids alone, there is no one around to help him or her during an overdose. Without help from someone who can respond an overdose is more likely to become fatal.

Key Points: View the Video

[View the Cambridge Prevention Coalition OPEN Project’s video describing risk factors](#)

Summary

This guide is intended for those participants in the MDPH Overdose Prevention Pilot that uses intra-nasal naloxone as part of a comprehensive strategy that includes prevention and response. A wide variety of materials have been developed since the inception of this ground breaking approach. Included in this document, are links and videos that provide support for these prevention and response strategies. This document is limited to the core competencies that are expected of participants in the MDPH Overdose Prevention Pilot.

This document is not an exhaustive presentation of opioid overdose prevention. A familiarity with strategies, resources, and tools are needed for each group of potential bystanders/responders, and are available through links within this document.

Contacts

The MDPH Overdose Prevention Pilot is a joint effort of the Commissioner’s Office, Bureau of Substance Abuse Services and the Office of HIV/AIDS.

Sarah Ruiz
Bureau of Substance Abuse Services
sarah.ruiz@state.ma.us
(617) 624-5136

Ed DeBortoli
Office of HIV/AIDS
Bureau of Infection Disease
ed.debortoli@state.ma.us
(617) 624-5368

Appendix I: Other Resources

General

- [Cambridge Prevention Coalition's OPEN Project's opioid overdose prevention videos](#)

For Public Safety

- [Boston Public Health Commission's guide for Opioid Overdose Prevention for Public Safety and Law Enforcement](#)

For Friends and Family Members

- [Boston Public Health Commission's guide for Opioid Overdose Prevention for Friend and Family Members](#)
- Learn to Cope is a support group for parents and family members dealing with a loved one addicted to heroin, Oxycontin and other drugs – www.learn2cope.org

Appendix II: Legal Opinion & Standing Order



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

JUDYANN BIGBY, MD
SECRETARY

JOHN AUERBACH
COMMISSIONER

To: Andy Epstein, RN, MPH
Special Assistant to the Commissioner

From: Grant Carrow
Director, Drug Control Program

Howard Saxner
Deputy General Counsel

Date: August 22, 2007

Re: Establishing a Pilot Program for Narcan Distribution and
Administration Under M.G.L. c.94C

The Bureau of Substance Abuse Services proposes to conduct a pilot Opioid Overdose Prevention Program, limited in time and scope, for the distribution of Naloxone ("Narcan") by Trainers to trained individuals ("Responders") for the purpose of emergency administration to injection drug users experiencing overdose.

While the proposal raises novel legal issues with respect to medication distribution and administration, we have concluded that a pilot program for the distribution and administration of Narcan (a Schedule VI controlled substance) could be established by policy, in accordance with M.G.L. c. 94C and DPH/Drug Control Program regulations at 105 CMR 700.000. Should the Department decide to establish a permanent program based upon the results of the pilot, however, we recommend that standards for the distribution and administration of Narcan through the program be set forth in Department regulations.

To carryout the pilot project, a Medical Director (physician) must be able to distribute Narcan to a Trainer, a Trainer must be able to further distribute Narcan to a trained Responder and a Responder must be able to administer Narcan to an injection drug user experiencing overdose. These activities may be authorized by a combination of Department policy and the standing order of the Medical Director, as outlined below.

A. For purposes of this analysis, the following definitions shall apply:

Trainer means an individual authorized pursuant to Department policy to train Responders in the administration of Narcan to injection drug users experiencing overdose and to distribute Narcan to Responders as directed by the standing order of the Medical Director.

Responder means an individual trained in accordance with Department policy in the administration of Narcan to injection drug users experiencing overdose, and authorized by standing order of the Medical Director to administer Narcan to an injection drug user experiencing overdose.

Standing order means an order, approved by the Department and signed by the Medical Director, for distribution and administration of Narcan, a Schedule VI controlled substance.

B. With respect to the pilot Opioid Overdose Prevention Program, the following activities would be permissible under M.G.L. c.94C:

1. The Medical Director of the Opioid Overdose Prevention Program, as a duly licensed and registered physician¹ acting in accordance with Department policy, may possess and distribute Narcan to Trainers.

Rationale: M.G.L. c.94C, s7(d) permits possession and distribution of a controlled substance by:

(3) any public official ...acting in the regular performance of his official duties.

In addition, by M.G.L. c.94C, ss. 1 and 9(b), for purposes of immediate treatment, a physician may also deliver Narcan to an ultimate user (Responder) or an agent of the physician (Trainer) in such quantity as is essential for the immediate treatment of the patient. A physician also may write orders for the possession and administration of Narcan, pursuant to the authority of c.94C, s.7(e).

2. A Trainer may possess and distribute Narcan to a Responder in accordance with DPH policies, without registration. Such possession and distribution of Narcan may be sanctioned through a standing order approved by the Department and issued by the Medical Director. The standing order must authorize the administration of Narcan by Responders to injection drug users experiencing overdose (see #3 below).

Rationale: M.G.L. c. 94C, s.7(d)(1) permits an agent of a physician (in this case, the Medical Director), acting in the usual course of business, to possess and distribute a controlled substance. This allows the Trainer, in accordance with the Medical Director's written order and policies of the Department, to possess Narcan and distribute it to Responders.

3. A Responder may possess and administer Narcan to an injection drug user experiencing a drug overdose, as directed by a standing order duly issued by the Medical Director.

Rationale: M.G.L. c.94C, s.7(e) provides that an "ultimate user ...may lawfully possess or administer a controlled substance at the direction of a (physician) in the course of professional practice." In the case of Narcan possession and administration, the Responder shall be regarded as the ultimate user.

¹ The Medical Director must hold both a valid license from the Board of Registration in Medicine and a valid Massachusetts Controlled Substances Registration from the Drug Control Program.

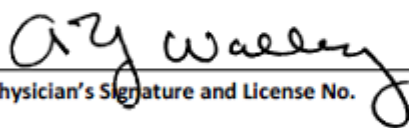
**MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
NALOXONE DISTRIBUTION IN THE OVERDOSE PREVENTION PILOT PROGRAM**

STANDING ORDERS

Naloxone is indicated for reversal of opioid overdose in the setting of respiratory depression or unresponsiveness. It may be delivered intranasally with the use of a mucosal atomizer device.

1. This standing order authorizes Registered Programs to maintain supplies of nasal naloxone kits for the purposes of distributing them as part of the MDPH Overdose Prevention Pilot Program.
2. This standing order authorizes Approved Opioid Overdose Trainers to possess and distribute nasal naloxone to Approved Opioid Overdose Responders.
3. This standing order authorizes Approved Opioid Overdose Responders, trained by Approved Opioid Overdose Trainers, who are trained employees of a Registered Program, to possess and administer nasal naloxone to person who is experiencing a drug overdose.
4. **Administration of nasal naloxone:** Administer nasal naloxone to a person suspected of an opioid overdose with respiratory depression or unresponsiveness as follows:
 1. Pop off two yellow caps from the delivery syringe and one red cap from the naloxone vial.
 2. Screw the naloxone vial gently into the delivery syringe.
 3. Screw the mucosal atomizer device onto the top of the syringe.
 4. Spray half (1ml) of the naloxone in one nostril and the other half (1ml) in the other nostril.
 5. Remain with the person until he or she is under care of a medical professional, like a physician, nurse or emergency medical technician.

Do not administer nasal naloxone to a person with known hypersensitivity to naloxone.

 Physician's Signature and License No.	Mass Lic # [REDACTED] 10/01/2011
Alexander Y. Walley	12/31/2012
Physician's Name (Print)	Order Expiration Date

Definitions (for further detail about the program, see the Massachusetts Department of Public Health Guidelines for Registration of Opioid Overdose Prevention Programs):

Nasal naloxone kits contain the following at a minimum:

- Two 2ml Luer-Jet luer-lock syringes prefilled with naloxone (concentration 1mg/ml)
- Two mucosal atomization device
- "Get the SKOOP" overdose prevention pamphlet
- Step-by-step instructions for administration of nasal naloxone

Registered Program: A program approved by the Department of Public Health to provide overdose education and naloxone distribution services and train potential overdose bystanders in accordance with these guidelines.

Standing Order – Opioid Overdose Prevention Pilot Program
Alexander Y. Walley, MD, MSc - Medical Director

As of 10/01/2011 the registered programs include:

- AIDS Action Committee (formerly Cambridge Cares About AIDS)
- Seven Hills Behavioral Health
- Tapestry Health
- AHOPE - Boston Public Health Commission
- Northeast Behavioral Health
- AIDS Support Group of Cape Cod
- Brockton Area Multi-Services Inc. (BAMSI)
- Bay State Community Services (Quincy)
- Statewide Partnership for HIV Education in Recovery Environments (SPHERE)
- Lowell Community Health Center
- Lawrence Family Health Center
- Holyoke Health Center
- AIDS Project Worcester
- ED SBIRT Hospitals
- Learn to Cope

Approved Opioid Overdose Trainer: A person designated by the Registered Program to serve as its trainer and trained by MDPH to conduct Opioid Overdose Responder trainings.

Approved Opioid Overdose Responder: A person, who successfully completed an Opioid Overdose Prevention Training, provided the training was presented by an approved Opioid Overdose Trainer.