

Connecticut Department of Public Health TB, HIV, STD, & Viral Hepatitis Program



DPH

Guidelines for Opioid Overdose Education and Naloxone Distribution

CONNECTICUT OPIOID OVERDOSE PREVENTION EDUCATION AND NALOXONE (OPEN) ACCESS CT PROGRAM POLICIES & PROCEDURES

The following is a sample policies and procedures manual to be used by overdose prevention education and naloxone **(OPEN) Access CT** Programs in Connecticut. This manual will serve as a guide when developing Overdose Prevention (OD) program policies and procedures in CT. Participating OPEN Access CT Programs will be required to develop and tailor programs after being trained on overdose prevention by an OPEN Access CT Member organization or agency.

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INTRODUCTION

Overdose is common among persons who use illicit opioids such as heroin and among those who misuse medications prescribed for pain, such as oxycodone, hydrocodone, and morphine. The incidence of opioid overdose is rising nationwide and deaths from drug overdose have been rising steadily over the past two decades and have become the leading cause of injury death in the United States (Centers for Disease Control, 2014). Every day in the United States, 120 people die as a result of drug overdose, and another 6,748 are treated in emergency departments (ED) for the misuse or abuse of drugs. Nearly 9 out of 10 poisoning deaths are caused by drugs ([CDC, Prescription Drug Overdose](#)). Between 2009 –2014, there were **over 2,000 accidental and unintentional opioid involved deaths that occurred in 150 of Connecticut's 169 cities and towns** (Statewide Overdose Workgroup Fact Sheet, 2014). Overdose education provides the knowledge and skills to save a life while sending a clear message to individuals that their lives matter. It is an important intervention, within comprehensive treatment and support, which can help reduce harm, encourage connection to services, and support people in improving their health.

Background on Opioid Use and Overdose in Connecticut

Naloxone or Narcan® is the life-saving antidote to an opioid overdose. It is a short acting medication which revives a person within a minute or two and allows a window of opportunity to access medical help. Naloxone has no street value, little to no side effects, and has a lower incidence of adverse reactions than an Epi-pen, antibiotics or Aspirin. Unlike many other medications, naloxone cannot be abused, or misused. Naloxone has been used in hospitals and ambulances for decades; the medication has no abuse potential. (Why Naloxone? Retrieved on April 1, 2015 from <http://www.naloxoneinfo.org/>). Additional information on relevant CT statutes related to opioid overdose, liability, syringe access, the Good Samaritan law are included in this manual (See Appendix A).

Purpose of this Document

This purpose of this document is to provide OPEN Access CT member staff with the core knowledge that must be transmitted to the clients who participate in Syringe Exchange Services (SSPs) and Community Naloxone Distribution Programs. This manual contains information and resources that will assist programs in implementing their OPEN Access CT program. Training can be modified to meet the requirements of the staff, available resources, and the group dynamics (i.e. size, history of drug use, etc.) or individual circumstances. The core information needed to be understood by participants is basic overdose prevention for stimulants and opioids, identification of an overdose, and response, including naloxone administration.

Finally, the DPH encourages programs to use this document to train staff who will be conducting training in the community. This manual includes 1) information on standard training topics for agencies who seek to distribute naloxone to clients, 2) guidelines for the distribution of naloxone, 3) general data collection parameters surrounding the distribution of naloxone and 4) resources and worksheets surrounding the prevention and treatment of substance use, and support for individuals, families and friends dealing with substance use issues.

OPEN Access CT Initiative

In 2014, the DPH in collaboration with the Statewide Overdose Prevention Workgroup implemented the overdose prevention education and naloxone (OPEN) Access in CT initiative. A listing of participating OPEN Access CT programs in CT is included in this manual (See Appendix B).

The mission of OPEN Access CT is to educate and train Connecticut residents on how to prevent opiate-related overdoses by using naloxone.

OPEN Access CT Vision:

No deaths due to opiate-related overdoses in Connecticut

Core Values:

- Diversity
- Integrity
- Respect for the individual
- Empathy
- Solidarity
- Creativity

OPEN Access CT Programs will be required to have a copy of policies and procedures on site. Policies and procedures should be signed and dated by the HIV Prevention Program Coordinator or other manager/ director. OD policies and procedures should be reviewed a minimum of once a year to ensure they continue to meet the needs of the program and to be reflective of the program's operations.

Principles of Harm Reduction

The core of harm reduction is to minimize the negative effects of behaviors such as drug use. Harm reduction methods accept that people use drugs and attempt to meet him/her where he/she is at currently. For example, if a person is actively injecting drugs and has no intention of quitting, the harm reductionist would meet him/her where he/she is at by providing a clean syringe, overdose prevention education and naloxone. This minimizes negative effects of

injection drug use (e.g., disease transmission); therefore benefiting the individual and the community at large. Harm reduction seeks to empower the individual to make his/her own decisions and to reduce his/her own risk. Harm reduction calls for dealing with individuals in a non-judgmental manner. The CT DPH encourages the standard practice to include overdose prevention in syringe access operations since overdose is the single most common cause of death among people who inject drugs (more than HIV and Hepatitis C). For more information: <http://harmreduction.org/our-work/overdose-prevention/>

Integrate Overdose Prevention Messages as Standard Practice

There are several practical, participant-centered strategies that can be employed to assist staff in promoting overdose prevention messaging. Overdose prevention messages are relevant to anyone who uses drugs, whether they use prescription drugs or “street drugs.” These messages can easily be incorporated into various settings, including primary health care, mental health services, drug treatment programs, shelters, supportive housing or correctional settings. For example, staff can engage participants around overdose risk during informal conversations by asking if they plan to use alone or if they have friends that know they use. For participants who have recently been released from jail or come out of drug treatment, a conversation reminding them about the increased risk of overdose can be lifesaving (Harm Reduction Coalition, 2012).

Additional information on integrating syringe exchange services can be found on the [National Association for State and Territorial AIDS Directors \(NASTAD\) developmental guidance for SSPs](#).

Program Requirements

Staffing

OPEN Access CT Program Coordinator – SSPs and or other community naloxone distribution programs participating in the OPEN Access CT Program must have a designated Program Coordinator. The program coordinator will be responsible for overseeing all elements of the program and ensuring compliance with program requirements including, but not limited to:

- Establish policies and procedures for operating an OPEN Access CT program;
- Ensure that OPEN Access CT Program staff are trained using the approved curriculum and routinely evaluated for effectiveness and adherence to program guidelines;
- Keep track of and maintain data of all trainings to OPEN Access CT Program participants.
- Securely maintain all required records, logs, databases and submit required reports to the DPH;
- Conduct regular quality improvement concerning community assessment for ODs, how to reach out to at-risk populations, safe storage of naloxone and appropriate documentation and reporting;

- Establish and maintain relationships with area services providers and stakeholders who may be appropriate to receive an OPEN Access CT Training, who may have access to segments of the target population, and/or, who may collaborate with the program in other ways.

GENERAL INFORMATION

(Information provided by the Massachusetts Department of Health Policies and Procedures)

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.

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.

Risk Factors for an Opioid Overdose

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 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. 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.

Drug Purity

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.

Drug Administration

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 if the person survives. This damage may make possible future overdoses more risky and more likely to be fatal.

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.

How to Recognize an Opioid Overdose

- Blue skin tinge- usually lips, nail beds and fingertips show first
- Very limp body
- Very pale face
- 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, shallow or has stopped
- Unable to respond
- Lack of response to stimulation (e.g., sternal rub or yelling of name)

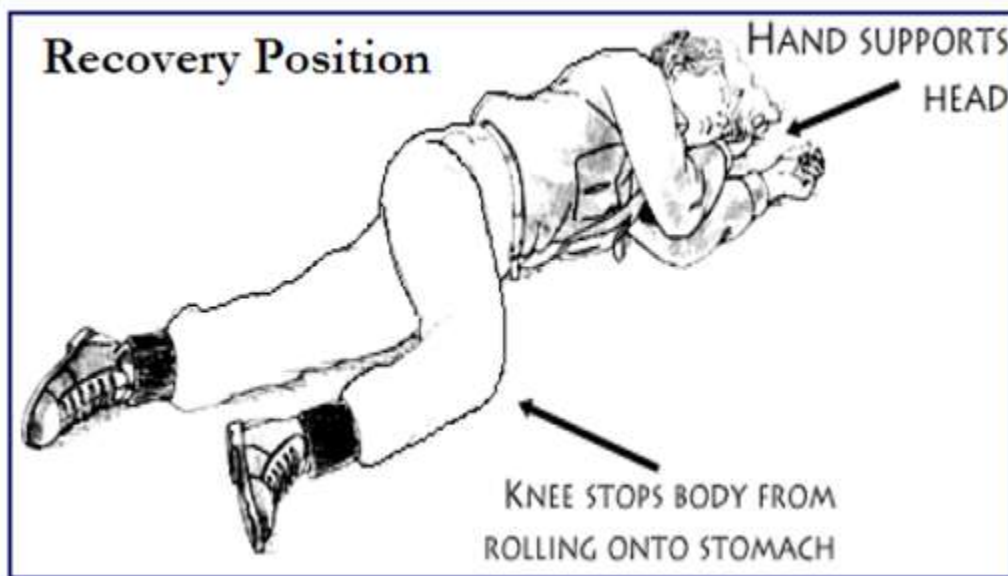
How to Respond to an Opioid Overdose

1. Tilt person on their side and make sure passageway is clear

2. Call 911
3. Place person on their back and provide rescue breathing until medical professionals arrive
4. Administer Naloxone in between rescue breaths
5. Stay with the person until medical professionals arrive (the Good Samaritan Law protects you)

1. Tilt Person on His/Her Side and Make Sure Airway is Clear

Turn the person so that he/she are laying on his/her side. Open his/her mouth and check to make sure nothing is in the person's throat blocking them from breathing. Keep individual on his/her side (see Recovery Position below) while you call 911.



Credit: Massachusetts Department of Public Health Opioid Overdose Education and Naloxone Distribution: MDPH Naloxone pilot project Core Competencies.

2. Call 911

When you call 911 let the operator know as much as possible. Tell the operator the condition of the person who is experiencing an overdose. For example, is the person breathing? What substance(s) has the person taken? Is the person responsive? Did you give Naloxone?

3. Perform Rescue Breathing (credit: MA DPH)

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.
4. Administer Naloxone

The administration of Naloxone should be completed between rescue breathing.

INJECTABLE (with intramuscular syringe)

1. Open syringe packet
2. Attach needle to body of syringe by pressing blue side of cap into top of syringe
3. Remove cap from Naloxone and syringe
4. Insert needle into Naloxone vial
5. Pull 1cc of Naloxone into syringe
6. Make sure there are no air bubbles in syringe
7. Administer Naloxone into person's arm, thigh or buttocks
8. Replace cap onto needle
9. Administer a second dose if person is not responsive after 3-5 minutes.

NASAL (with intramuscular syringe)

1. Open syringe packet
2. Attach needle to body of syringe by pressing blue side of cap into top of syringe
3. Remove cap from Naloxone and syringe
4. Insert needle into Naloxone vial
5. Pull 1cc of Naloxone into syringe
6. Make sure there are no air bubbles in syringe
7. Replace cap onto need and remove needle by twisting top
8. Twist plastic side of nasal atomizer onto syringe body
9. Insert side with white foam tip into person's nostril
10. Push half of Naloxone out of syringe into person's nostril, then push remaining half into the other nostril
11. Re-administer if person is not responsive after 3-5 minutes.

NASAL (with pre-filled syringe)

1. Remove small purple and yellow caps from Naloxone vial and injector
2. Attached vial to injector using three half turns or until stopper is pierced by needle
 - a. ****Do not push vial into injector****
3. Remove large yellow cover from injector

4. Make sure there are no air bubbles in injector
5. Twist plastic side of nasal atomizer onto injector
6. Insert side with white foam tip into person's nostril
7. Push half of Naloxone out of injector into person's nostril, then push remaining half into the other nostril
8. Administer a second dose of Naloxone if person is not responsive after 3-5 minutes.

Evzio

- Follow instructions as recited by device
1. Pull off red safety guard
 2. Place black end on out thigh of person overdosing
 3. Press the device firmly into the person's thigh and hold for 5 seconds
 4. Remove device
 5. Administer a second dose if person is not responsive after 3-5 minutes

Evzio is reserved for those at high-risk, agencies, those with reading/learning disabilities, those who use alone (someone finds them and can easily administer Naloxone with the Evzio), etc.

5. Stay with the person until medical professionals arrive

Stay with the individual until medical professionals arrive—the Good Samaritan Law (see “Relevant CT Statutes/Laws”) protects you from arrest. If you are unable to stay with the individual, place them in the Recovery Position before leaving.

If medical professionals are not called, stay with the individual who received the Naloxone administration. After Naloxone wears off, the individual may go back into an overdose if the drugs have not worked through his/her system yet. In this case, another dose of Naloxone may be needed.

What Not To Do When Someone Is Overdosing

There is a lot of street knowledge 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 that are not as effective as Naloxone and rescue breathing:

- Do not put the victim in a bath. He/she could drown.
- Do not induce vomiting. He/she could choke.
- Do not give the victim something to drink. He/she could throw up or choke.

- Do not put ice down the victim’s pants. Cooling down the core body temperature of someone who is overdosing is dangerous because it will slow down his/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 anymore than physical stimulation and can waste time. Also, every injection brings a risk of bacterial and viral infection, abscesses, endocarditis, cellulitis, etc.

What is Naloxone?

Naloxone is an opioid antagonist, meaning it blocks opioids from attaching to receptors in a person’s brain. This negates the effects of the opioid. Naloxone is non-addictive, does not make a person “high” and its sole use is to reverse an opioid overdose.

Possible side effects: <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a612022.html>

- Pain, redness or burning at the injection site
- Sweating
- Hot flashes or flushing
- Irregular heartbeat
- Hallucinations
- Loss of consciousness
- Seizures
- Opioid withdrawal (body aches, rapid heartbeat, restlessness, weakness, nausea, vomiting)

Who Carries Naloxone in Connecticut?

- State Troopers
- Some police officers (dependent upon town/city)
- EMTs (Emergency Medical Technicians)
- Emergency Rooms
- Syringe Exchange Programs (SEPs)
- Funded HIV Community Distribution Programs

Distribution of Overdose Prevention Kits

Assessing for OD Prevention in the community

Participating OPEN Access CT programs should conduct regular assessments to determine the OD prevention service needs in the community. A sample community assessment is included in this manual (See Appendix D). This should be done before the program is implemented. In addition, participating programs must include how the program will reach out to at risk populations and engage them into services. A sample worksheet is included in this manual (See Appendix E).

Supplier

The Connecticut Department of Public Health will provide overdose prevention (OD) kits, including Naloxone. OD Kits will be distributed to trained OPEN Access CT affiliated partners and providers, such as **Syringe Exchange Services** staff and **funded HIV Prevention Providers** integrating overdose education and distribution of naloxone. Nonaffiliated providers and others in the community can request kits and OD prevention posters, and trainer stickers through the community distribution center website at <http://www.aids-ct.org/cdc.html> or by calling (860) 247-2437 x312.

Distributors

Community distribution is meant for community based organizations that do not have a staff member who is able to write a prescription for naloxone, this includes Syringe Services Programs (SSPs) funded through the DPH. In order to participate in the community distribution of naloxone and overdose prevention kits, agency staff must participate and complete the basic OD prevention training provided by DPH's OPEN Access CT staff. Newly hired agency staff must attend required training as specified by CT DPH. The following are the basic trainings required for staff.

- HIV Pre-requisite Training
- Basic Harm Reduction Training
- CPR training
- OD Prevention Training

At a minimum the training curriculum shall address:

- Risk factors for opioid overdose
- Prevention strategies
- Recognizing overdose
- Signs of an overdose
- Calling 911

- Rescue breathing
 - Administering nasal naloxone
 - Completion of proper documentation
 - Proper storage of naloxone
 - Post-overdose care
 - Refill procedure
- Attend DPH related Syringe Services Program (SSP) regular meetings
 - Attend other relevant trainings as requested

Contents of Intramuscular/Nasal Overdose Prevention Kits:

- (2) Naloxone Hydrochloride 2mL single-use Luer-Lock prefilled syringes
- (2) sterile alcohol prep pads
- (1) face shield (for CPR rescue breathing)
- (1) nasal atomizer
- (1) pair latex gloves
- (1) instruction card in English and Spanish (See Appendix F)

Storage of Naloxone

When not actively handing out naloxone, keep naloxone and the overdose prevention kits in a locked area. Naloxone should be stored at room temperature and out of sunlight (<http://www.nlm.nih.gov/medlineplus/druginfo/meds/a612022.html>).

The Program Coordinator will ensure that naloxone is stored safely and consistent with the manufacturer’s guidelines. The Program Coordinator will ensure that an adequate inventory of naloxone be maintained consistent with reasonable projected demand. The naloxone inventory should be routinely assessed to ensure that OPEN Access CT member agencies have on site an adequate supply of naloxone (which has at least 9 months—and preferably 12 months prior to the expiration date).

TRAINING

OPEN Access CT Participant Education

At a minimum, the following topics should be covered to participants (SSP clients/Community Distribution clients) that receive naloxone:

- Signs of an overdose
- How to use Naloxone
- How to respond to an overdose. SAVE ME Poster (See Appendix G)
- Overdose Prevention Tips (See Appendix H)
- Statutes protecting them when helping someone who is overdosing

- Data collection (client should come back to get a refill and answer questions on how naloxone was used)
- A training video is also available for viewing in addition to the training for trainers to see how to conduct an OD educational session. The video is available on You Tube at <https://www.youtube.com/watch?v=6OgOuUxvCpU&feature=youtu.be>

Trainers

Any persons who are interested in becoming OPEN Access CT trainer are eligible to be trained. Trainers may be program staff, peers or volunteers. They may be trained by program staff or in trainings held by other agencies. Each trainer must be approved by the DPH OPEN Access Program Coordinator. Each trainer will meet with or be supervised at least once by the participating OPEN Access CT Program Coordinator or by an affiliated OPEN Access CT Speaker that has been completed the training of trainers.

Training of Trainers

DPH will offer general training of trainers (ToT) training for funded providers twice a year and refreshers can be provided to newly hired staff upon request. Nonaffiliated providers or community members who would like to be trained, such as at risk persons, family members, and other providers can request training by contacting the CT DPH's OPEN Access CT Program Coordinator at (860) 809-8053 or via email at marianne.buchelli@ct.gov. All requests for training will be monitored and coordinated through the DPH OPEN Access CT Program Coordinator. A list of available trainers can be found on the OPEN Access CT Facebook page. Each OPEN Access CT member agency will maintain a training record of staff, clients, and others persons trained. DPH will monitor and review as part of the QI protocol for OPEN Access CT Member agencies.

If a participant appears to be unable to understand adequately the training instruction, they will be invited to return another time.

Minors as Trained Overdose Responders

A minor who has attained the age of 16 may become a trained overdose responder if, in the opinion of the program staff, there are reasonably foreseeable circumstances in which this minor will be positioned to save a life by administering naloxone. This minor must be deemed to be sufficiently mature with respect to intellect and emotions to carry out all the responsibilities of a trained overdose responder. The program's records should document this maturity in its records on this responder; and the OPEN Access CT Program Coordinator, SSP Program Coordinator, and or Clinical Director of Affiliated Prescriber should document his or her approval for the training of all minors. If the required maturity appears to be lacking, an effort should be made to make the minor a trained overdose responder in all ways other than

furnishing that minor with naloxone, i.e. training the minor in recognizing an opioid overdose; in calling 911 and in waiting with the victim until EMS arrives.

Training Protocol

The program must maintain an up-to-date training curriculum, which has been approved by the CTDPH. The [Toward the Heart Curriculum](#) is an example of such a curriculum. A link for the Toward the Heart Training is included in the resources section of this manual

All trainings will address at a minimum:

Trainings may take place in a variety of settings, including on the street or in a more conventional classroom setting. The trainings may be in small groups or conducted one on-one. They may be as short as ten (10) minutes or may last thirty (30) minutes or longer, depending on the OPEN Access member's familiarity with drug injection and overdose and on other factors. CT DPH recognizes the importance of ensuring the community at large is aware of basic OD prevention education, so a sample of training tips for different settings is included in this manual to share with friends, colleagues, and family members (See Appendix I).

Incentives for Participation in Training- If incentives are offered, there should be a policy with respect to how frequently individuals will be eligible for these incentives, when they should be offered, and the mechanism in which the incentives will be tracked. If incentives provided through DPH, please see DPH HIV Prevention Incentive Policy at <http://www.ct.gov/dph/>

Training Certificate of Completion

At the conclusion of training, each person who has demonstrated adequate understanding of the training material will receive a certificate of completion (See Appendix J). This certification is valid for a period not to exceed two (2) years from the date of the training.

Refresher Course

OPEN Access CT members will be required to take a refresher training in order to retain their status if more than two (2) years have passed since their previous training. OPEN Access CT members who conduct trainings, will track and record the # of trainings provided, # of requests for new kit for loss, use or expiration date. Refresher courses may be offered prior to the expiration of two (2) years to ensure current knowledge regarding overdose protocols and seamless ability of trainer to administer naloxone. A copy of the training log is included in this manual (See Appendix K).

Training Recordkeeping

The Program Coordinator will maintain a log of all persons trained. The following information is required to be collected: OPEN Access CT site name, the date trained the location of the training, the name of the trainer and the names of persons trained. DPH will maintain and update a list of all persons who are designated trainers across the state. The Program Coordinator must also maintain records in order to comply with the requirement of reporting opioid antagonist administrations to the CT DPH, as detailed below under Overdose Reversals. The DPH will also maintain a log of current affiliated prescribers, and this information will be shared with the community and will be posted on the DPH HIV Prevention website.

Speaker's Bureau OD Prevention Trainings- DPH OPEN Access CT Coordinator will track all trainings requested from the community and will develop and maintain a region wide speaker's bureau. OPEN Access CT Member and staff will be included on the speaker's bureau list. The speaker's bureau list will be available on the DPH website (See Appendix L). OPEN Access CT Members must report to DPH the number of OD Prevention trainings conducted per reporting period.

Quality Improvement

Data Collection

Syringe Exchange Services (SSP) clients will be trained on overdose prevention and provided with OD Kit at intake when registered into the SSP. The OPEN Access CT Program Coordinators will ensure that data will be collected on the required SSP (XeringaDB) or documented on community distribution forms (See Appendices M and N). Completed forms shall be securely stored at the program site. Data variables such as the outcome of the overdose and or request for a kit refill should be documented and completed for each report of the use of the naloxone or request for a refill.

Record Keeping

- **OD Kit Distribution-** OPEN Access CT Programs will keep track of all kits disseminated to clients. SSP will keep track using the DPH XeringaDB and forms. These forms include the general SSP Daily Log and Intake Form Log: Indicates who have was provided an OD kit to and the education provided. All other community naloxone distribution programs can use the sample community naloxone distribution data collection form included in this manual, such as AIDS CT Naloxone Distribution Tracking (non-SEP Van) Form (See Appendix O).
- **Overdose Reversals-** All overdose reversals will be recorded on the form supplied by the CT DPH and reviewed immediately by the Program Coordinator. The reports will be reviewed monthly with the program director. Copies of these reports will be submitted

to the CT DPH as part of the DPH tri-annual reports. If there are more than two reversals in a week or if there are specific concerns over either the strength or contamination of drugs in the area, the concern will be discussed with the clinical director and reported immediately to the local health department as well as to the CT DPH.

- **Inventory Tracking-** An inventory of overdose prevention kits is to be maintained by OPEN Access CT distributing agencies. Distributing agencies will track: how many overdose prevention kits distributed and how many are used per the data collection requirements listed below (see “Quality Improvement” section).
- **Documentation of refill or Loss of Naloxone Kit-** OPEN Access CT member agencies will be strongly encouraged to make best efforts to report all use, loss, and refill of OD kits to the Program Coordinator, clinical director or affiliated prescriber. Documentation of reported use or loss of naloxone kits should be collected using the SSP database for all funded syringe exchange programs. For other community distribution programs, a sample refill log is included in this manual (See Appendix P).

Supervision:

The OPEN Access CT Program Coordinator will observe at least one SSP/community distribution staff providing an overdose prevention education training in the field on an annual basis, and will provide feedback if needed.

The OPEN Access CT Program Coordinator will review all documentation completed by the trainers monthly, including the intake, refill forms and logs to ensure accuracy. Any clinical issues related to the dispensing of naloxone and other adverse events reported by participants will be referred immediately to DPH Open Access CT Program Coordinator.

REFERENCES

1. Centers for Disease Control and Prevention. National Vital Statistics System mortality data. (2015) Available from URL: <http://www.cdc.gov/nchs/deaths.htm>.
2. AIDS CT. (2014). Statewide Overdose Prevention Workgroup Fact Sheet.
3. Harm Reduction Coalition. (2012). Guide to OD and Take Home Naloxone Projects. Retrieved from <http://www.harmreduction.org/>
4. Massachusetts Department of Public Health
5. Substance Abuse and Mental Health Services Administration. Highlights of the 2011 Drug Abuse Warning Network (DAWN) findings on drug-related emergency department visits. The DAWN Report. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; 2013. Available from URL: <http://www.samhsa.gov/data/2k13/DAWN127/sr127-DAWN-highlights.htm>
6. Toward the heart.com. A project of the Provincial Harm Reduction Program. Training Manual: Overdose Prevention and Response. (2012) Retrieved from <http://towardtheheart.com/naloxone/siteresources/>

RESOURCES

American Association for the Treatment of Opioid Dependence (AATOD) Prevalence of Prescription Opioid Abuse: <http://www.aatod.org/>

Association of State and Territorial Health Officials (ASTHO) Prescription Drug Overdose: State Health Agencies Respond (2008): <http://www.astho.org/PreventingPrescriptionDrugOverdose>

Centers for Disease Control and Prevention (CDC)

<http://www.cdc.gov/Features/VitalSigns/PainkillerOverdoses>

<http://www.cdc.gov/HomeandRecreationSafety/Poisoning> White House Office of National Drug Control Policy (ONDCP) State and Local Information:

<http://www.whitehouse.gov/ondcp/state-map>

Harm Reduction Coalition: <http://www.harmreduction.org/>

SAMHSA (Substance Abuse and Mental Health Services Administration) Behavioral Health Treatment Services Locator: <https://findtreatment.samhsa.gov/locator/home>

SAMHSA Buprenorphine Physician and Treatment Program Locator:

http://www.buprenorphine.samhsa.gov/bwns_locator/index.html

ACCESS Line (substance use treatment in the Hartford Area): 1/800/563-4086

My Bottom Line (monthly support group for parents with children involved with opioids, North Haven, CT): <http://mybottomline.info/> or mary@mybottomline.info

National Association of State Alcohol and Drug Abuse Directors (NASADAD) State Substance Abuse Agencies, Prescription Drug Abuse, and Heroin Abuse: Results from a NASADAD Membership Inquiry. <http://nasadad.org/wp-content/uploads/2014/06/NASADAD-Prescription-Drug-and-Heroin-Abuse-Inquiry-Full-Report-Final.pdf>

National Association for State and Territorial AIDS Directors (NASTAD) Syringe Services Program (SSP) Development and Implementation Guidelines for State and Local Health Departments. August (2012)

http://www.nastad.org/Docs/055419_NASTAD%20UCHAPS%20SSP%20Guidelines%20August%202012.pdf

Opiate OD Prevention /Intervention Training:

<http://www.anypositivechange.org/odslide.pdf>

Opiate OD Prevention/Intervention Training Pre/Post Test

<http://www.anypositivechange.org/naltest.pdf>

Overdose Prevention Alliance:

<http://www.overdosepreventionalliance.org/>

Prevention to Prescribe

<http://prescribetoprevent.org/>

Project Lazarus: <http://www.projectlazarus.org/>

2-1-1 or 211ct.org

24 Hour Crisis Intervention Team Directory:

<http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=378578>

The Chicago Recovery Alliance's video on Naloxone administration:

<http://www.anypositivechange.org/menu.html>

Toward the Heart: <http://www.towardtheheart.com/naloxone>

APPENDICES

Appendix A: Relevant Connecticut Statutes

OPIOID OVERDOSE

In October 2012, CT law (PA 12-159) allowed prescribers (physicians, surgeons, PAs, APRNs, dentists and podiatrists) to prescribe, dispense or administer Naloxone to treat or prevent an opioid overdose. This is important because people who are overdosing cannot administer Naloxone to themselves. This provides parents, family members, friends and others peace of mind if someone they care about overdoses.

Sec. 17a-714a. Treatment or prevention of drug overdose with opioid antagonist. Immunity. A licensed health care professional who is permitted by law to prescribe an opioid antagonist may, if acting with reasonable care, prescribe, dispense or administer an opioid antagonist to treat or prevent a drug overdose without being liable for damages in a civil action or subject to criminal prosecution for prescribing, dispensing or administering such opioid antagonist or for any subsequent use of such opioid antagonist. For purposes of this section, "opioid antagonist" means naloxone hydrochloride or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of drug overdose.

LIABILITY

PA 14-61 Section 1. Section 17a-714a of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2014):

(a) For purposes of this section, "opioid antagonist" means naloxone hydrochloride or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of drug overdose.

(b) A licensed health care professional who is permitted by law to prescribe an opioid antagonist may, if acting with reasonable care, prescribe, dispense or administer an opioid antagonist to treat or prevent a drug overdose without being liable for damages in a civil action or subject to criminal prosecution for prescribing, dispensing or administering such opioid antagonist or for any subsequent use of such opioid antagonist. [For purposes of this section, "opioid antagonist" means naloxone hydrochloride or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of drug overdose.]

(c) Any person, who in good faith believes that another person is experiencing an opioid-related drug overdose may, if acting with reasonable care, administer an opioid antagonist to such other person. Any person, other than a licensed health care professional acting in the ordinary course of such person's employment, who administers an opioid antagonist in accordance with this subsection shall not be liable for damages in a civil action or subject to criminal prosecution with respect to the administration of such opioid antagonist.

Approved May 28, 2014

SYRINGES

Sec. 21a-65. (Formerly Sec. 19-209a). Sale of hypodermic needles and syringes restricted. (a) A licensed manufacturer or licensed wholesaler may sell hypodermic needles and syringes only to the following: (1) To a licensed manufacturer, licensed wholesaler or licensed pharmacy; (2) to a physician, dentist, veterinarian, embalmer, podiatrist or scientific investigator licensed to practice in this state; (3) to a person in charge of a care-giving institution, as defined in subdivision (2) of section 20-571, incorporated college or scientific institution, but only for use by or in such care-giving institution, college or institution for medical or scientific purposes; (4) to a person in charge of a licensed or registered laboratory, but only for use in that laboratory for scientific and medical purposes; (5) to a farmer but only for use on the farmer's own animals or poultry; (6) to a business authorized in accordance with the regulations adopted under section 21a-66 to purchase hypodermic needles and syringes but only for legitimate industrial or medical use within that business; and (7) to a needle and syringe exchange program established pursuant to section 19a-124.

(b) Except as provided in subsection (a) of this section, no licensed manufacturer, licensed wholesaler or licensed pharmacist shall sell and no person shall buy a hypodermic needle or syringe except upon a prescription of a prescribing practitioner, as defined in subdivision (22) of section 20-571, in a quantity greater than ten. Any such prescription shall be retained on file by the seller for a period of not less than three years and shall be accessible to any public officer engaged in the enforcement of this section. Such a prescription shall be valid for one year from the date thereof and purchases and sales may be made thereunder during such period, provided the seller shall confirm the continued need for such sales with such practitioner at least every six months if sales continue to be made thereunder. Hypodermic needles and syringes in a quantity of ten or less without a prescription may be provided or sold at retail only by the following: (1) By a pharmacy licensed in accordance with section 20-594 and in such pharmacy only by a licensed pharmacist or under his direct supervision; (2) by a needle exchange program established pursuant to section 19a-124; and (3) by a health care facility or a licensed health care practitioner for use by their own patients.

(c) At all locations where hypodermic needles and syringes are kept they shall be stored in a manner so as to be available only to authorized personnel and not be openly available to customers or patients. All used, disposable hypodermic needles and used, disposable syringes shall be destroyed. Destruction shall be conducted in a manner which renders such needles and syringes nonrecoverable. Used needles and syringes which have been discarded and are awaiting destruction shall be securely safeguarded or rendered nonreusable.

(d) Any person who violates any provision of this section shall be fined not more than five hundred dollars or imprisoned not more than one year or both

Sec. 21a-66. (Formerly Sec. 19-209b). Regulations re sale, purchase, handling and disposal of hypodermic needles and syringes. The Commissioner of Consumer Protection shall adopt regulations in accordance with the provisions of chapter 54 to control the sale, purchase, handling and disposal of hypodermic needles and syringes pursuant to section 21a-65.

GOOD SAMARITAN

PA – 11-210

Section 1. Section 21a-279 of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2011):

d) The provisions of subsection (a) of this section shall not apply to any person (1) who in good faith, seeks medical assistance for another person who such person reasonably believes is experiencing an overdose from the ingestion, inhalation or injection of intoxicating liquor or any drug or substance, (2) for whom another person, in good faith, seeks medical assistance, reasonably believing such person is experiencing an overdose from the ingestion, inhalation or injection of intoxicating liquor or any drug or substance, or (3) who reasonably believes he or she is experiencing an overdose from the ingestion, inhalation or injection of intoxicating liquor or any drug or substance and, in good faith, seeks medical assistance for himself or herself, if evidence of the use or possession of drug paraphernalia in violation of said subsection was obtained as a result of the seeking of such medical assistance. For the purposes of this subsection, "good faith" does not include seeking medical assistance during the course of the execution of an arrest warrant or search warrant or a lawful search.

Appendix B: OPEN Access CT Program Member List

OPEN Access CT Program	Address	Telephone	Program Coordinator	Program Email
AIDS CT (Servicing Hartford & Windham County)	110 Bartholomew Avenue, Suite 3050 Hartford, CT 06106	860-247-2437	Carter Lennon	clennon@aids-ct.org
AIDS Project Greater Danbury	30 West Street Danbury, CT	203-797-1483	Lise Probst	inkainka15@gmail.com
GBAPP Harm Reduction Program Recovery Network of Programs	1470 Barnum Avenue-Suite 301 Bridgeport, CT 06610	203-366-8255	Nancy Kingwood	nkingwood@gbapp.org
Greater Hartford Harm Reduction Coalition	1229 Albany Ave. Hartford, CT 06112	860-250-4146	Mark Jenkins	markj@ghhrc.org
New Haven Health Department	54 Meadow Street New Haven, CT 06519	203-901-7687	Brooke Logan	blogan@newhavenct.net

Appendix C: Rescue Breathing Worksheet

WORKSHEET

Rescue Breathing

This worksheet is a component of *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*, produced by Harm Reduction Coalition. More information at harmreduction.org

These are the steps for rescue breathing:

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



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

Appendix D: Community Assessment OD Worksheet

WORKSHEET

Overdose in Your Community

This worksheet is a component of *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*, produced by Harm Reduction Coalition. More information at harmreduction.org

The key elements of a community assessment process include:

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

Understanding Overdose in Your Community

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

- What drugs are people taking when they overdose?

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

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

- In what settings are people overdosing?

Who are the stakeholders in your community?

Appendix E: Reaching Out to At-Risk Populations Worksheet

WORKSHEET

Reaching Out to At-Risk Populations

This worksheet is a component of *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*, produced by Harm Reduction Coalition. More information at harmreduction.org

How to make contact with people:

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

Strategies specific to your community:

Appendix F: Developing Naloxone Kits & Educational Materials Worksheet

WORKSHEET

Developing Naloxone Kits and Educational Materials

This worksheet is a component of *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*, produced by Harm Reduction Coalition. More information at harmreduction.org



Assembling Naloxone Kits:

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

Written Materials:

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

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

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

Photo credit: Nabarun Dasgupta, hands: Roxanne Saucier

Appendix F: Naloxone Educational Materials Palm Card for Kit

NALOXONE	
<ul style="list-style-type: none">* Naloxone starts working in 3—5 minutes, and lasts 30—90 minutes.* Keep rescue breathing until Naloxone starts to work.* If there is no improvement in 5 minutes, give another dose.* Naloxone may cause withdrawal symptoms—DO NOT let the person use more opioids.	
NASAL	
<ol style="list-style-type: none">1. Remove small purple and yellow caps from Naloxone vial and injector.2. Attach vial to injector using three half turns or until stopper is pierced by needle. **DO NOT PUSH VIAL INTO INJECTOR**3. Remove large yellow cover from injector.4. Make sure there are no air bubbles in injector.5. Twist plastic side of nasal atomizer onto injector.6. Insert side with white foam tip into person's nostril.7. Push half of Naloxone out of injector into person's nostril, then push remaining half into the other nostril.8. Administer a second dose of Naloxone if person is not responsive after 3-5 minutes.	

(English)

NALOXONA	
<ul style="list-style-type: none">* La Naloxona comienza a actuar después de 3—5 minutos de administrada; su efecto persiste de 30—90 minutos.* Continúe con la respiración boca a boca hasta que la Naloxona comience a actuar.* Si no observa ninguna mejora en 5 minutos, aplique otra dosis.* La Naloxona puede ocasionar síndrome de abstinencia— NO permita a la persona consumir más opioides.	
NASAL	
<ol style="list-style-type: none">1. Remueva la pequeña tapa violeta y amarilla del el frasco e inyector de Naloxone.2. Adjunte el vial al inyector usando tres medias vueltas o hasta que el tapón sea perforado por la aguja. **No empuje el frasco hacia dentro del inyector**3. Remueva la tapa grande amarilla del inyector.4. Asegúrese que no haiga burbujas de aire en el inyector5. Gire el lado plástico del atomizador nasal hacia el inyector.6. Introduzca el lado que tiene punta blanca de esponja dentro de la nariz de la persona.7. Empuje mitad de Naloxone fuera del inyector hacia la fosa nasal de la persona, luego empuje la mitad restante dentro de la otra fosa nasal de la persona.8. Administre una segunda dosis de Naloxone si la persona no responde dentro de 3-5 minutos.	

(Spanish)

Appendix G: SAVE ME OD Prevention Instructional Fact Sheet

Follow the **SAVE ME** steps below to respond.



If the person must be left unattended at any time, put them in the recovery position.



Stimulate
Unresponsive? **CALL 911**



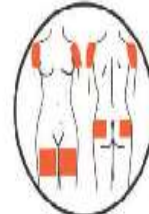
Airway



Ventilate
1 breath every 5 seconds



Evaluate



Muscular Injection
1 mL of naloxone



Evaluate
2nd dose?

For more information visit www.towardtheheart.com

Appendix H: Overdose Prevention Tips

WORKSHEET

Overdose Prevention Tips

This worksheet is a component of *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*, produced by Harm Reduction Coalition. More information at harmreduction.org

This worksheet highlights common overdose risks and provides prevention tips.

We understand that every prevention message might not be applicable or pragmatic in every situation; we hope these tips can provide and messages can be shared and adapted as needed.

More information on each risk factor can be found at harmreduction.org.

Mixing Drugs:

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

Tolerance:

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

Quality:

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

Using Alone:

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

continued on next page

Appendix I: OD Training Tips for Different Settings

WORKSHEET

Training Tips for Different Settings

This worksheet is a component of *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*, produced by Harm Reduction Coalition. More information at harmreduction.org

Tips for Providing Overdose Prevention and Naloxone Trainings

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

Tips for Training Drug Treatment Program Staff

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

Notes:

continued on next page

Appendix J: Certificate of Training

Certificate of Completion

This certificate is awarded to

*In recognition of Overdose and Naloxone Education training
to save a life*

OPEN Access CT Program

Signature _____

Date _____

Signature _____

Date _____

Signature _____

Date _____



Appendix K Sample OPEN Access Training Log



COMMUNITY NALOXONE DISTRIBUTION: TRAINING ATTENDANCE SHEET

Site:									
Educator/Trainer(s):				Affiliation/Agency:					
	Date (MM/DD/YYYY)	Participant's First Name	Participant's Last Name	CHECK ONE OPTION THAT BEST DESCRIBES WHY YOU ARE RECEIVING TRAINING TODAY:			COMPLETED TRAINING?		
				Use opioids (eligible for naloxone)	Staff/ Volunteer	Care about someone who uses opioids	Yes	No	
1				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
10				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
11				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
12				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
13				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
14				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
15				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
16				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Note: Staff to fill out form to ensure confidentiality

Adopted from: towardtheheart.com - Harm Reduction Program, 2015

Appendix L: SSP OD Data Collection Forms

SSP's Client Intake Form <small>Beta v.1.3</small>			
Syringe Services Program (SSP) Name: _____		<input type="checkbox"/> Entered in SSP Database	
In-annual Period: <input type="checkbox"/> 1 ST <input type="checkbox"/> 2 ND <input type="checkbox"/> 3 RD	Year: _____		
Referral From:			
Client URN/DUN Identifier: _____	New Client: <input type="checkbox"/> Yes <input type="checkbox"/> No	New Client Date: ____/____/____	
Client Assigned Sex at Birth: _____	Client Current Gender Identity: _____	Date of Birth: _____	
Ethnicity: _____	Race: _____		
Client's Address: _____	Client's Town: _____	Client's State: _____	Client's Zip code: _____
Reported HIV/AIDS status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	HIV/AIDS Dx Date: _____		
Reported HEP C status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	HEP C Dx Date: _____		
Reported TB status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	TB Dx Date: _____		
SSP Visit Date: ____/____/____	SSP's Site Name: _____	Time of SSP Visit: ____:____ AM/ PM	
Number of Syringes Collected: _____	Number of Syringes Distributed: _____		
Number of People Client Obtains Syringes from: _____	Supplies Distributed (Overdose prevention kit, alcohol wipes, cookers, tourniquets, cotton, condoms, bacitracin ointment): <input type="checkbox"/> Yes <input type="checkbox"/> No		IDU Trainings: _____
Has the client ever overdosed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date overdose occurred: ____/____/____	Overdose location zip code: _____	
OD Training Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	OD Kit Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date OD Kit was provided: ____/____/____	
Referred <u>1a</u> (RT1): _____	Referred <u>1a</u> (RT2): _____	Referred <u>1a</u> (RT3): _____	

SSP's Client Daily Log Form <small>Beta v.1.3</small>		
Client URN/DUN Identifier: _____	<input type="checkbox"/> Entered in SSP Database	
SSP Visit Date: ____/____/____	SSP's Site Name: _____	Time of SSP Visit: ____:____ AM/ PM
Number of Syringes Collected: _____	Number of Syringes Distributed: _____	
Number of People Client Obtains Syringes from: _____	Supplies Distributed (Overdose prevention kit, alcohol wipes, cookers, tourniquets, cotton, condoms, bacitracin ointment): <input type="checkbox"/> Yes <input type="checkbox"/> No	IDU Trainings: _____
Has the client ever overdosed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date overdose occurred: ____/____/____	Overdose location zip code: _____
OD Training Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	OD Kit Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date OD Kit was provided: ____/____/____
Was OD Kit used? <input type="checkbox"/> Yes <input type="checkbox"/> No	OD Kit was used on...? <input type="checkbox"/> Self <input type="checkbox"/> Other Person	Date OD Kit was used: ____/____/____
Referred <u>1a</u> (RT1): _____	Referred <u>1a</u> (RT2): _____	Referred <u>1a</u> (RT3): _____

Appendix M: Community OD Data Collection Form (ACT)



110 Bartholomew Ave, Ste 3050, Hartford CT 06106 • T 860-247-4105 • F 860-951-1779 • aids-ct.org

Hartford & Windham Syringe Services Program: Naloxone/OD Kit Use—Data Collection

Today's Date: _____ SEP Stop/Time: _____

Client Code: _____ Did you get the OD kit from here?: Yes No Don't Know

Reason for refill: Used during an OD Lost Stolen Confiscated Given away Sold Expired
Other: _____

Date OD Kit was used: _____ City/Zip Code where Kit was used: _____

OD Kit was used on: Self Friend Partner Family Stranger Other: _____

Gender of person who overdosed: Male Female MtF FtM Other: _____

Type of kit used: Intramuscular Intranasal Evzio Pre-filled Intramuscular Pre-filled Intranasal

Did the naloxone work?: Yes No If no, please explain: _____

If the naloxone worked, how much total time did it take for the person to respond since the first dose was given?: Less than 1 min 1-3 min 3-5 min >5 min

How did the individual (Self/Other person) respond?

Resuscitated, no further assistance needed Resuscitated, assistance needed Died

Overdosed on what drugs?: Heroin Benzos/Barbituates Cocaine/Crack Methadone Suboxone
Any other Opioid Clonidine Methamphetamine Alcohol Don't Know Other: _____

What setting did the overdose occur in?: Private (apt/house) Public (park, subway, car) Don't Know

Was 911 called?: Yes No Don't Know

Were Police/EMTs/Firefighters/etc. present?: Yes No Don't Know

If Yes, was the interaction with them: Positive Neutral Negative

Did you stay with the person until the naloxone wore off and/or medical help arrived? Yes No

Any post/naloxone withdrawal symptoms?: None Physically combative Irritable or Angry

Vomiting Dope Sick (e.g., nauseous, muscle aches, runny nose and/or watery eyes)

Other: _____

What else was done?: Rescue Breathing (If Yes, was a barrier used? Yes No Sternal/Lip Rub

Slap Ice/Water Salt/Cocaine Shot Recovery Position Other: _____

Notes/Comments (e.g., 2 doses used):

Appendix N: Sample OPEN Access CT Distribution Log



COMMUNITY NALOXONE DISTRIBUTION LOG:

Affiliation/Site/Agency:						
Educator/Trainer(s):						
	URN (Client ID)	COMPLETED TRAINING?		OD KIT ID #	Date of Distribution (MM/DD/YYYY)	Refill?
		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
1		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
2		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
3		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
4		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
5		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
6		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
7		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
8		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
9		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
10		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
11		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
12		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
13		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
14		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
15		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
16		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
17		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
18		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
19		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
20		<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: Staff to fill out form to ensure confidentiality

Adopted from: towardtheheart.com- Harm Reduction Program, 2015

Form v1.0.1 Beta

Appendix O: Sample OPEN Access CT Inventory Log



COMMUNITY NALOXONE DISTRIBUTION INVENTORY LOG:

Affiliation/Site/Agency:									
Program Manager Name:									
	Month/Year Received	Quantity Received	Naloxone Box Log Number	Naloxone Box Expiration Date (MM/YY)	Quantity Distributed	Balance Quantity*	Inventory Check		Comments
							Month/Year	Staff Initials	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									

Form v1.0.1 Beta

Note. * = (Quantity Received – Quantity Distributed) = Balance Quantity

Appendix P: Sample Refill Form

REFILL QUESTIONNAIRE

REFILL DUE TO LOSS

Describe circumstances of loss (e.g. stolen bag, taken by DPW, taken by police, etc.):

Date of Loss: ____/____/____

REFILL DUE TO USE

Since you participated in the overdose training or since your last follow-up, how many overdoses have you witnessed? _____

Describe circumstances of overdose:

Date of Overdose: ____/____/____

Who overdosed?

Friend Partner Client Family member Stranger Self Other:

What was the gender of the person who overdosed? _____

What was their approximate age? _____

What drugs had they taken (only check the ones that you are sure of)?

- Heroin
- Methadone
- Suboxone/Subutex/buprenorphine
- Benzos (Klonopin, Xanax, Ativan, Valium, Librium)
- Other opioid (Percocet, OxyContin, Oxycodone, Vicodin, Morphine, Fentanyl, etc)
- Clonidine
- Cocaine/Crack

- Alcohol
- Methamphetamine/Speed
- Other: _____

What setting did it occur in?

- Private house/apartment
- Public park
- Public bathroom
- SRO room
- Other:

Nearest intersection:

Did you do any of the following (Check all that apply)

- Sternum Rub
- Call 911
- Rescue breathing
- Gave Narcan
- Revived overdosing person by other means (specify)

If you DID give naloxone/Narcan, how many doses did you give? _____

How long did it take for Narcan to work?

- Less than 1 min
- 1-3 min
- 3-5 min
- >5 min

Did you have any trouble putting together the Narcan or using it? (specify)

What was the result of this person's overdose? (Check ONLY ONE)

- They woke up without any help
- They woke up because of my help
- Paramedics came and revived the person
- Paramedics came and I don't know what happened next
- Other (specify) _____
- They woke up because
- Don't know
- They died

Were there any negative consequences of the overdose? (Check ALL THAT APPLY)

- Arrest of overdosing person or witnesses
- Vomiting

- Harassment by police dept
- Seizure
- Felt Dopesick/went into withdrawal (specify)_____

- Harassment by paramedics/fire
- Anger
- Other

Naloxone Lot#_____

Expiration Date_____