Prescription Drug/Opioid Overdose-Related Deaths (PDO)

Arkansas Strategic Plan 2016-2021

Arkansas Department of Human Services – Division of Aging, Adult, and Behavioral Health Services

Grant Number: 1H79SP022134-01

Table of Contents

Glossary

Opioid: A class of drugs that interact with opioid receptors on nerve cells and include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription

Naloxone: A medication classified as an “opioid antagonist” used to quickly reverse the effects of opioid overdoses; works by binding to opioid receptors to temporarily block the effect of opioids

First responder: Law enforcement, fire department, and emergency medical personnel who are deployed in the event of emergencies

Harm reduction organization: Organization that provides direct assistance through counseling, drug treatment, homeless services, or advocacy to individuals at risk or experiencing a drug overdose

Good Samaritan Law: Laws that provide civil protection to people who give reasonable emergency assistance to those who are injured, ill, or otherwise incapacitated; protects an individual who administers Naloxone in the event of an overdose

Memorandum of Understanding: Agreement

Introduction

The Department of Human Services (DHS) Division of Aging, Adult, and Behavioral Health Services (DAABHS) was awarded funding by the Substance Abuse and Mental Health Services Administration (SAMHSA) in September 2016 for the Arkansas Prescription Drug/Opioid Overdose-Related Deaths (PDO) Prevention grant. The purpose of this grant is to reduce prescription drug/opioid overdose-related deaths and adverse events among individuals by training first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and implementing secondary prevention strategies, including the purchase and distribution of naloxone. The goals of Arkansas' PDO program are to:

1. **Reduce the number of prescription drug/opioid overdose-related deaths and adverse events among Arkansans 18 years of age and older.**
2. **Develop a comprehensive PDO prevention program.**
3. **Address behavioral health disparities by encouraging implementation of strategies to decrease differences in access, service use, and outcomes among the populations served.**

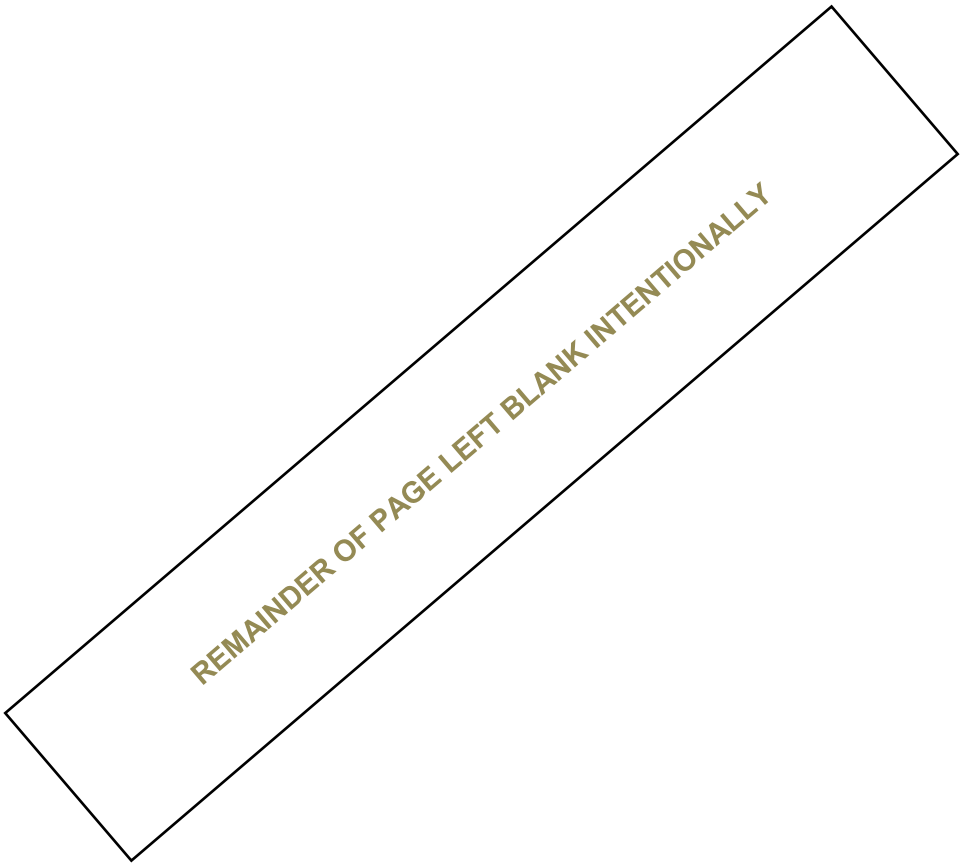
This project includes three major community-focused components: in high-risk areas, training and supplying first responders and others to administer naloxone in the event of an opioid-related overdose, engaging/informing local communities about opioid misuse and the importance of calling 911 in the event of an overdose, and promoting health literacy to increase proper use of prescribed opioid pain relievers.

Arkansas Data Background

To guide activities and determine county level indicator rates, researched used data from the following sources:

- Arkansas Crime Information Center (ACIC)
- Arkansas Department of Human Services (DHS)
    - Division of Aging, Adult, and Behavioral Health Services (DAABHS)
        - Alcohol/Drug Management Information System (ADMIS)
        - Arkansas Prevention Needs Assessment – Student Survey (APNA)
    - Division of Child and Family Services (DCFS)
- Arkansas Department of Health (ADH)
    - Emergency Medical Services (EMS)
    - Prescription Monitoring Program (PMP)
- Arkansas State Crime Lab (ASCL)
- U.S. Department of Health & Human Services (DHHS)
    - Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP)
    - Centers for Disease Control and Prevention, National Center for Health Statistics (NCHS)

- National Poison Data System (NPDS), provided through the Partnerships for Success (PFS) Grant



Data collected by the Arkansas State Crime Lab show that in 2014, 2015, and 2016 respectively, there were 349, 287, and 335 nonspecific drug overdose deaths. These are rates of 11.8 (2014), 9.6 (2015), and 11.2 (2016) per 100,000 of the 2015 Arkansas population. Data provided by the Arkansas Department of Health Emergency Management System indicate that during state fiscal year 2016, 2,456 emergency medical calls required administration of either single or multiple doses of Naloxone. This count is almost twice the number of incidents (1,344) reported between Jan. 1, 2015 and Jan. 1, 2016. Arkansas ranks 8th in the U.S. for its opioid prescription rate s per 100 people; 116 prescriptions exist for every 100 Arkansans.

According to 2013-14 prevalence estimates based on the National Survey on Drug Use and Health (NSDUH), Arkansas had the highest estimated nonmedical use of pain relievers by children ages 12-17 (6.15%) compared to the United States overall. Table 1 shows the most recent estimates (percent) by age group for both Arkansas and the United States, as well as Arkansas's rank by age group relative to other states.

Table 1. NSDUH 2013-2014 Prevalence estimates for nonmedical use of pain relievers in the past 30 days

Age group	Ark.	U.S.	Rank*
12 and over	4.6%	4.1%	9th
18 and over	4.4%	4.0%	11th
26 and over	3.5%	3.3%	19th
12-17	6.2%	4.7%	1st
18-25	9.7%	8.3%	4th

* The rank represents Arkansas' rank when all states and Washington, D.C., are compared.

Statistical analysis identified five indicators that best predicted non-specific overdose deaths: opiate-related arrests, treatment admissions, opioid diagnosis on hospital inpatient discharges, opioid diagnosis on emergency department discharges and opioid distribution by prescription.

After compiling data and weighing indicators, a map was created, ranking counties on risk and outcome measures. Figure 1 shows scores for each county, color-coded by score category (red=highest, green=lowest). This aggregate map was used to identify high-risk communities to in which to focus resources.

Raw data in the form of counts were converted to rates using the same year's denominator where possible. When it was not possible to use a denominator collected during the same timeframe as the indicator's numerator, the most recent denominator available was used. Ranges of rates by county were converted to scores depending on the number of ranges, where one was the lowest score. Raw data that was already a rate were used as is.

The number of years analyzed for each indicator ranged between one to five years. In cases where more than one year was collected, the final rates provided in this report are averages for each indicator across the years that were available.

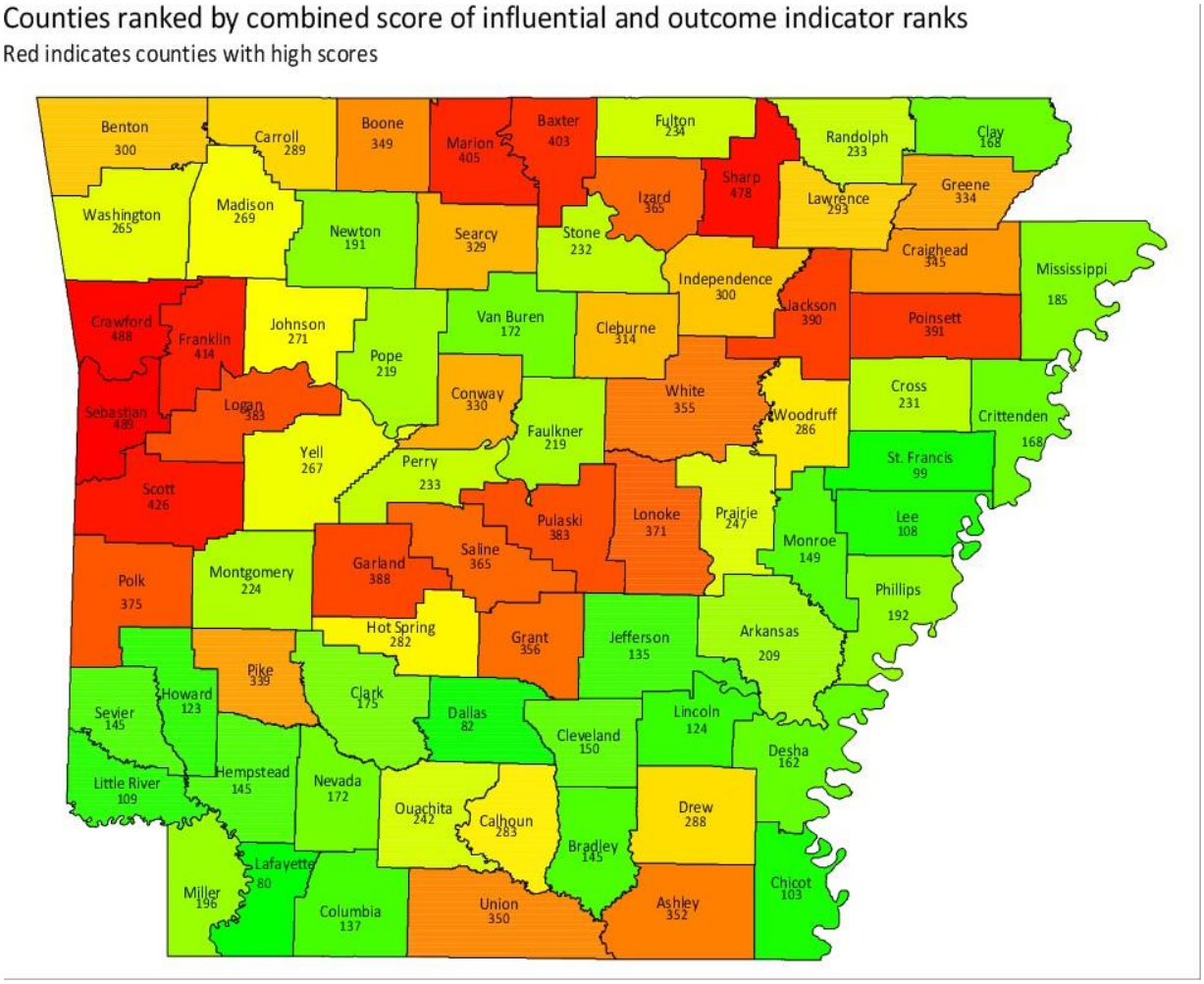
Correlation Analysis and Location Selection

Indicators with the most influence on the opioid overdose deaths outcome measure were assessed to identify target counties for prevention. Two available indicators representing overdose deaths were selected as primary outcomes. The analytics team considered running linear regressions on all indicators with the primary outcome measures. However, a close examination of the indicators showed that many of them were not normally distributed. For this reason, Spearman correlation analyses were conducted for each indicator with *Drug overdose deaths (nonspecific) based on autopsy results* and *Overdose deaths (nonspecific)* from NCHS. This allowed the analytics team to determine the individual indicators influencing both outcomes. Indicators that were significant and correlated with both overdose death measures, with a probability of <0.05 were selected. Counties were then ranked based on the value for each indicator. Summed ranks were used to identify the 20 counties most at risk.

Analysis Results

Detailed results are reported in Appendix 7: Needs Assessment/Results (pp. 61-77 below). Table 5 shows each indicator (as above, related to opioid overdose deaths), and for each indicator, the five Arkansas counties with the highest rates/scores. Color-coded maps displaying scores and ranks for all counties are also found in Appendix 7 (pp. 73-77).

Figure 1 – Indicator Map



Contracting and Advisory Workgroup

PDO Advisory Workgroup Objectives

PDO requires the PDO Advisory Workgroup to address the objectives, oversee activities, develop the strategic plan, and implement interventions. Objectives of the council (henceforth PDO Advisory Workgroup) have been set as follows:

Objective 1: DAABHS and the State Drug Director will form a PDO Advisory Workgroup.

Objective 2: A comprehensive statewide needs assessment will be done by an Evaluation and Data Agency, and the PDO Advisory Workgroup will select target high- needs communities.

Objective 3: The PDO Advisory Workgroup will develop a strategic plan based on the needs assessment data to promote policies and best practices to respond appropriately to prescription drug/opioid related overdoses

Objective 4: The PDO Advisory Workgroup will use information gathered during implementation of the project to determine needs for policy changes and best practice recommendations and determine the next layer of high-needs communities to be targeted as the program expands to a statewide effort

Objective 5: The PDO Advisory Workgroup will utilize the needs assessment to determine behavioral health disparities among racial/ethnic minorities in target communities

Objective 6: The PDO Advisory Workgroup will evaluate the effectiveness of strategies used by target communities to reduce behavioral health disparities for statewide policy change and publish recommendations to all 75 counties

The PDO Advisory Workgroup met in May, July, and September of 2017 to review the needs assessment, prioritize High Needs Communities (HNCs), and develop a strategic plan for Arkansas. During this planning process, the group performed SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis, identified risk and protective factors in the HNCs, and discussed intervention approaches. The Workgroup continued to meet quarterly to guide decision-making and activities.

High Needs Communities Selection

Utilizing data from the needs assessment, the PDO Advisory Workgroup met in May 2017 selected HNCs on which to focus interventions in the following year. Activities of the workgroup began with an overview of the Strategic Planning Framework (SPF) process presented by the Southwest Center for the Application of Prevention Technologies (CAPT). This assured foundational knowledge before decisions were made. Data were reviewed by the group, followed by discussion of how ‘community’ would be defined and which communities would be ranked and selected for inclusion.

‘Community’ was ultimately defined as both individual counties and county clusters for data collection and resource efficiency purposes. Several high-risk counties were geographically adjacent and shared similar levels of need; thus such clusters of counties were identified and defined as single communities. Selected communities were a mixture of rural and urban communities by local standards. Hot Springs, Van Buren and Fort Smith were the largest cities in the group; Fort Smith was the only city with a population that met the U.S. Census definition of an urban area.

Three communities were selected to as HNCs for funding with PDO grant funds. Because Arkansas is also a recipient of the State-Targeted Response to the Opioid Crisis grant (STR), two additional HNCs were included as part of that grant's supplemental funding to PDO. Three alternate communities were chosen in case any of the five priority communities declined to participate. Identified communities in rank order were:

PDO funded:

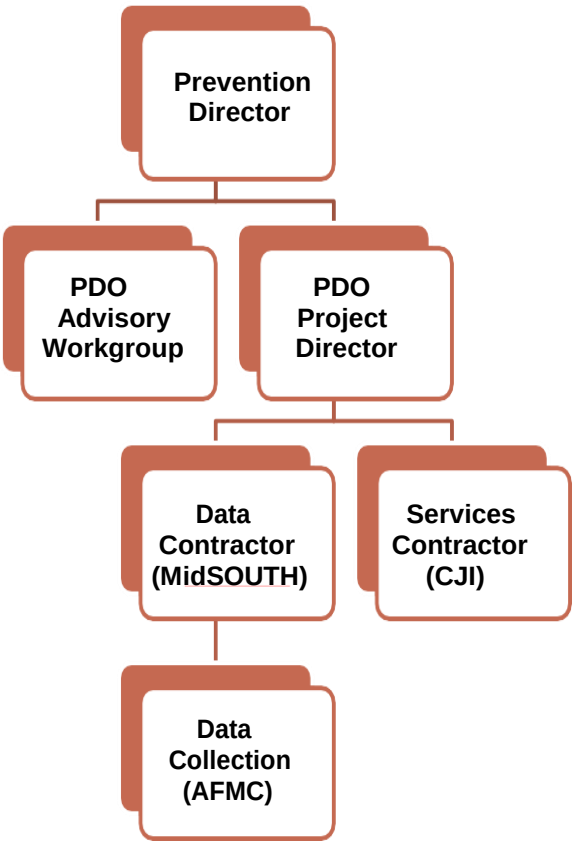
1. **Crawford and Franklin Counties as one community**
2. **Sebastian and Scott Counties as one community**
3. **Sharp County**

STR funded:

4. **Marion and Baxter Counties as one community**
5. **Garland County**

Community Alternates:

6. **Poinsett and Jackson Counties as one community**
7. **Union and Ashley Counties as one community**
8. **Lonoke County**



Contracts and Responsibilities

DAABHS is responsible for developing sub-grants for evaluation/data and community implementation. They also manage contracts, timelines, budget, communication planning, and federal reporting. DAABHS will coordinate the PDO program and work directly with contractors. They will utilize two contracts with the Data Contractor University of Arkansas at Little Rock MidSOUTH (UALR MidSOUTH) and the Community Services Contractor Criminal Justice Institute (CJI). The planning/administrative agency UALR MidSOUTH will subcontract with the evaluation/data agency Arkansas Foundation for Medical Care (AFMC), which is responsible for a statewide needs assessment, data collection, and evaluation activities for the PDO grant. The community services contractor CJI will be responsible for naloxone training components, local advisory council development, media campaigns, and health literacy promotion.

Naloxone Training and Distribution

Naloxone Access

Arkansas has budgeted for 4,000 doses per year from the PDO funding and 2,143 doses from the STR funding. That amount will be modified based on the prevalence, incidence, population, and numbers of trained responders. The contractor Criminal Justice Institute (CJI) will purchase Naloxone and distribute it as kits that include two 4mg doses of Naloxone, instructions for administration, nitrile gloves, alcohol pads, CPR face shields, and referral cards to a local substance use disorder treatment facility. Each community is required to identify a medical director to implement the Intranasal Naloxone Program. An executed Memorandum of Understanding (MOU) between the medical director and the participating agencies allows NARCAN to be ordered by CJI staff and shipped to the office of the medical director. Once the shipment is received, CJI staff will pick up the Naloxone from the medical director's office, assemble the Naloxone kits, and provide them to the officers who have completed the training.

A standing order and MOU was executed by a centrally located physician familiar with the training program who has agreed to act as a statewide point of distribution for orders of NARCAN for the targeted communities under this program. This medical director will function to assist in the acquisition of Naloxone for rural counties. Because of the centralized location, Naloxone can be retrieved from the medical director’s office and placed in kits before the training sessions.

FDA-Approved Naloxone Products Purchasing

Intranasal *NARCAN* spray (Naloxone HCl) is the Federal Drug Administration-approved product that will be bought and distributed to program trainees.

Training

As the Community Services Contractor, Criminal Justice Institute (CJI) is responsible for providing trainings related to PDO. CJI is the primary trainer of first responders in the state for continuing education credits and houses the Arkansas Alliance for Drug Endangered Children. CJI previously performed extensive work in communities addressing the methamphetamine epidemic. For this grant, CJI will be responsible for administering training, purchasing naloxone, and distributing kits.

First responders in this program include law enforcement, fire department staff, and emergency medical personnel. Naloxone training curriculum for first responders will combine information from Benton Police Department training, the SAMHSA Opioid Overdose Toolkit, and information specific to NARCAN. First responder training will also emphasize fentanyl and other synthetic opioids due to greater occupational risk of contact.

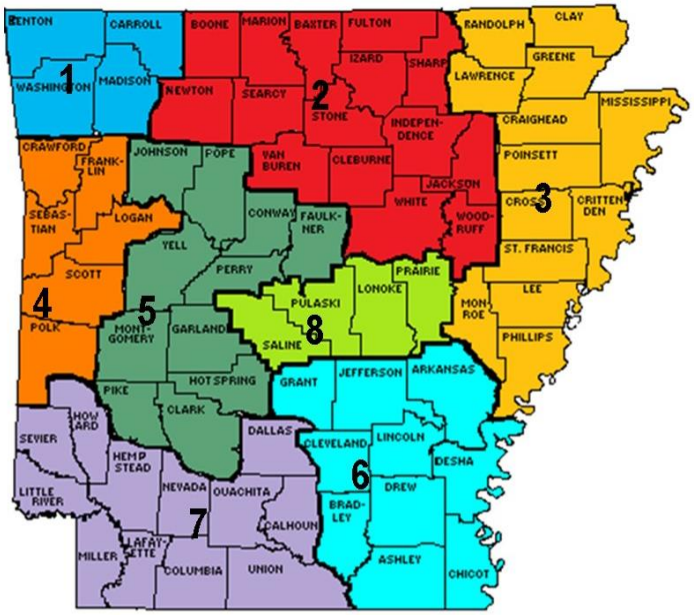
CJI will administer a modified training for family/loved ones of individuals at risk of opioid overdose. Designated public library staff within HNCs will also receive administration training and be issued naloxone kit supplies as additional publicly-accessible resources. Additional information from the toolkit will be incorporated into the curriculum according to the appropriate audience. The trainings will be submitted to DAABHS for approval. All training courses' effectiveness will be evaluated using pre/post-tests to determine level of change in knowledge.

CJI will train treatment centers in HNCs to train family/friends of individuals completing opioid-related treatment who are at a higher risk for overdose. Figure 2 shows funded treatment facilities serving the designated communities—currently Harbor House, Inc., Preferred Family Services, Inc., and Quapaw House. Assembled kits will also be delivered to treatment center staff to provide to members of a treatment center client's support system (family, friends, etc.) who have received program training. Treatment center staff will provide an estimate of the number of individuals who will receive training. Centers will be provided Naloxone kits before training events and required to submit information to CJI program staff concerning the number of individuals trained and inventory of kits distributed.

When all sectors of training are fully operational, training materials will be posted and links made available for online viewing. This will increase accessibility and convenience of access to information, and facilitate convenient, self-paced review of materials by stakeholders as needed/desired.

Figure 2: Funded Treatment Provider Map

Department of Human Services
Division of Aging, Adult, and Behavioral Health Services
Substance Abuse Treatment Services
Catchment Areas, Funded Contractors



Catch-ment Area	Contractor Name
1	Preferred Family Service, Inc. DBA Decision Point
2	Preferred Family Services Inc. DBA Health Resources of AR (HRA)
3	Northeast AR Community Mental Health Center DBA Mid-South Health Systems
4	Harbor House, Inc.
5	Quapaw House
6	10th District Substance Abuse Program DBA New Beginnings C.A.S.A.,
7	Southwest Arkansas Coun-seling and Mental Health Center (SWACMHC)
8	Recovery Centers of Arkan-sas (RCA)

Revised 12/18/2017

State Laws Governing Naloxone

In 2015, the Arkansas legislature passed Act 1222—the Naloxone Access Act—which explicitly identifies the requirements surrounding naloxone access and distribution. The law allows a healthcare professional acting in good faith to prescribe (directly or by standing order) and dispense an opioid antagonist to:

- A person at risk of experiencing an opioid-related drug overdose;
- A pain management clinic;
- A harm reduction organization;
- An emergency medical services technician;
- A first responder
- A law enforcement officer or agency; or
- A family member or friend of a person at risk of experiencing an opioid-related drug overdose.

The Act also provides immunity from civil or criminal charges and professional sanctions to a person acting in good faith who reasonably believes that another person is experiencing an opioid-related drug overdose. The opioid antagonist administered must have been prescribed and dispensed in accordance with Arkansas Code Annotated §20-13-1601, which requires the individual obtain the drug through a prescription from a health care professional. Given the broad nature of the law as to who can possess and administer naloxone, it will allow Arkansas to train the people outlined in our grant application including first responders, treatment centers, and family or friend supporters of the person at risk.

Local Activities and Health Literacy

CJI is responsible for implementing activities in the HNCs chosen by the PDO Advisory Workgroup, including developing media campaigns and creating local advisory councils within local communities to promote prescription opioid prevention. These councils will provide credibility and buy-in of the initiatives with local citizens and will be a crucial source for community engagement. Local initiatives will be preceded by prescription overdose kick-off events in selected communities. CJI and the local councils will implement the SAMHSA media campaign that promotes calling 911 and disseminate information about Arkansas' Good Samaritan Law. A patient directed handbook titled *How to Talk to Your Doctor,* developed by the University of Arkansas Cooperative Extension Service, will be used for local grant activities. (Copy of handbook in Appendix 8, p. 78.) Media materials will be modified to fit individual communities while maintaining consistent core messaging. Additionally, CJI will work with pharmacists, local councils, and prevention/treatment centers to implement the health literacy program.

Evaluation

AFMC is responsible for evaluation components of PDO. They have developed the Naloxone Reporting Tool to collect necessary information when Naloxone is administered by a first responder or another individual in the HNCs. Access and directions to utilize the Naloxone survey tool are included in the trainings. This will guide decision-making, gauge changes in overdose outcomes, and track naloxone use. AFMC has also created a PDO Community Service Monthly Report to use for grant activities. The Community Service Monthly Report will be used to track community activities such as trainings, events, and other required deliverables.

All SAMHSA grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results (GPRA) Modernization Act of 2010. Grantees are required to report performance on the following performance measures:

Long-term Outcomes for Education and Distribution of Naloxone

1. Rate of intentional, unintentional, and undetermined intentional opioid overdose (using hospitalization, emergency department, police, or other accessible data);
2. Number of opioid overdose-related deaths;
3. Number of opioid overdose reversals;
4. Number of referrals to substance abuse treatment services; and
5. Number of naloxone kits that reached communities of high need.

Short-term Outcomes of Education/Training Programs

1. Number of trainings conducted on opioid overdose death prevention strategies;
2. Number of medical professionals trained on the risks of overprescribing;
3. Number of first responders trained;
4. Number of participants per session by type of participant (substance abuse treatment provider, family member, law enforcement, Emergency Medical Technician (EMT), etc.);
5. Number of people reporting learning new information or skills as a result of education/training;
6. Number of people reporting using the information/skills learned;
7. Number of people feeling confident in using the skills learned;
8. Number of individuals accurately recognizing overdose symptoms; and

9. Number/rate of successful (person's unresponsiveness and respiratory depression improved) administrations tracked in real time.

Short-term Outcomes of Distribution

1. Number of kits used in each administration by type of kit (nasal, auto injector, etc.);
2. The total amount of funds spent and percentage of total funds utilized to purchase naloxone products;
3. Number of post-administration referrals to professional services for additional resources (e.g., medical treatment, substance use/recovery program, etc.);
4. Number of persons administering naloxone by: type (e.g., substance abuse treatment provider, collateral (i.e., family member, friend/acquaintance), law enforcement, EMT, public facility staff, etc.) and location;
5. Number of naloxone-recipient/patients by: location type (substance abuse treatment facility, home, street, party, etc.); patient demographics (age, sex, race, ethnicity, etc.); number of prior administrations; and location zip code/census tract;
6. Number of kits distributed by: county; dosage amount; recipient type (substance abuse treatment provider, law enforcement, EMT, public facility, etc.); and type of kit (nasal, auto injector, etc.).

STR Prevention Components

Summary

With 80% of the STR grant set aside for treatment and recovery and 5% set aside for administration, 15% of funds are left available to complete the continuum of care for substance misuse by implementing prevention strategies. A requirement of the STR Grant is to include both primary and secondary prevention strategies to address the opioid issues. Prevention education and information dissemination are two evidence-based strategies used in primary prevention. Secondary prevention strategies intervene after initial misuse occurs but before individuals experience various adverse outcomes. The STR award provided to DAABHS provided included a prevention plan based on primary and secondary opioid prevention strategies.

Opioid Education

Because Arkansas physicians rank 8th in the nation for the number of opioids prescribed per person (according to the Center for Disease Control and Prevention), providing information and education to medical personnel is crucial. DAABHS plans to accomplish this in a variety of ways. First, it will work with key physicians at the Division of Medical Services, UAMS, and other organizations to assist with prevention. By working with various professional associations to contribute data to their publications, information can be disseminated to physicians, nurses, dentists, veterinarians, and other professionals who practice pain management. Providing guest speakers at conferences and information through the provider relations staff associated with Medicaid will reiterate information shared from the website and publications.

Arkansas plans to develop an opioid-specific website. This website will be similar to that designed by Wisconsin titled Dose of Reality (see http://doseofrealitywi.gov/). Arkansas' website will contain a variety of information concerning opioids. The site will include the dangers of misuse of opioids, how to recognize symptoms of misuse disorders, the dates, drug takeback information, proper storage of drugs, treatment information, and where to access help. For medical personnel, information on the website will include the dangers of overprescribing, steps to follow in speaking with patients about opioid misuse, and resources for referrals. Additional components like emerging best practices will be incorporated on the website as it becomes available. If possible, messaging from the governor will be included as well

Extension of PDO Grant Activities

Other components of prevention within STR include an expansion of activities corresponding to the PDO grant. DAABHS aims to enhance health literacy by providing information to improve communication from patients to doctors about opioids. Specifically, this information process will include instructions for proper use of opioids. Through additional funding to the CJI-developed media campaign, we will provide the public information about Arkansas' Good Samaritan Laws and the importance of calling 911 in the event of an overdose. Moreover, first responders and families in STR-funded high needs communities (Marion, Baxter, and Garland) will be trained and provided with Naloxone. As PDO will extend past the duration of STR, further funding will be assessed in the future.

Appendix 1: PDO/STR Flow Chart Infographic

(PDO) PRESCRIPTION DRUG OVERDOSE RELATED DEATHS GRANT (5 yrs.)
(2 GRANT RELATED CONTRACTS)
Grant Awarded 9/1/2016

(STR) STATE TARGETED RESPONSE TO OPIOIDS GRANT (2 yrs.)
(7 GRANT RELATED CONTRACTS)
Grant Awarded 5/1/2017

DATA & EVALUATION CONTRACT –
Vendor: UALR MIDSOUTH/AFMC

- Collect & Compile Data for reporting
- Administrative Role, coordinate meetings
- Evaluator of AFMC

COMMUNITY LEVEL SERVICES CONTRACT—
Vendor: Criminal Justice Institute

- TRAIN 1ST RESPONDERS (PDO)
- MEDIA CAMPAIGN
- NALOXONE DISTRIBUTION

Community Level was extended to PDO to encompass additional counties.

AFMC SUBCONTRACTOR

- **Needs Assessment/County Selection Criteria:**
  Identified indicators: five top statistical predictors of non-specific overdose deaths:
  - Opiate-related arrests
  - Treatment admissions
  - Inpatient discharge opioid diagnosis rate
  - Emergency department opioid discharge diagnosis rate
  - Prescription opioid distribution rate
- **Reporting:**
  - **Community Services (monthly)**
  - **Naloxone Report /Toolkits**
- **Data Entry** (PepCI and/or SPARS)

TREATMENT

- DATA COLLECTION-TREATMENT
- GRANT EVALUATION CONTRACT
- 8 FUNDED RECOVERY SERVICE PROVIDERS
- MEDICATION-ASSISTED TREATMENT
- PEER RECOVERY SUPPORT PROVIDER TRAINING

PREVENTION
(PDO) COMMUNITY LEVEL SERVICES
Vendor: Criminal Justice Institute

- Health Literacy/Media Campaign
- Naloxone Purchase
- **MEDICAL PRESCRIBER EDUCATION-**
- **Vendor: UALR MID-SOUTH**
- **Web Portal Development**
  - [CDC & PDMP Guidelines, Alternative Prescribing/ Best Practices]

COMMUNITIES PDO GRANT COVERS:
1) CRAWFORD/FRANKLIN COUNTIES
2) SEBASTIAN /SCOTT COUNTIES
3) SHARP COUNTY

COMMUNITIES STR GRANT COVERS:
4) MARION /BAXTER COUNTIES
5) GARLAND COUNTY

Appendix 2: *Activity and Milestone Timeline*

Activity and Milestones	Timeline	Accomplished or Due
Creation of PDO Advisory Council		
Appointment of PDO Advisory Council membership & council meets for the first time	Within 2 months of award	October 2016
Grant expectations presented to PDO Council	Within 2 months of award	October 2016
Assessment of Needs, Available Resources, and Causes		
DAABHS contracts with an Evaluation and Data Agency for needs assessment, training, & evaluation	By 4th month after award	December 2016
Needs assessment results presented to PDO Advisory Council & identification of communities of greatest need. Advisory Council selects high-needs communities to be the focus of grant prevention activities	By 9th month after award	May 11, 2017
Develop a Strategic Plan		
Development of strategic plan	By end of year 1	August 2017 – Subcommittee met and set framework. Monthly meetings beginning in May 2017. (In process)
Determination of best practices, strategies and action plans	By end of year 1, ongoing semiannual review for the life of the grant	August 2017– Subcommittee selected in January 2017. (In process)
DAABHS hires a contractor to implement the training plan	By end of year 1	March 2017
BNPD naloxone program used as model for community implementation	By beginning of year 2	September 2017
Naloxone product selected		February 2017
Build Community Capacity/ Infrastructure Development		
Target communities contacted & community entities selected to participate in project implementation	By 10th month after award	June 2017
Needs assessment results distributed to target communities	By the beginning of year 2	September 2017 and ongoing
Training of first responders	By beginning of year 2	September 2017 and ongoing
Distribution of health literacy materials to pharmacists	By beginning of year 2	September 2017 and ongoing
Substance abuse treatment & prevention centers receive materials & training to teach overdose response to family & support networks of clients with opioid misuse disorders	By middle of year 2	September 2017 and ongoing

Target communities implement local public awareness activities	By beginning of year 2	October 2017 and ongoing
Community Implementation		
First responders in target communities implement naloxone program	By end of 1st quarter of year 2	November 2017 and ongoing
Evaluate Effectiveness		
Review data of naloxone usage, overdose incidents, and treatment admission referrals	By end of year 2 & ongoing	August 2018 and ongoing
Review process and outcome data for public awareness and education campaigns	By end of year 2 & ongoing	August 2018 and ongoing
Present findings to PDO Advisory Council	Annually at year's end	August 2018 and ongoing
Utilize evaluation results to assess policy gaps and best practices to publish a report with recommendations for both local and statewide policies and practices.	By end of year 5	August 2021
Publish recommendations on policies and practices based on evaluation	Annually at end of each year	August 2018
Expansion to Statewide Implementation		
Recommend modifications based on effectiveness	By end of year 2& each year thereafter	August 2018
Media campaign expanded statewide	By end of year 5	August 2021
Replicate program on a statewide basis	During years 4 & 5	August 2020 and August 2021

***Note: All dates are subject to change as the program progresses**

Appendix 3: *Arkansas Naloxone Distribution Plan*

High Needs Community Selection

The University of Arkansas Little Rock's MidSouth Training Academy was hired as the data and evaluation contractor and worked with Arkansas Foundation for Medical Care to collect and analyze the data requested by the PDO Advisory Council as the basis for that group's selection of the high-risk communities.

Utilizing needs assessment data submitted on May 18, 2017, the Arkansas PDO Advisory Council met on May 11, 2017 to select the high need communities to be served during the following year. To provide foundational knowledge before decisions were made, the meeting began with an overview of the SPF process presented by the Southwest CAPT. The data were reviewed by the PDO Advisory Council group and a lengthy discussion followed on both how "community" would be defined and which communities would be selected and ranked.

Community was defined as either individual counties or clusters of counties. For consistency, data were collected and compared at the county level. Because some counties were contiguous and shared similar levels of need; groupings or clusters of counties were also defined as one community. The selected counties are a mixture of rural and urban areas. Hot Springs, Van Buren and Fort Smith are the largest cities in the group, with Fort Smith being the only city meeting the U.S. Census definition of an urban area based on population size.

Three communities were selected to be the High Needs Communities (HNC) for PDO grant funding. Because Arkansas is also a STR grant recipient, two additional HNCs were selected to be funded as part of the STR grant. Three alternate communities were selected in the event that one of the five other communities declines to participate. The selected communities in rank order are:

PDO funded:

1. Crawford and Franklin Counties as one community
2. Sebastian and Scott Counties as one community
3. Sharp County as one community

STR funded:

4. Marion and Baxter Counties as one community
5. Garland County as one community

Alternates:

6. Poinsett and Jackson Counties as one community
7. Union and Ashley Counties as one community
8. Lonoke County as one community

Access to Naloxone

Intranasal NARCAN (Naloxone HCI) is the FDA-approved product that will be distributed to program trainees. It will be distributed in kits that contain two 4mg doses of NARCAN, instructions for administration, nitrile gloves, alcohol pads, CPR face shields, and referral cards to a local substance use disorder treatment facility. Each community is required to identify a medical director for the purpose of implementing the Intranasal Naloxone Program. An executed Memorandum of Understanding (MOU) between the medical director and the participating agencies allows NARCAN to be ordered by CJI staff and shipped to the office of the medical director. Once the shipment of NARCAN is received, CJI staff will pick up the shipment from the medical directors office, assemble the Naloxone kits, and provide them to the officers who have completed the training.

Additionally, a standing order and MOU was executed by a centrally located physician familiar with the training program who has agreed to act as a statewide point of distribution for orders of NARCAN for the targeted communities under this program. This medical director will function to assist in the acquisition of NARCAN for rural counties. In addition, by being centrally located, the NARCAN can be retrieved from the medical director's office and placed in kits before the training sessions. Assembled kits will also be delivered to treatment center staff to provide to members of a treatment center client's support system (family, friends, etc.) who have received program training. Treatment center staff will provide an estimate of the number of individuals who will receive training. They will be provided with Naloxone kits prior to the training and required to submit information to CJI program staff concerning the number of individuals trained and the kits that were distributed.

The Arkansas Naloxone Access Act (Act 1222 of 2015) very explicitly identifies the requirements surrounding Naloxone access and distribution. The act also provides immunity to law enforcement, healthcare professionals, and first responders from civil liability, criminal liability, or professional sanctions for administering, prescribing, or dispensing an opioid antagonist.

A healthcare professional acting in good faith may directly or by standing order prescribe and dispense an opioid antagonist to:

- A person at risk of experiencing an opioid-related drug overdose;
- A pain management clinic;
- A harm reduction organization;
- An emergency medical services technician;
- A first responder;
- A law enforcement officer or agency; or
- A family member or friend of a person at risk of experiencing an opioid-related drug overdose.

First responders are defined as law enforcement, fire department, and emergency medical personnel who are deployed in the event of emergencies. Harm reduction organizations are defined as organizations that provide direct assistance through counseling, drug treatment, homeless services, or advocacy to individuals at risk or experiencing a drug overdose.

The broad nature of Act 1222 allows first responders, treatment center staff, and families in recovery to be trained in the administration of Naloxone and provided with Naloxone kits.

Training

DAABHS has selected the University of Arkansas System's Criminal Justice Institute (CJI) as the community service provider, with a May 19, 2017, contract date. CJI is the primary trainer of law enforcement in the state in advanced and specialized areas. CJI also implemented a drug endangered children program and has also conducted extensive work in communities concerning the methamphetamine epidemic. CJI also offers online programs on illicit drugs statewide and nationally. For this grant, CJI will be responsible for the purchase and distribution of Naloxone, conducting the first responder Naloxone administration training, coordinating the media and health literacy campaigns, and developing community level advisory councils within the selected communities.

The first responder training curriculum combines information from the Benton, Arkansas Police Department's Naloxone training program, the SAMHSA Opioid Toolkit, and information specific to administration and storage of NARCAN. This curriculum is attached in a PowerPoint format.

A major component of this program is the implementation of a MOU between a local medical provider and a first responder agency(s) or treatment center in the identified community. First responder agencies must also adopt a departmental policy on the administration of Naloxone. They are provided with a model policy as an example, which is included as Attachment 2.

The curriculum has been reviewed and approved by DAABHS program staff and certified by the Arkansas Commission on Law Enforcement Standards and Training. The curriculum is applicable to all first responders and not solely to law enforcement.

Information included in the training was obtained from SAMHSA's Opioid Toolkit such as recognizing symptoms of overdose, what to do after administration, and other items. Additional information from the toolkit will be incorporated into the curriculum according to the appropriate audience. For example, the parts of the toolkit specific to physicians will not be used in the first responder training.

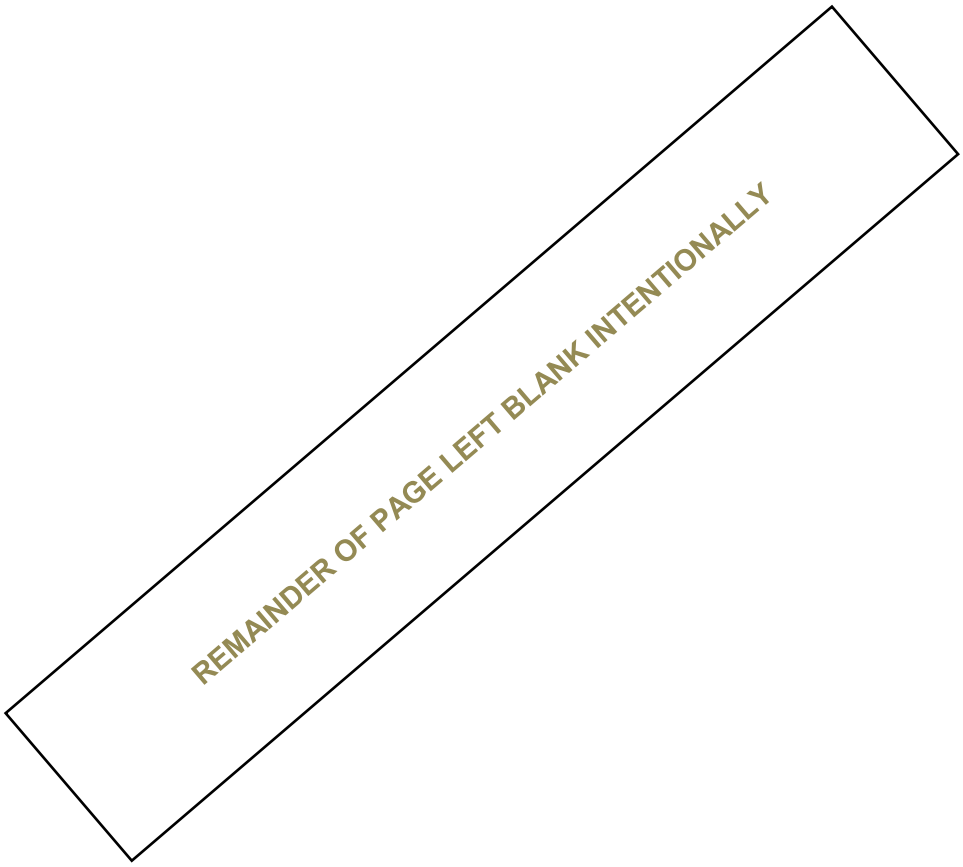
The training's effectiveness with be evaluated through the use of pre- and post-testing to determine the participant's level of change in knowledge and completion of a post class survey to determine whether they feel confident in the administration of NARCAN following the completion of the course. See attachment 3 for sample tests and the evaluation which were developed using both the model program by Benton Police Department and the Opioid Toolkit.

Distribution

NARCAN will be ordered from a distributor and shipped to the local medical director. Once the shipment of NARCAN is received, CJI staff will pick up the shipment from the medical directors office, assemble the Naloxone kits, and provide them to the individuals who have completed the training and met all program requirements that include CPR certification and adoption of a standard Naloxone policy by each agency

Arkansas has budgeted approximately 4,000 doses of NARCAN per year but that number will be modified as needed based on the prevalence, incidence, population and numbers of trained individuals under this program. This number of doses was determined by estimating the average numbers of all first responders in program communities and allowing for two 4mg doses of NARCAN per kit. First responders include members of the local fire department, police or sheriff department, and volunteer ambulance crews. Family members trained in Naloxone administration through substance abuse centers will be treated as first responders and will receive a Naloxone kit through the treatment center's medical director. 4,000 doses were budgeted at a cost of $50 per dose. Adapt Pharma allowed the drug to be purchased for this program under a special interest pricing structure which reduced the cost to $37.50 per dose.

Currently, only certified paramedics and officers in the Benton Police Department, Maumelle Police Department, Independence County Sheriff's Office, and Jacksonville Police Department have access to Naloxone on a regular basis. A limited number of Arkansas State Police Troopers on HIDTA interdiction also carry the drug. No community or organization in Arkansas was awarded the Rural Opioid Overdose Reversal grant so Naloxone is not being distributed through that process.



Attachment 1

Arkansas Training Curriculum

Introduction: The objectives and information listed below were established as the Benton, Arkansas Police Department standardized their training for use of Naloxone. This information was utilized to achieve accreditation by the Arkansas Law Enforcement Trainings and Standards Commission.

Purpose

For purposes of this grant, Arkansas will replicate this training with two modifications. One will be a substitution of the slides related to the drug preparation so that it depicts NARCAN rather than the two part intranasal solution. The other change will be that the information from SAMHSA's Opioid Toolkit will be taught in conjunction to the Benton Police model. There are numerous similarities between the two programs especially in the section for first responders. These similarities include checking the signs for overdose, supporting breathing, administration of Naloxone, and monitoring for response. Information from the toolkit will also be added to the basic administration instruction to assist family members in understanding Naloxone and its use in order to create a family training which substance abuse treatment centers will present.

Benefits

Participants will have a better understanding of the importance of intervention in case of an overdose, the appropriate responses, and how to safely administer Naloxone along with what follow-through measures need to be taken. By training first responders, they will have the capability to assess and intervene immediately upon arrival at an emergency scene involving overdose. Given the rural nature of the state, there are many times when family or friends will be in closer proximity and therefore can act more quickly than first responders.

Target Audience

Training for first responders will include law enforcement officers, firefighters, volunteer ambulance crews, and county emergency management personnel. Substance abuse treatment facility staff will receive training with additional instruction for how to train family and friends of persons with opioid use disorders.

Teaching Methods

The community services contractor will be responsible for assuring training and this entity will be allowed to subcontract the training portion. The following PowerPoint slides are only one part of the training. Before the training is implemented to the communities, the slides about the appropriate way to put together the atomizer will be changed to reflect the one piece NARCAN atomizer which is FDA approved and will be utilized for this grant. It also includes a video

demonstrating appropriate assessment and administration which could not be successfully attached to this document. For some communities, face-to-face training may be the best method. For others, an online course may be more efficient for the first responders. For the training of trainers with the substance abuse treatment providers, a face-to-face method will be used and they in turn will train families in a face-to-face method.

Instructional Objective: Upon completion of this course, the students will be able to identify the reasons law enforcement officers should carry intranasal Naloxone; explain the purpose of Act 1222 of 2015 (the Good Samaritan Act); identify the characteristics of an opioid overdose; identify the steps in care of a person who has overdosed on an opioid; and demonstrate how to use the intranasal Naloxone to treat an opioid overdose.

Length of course: 2 hours

Prepared by: Dr. Cheryl May of Criminal Justice Institute

Target group: 1st Responders throughout Arkansas

Date of preparation: April 27, 2016

Sources: Benton, Arkansas Police Department Policy and Procedures
Arkansas Criminal Code
Harm Reduction Coalition
Bureau of Justice Assistance Training and Technical Assistance Center
SAMSHA Opioid Toolkit

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ARKANSAS PRESCRIPTION DRUG AND OPIOID OVERDOSE PREVENTION PROGRAM *FOR* FIRST RESPONDERS

Dr. Cheryl P. May

Director

Criminal Justice Institute
University of Arkansas System

ABOUT THE PROGRAM

The Arkansas Department of Human Services, Department of Aging, Adult, and Behavioral Health Services (DAABHS) was awarded a Prescription Drug/Opioid Overdose-Related Deaths (PDO) prevention grant by the Substance Abuse Mental Health Services Administration (SAMHSA) in September 2016 to assist in reducing the number of overdose deaths related to prescription drug and other opioid drugs in Arkansas.

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ROLE

As a sub-grantee for this program, the Criminal Justice Institute (CJI), University of Arkansas System, will provide training and support to first responders, substance abuse treatment providers, and other key stakeholders across the state in the administration of naloxone.

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PURPOSE

The purpose of the Arkansas Prescription Drug and Opioid Overdose Prevention Program is to reduce the number of prescription drug and opioid overdose-related deaths.

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OBJECTIVE

To reduce the number of fatalities which occur as a result of opiate overdose by the proper pre-hospital administration of intranasal naloxone.

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TARGET AUDIENCE

- First responders include law enforcement, firefighters and volunteer ambulance crews.
- Substance abuse treatment facility staff will also receive training as well as additional instruction on how to train family and friends of persons with opioid use disorders.

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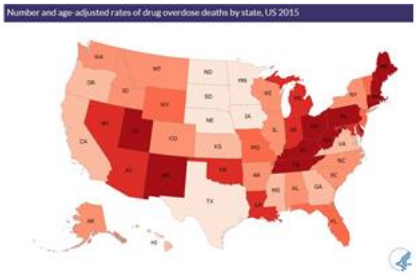
ARKANSAS

Arkansas has the 37th highest drug mortality rate in the United States in 2014, with 12.6 per 100,000 people suffering from drug overdose fatalities.

Source: Center for Disease Control



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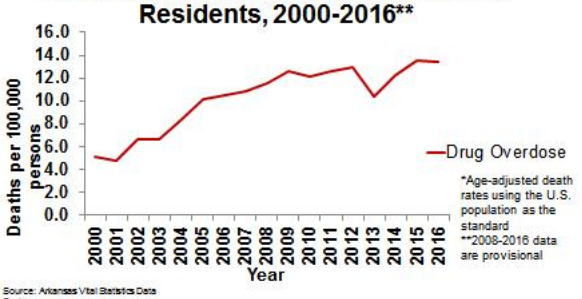
Drug Overdose Death Rates*, Arkansas Residents, 2000-2016**



Source: Arkansas Vital Statistics Data System

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LIVES ARE BEING SAVED

To date, 26 lives have been saved in Arkansas with NARCAN.

BENTON POLICE DEPARTMENT OFFICERS SAVE LIFE WITH NALOXONE KIT

Benton – Officers with the Benton Police Department saved the life of an individual late Sunday through the use of a Naloxone kit and through their previous Naloxone training.

Benton Police Department, Press Release, KTHV 1:01 P.M. CDT October 03, 2016
http://www.thv11.com/news/local/benton-police-save-life-with-naloxone-kit/326632723

"I think it is an understatement how important the Naloxone kits and training are to the public," Chief Kirk Lane said. "Today the kits combined with our officers training saved the life of an individual and that is why we felt the Naloxone was so important to bring to and instill in this department. We were the first agency in the state to give Naloxone kits to every officer and the first to train every officer with Naloxone kits. We hope this incident in which Naloxone was used to save a life will positively influence every agency, across the state and country, to acquire Naloxone kits."

At approximately 11:58 p.m. Sunday, officers responded to the I-30 Courts for a report of a person possibly overdosed from suspected heroin. The individual was found unresponsive with labored breathing. Officers administered the Naloxone into the right nostril of the individual, but received no response. Officers administered the Naloxone a second time into the left nostril of the individual as Emergency Medical Technicians from Saline Memorial Hospital MedTran unit arrived and began giving oxygen to the individual.

An officer also rode with the individual in the ambulance, continuing to administer oxygen to the individual, while enroute to the Saline Memorial Hospital Emergency Room. Officers said the individual became responsive upon arrival to the Emergency Room.

ARKANSAS SAVES

Date	Reporting Agency	Location	Sex	Race	Age	Type Drug	Number of Doses	Officer
10-02-2016	Benton Police Department	Benton	M	W	36	Heroin	1	Sergeant Jeremy Reidmueller
05-11-2017	Pulaski County Sheriff's Office	Little Rock	M	W	51	Fentanyl	1	Deputy William Adkins
05-12-2017	Independence County Sheriff's Office	Batesville	M	W	20	UNK Opioid	1	Deputy Justin Kirk
05-16-2017	Pulaski County Sheriff's Office	North Little Rock	M	W	33	UNK Opioid	1	Deputy Jeffery Scott
05-18-2017	Independence County Sheriff's Office	Oil Trough	M	W	59	UNK Opioid	1	Sheriff Shawn Stephens
05-20-2017	Maumelle Police Department	Maumelle	M	W	23	Heroin	1	Officer Christopher Cruse
06-02-2017	Independence Co. Sheriff's Office	Newark	M	W	34	UNK Opioid	1	Deputy Jason Jordan
06-02-2017	Pulaski County Sheriff's Office	North Little Rock	M	W	52	Oxycodone	1	Deputy Thomas Scruggs
07-31-2017	Maumelle Police Department	Maumelle	M	W	25	Heroin	2	Sergeant Glyneth Hicks
08-09-2017	Independence County Sheriff's Office	Batesville	M	W	40	UNK Opioid	1	Deputy Justin Kirk
08-12-2017	Maumelle Police Department	Maumelle	F	W	18	Mixed Drugs UNK Opioid	1	Officer Casey Canady
08-15-2017	Arkansas State Police	Norman	F	W	22	Mixed Drugs UNK Opioid	1	Corporal Benjamin Harrison
08-17-2017	Arkansas State Police	(Rural) Ouachita	F	W	44	Mixed Drugs UNK Opioid	1	Trooper Matthew Schenzlin
09-04-2017	Independence County Sheriff's Office	Batesville	F	W	20	Mixed Drugs UNK Opioid	1	Deputy Chris Martin

ARKANSAS SAVES (Cont.)

Date	Reporting Agency	Location	Sex	Race	Age	Type Drug	Number of Doses	Officer
08-24-2017	Independence County Sheriff's Office	Bradford	Female	W	47	Xanax (Mixed Drug)	1	Deputy Chris Martin
10-28-2017	Saline County Sheriff's Office	Alexander	Male	W	23	Meth/Suboxone	1	Corporal Joseph Traylor
11-12-2017 *	Independence County Sheriff's Office	Batesville	Female	W	37	Soma	2	Chief Deputy Jeff Sims
11-14-2017	Saline County Sheriff's Office	Mablevale	Male	W	50	Heroin	1	Deputy Justin Oliver
11-20-2017	Pulaski County Sheriff's Office	Roland	Male	W	23	Heroin	1	Deputy G. Hooker

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YOUR RIGHTS UNDER THE LAW

a. A healthcare professional acting in good faith may directly or by standing order prescribe and dispense an opioid antagonist to:
   - A first responder;
   - A law enforcement officer or agency; or
   - A family member or friend of a person at risk of experiencing an opioid-related drug overdose

A.C.A. 20-13-1604: Naloxone Access Act

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YOUR RIGHTS UNDER THE LAW (Cont.)

b. A person acting in good faith who reasonably believes that another person is experiencing an opioid-related drug overdose may administer an opioid antagonist that was prescribed and dispensed under subsection (a) of this section.

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YOUR RIGHTS UNDER THE LAW (Cont.)

c. The following individuals are immune from civil liability, criminal liability, or professional sanctions for administering, prescribing, or dispensing an opioid antagonist under this section:
   - A person other than a healthcare professional who administers an opioid antagonist under subsection (b) of this section.

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DEFINITION OF OPIATE

Opiate drugs are narcotic sedatives that depress activity of the central nervous system, reduce pain, and induce sleep.

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WHAT ARE OPIOIDS?

- Prescription pain drugs such as morphine, codeine, methadone, oxycodone, hydrocodone, fentanyl, hydromorphone, and buprenorphine
- Illegal drugs such as heroin

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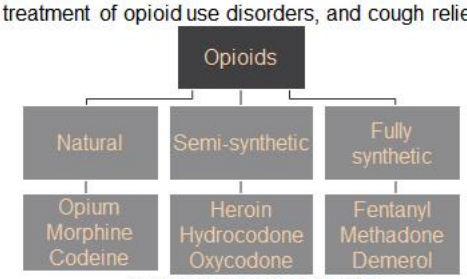
TYPES OF OPIOIDS

Opioids are used primarily in medicine for pain relief, treatment of opioid use disorders, and cough relief.



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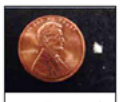
SYNTHETIC OPIOIDS ARE ESPECIALLY DANGEROUS

- Fentanyl is a powerful synthetic opioid analgesic that is similar to morphine but is 50 to 100 times more potent.
- It is a schedule II, high potential for abuse, prescription drug and it is typically used to treat patients with severe pain or to manage pain after surgery.



2 milligrams of powder next to a penny.

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SYNTHETIC OPIOIDS (Cont.)

- Fentanyl, in its prescription form, is known by such names as Actiq®, Duragesic®, and Sublimaze®.
- Street names for fentanyl or for fentanyl-laced heroin include Apache, China Girl, China White, Dance Fever, Friend, Goodfella, Jackpot, Murder 8, TNT, and Tango and Cash.

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SYNTHETIC OPIOIDS (Cont.)

- Carfentanil or carfentanyl (Wildnil) is an version of the popular synthetic opioid analgesic fentanyl.
- It has a potency approximately 10,000 times that of morphine and 100 times that of fentanyl.
- Carfentanil is intended for large-animal use only as its extreme potency makes it inappropriate for use in humans.

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THREAT TO FIRST RESPONDERS

There is a significant threat to law enforcement personnel and other first responders who may come in contact with fentanyl and other fentanyl-related substances through routine law enforcement, emergency or life-saving activities. Since fentanyl can be ingested orally, inhaled through the nose or mouth, or absorbed through the skin or eyes, any substance suspected to contain fentanyl should be treated with extreme caution as exposure to a small amount can lead to significant health-related complications, respiratory depression, or death.

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PERSONAL PROTECTIVE EQUIPMENT

Because of the potency, personal protective equipment (PPE) is especially important when encountering Fentanyl and Carfentanil.

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PERSONAL PROTECTIVE EQUIPMENT (Cont.)

PPE includes but is not limited to:

- Nitrile protective gloves
- Eye protection
- Respirator masks
- Tyvek® protective suits

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VIDEOS

The following videos are real life stories of law enforcement officers who came in contact with fentanyl while on duty.

Source:
Video 1 Drug Enforcement Administration (DEA)
WoodTV8
Published January 9, 2017
Video 2 Royal Canadian Mounted Police (RCMP)
Published September 13, 2016

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EXPOSURE EXAMPLE

EAST LIVERPOOL, Ohio -- East Liverpool patrolman Chris Green nearly died from contact with the drug, requiring four doses of NARCAN. Green pulled over a car and arrested two men. He put on gloves and a mask after noticing white powder in the car. However, once he returned to the police station another officer pointed out that Green had powder on his shirt. Green instinctively brushed at the powder while not wearing gloves and an hour later, Green passed out at the station after contact with the powder.

Emergency workers gave Green a dose of NARCAN at the station and three more doses at the hospital. He is now recovering at home and will return to work when he feels better.

Posted on September 8, 2017
METRO NEWS

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EXPOSURE EXAMPLE (Cont.)

Officers suspected heroin was being bagged at a Hartford apartment for street level sale along with firearms. While making a tactical entry, the flash-bangs meant to stun anyone in the apartment went off and turned powdered drugs on a table into an aerosol going airborne.

Eleven SWAT team members were breathing it in while trying to secure three suspects. A few members became dizzy nauseous, some of them vomited. The whole team was sent to the hospital.

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EXPOSURE EXAMPLE (Cont.)

About 50,000 bags of heroin were taken from the home with $3 to $5 a bag estimated it could be worth $150,000, to $250,000. The powdered drugs turned out to contain fentanyl. **Source:** Hartford Courant, Monday, September 14, 2016

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VIDEO

Synthetic Opioid Fentanyl Causing Overdoses In Police K-9s

Source:
http://www.abc2news.com/
Catherine Hawley
6:12pm, Jun 8, 2017
ABC:WMAR:BALTIMORE

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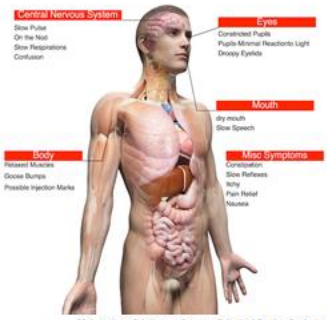
HOW DOES OVERDOSE OCCUR?

- Can be accidental or intentional
- Can be the result of mixing medicines, changes in tolerance, relapse, etc.
- Overmedicating
- When a patient misunderstands the directions for use

IDENTIFYING AN OPIOID OVERDOSE

Opiates
Signs & Symptoms



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IDENTIFYING AN OPIOID OVERDOSE

Signs of Overmedication

- Unusual sleepiness, drowsiness, or difficulty staying awake
- Mental confusion, slurred speech
- Shallow or slow breathing
- Slow heartbeat, low blood pressure

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IDENTIFYING AN OPIOID OVERDOSE

Signs of Overdose

- Extreme sleepiness, inability to awaken verbally or upon chest rubbing
- Breathing problems like shallow breathing or no breathing at all
- Fingernails or lips turning blue/purple

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HOW PEOPLE BECOME ADDICTED

- Prescription medication for existing pain
- Continuing medication after symptoms are gone
- Major event happened in life, i.e., trauma
- Deliberately misuses a prescription opioid or an illicit drug like heroin

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OPIOID TREATMENT

Naloxone

- Naloxone is an easy-to-use, lifesaving antidote to overdose from heroin or other opioids
- It is intended for rescue use and not long-term treatment
- Individuals receiving naloxone must go to the hospital immediately

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WHAT IS NALOXONE?

"Opioid antagonist"

- Naloxone is a drug used to reverse the effects of opioids
- Temporarily takes away the "high"
- Naloxone works in 1 to 3 minutes and lasts 30 to 90 minutes
- Naloxone has no effect on non-opioid overdoses
  - Naloxone CANNOT get you high

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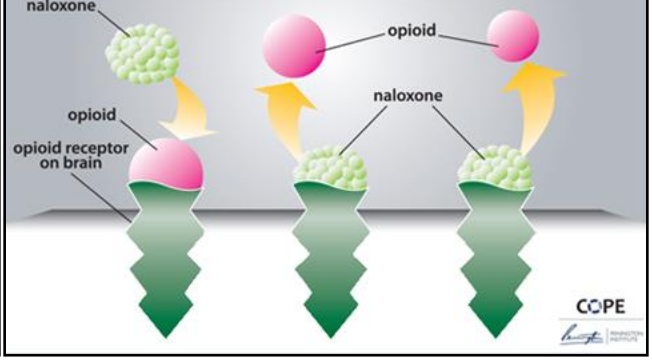
WHAT IS NALOXONE? (Cont.)

In the United States:

- Over 50,000 people trained to dispense naloxone.
- Over 10,000 overdose reversals (lives saved).

Naloxone reversing an overdose

Naloxone has a stronger affinity to the opioid receptors than opioids, such as heroin or oxycodone, so it knocks the opioids off the receptors for a short time (30-90 minutes). This allows the person to breathe again and reverse the overdose.



COPE

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NALOXONE RECIPIENTS MUST GO TO THE HOSPITAL

- Naloxone stays in the body for up to 2 hours
- Opioids stay in the body much longer
- Once the naloxone wears off, the opioids will re-attach to the opioid receptors
- This makes overdose a possibility again without ingesting more opioids

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SIDE EFFECTS OF NALOXONE

- Feeling nervous, restless, or irritable
- Body aches
- Dizziness or weakness
- Diarrhea, stomach pain, or nausea
- Fever, chills, or goose bumps
- Sneezing or runny nose in the absence of a cold

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STEPS TO RESPOND TO AN OVERDOSE

1. Stimulate
2. Alert EMS – Call 911
3. Administer Naloxone
4. CPR – Rescue breathing/ventilations
5. Monitor Response
6. Recovery position, if breathing

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#1 AND #2: STIMULATE AND ALERT EMS

If you suspect an overdose:
- Call 911
- Listen to breathing

Stimulate with:
- Sternum rub

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Sternum Rub Video

You Tube video posted by GilaValleyJon

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STIMULATE AND CALL 911 (Cont.)

Call 911:
- Be brief
- Give clear address or description of location

Example: "Someone is not breathing and I need help. I am located at 123 Main Street."

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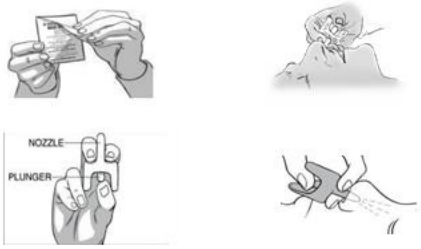
#3 - ADMINISTER NALOXONE



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NALOXONE TRAINING VIDEO

Source: Adapt Pharma, Inc. 2016

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#4 – STEPS FOR CPR RESCUE BREATHING/VENTILATIONS

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
4. Pinch their nose with one hand, and give 2 even, regular-sized breaths.
5. Give one breath every 5 seconds.

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#5 - MONITOR RESPONSE

1. It takes approximately 3-5 minutes for Naloxone to start working
2. Naloxone will last 30-90 minutes
3. Monitor comfort level
4. Administer Naloxone, if necessary
5. Repeat monitor comfort level

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#6 – PREPARE FOR RESPONSE

- Naloxone can result in projectile vomiting, therefore, the recovery position is important to avoid aspiration and choking.
- Some individuals may become combative when regaining consciousness.

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#7 RECOVERY POSITION

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INFORM EMERGENCY MEDICAL SERVICES

Make sure you tell Emergency Medical Services that you have given Naloxone when they arrive!

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DON'TS

- Slap or try to forcefully stimulate the person
- Put the person into a cold bath or shower
- Inject the person with any substance
- Try to make the person vomit drugs that he or she may have swallowed. They may choke or inhale vomit.

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PERSONAL SAFETY

- Assume all bodily fluids present a possible risk for infection.
- Assume more powerful opioids may be present such as Fentanyl and Carfentanyl.
- Wear personal protective equipment.
- Beware of needles, oncoming traffic, leaking gasoline, downed electrical lines, and hazardous materials.

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PERSONAL PROTECTIVE EQUIPMENT (PPE)

PPE includes but is not limited to:

- Nitrile protective gloves
- Eye protection
- Respirator masks
- Tyvek® protective suits.

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STORING NARCAN

- Store NARCAN® Nasal Spray at room temperature
- Do not freeze NARCAN® Nasal Spray
- Keep the NARCAN® Nasal Spray in its protective packaging until ready to use
- Protect from light
- Replace NARCAN® Nasal Spray before the expiration date on the box
- Keep NARCAN® Nasal Spray and all medicines out of the reach of children

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POLICY FOR DISTRIBUTION OF NARCAN

A departmental policy is necessary to establish guidelines and regulations governing utilization of Intranasal Naloxone administered by the Department.

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PROVIDE TREATMENT INFORMATION

A business card sized pamphlet titled "Drug Treatment" and with the imprint: Your Life Was Saved with NARCAN will be given to resuscitated individual or a family member or friend before departure to the hospital. This pamphlet serves as referral to grant funded treatment.

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MANDATORY INCIDENT REPORTING

- It is mandatory that participants of this program complete the incident report at https://surveys.afmc.org/surveys/?s=MTLY7L93WW in order to evaluate the administration of the grant funded Naloxone medication.
- Most of the information gathered involves checklists to determine patterns of naloxone administration, overdoses, and need for the service.

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INCIDENT REPORTING (Cont.)

The following information will be necessary to complete the form:

- Date of administration
- County and city of administration
- Agency administering
- Number of doses administered
- Type of location
- Outcome of administration
- Recipient information

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INCIDENT REPORTING (Cont.)

- Recipient Information
  - Date of Birth
  - Race
  - Ethnicity
  - Gender
  - Education
  - Occupation

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JOSHUA ASHLEY-PAULEY ACT

A person shall not be arrested, charged, or prosecuted for possession of a controlled substance if the evidence results solely from seeking medical assistance if:

1. The person in good faith seeks medical assistance for another person who is experiencing a drug overdose; or
2. A person who is experiencing a drug overdose and in good faith seeks medical assistance for himself or herself.

Act 1114 of 2015

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LAW DOES NOT LIMIT

Admissibility of evidence:

1. In connection with investigation or prosecution of crime with regard to a person who is not seeking medical assistance;
2. With regard to other crimes committed;
3. Any seizure of evidence or contraband otherwise permitted by law; or
4. The authority of law enforcement to detain a person in the course of the investigation or for any other offense.

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SAMHSA OPIOID OVERDOSE PREVENTION TOOLKIT

For additional information, see the Substance Abuse and Mental Health Services Administration (SAMHSA) Opioid Overdose Prevention TOOLKIT available at www.samhsa.gov or 1-877-SAMHSA.

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SAMHSA OPIOID OVERDOSE PREVENTION TOOLKIT (Cont.)

The toolkit contains additional information on:

1. Facts for Community Members
2. Five Essential Steps for First Responders
3. Information for Prescribers
4. Safety Advice for Patients
5. Family Members Recovering From Opioid Overdose

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ARKANSAS DRUG TAKE BACK:

http://www.artakeback.org/

This website includes information about opioid reversal, treatment resources, upcoming and past drug takeback events and additional information about opioid misuse and efforts to combat the epidemic.

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ARKANSAS DRUG TAKE BACK (Cont.):

APRIL 2016 Take BACK
25,289 Pounds

APRIL 2017 Take BACK
24,483 Pounds

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RESOURCES

NARCAN NOW is a smartphone app and video that can be used as a refresher training.

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RESOURCES

https://opirescue.com/ is a smartphone app endorsed by SAMHSA and provides directions for rescue.

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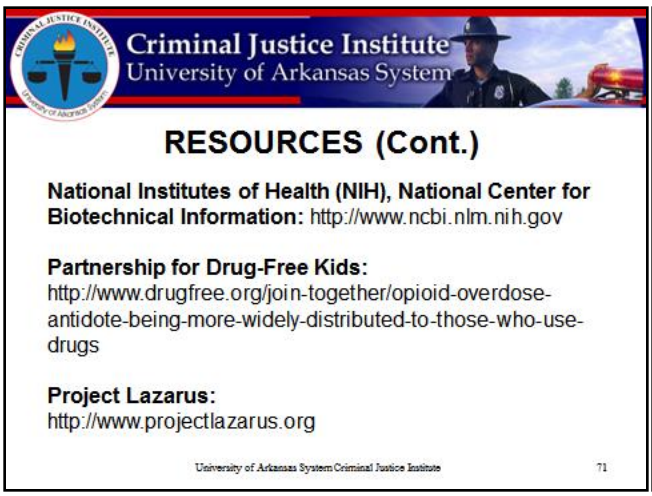
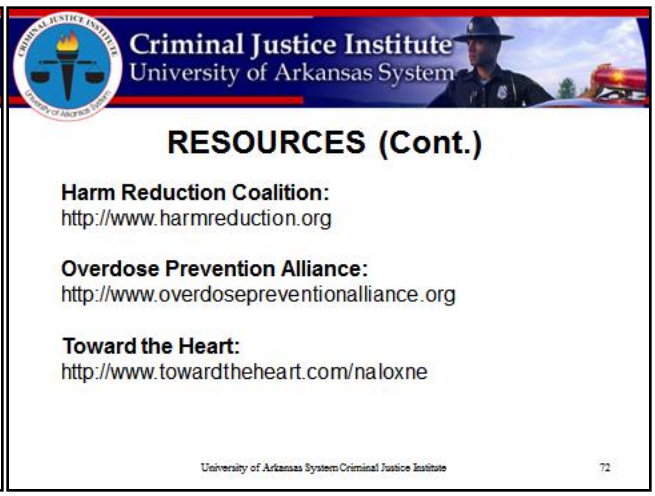
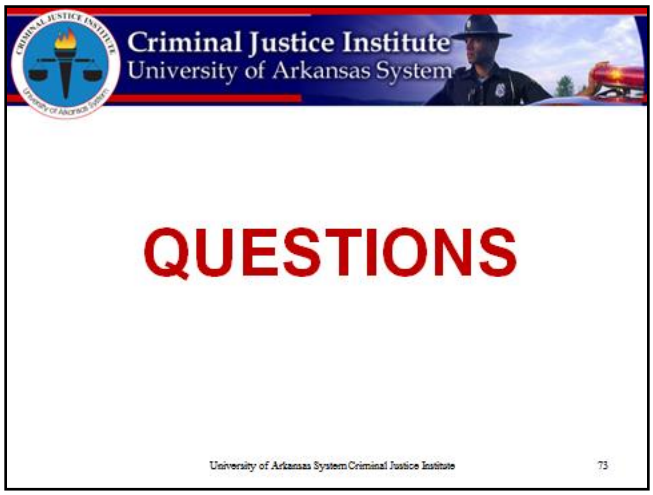
RESOURCES (Cont.)

State Substance Abuse Agencies:
https://findtreatment.samhsa.gov/TreatmentLocator/faces/about.jspx

Centers for Disease Control and Prevention (CDC):
http://www.cdc.gov/drugoverdose/epidemic







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Attachment 2: SAMPLE NALOXONE POLICY

[Department Name]

Policy:

Effective:

Date of Origin:

INTRANASAL NALOXONE PROGRAM

PURPOSE:
The purpose of the Intranasal Naloxone Program is to address the number of opioid-related drug overdoses in Arkansas by establishing protocols, best practices, and procedures for the administration of Naloxone by certified personnel as it becomes necessary within the department's service area.

Naloxone***** is an opioid antagonist, which means it displaces the opioid from receptors in the brain and can therefore reverse an opiate overdose. It has no euphoric properties and minimal side effects. If it is administered to a person who is not suffering an opiate overdose, it will do no harm. Naloxone has been available as an injectable since the 1960s, but now it is commonly used as an intranasal spray to reverse the effects of opioids.

To reduce the number of fatalities that can result from opiate overdoses, the [Department Name] will train its officers in the proper pre-hospital administration of intranasal Naloxone. To implement a safe and responsible intranasal Naloxone plan, the Department will establish and maintain a professional affiliation with a Medical Control Physician (MCP) who will provide medical oversight of its use and administration. The MCP shall be licensed to practice medicine within the State of Arkansas. At his or her discretion, he or she may make recommendations regarding the policy, oversight, and administration of the intranasal Naloxone program developed and implemented by the Department.

To implement this policy, the [Department Name] relies upon the following statute:

A.C.A. 20-13-1804: **Naloxone Access Act**
(a) A healthcare professional acting in good faith may directly or by standing order prescribe and dispense an opioid antagonist to:
(1) A person at risk of experiencing an opioid-related drug overdose;
(2) A pain management clinic;
(3) A harm reduction organization;
(4) An emergency medical services technician;
(5) A first responder;
(6) A law enforcement officer or agency; or
(7) A family member or friend of a person at risk of experiencing an opioid-related drug overdose.

*****_For purposes of the Prescription Drug Overdose grant and State Targeted Response grant, CJI will purchased and distribute NARCAN, a Naloxone 4 MG intranasal spray manufactured by ADAPT Pharma_.

(b) A person acting in good faith who reasonably believes that another person is experiencing an opioid-related drug overdose may administer an opioid antagonist that was prescribed and dispensed under section (a) of this section:

(c) The following individuals are immune from civil liability, criminal liability, or professional sanctions for administering, prescribing, or dispensing an opioid antagonist under this section;

(1) A healthcare professional who prescribes an opioid antagonist under subsection (a) of this section;

(2) A healthcare professional or pharmacist who acts in good faith and in compliance with the standard of care that dispenses an opioid antagonist under subsection (a) of this section; and

(3) A person other than a healthcare professional who administers an opioid antagonist under subsection (b) of this section.

PURPOSE:
To establish guidelines and regulations governing utilization of Intranasal Naloxone administered by the [Department Name]. The objective is to reduce the number of fatalities that occur as a result of opiate overdose by the proper pre-hospital administration of intranasal Naloxone.

DEFINITIONS:
Opiate: An opiate is a medication or drug that is derived from the opium poppy or that mimics the effect of an opiate (a synthetic opiate). Opiate drugs are narcotic sedatives that depress activity of the central nervous system, reduce pain, and induce sleep. Police often encounter opiates in the form of morphine, methadone, codeine, heroin, fentanyl, oxycodone (OxyContin®, Percocet®, and Percodan®) and hydrocodone (Vicodin®).

Naloxone: Naloxone is an opioid antagonist that can be used to counter the effects of opiate overdose. Specifically, it can displace opioids from the receptors in the brain that control the central nervous system and respiratory system.

Medical Control Physician: The Medical Control Physician, herein after referred to as MCP, shall be a designated medical doctor who is licensed to practice medicine in the State of Arkansas. The [Department Name] shall maintain an affiliation with the MCP. The Chief of Police or his/her designee shall periodically consult with the MCP to review overall training, equipment, procedures, changes to applicable laws and regulations, and/or the review of specific medical cases.

Body Substance Isolation: Body substance isolation shall mean equipment that is provided to members of the [Department Name] that may include but is not limited to nitrile protective gloves, eye protection, respirator masks, Tyvek® protective suits, and other personal protection equipment as available.

POLICY:
Naloxone will be deployed with all [Department Name] CPR-certified sworn officers who have successfully completed the Criminal Justice Institute's Intranasal Naloxone Training program and have become familiar with this policy. Intranasal Naloxone will be used for the treatment of drug overdose victims. A patrol unit shall be dispatched to any call that relates to a drug overdose. The goal of the responding officer(s) shall be to provide immediate assistance via the use of Naloxone where appropriate, to provide any treatment commensurate with their training as first responders, to assist other EMS personnel on scene, and to handle any criminal investigations that may arise.

PROCEDURE:
When an officer of the [Name] Department has arrived at the scene of a medical emergency prior to the arrival of EMS, and has made a determination that the patient is suffering from an opiate overdose, the responding officer should administer four (4) milligrams of Naloxone to the patient by way of the intranasal passages through one nostril.

The following steps should be taken:

1. Prior to the assessment of a patient, body substance isolation should be employed by responding officers.
2. Officers should conduct a medical assessment of the patient to determine if the patient is encountering an opiate overdose based upon an initial assessment or witness accounts from witnesses and/or family members regarding drug use.
3. If the officer makes a determination that there has been an opiate overdose, the Naloxone kit should be used.
4. The officer shall use the intranasal mist to administer a four (4) milligram intranasal dose of Naloxone to one (1) nostril, observe for 2-3 minutes and if no response, administer a second four (4) milligram intranasal dose of Naloxone to the opposite nostril for a complete dosage of eight (8) milligrams. Officers should be aware that a rapid reversal of an opiate overdose may cause projectile vomiting by the patient and/or violent behavior.
5. The patient should continue to be observed and treated as the situation dictates.
6. The treating officer shall inform incoming EMS about the treatment and condition of the patient, and shall not relinquish care of the patient until relieved by a person with a higher level of training.

REPORTING
A complete offense report of the event shall be completed by the treating officer, or the primary responding officer, prior to the end of his/her shift. The report shall detail the nature of the incident, the care the patient received, and the fact that the Intranasal Naloxone was deployed.

Administration of grant-funded Naloxone requires accessing https://surveys.afmc.org/surveys/?s=MTLY7L93WW to report the incident and provide basic demographics of the individual receiving Naloxone.

EQUIPMENT AND MAINTENANCE
It shall be the responsibility of officers to inspect their assigned Naloxone kit prior to the start of each shift and to ensure that the kits are intact. Damaged equipment shall be reported to a shift supervisor immediately.

It shall be the responsibility of the program coordinator to inspect Naloxone kits stored in the [Department Name] patrol equipment storage locker on a weekly basis to ensure that the kits are intact. Naloxone kits shall be returned to the patrol equipment storage locker at the end of each shift.

The Department's Intranasal Naloxone Program Coordinator will maintain an inventory documenting the quantities and expirations of Naloxone replacement supplies, and a log documenting the issuance of replacement units.

REPLACEMENT
Shift supervisors shall immediately replace Naloxone kits that have been used during the course of a shift and notify the program coordinator via departmental email.

TRAINING

Officers shall receive a standard training course administered by Criminal Justice Institute (CJI) prior to being allowed to carry and use Naloxone. The Department will make available and assure that all Naloxone-certified officers complete a refresher course each year.

INTRANASAL NALOXONE PROGRAM COORDINATOR RESPONSIBILITIES

The program coordinator will:

(1) Identify an Arkansas State-licensed physician to oversee the clinical aspects of the opioid overdose prevention program (Intranasal Naloxone) prior to the initiation of the program;

(2) Contact CJI for training;

(3) Ensure that each sworn officer of the [Department Name] is qualified as a trained overdose responder (TOR);

(4) Ensure that all trained overdose responders successfully complete all components of the training program;

(5) Maintain Intranasal Naloxone program records, including overdose responder training records, Intranasal Naloxone usage records, and inventories of Intranasal Naloxone supplies and materials;

(6) Provide liaison with EMS, where appropriate; and

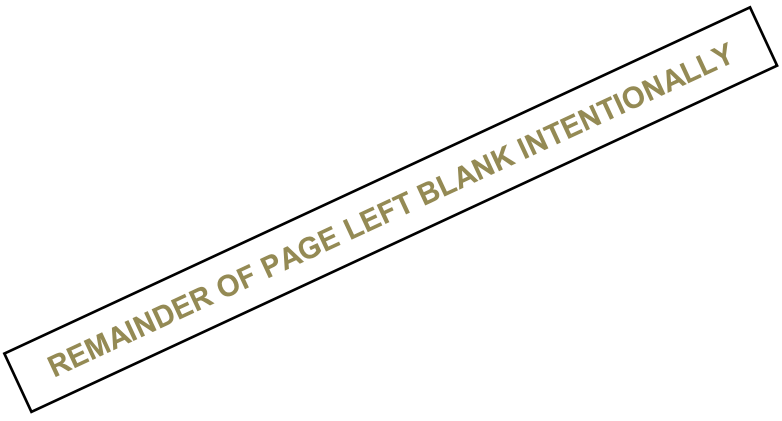
(7) Assist the overseeing physician with review of all overdose reports, particularly those including Intranasal Naloxone administration.

MEDICAL CONTROL PHYSICIAN RESPONSIBILITIES

The Medical Control Physician, who must be an Arkansas state-licensed physician, will:

(1) Provide clinical consultation, expertise, and oversight of medical issues related to the Intranasal Naloxone Program;

(2) Review reports of all administration of Intranasal Naloxone with the department's program coordinator quarterly.



Attachment 3

Pre- and Post-Test used to determine increase in knowledge and effectiveness of training

First Responder's Training

Arkansas Prescription Drug and Opioid Overdose Prevention for First Responders

Date_____ Pre____ Post_____

1. Naloxone is not harmful to a person not taking opioids:
   True or False

2. Overdose symptoms may return after 30 to 90 minutes:
   True or False

3. Which of the following is NOT a step to be taken in administering NARCAN:
   a. Lay the person on their back
   b. Support neck and tilt head back
   c. Shaking the person to awaken
   d. Spray the NARCAN in a person's nose

4. A person is placed on their side after administration of NARCAN in order to:
   a. Avoid aspiration of vomit
   b. Promote improved and independent breathing
   c. To keep the person still
   d. All the above

5. A person shall not be arrested, charged, or prosecuted for possession of a controlled substance if the evidence results solely from seeking medical assistance:
   True or False

6. Which of the following are signs of opioid withdrawal:
   a. Vomiting or diarrhea
   b. Sweating
   c. Shivering and trembling
   d. All the above

7. When a first responder administers Naloxone to a patient, that patient can sue them for administering the drug:
   True or False

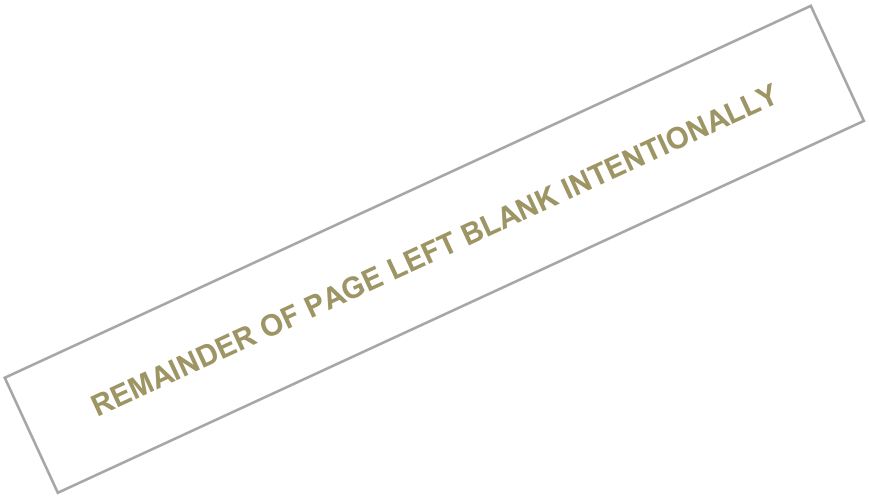
8. More than one dose of Naloxone may be needed to revive someone who is overdosing:
   True or False

9. Someone receiving NARCAN does not require additional medical attention:
   True or False

10. Personal Protective Equipment should be used to avoid potential contact with fentanyl or carfentanyl: True or False

Additional test questions for family members:

1. The following are Naloxone side effects that should be noted in those being treated for opioid use disorder:
   a. Feeling nervous, restless, or irritable
   b. Sneezing or runny nose in the absence of a cold or flu
   c. Respiratory arrest
   d. Dizziness or weakness
2. True or False: Naloxone should be stored in an unlocked cabinet.
3. Which of the following are ways to avoid opioid overdose:
   a. Sharing medications
   b. Take only the amount prescribed and no more often than prescribed
   c. Dispose of unused medication properly
   d. Call a doctor if the pain gets worse.
4. True or False: Both overdose survivors and their family should seek a support network.
5. Allergic reaction to Naloxone includes which of these side effects:
   a. Hives
   b. Difficulty breathing
   c. Swelling of face, lips, tongue or throat
   d. Chest pain
   e. Slow heart rate
   f. All of the above

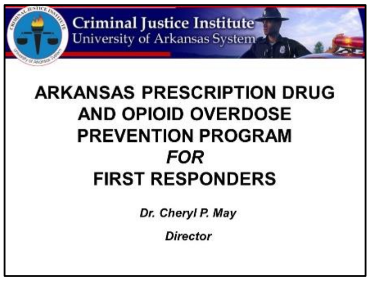


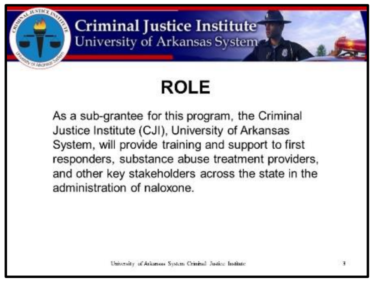
Course Evaluation Form

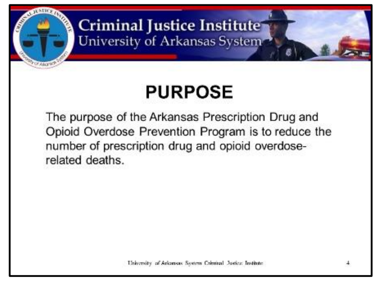
Usefulness of Topics	Very Useful	Useful	Somewhat Useful	Not Useful at All
Now that you have completed this course, how ***useful*** will it be to you and your agency as you build from the knowledge you have gained?				
1. Types of opioids and synthetic opioids				
2. Accurately recognizing opioid overdose symptoms				
3. Proper handling of opioids and synthetic opioids and the hazards of exposure				
4. Administering Naloxone during a suspected overdose				
5. Responding to an overdose				
6. Steps to Mandatory Incident Reporting				
7. First responders rights under the law				
Comments:				

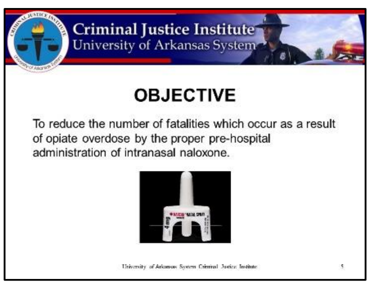
Instructors	Excellent	Very Good	Good	Fair	Poor
Knowledge: How well did the instructor's/ instructors' knowledge and concepts positively impact your understanding of the material?					
Responsiveness: How enthusiastic was/were the instructor(s) as it relates to answering questions and responding to concerns?					
Ability to Relate Training to Practice: How well did the instructor(s) fulfill the intended purpose(s) of this course as it relates to your job duties?					
Teaching Strategies: How well were the training methods used for this course? (i.e. lectures, hands-on exercises, discussions, electronic course material/CD/DVD/book(s), handouts)					
Comments:					

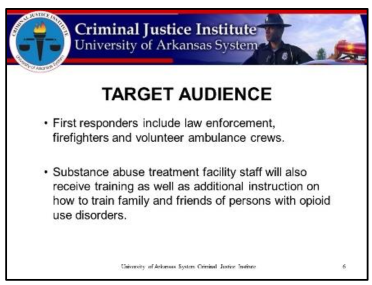
Appendix 4: *First Responder Naloxone Training Curriculum*

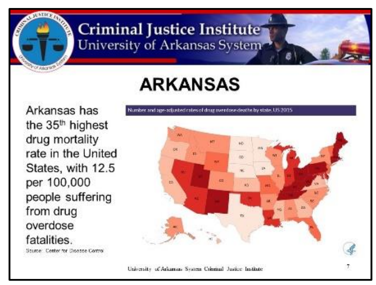


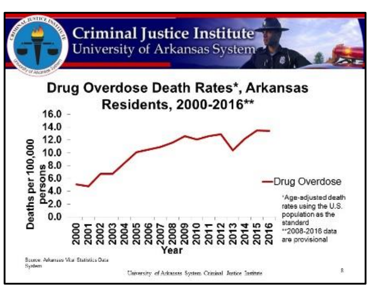


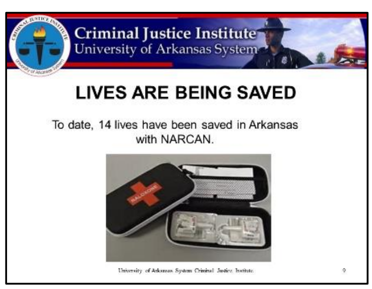


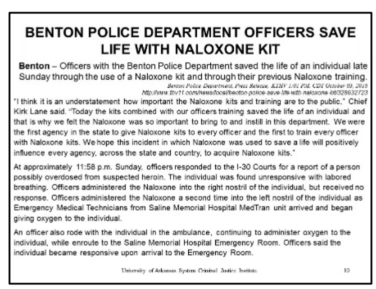












ARKANSAS SAVES

Date	Reporting Agency	Location	Sex	Race	Age	Type Drug	Number of Doses	Officer
10-02-2016	Benton Police Dept.	Benton	M	W	36	Heroin	1	Sgt. Robinsette
04-11-2017	Pulaski Co. Sheriff Office	Little Rock	M	W	31	Fentanyl	1	Deputy Adams
04-13-2017	Independence Co. Sheriff Office	Batesville	M	W	39	UNK Opioid	1	Deputy Kirk
05-16-2017	Pulaski Co. Sheriff Office	North Little Rock	M	W	33	UNK Opioid	1	Deputy Scott
05-18-2017	Independence Co. Sheriff Office	Oil Trough	M	W	29	UNK Opioid	1	Sheriff Stopford
05-29-2017	Maumelle Police Dept	Maumelle	M	W	33	Heroin	1	Officer Cross
06-02-2017	Independence Co. Sheriff Office	Newark	M	W	34	UNK Opioid	1	Deputy Jordan
06-02-2017	Pulaski Co. Sheriff Office	North Little Rock	M	W	52	Oxycodone	1	Deputy Scruggs
06-01-2017	Maumelle Police Dept.	Maumelle	M	W	28	Heroin	2	Officer Cross
06-01-2017	Maumelle Police Dept.	Maumelle	F	W	18	UNK Pills	1	Officer Cassidy
06-09-2017	Independence Co. Sheriff Office	Batesville	M	W	40	UNK Opioid	1	Deputy Kirk
06-15-2017	Arkansas State Police	Norman	F	W	22	Mixed Drugs	1	Cpl. Hansen
06-17-2017	Arkansas State Police	(Rural) Ouachita	F	W	44	Mixed Drugs	1	Trooper Schanzle
06-04-2017	Independence Co. Sheriff Office	Batesville	F	W	28	Mixed Drugs	1	Deputy Morris

YOUR RIGHTS UNDER THE LAW (Cont.)

b. A person acting in good faith who reasonably believes that another person is experiencing an opioid-related drug overdose may administer an opioid antagonist that was prescribed and dispensed under subsection (a) of this section.

YOUR RIGHTS UNDER THE LAW (Cont.)

c. The following individuals are immune from civil liability, criminal liability, or professional sanctions for administering, prescribing, or dispensing an opioid antagonist under this section:

- A person other than a healthcare professional who administers an opioid antagonist under subsection (b) of this section.

DEFINITION OF OPIATE

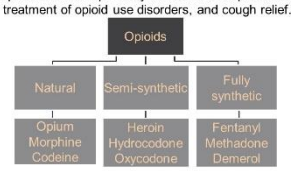
Opiate drugs are narcotic sedatives that depress activity of the central nervous system, reduce pain, and induce sleep.

WHAT ARE OPIOIDS?

- Prescription pain drugs such as morphine, codeine, methadone, oxycodone, hydrocodone, fentanyl, hydromorphone, and buprenorphine
- Illegal drugs such as heroin

TYPES OF OPIOIDS

Opioids are used primarily in medicine for pain relief, treatment of opioid use disorders, and cough relief.



SYNTHETIC OPIOIDS ARE ESPECIALLY DANGEROUS

- Fentanyl is a powerful synthetic opioid analgesic that is similar to morphine but is 50 to 100 times more potent.
- It is a schedule II, high potential for abuse, prescription drug and it is typically used to treat patients with severe pain or to manage pain after surgery.

SYNTHETIC OPIOIDS (Cont.)

- Fentanyl, in its prescription form, is known by such names as Actiq®, Duragesic®, and Sublimaze®.
- Street names for fentanyl or for fentanyl-laced heroin include Apache, China Girl, China White, Dance Fever, Friend, Goodfella, Jackpot, Murder 8, TNT, and Tango and Cash.

SYNTHETIC OPIOIDS (Cont.)

- Carfentanil or carfentanyl (Wildnil) is an version of the popular synthetic opioid analgesic fentanyl.
- It has a potency approximately 10,000 times that of morphine and 100 times that of fentanyl.
- Carfentanil is intended for large-animal use only as its extreme potency makes it inappropriate for use in humans.

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THREAT TO FIRST RESPONDERS

There is a significant threat to law enforcement personnel and other first responders who may come in contact with fentanyl and other fentanyl-related substances through routine law enforcement, emergency or life-saving activities. Since fentanyl can be ingested orally, inhaled through the nose or mouth, or absorbed through the skin or eyes, any substance suspected to contain fentanyl should be treated with extreme caution as exposure to a small amount can lead to significant health-related complications, respiratory depression, or death.

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PERSONAL PROTECTIVE EQUIPMENT

Because of the potency, personal protective equipment (PPE) is especially important when encountering Fentanyl and Carfentanil.

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PERSONAL PROTECTIVE EQUIPMENT (Cont.)

PPE includes but is not limited to:

- Nitrile protective gloves
- Eye protection
- Respirator masks
- Tyvek® protective suits

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VIDEOS

The following videos are real life stories of law enforcement officers who came in contact with fentanyl while on duty.

Source:
Video 1 Drug Enforcement Administration (DEA)
Wood TV8
Published January 9, 2017
Video 2 Royal Canadian Mounted Police (RCMP)
Published September 13, 2016

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EXPOSURE EXAMPLE

EAST LIVERPOOL, Ohio -- East Liverpool patrolman Chris Green nearly died from contact with the drug, requiring four doses of NARCAN. Green pulled over a car and arrested two men. He put on gloves and a mask after noticing white powder in the car. However, once he returned to the police station another officer pointed out that Green had powder on his shirt. Green instinctively brushed at the powder while not wearing gloves and an hour later, Green passed out at the station after contact with the powder.

Emergency workers gave Green a dose of NARCAN at the station and three more doses at the hospital. He is now recovering at home and will return to work when he feels better.

Posted on September 8, 2017
METRO NEWS

University of Arkansas System Criminal Justice Institute 27

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EXPOSURE EXAMPLE (Cont.)

Officers suspected heroin was being bagged at a Hartford apartment for street level sale along with firearms. While making a tactical entry, the flash-bangs meant to stun anyone in the apartment went off and turned powdered drugs on a table into an aerosol going airborne.

Eleven SWAT team members were breathing it in while trying to secure three suspects. A few members became dizzy nauseous, some of them vomited. The whole team was sent to the hospital.

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EXPOSURE EXAMPLE (Cont.)

About 50,000 bags of heroin were taken from the home with \$3 to \$5 a bag estimated it could be worth \$150,000, to \$250,000. The powdered drugs turned out to contain fentanyl. Source: Hartford Courant, Monday, September 14, 2016

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VIDEO

Synthetic Opioid Fentanyl Causing Overdoses In Police K-9s

Source:
http://www.abc2news.com/
Catherine Hawley
6:12pm, Jun 8, 2017
ABC WMAR BALTIMORE

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31

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HOW DOES OVERDOSE OCCUR?

- Can be accidental or intentional
- Can be the result of mixing medicines, changes in tolerance, relapse, etc.
- Overmedicating
- When a patient misunderstands the directions for use

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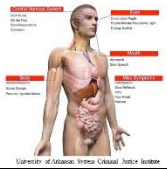
IDENTIFYING AN OPIOID OVERDOSE

Opiates
Signs & Symptoms



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IDENTIFYING AN OPIOID OVERDOSE

Signs of Overmedication

- Unusual sleepiness, drowsiness, or difficulty staying awake
- Mental confusion, slurred speech
- Shallow or slow breathing
- Slow heartbeat, low blood pressure

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IDENTIFYING AN OPIOID OVERDOSE

Signs of Overdose

- Extreme sleepiness, inability to awaken verbally or upon chest rubbing
- Breathing problems like shallow breathing or no breathing at all
- Fingernails or lips turning blue/purple

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HOW PEOPLE BECOME ADDICTED

- Prescription medication for existing pain
- Continuing medication after symptoms are gone
- Major event happened in life, i.e., trauma
- Deliberately misuses a prescription opioid or an illicit drug like heroin

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OPIOID TREATMENT

Naloxone

- Naloxone is an easy-to-use, lifesaving antidote to overdose from heroin or other opioids
- It is intended for rescue use and not long-term treatment
- Individuals receiving naloxone must go to the hospital immediately

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WHAT IS NALOXONE?

"Opioid antagonist"

- Naloxone is a drug used to reverse the effects of opioids
- Temporarily takes away the "high"
- Naloxone works in 1 to 3 minutes and lasts 30 to 90 minutes
- Naloxone has no effect on non-opioid overdoses
  - Naloxone CANNOT get you high

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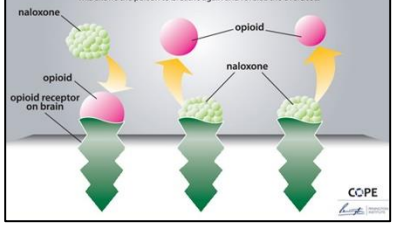
WHAT IS NALOXONE? (Cont.)

In the United States:

- Over 50,000 people trained to dispense naloxone.
- Over 10,000 overdose reversals (lives saved).

Naloxone reversing an overdose

Naloxone has a stronger affinity to the opioid receptors than opioids, such as heroin or oxycodone, so it knocks the opioids off the receptors for a short time (30-90 minutes). This allows the person to breathe again and reverse the overdose.



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NALOXONE RECIPIENTS MUST GO TO THE HOSPITAL

- Naloxone stays in the body for up to 2 hours
- Opioids stay in the body much longer
- Once the naloxone wears off, the opioids will re-attach to the opioid receptors
- This makes overdose a possibility again without ingesting more opioids

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SIDE EFFECTS OF NALOXONE

- Feeling nervous, restless, or irritable
- Body aches
- Dizziness or weakness
- Diarrhea, stomach pain, or nausea
- Fever, chills, or goose bumps
- Sneezing or runny nose in the absence of a cold

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STEPS TO RESPOND TO AN OVERDOSE

1. Stimulate
2. Alert EMS – Call 911
3. Administer Naloxone
4. CPR – Rescue breathing/ventilations
5. Monitor Response
6. Recovery position, if breathing

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#1 AND #2: STIMULATE AND ALERT EMS

If you suspect an overdose:
- Call 911
- Listen to breathing

Stimulate with:
- Sternum rub

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Sternum Rub Video

You Tube video posted by GilaValleyJon

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STIMULATE AND CALL 911 (Cont.)

Call 911:
- Be brief
- Give clear address or description of location

Example: "Someone is not breathing and I need help. I am located at 123 Main Street."

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#3 - ADMINISTER NALOXONE

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NALOXONE TRAINING VIDEO

Source: Adapt Pharma, Inc. 2016.

NARCAN® (naloxone HCl)
NASAL SPRAY 4mg

Law Enforcement Training Module

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#4 – STEPS FOR CPR RESCUE BREATHING/VENTILATIONS

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
4. Pinch their nose with one hand, and give 2 even, regular-sized breaths.
5. Give one breath every 5 seconds.

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#5 - MONITOR RESPONSE

1. It takes approximately 3-5 minutes for Naloxone to start working
2. Naloxone will last 30-90 minutes
3. Monitor comfort level
4. Administer Naloxone, if necessary
5. Repeat monitor comfort level

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#6 – PREPARE FOR RESPONSE

- Naloxone can result in projectile vomiting, therefore, the recovery position is important to avoid aspiration and choking.
- Some individuals may become combative when regaining consciousness.

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#7 RECOVERY POSITION

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INFORM EMERGENCY MEDICAL SERVICES

Make sure you tell Emergency Medical Services that you have given Naloxone when they arrive!

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DON'TS

- Slap or try to forcefully stimulate the person
- Put the person into a cold bath or shower
- Inject the person with any substance
- Try to make the person vomit drugs that he or she may have swallowed. They may choke or inhale vomit.

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PERSONAL SAFETY

- Assume all bodily fluids present a possible risk for infection.
- Assume more powerful opioids may be present such as Fentanyl and Carfentanyl.
- Wear personal protective equipment.
- Beware of needles, oncoming traffic, leaking gasoline, downed electrical lines, and hazardous materials.

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PERSONAL PROTECTIVE EQUIPMENT (PPE)

PPE includes but is not limited to:

- Nitrile protective gloves
- Eye protection
- Respirator masks
- Tyvek® protective suits.

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STORING NARCAN

- Store NARCAN® Nasal Spray at room temperature
- Do not freeze NARCAN® Nasal Spray
- Keep the NARCAN® Nasal Spray in its protective packaging until ready to use
- Protect from light
- Replace NARCAN® Nasal Spray before the expiration date on the box
- Keep NARCAN® Nasal Spray and all medicines out of the reach of children

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POLICY FOR DISTRIBUTION OF NARCAN

A departmental policy is necessary to establish guidelines and regulations governing utilization of Intranasal Naloxone administered by the Department.

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PROVIDE TREATMENT INFORMATION

A business card sized pamphlet titled "Drug Treatment" and with the imprint: Your Life Was Saved with NARCAN will be given to resuscitated individual or a family member or friend before departure to the hospital. This pamphlet serves as referral to grant funded treatment.

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MANDATORY INCIDENT REPORTING

- It is mandatory that participants of this program complete the incident report at https://surveys.afmc.org/surveys/?s=MTLY7L93WW in order to evaluate the administration of the grant funded Naloxone medication.
- Most of the information gathered involves checklists to determine patterns of naloxone administration, overdoses, and need for the service.

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INCIDENT REPORTING (Cont.)

The following information will be necessary to complete the form:

- Date of administration
- County and city of administration
- Agency administering
- Number of doses administered
- Type of location
- Outcome of administration
- Recipient information

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INCIDENT REPORTING (Cont.)

- Recipient Information
  - Date of Birth
  - Race
  - Ethnicity
  - Gender
  - Education
  - Occupation

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JOSHUA ASHLEY-PAULEY ACT

A person shall not be arrested, charged, or prosecuted for possession of a controlled substance if the evidence results solely from seeking medical assistance if:

1. The person in good faith seeks medical assistance for another person who is experiencing a drug overdose; or
2. A person who is experiencing a drug overdose and in good faith seeks medical assistance for himself or herself.

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LAW DOES NOT LIMIT

Admissibility of evidence:

1. In connection with investigation or prosecution of crime with regard to a person who is not seeking medical assistance;
2. With regard to other crimes committed;
3. Any seizure of evidence or contraband otherwise permitted by law; or
4. The authority of law enforcement to detain a person in the course of the investigation or for any other offense.

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SAMHSA OPIOID OVERDOSE PREVENTION TOOLKIT

For additional information, see the Substance Abuse and Mental Health Services Administration (SAMHSA) Opioid Overdose Prevention TOOLKIT available at www.samhsa.gov or 1-877-SAMHSA.

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SAMHSA OPIOID OVERDOSE PREVENTION TOOLKIT (Cont.)

The toolkit contains additional information on:

1. Facts for Community Members
2. Five Essential Steps for First Responders
3. Information for Prescribers
4. Safety Advice for Patients
5. Family Members Recovering From Opioid Overdose

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ARKANSAS DRUG TAKE BACK:

http://www.artakeback.org/

This website includes information about opioid reversal, treatment resources, upcoming and past drug takeback events and additional information about opioid misuse and efforts to combat the epidemic.

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ARKANSAS DRUG TAKE BACK (Cont.):

APRIL 2016 Take BACK
25,289 Pounds

APRIL 2017 Take BACK
24,483 Pounds

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RESOURCES

NARCAN NOW is a smartphone app and video that can be used as a refresher training.

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RESOURCES

https://opirescue.com/ is a smartphone app endorsed by SAMHSA and provides directions for rescue.

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RESOURCES

Information on opioid overdose and helpful advice for overdose survivors and their families can be found at:

A.C.A. 20-13-1604: Naloxone Access Act

Substance Abuse and Mental Health Services Administration (SAMHSA)
National Helpline 1-800-662-HELP (4357) or 1800-487-4889 (TDD—for hearing impaired)

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RESOURCES (Cont.)

Substance Abuse and Mental Health Services Administration (SAMHSA) (Cont.)

Behavioral Health Treatment Services Locator: https://findtreatment.samhsa.gov to search by address, city, or zip code

Buprenorphine Treatment Physician Locator: http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator

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RESOURCES (Cont.)

State Substance Abuse Agencies:
https://findtreatment.samhsa.gov/TreatmentLocator/faces/about.jspx

Centers for Disease Control and Prevention (CDC):
http://www.cdc.gov/drugoverdose/epidemic

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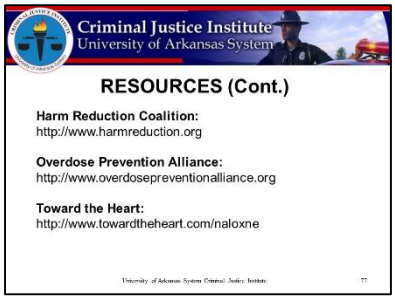
RESOURCES (Cont.)

National Institutes of Health (NIH), National Center for Biotechnical Information: http://www.ncbi.nlm.nih.gov

Partnership for Drug-Free Kids:
http://www.drugfree.org/join-together/opioid-overdose-antidote-being-more-widely-distributed-to-those-who-use-drugs

Project Lazarus:
http://www.projectlazarus.org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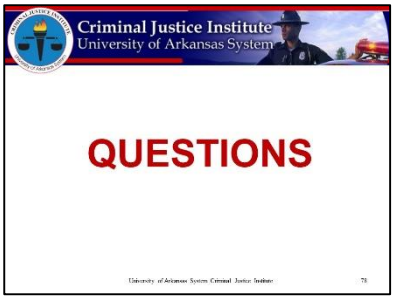
RESOURCES (Cont.)
Harm Reduction Coalition:
http://www.harmreduction.org
Overdose Prevention Alliance:
http://www.overdosepreventionalliance.org
Toward the Heart:
http://www.towardtheheart.com/naloxne


Criminal Justice Institute
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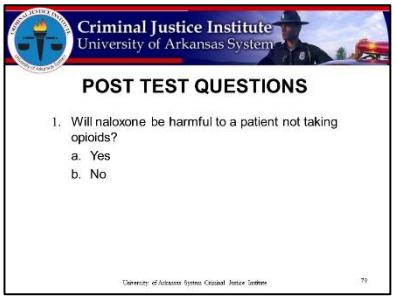
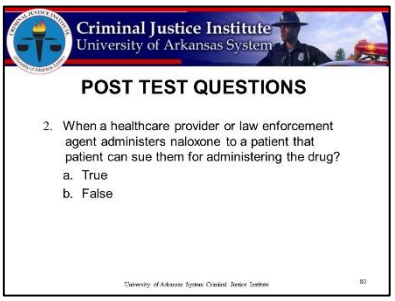
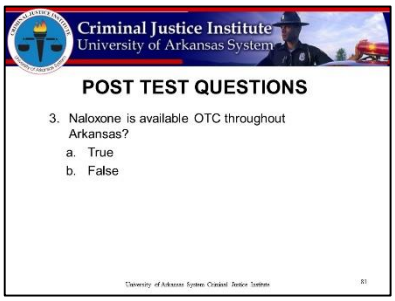
QUESTIONS


Criminal Justice Institute
University of Arkansas System
POST TEST QUESTIONS
1. Will naloxone be harmful to a patient not taking opioids?
a. Yes
b. No


Criminal Justice Institute
University of Arkansas System
POST TEST QUESTIONS
2. When a healthcare provider or law enforcement agent administers naloxone to a patient that patient can sue them for administering the drug?
a. True
b. False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POST TEST QUESTIONS
3. Naloxone is available OTC throughout Arkansas?
a. True
b. False

Appendix 5: *Treatment Center Family Training Plan*

UNIVERSITY OF ARKANSAS SYSTEM
CRIMINAL JUSTICE INSTITUTE

Treatment Center Family Training Plan

I. CONTACT TREATMENT CENTERS

Criminal Justice Institute (CJI) will contact block-grant funded treatment centers serving identified high needs communities to ensure their participation.

- **Harbor House**, **HRA**, and **Quapaw House** have already agreed to participate. Meetings with trainers and a focus group of licensed substance abuse counselors may modify curriculum and process details.

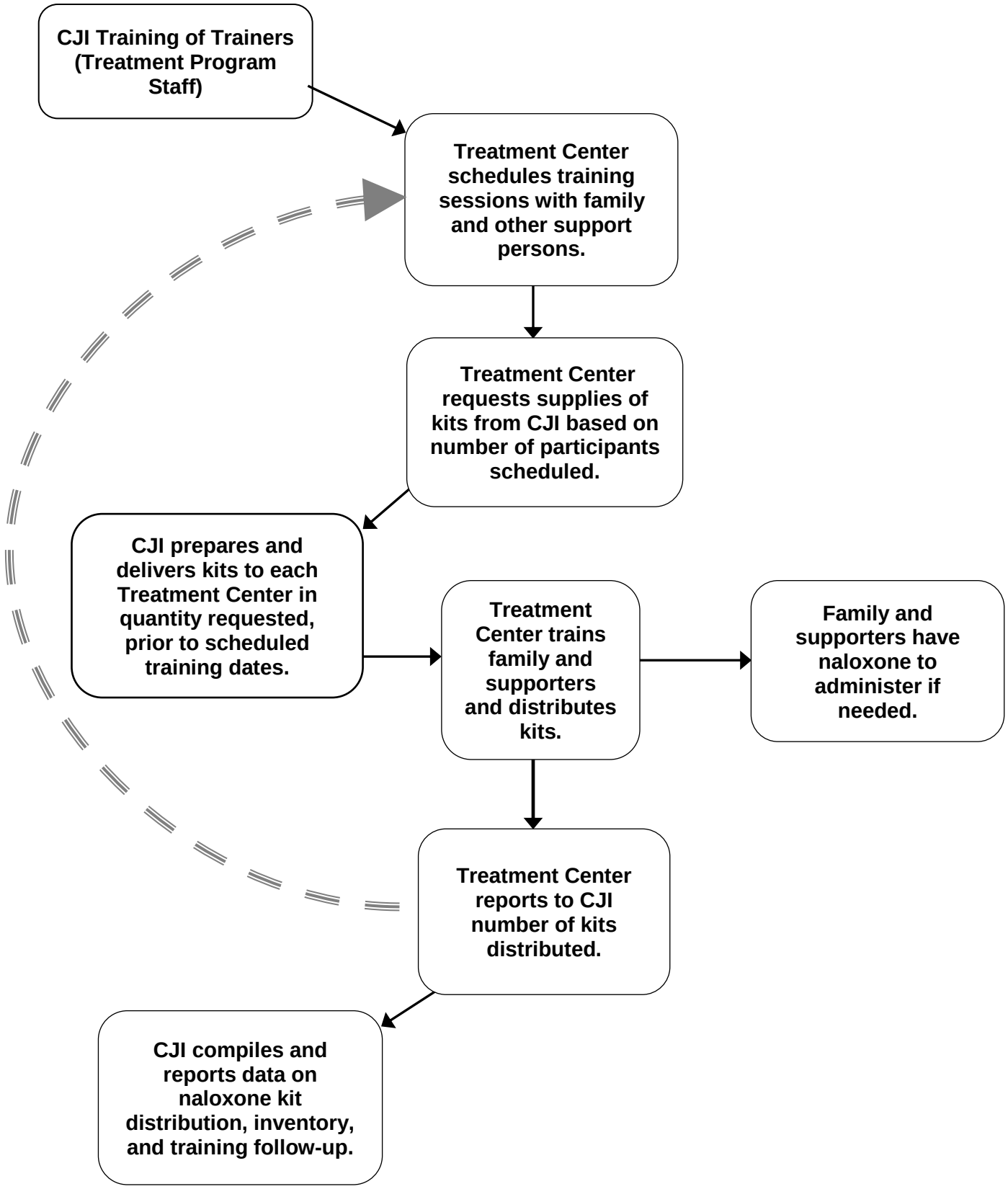
II. TRAIN TREATMENT STAFF

- Treatment centers will designate staff to be trained.
- CJI staff and instructors will schedule time with each treatment center to conduct Training Of Trainers (TOT).
- TOT sessions will: 1) last about 2 hours, 2) demonstrate curriculum, and 3) provide best practices on how to teach it.
- Treatment center staff will be provided with a jump drive containing: curriculum, handouts, reporting forms, and promotional materials.

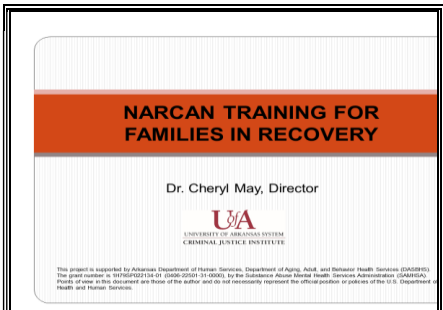
III. TRAIN FAMILY MEMBERS

- Upon intake, treatment centers will: 1) identify appropriate individuals, usually family members and/or friends who are most supportive of the client's recovery, and 2) invite them to receive Family Training.
- Family Training will be flexible, conducted anytime during the client's stay (ranging 28-90 days determined by treatment center policies and protocols). These sessions will last approximately 90 minutes.
- Upon completion of training, one family member will receive one Naloxone Kit. Each will be instructed how to complete an online report in the event of naloxone administration. This information will also be given as a handout.

The flow chart below demonstrates how centers will receive and distribute naloxone kits, and roles/responsibilities of involved parties.


CJI Training of Trainers (Treatment Program Staff)
Treatment Center schedules training sessions with family and other support persons.
Treatment Center requests supplies of kits from CJI based on number of participants scheduled.
CJI prepares and delivers kits to each Treatment Center in quantity requested, prior to scheduled training dates.
Treatment Center trains family and supporters and distributes kits.
Family and supporters have naloxone to administer if needed.
Treatment Center reports to CJI number of kits distributed.
CJI compiles and reports data on naloxone kit distribution, inventory, and training follow-up.

Appendix 6: *Family Naloxone Training Curriculum*



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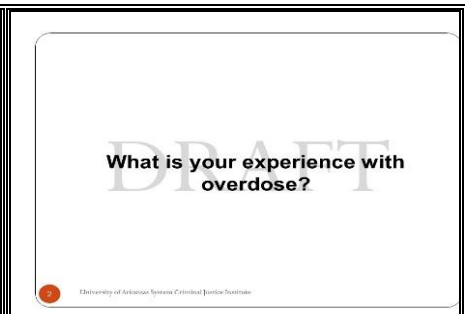

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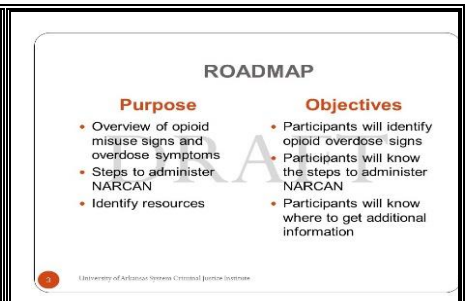

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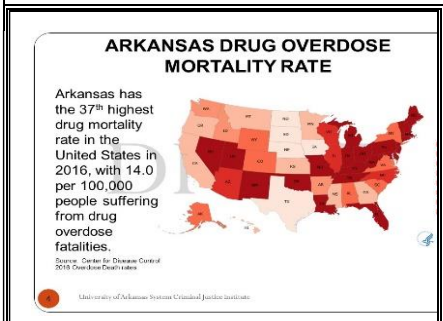

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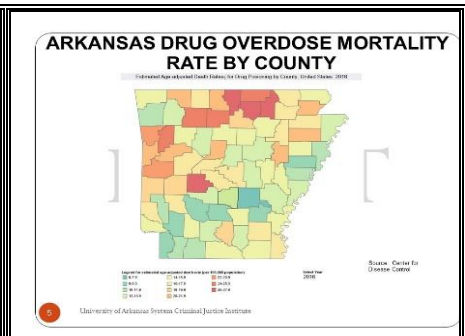

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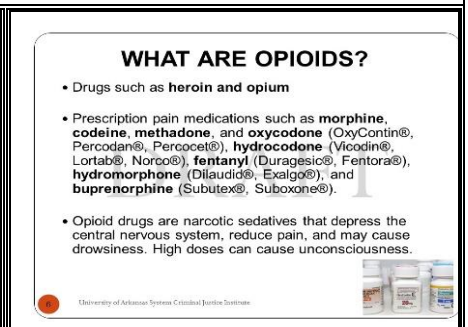

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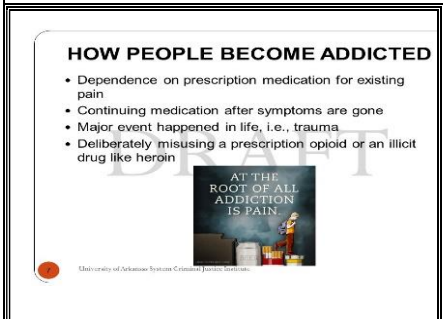

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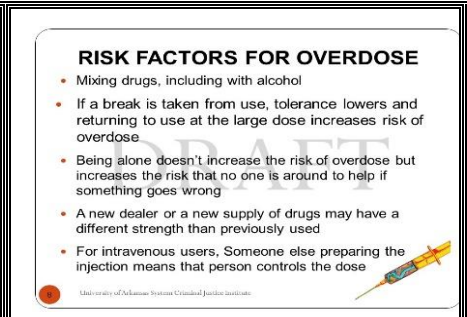

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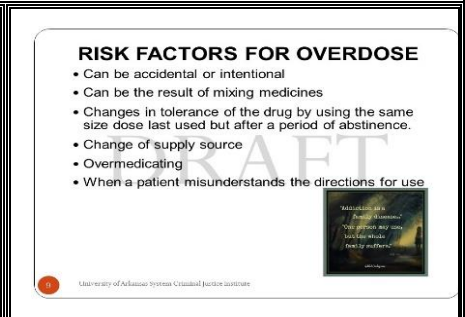

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IDENTIFYING AN OPIOID OVERDOSE

- Inability to awaken verbally or upon chest rubbing
- Shallow breathing, slow breathing of less than 3 to 5 breaths per minute, or no breathing at all
- Exhaled breath with a raspy, labored sound, or snoring sound.
- Fingernails or lips turning blue/purple
- Slow speech

10

MAN-MADE OPIOIDS ARE DANGEROUS AND DEADLY

- Some opioids, especially fentanyl and carfentanyl, are highly potent and endanger you through inhaling or accidental ingestion.
- Never search the living area or vehicle of a loved one yo suspect of using. You could accidently be exposed to on of these deadly drugs.

11

MAN-MADE OPIOIDS ARE DANGEROUS AND DEADLY

This amount of fentanyl is all it takes to cause dizziness, nausea, and other signs of overdose in anyone coming in contact with the drug.

Fentanyl is a powerful synthetic opioid analgesic that is similar to morphine but is 50 to 100 times more potent.

Carfentanyl has a potency approximately 10,000 times that of morphine and 100 times that of fentanyl.

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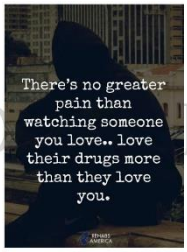


13

WHY CAN'T HE STOP? JUST STOP USING DRUGS!

YouTube video by Partnership for Drug-Free Kids

14

How many of you have heard of or used NARCAN?

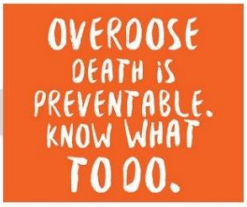
15

WHAT IS NARCAN?

- NARCAN is a drug used to reverse the effects of opioids
- NARCAN is safe and effective with no risk of abuse
- NARCAN has no effect on non-opioid overdoses
- NARCAN CANNOT get you high

- It is intended for rescue use and not long-term treatment

16



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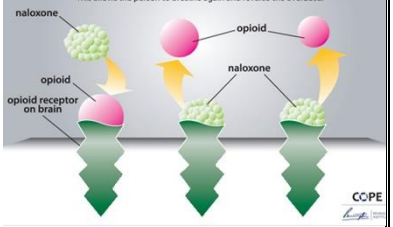
Naloxone reversing an overdose

Naloxone has a stronger affinity to the opioid receptors than opioids, such as heroin or oxycodone, so it knocks the opioids off the receptors for a short time (30-90 minutes). This allows the person to breathe again and reverse the overdose.



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NARCAN RECIPIENTS MUST GO TO THE HOSPITAL IMMEDIATELY

- NARCAN stays in the body for up to 2 hours
- Opioids stay in the body much longer
- Once the NARCAN wears off, the opioids will attach to the receptors again
- This makes overdose a possibility again without ingesting more opioids

19

SIDE EFFECTS OF NARCAN

- Feeling nervous, restless, or irritable
- Body aches
- Dizziness or weakness
- Diarrhea, stomach pain, or nausea
- Fever, chills, or goose bumps
- Sneezing or runny nose in the absence of a cold
- Vomiting makes placement in rescue position important
- Some individuals may become combative

20

SIDE EFFECTS OF NARCAN

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- Vomiting makes placement in rescue position important
- Some individuals may become combative

DRAFT

21

RESPONDING TO AN OPIOID OVERDOSE

22

WHAT TO DO IF YOU SUSPECT AN OVERDOSE

1. Stimulate by rubbing the person's breastbone with your knuckles
2. Alert Emergency Medical Services – Call 911
3. Administer NARCAN
4. Perform rescue breathing/ventilations
5. Place in recovery position, if breathing
6. Monitor Response

23

IT IS THE LAW

A person shall not be arrested, charged, or prosecuted for possession of a controlled substance if the evidence results solely from seeking medical assistance if:

1. The person in good faith seeks medical assistance for another person who is experiencing a drug overdose.
2. A person who is experiencing a drug overdose and in good faith seeks medical assistance for himself or herself.
3. Officers may still be able to arrest for other charges such as outstanding warrants or other crimes.

24

Steps 1 and 2: STIMULATE AND ALERT EMERGENCY MEDICAL SERVICES

If you suspect an overdose:

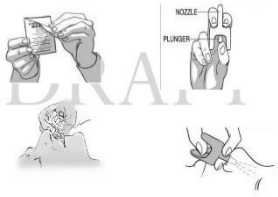
- Call 911
- Listen to breathing
- Stimulate with by rubbing knuckles up and down the breastbone

25

STERNAL RUB

26

STEP 3 ADMINISTER NARCAN



27

NARCAN VIDEO

28

STEP 4 PERFORM RESCUE BREATHING

- Place the person on their back
- Tilt their chin up to open the airway
- Check to see if there is anything in their mouth
- Pinch their nose with one hand, and give 2 even, regular-sized breaths
- Give one breath every 5 seconds

29

STEP 5 PLACE in RECOVERY POSITION

30

STEP 6 MONITOR RESPONSE

- It takes 2 to 3 minutes for NARCAN to start working
- Repeat steps 3 and 4 if necessary
- NARCAN will last 30-90 minutes but opioids stay in the system longer
- Individuals receiving NARCAN must go to the hospital
- NARCAN can result in projectile vomiting so the recovery position avoids choking.
- Some individuals may become combative when regaining consciousness.

31

TALK TO EMERGENCY MEDICAL SERVICES

Make sure you tell Emergency Medical Services that you have given NARCAN when they arrive!

32

AVOID DOING THESE

- Slap or try to forcefully stimulate the person—it will hurt them further if they are unconscious
- Put the person into a cold bath or shower because this increases the risk of falling, drowning, or going into shock
- Inject the person with any substance (saltwater, milk, "speed," heroin, etc.) because it won't help and may waste time; NARCAN is more effective
- Try to make the person vomit drugs that he or she may have swallowed. They may choke or inhale vomit

33

REVIEW STEPS

1. Stimulate with chest rub
2. Call 911
3. Administer NARCAN
4. Rescue Breathing
5. Recovery Position
6. Monitor Response

34

POST NARCAN TREATMENT

- Stay with the person in case a second dose is needed to revive
- Continue rescue breathing
- When the person is alert, explain what happened and that NARCAN was given
- Discourage the person from taking more drugs to reduce the withdrawal symptoms

35

STORING NARCAN

Safe NARCAN storage is important!

- Keep it in a place that is easy to access.
- Do not expose to extreme temperatures
- Keep at room temperature
- Store in the original blister pack
- Watch the expiration date on the package

36

REPORT NARCAN USE

- If you must use the NARCAN, please go to this website and report details of the use https://bit.ly/2j2rBo5
- You can remain anonymous
- In the box for first responder agency, write family or friend

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37

NARCAN ACCESS

- Individuals completing the training today will receive a rescue kit with two doses of NARCAN and personal protective equipment such as gloves and CPR shield
- If additional NARCAN is needed, it may be obtained through a local pharmacy under a statewide standing order which does not require a prescription

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RESOURCES

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HOW TO TALK TO YOUR DOCTOR HANDBOOK

The objectives of the "How to Talk to Your Doctor Handbook" are:

- Increase confidence in filling out medical forms
- Increase confidence in communicating with healthcare providers
- Increase confidence in taking medicines as prescribed

How to Talk to Your Doctor

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40

ARKANSAS DRUG TAKE BACK:

http://www.artakeback.org/

This website includes information about opioid reversal, treatment resources, upcoming and past drug takeback events and additional information about opioid misuse and efforts to combat the epidemic.

This event happens twice per year but many law enforcement agencies have permanent drop boxes. Go to artakeback.org to find the one closest to you.

OCTOBER 2017 Take BACK
28,035 Pounds

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41

RESOURCES

NARCAN NOW is a smartphone app and video that can be used as a refresher training.

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42

RESOURCES

Information on opioid overdose and helpful advice for overdose survivors and their families can be found at:

For additional information See the SAMHSA Opioid Overdose Prevention TOOLKIT available at www.samhsa.gov

Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline 1-800-662-HELP (4357) or 1800-487-4889 (TDD—for hearing impaired)

Behavioral Health Treatment Services Locator: https://findtreatment.samhsa.gov to search by address, city, or zip code

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43

RESOURCES

Buprenorphine Treatment Physician Locator: http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator

State Substance Abuse Agencies: https://findtreatment.samhsa.gov/TreatmentLocator/faces/about.jspx

Centers for Disease Control and Prevention (CDC): http://www.cdc.gov/drugoverdose/epidemic

National Institutes of Health (NIH), National Center for Biotechnical Information: http://www.ncbi.nlm.nih.gov

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44

RESOURCES

Partnership for Drug-Free Kids: http://www.drugfree.org/join-together/opioid-overdose-antidote-being-more-widely-distributed-to-those-who-use-drugs

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

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

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45

What is one new thing you have learned?

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46

QUESTIONS

47

47

If you have questions or comments, please don't hesitate to contact:

UA UNIVERSITY OF ARKANSAS SYSTEM CRIMINAL JUSTICE INSTITUTE
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48

Appendix 7: *Needs Assessment/Results*

Prescription Drug/Opioid Overdose Needs Assessment – 2017

Introduction

The Department of Human Services (DHS) Division of Behavioral Health Services (DAABHS) was awarded funding by the Substance Abuse and Mental Health Services Administration (SAMHSA) in September 2016 for the Arkansas Prescription Drug/Opioid Overdose (PDO) Prevention Program. Multiple Arkansas communities will be selected to implement the PDO program in their local areas. The goal of the PDO grant is to develop a comprehensive prescription-drug misuse prevention program in order to:

1. Reduce the number of prescription drug/opioid overdose-related deaths and adverse events among Arkansans 18 years of age and older
2. Address behavioral health disparities among racial/ethnic minorities
3. Replicate a successful local police department naloxone program

DAABHS will coordinate the PDO program and will work directly with The University of Arkansas at Little Rock MIDSOUTH as a planning agency, which works with an evaluation and data agency (Arkansas Foundation for Medical Care), and a community services contractor (Criminal Justice Institute). AFMC is responsible for a statewide needs assessment, data collection and evaluation activities for the PDO. The following document outlines the current 2017 needs assessment for the PDO prevention program.

Utilizing the data below, the Arkansas PDO Advisory council met on May 11, 2017 to select the high need communities to be served during the following year. The meeting began with an overview of the SPF process presented by the Southwest CAPT. This was done to assure foundational knowledge before decisions were made. The data was reviewed by the group and a lengthy discussion followed on both how “community” would be defined and which communities would be selected and ranked.

Community was defined as both individual and county clusters. For data collection and comparison purposes, county level communities were selected for consistency. Because some counties were contiguous and shared similar levels of need, groupings or clusters of counties were created and defined as one community. The selected communities are a mixture of rural and urban communities by Arkansas standards. Hot Springs, Van Buren and Fort Smith are the largest cities in the group with Fort Smith the only one meeting the U.S. Census definition of an urban area based on population size.

Three communities were selected to be the High Needs Communities (HNC) for funding with PDO grant money. Because Arkansas is also an STR recipient, two additional HNCs were selected to be funded as part of that grant. Three alternate communities were selected in the event that one of the five other communities declines to participate which is highly unlikely. The selected communities in rank order are:

PDO funded:

1. Crawford and Franklin Counties as one community
2. Sebastian and Scott Counties as one community
3. Sharp County as one community

STR funded:

4. Marion and Baxter Counties as one community
5. Garland County as one community

Alternates:

6. Poinsett and Jackson Counties as one community
7. Union and Ashley Counties as one community
8. Lonoke County as one community

Consumption, overdose deaths and naloxone usage rates in Arkansas

According to the 2013-14 prevalence estimates based on the National Survey on Drug Use and Health (NSDUH), Arkansas has the highest estimated rate of nonmedical use of pain relievers by children ages 12-17 (6.15**%**), compared to rates across the United States. Table 1 shows the most recent estimates based on age for both Arkansas and the United States.

Table 1.
NSDUH 2013-2014 Prevalence estimates for nonmedical use of pain relievers in the past 30 days

Age group	Ark.	U.S.	Rank*
12 and over	4.6%	4.1%	9th
18 and over	4.4%	4.0%	11th
26 and over	3.5%	3.3%	19th
12-17	6.2%	4.7%	1st
18-25	9.7%	8.3%	4th

* The rank represents Arkansas' rank when all states and Washington, D.C., are compared.

For the 2016-17 school year, the Arkansas Prevention Needs Assessment – School Survey showed that state heroin use rates for high school seniors are higher for both lifetime (1.3%) and past 30-day use (0.5%) compared with the national rates of 0.7 percent and 0.2 percent respectively. Table 2 displays use rates for the 2015-16 and 2016-17 school years.

Table 2.
APNA use rates (%) of heroin and prescription drugs for 6th, 8th, 10th and 12th grades in 2015 and 2016.

	Heroin use				**Prescription drug use**			
	Lifetime		***30-day***		***Lifetime***		***30-day***	
	2015	*2016*	*2015*	*2016*	*2015*	*2016*	*2015*	*2016*
6th	0.1	0.1	0.1	0.1	2.2	2.5	1.1	1.1
8th	0.3	0.5	0.1	0.2	5	5.1	2.3	2.4
10th	0.8	0.7	0.3	0.3	10.3	9.2	4.8	4.0
12th	1.6	1.3	0.5	0.5	14.1	13.2	5.8	5.2

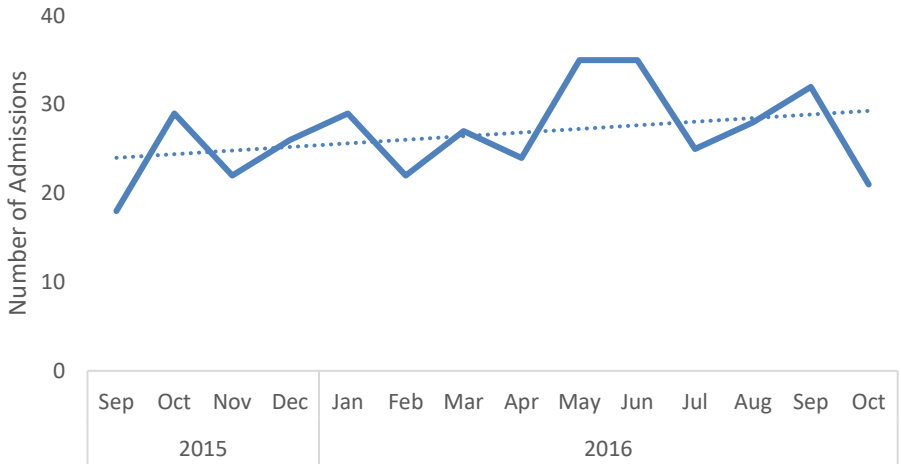
Table 3 shows the number of arrests for selling/manufacturing or possession of opiates in 2015, based on records submitted to the Arkansas Crime Information Center (ACIC).

Table 3.
ACIC 2015 arrests for selling/manufacturing or possession of opiates

Opiate	Possession	Sell/Manuf.	Total
Heroin	53	8	61
Morphine	46	12	58
Opium	47	7	54
Other narcotics	779	163	942

The number of people admitted for substance abuse treatment that listed heroin as the primary substance of use has increased since September 2015.

Figure 1. Admissions related with heroin as the primary substance of use



Data collected by the Arkansas State Crime Lab show that there were 349, 287, and 335 nonspecific drug overdose deaths in 2014, 2015 and 2016, respectively. These are rates of 11.8 (2014), 9.6 (2015), and 11.2 (2016) per 100,000 of the Arkansas population. Please note: the population of Arkansas in 2016 is not yet available so the state's 2015 population was used to calculate a rate for 2016.

Data provided by the Arkansas Department of Health Emergency Management System indicated that during state fiscal year 2016, 2,456 emergency medical calls required the administration of either single or multiple doses of naloxone. This is nearly twice the number of calls (1,344) made between Jan. 1, 2015 and Jan. 1, 2016.

PDO indicators

To determine county level indicator rates, data were collected from the following sources:

- Arkansas Crime Information Center (ACIC)

- Arkansas Department of Human Services
    - Division of Aging, Adult, and Behavioral Health Services
        - Alcohol/Drug Management Information System (ADMIS)
        - Arkansas Prevention Needs Assessment – Student Survey (APNA)
    - Division of Child and Family Services (DCFS)
- Arkansas Department of Health
    - Emergency Medical Services (EMS)
    - Prescription Monitoring Program (PMP)
- Arkansas State Crime Labe (ASCL)
- U.S. Department of Health & Human Services
    - Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP)
    - Centers for Disease Control and Prevention, National Center for Health Statistics (NCHS)
- National Poison Data System (NPDS), provided through the Partnerships for Success Grant

Table 4 summarizes the data available from each source.

Table 4. Description of indicators

Years	Indicator	Source	Denominator	Value type
2011-15	Opiate-related arrests for selling/manufacturing or possession	ACIC	Total pop.	Average rate
2011-15	Heroin-specific drug arrests for selling/manufacturing or possession	ACIC	Total pop.	Average rate
2016	Prisoner treatment admissions for opiates in 2016 based on county of residence	ADMIS	Total pop.	Rate
2011-15	Treatment admissions based on county of residence	ADMIS	Total pop.	Average rate
2012-16	Students using heroin (lifetime)	APNA	NA	Average rate
2012-16	Students using heroin (30-day)	APNA	NA	Average rate
2012-16	Students using prescription drugs (lifetime)	APNA	NA	Average rate

Table 4. Description of indicators

Years	Indicator	Source	Denominator	Value type
2012-16	Students using prescription drugs (30-day)	APNA	NA	Average rate
2012-16	Removal of children due to drug use	DCFS	Total removals	Average rate
SFY2016	New mothers testing positive for opiates in SFY 2016	DCFS	Total births	Rate
SFY2016	Naloxone administration in SFY 2016 based on county of incidence	EMS	Total pop.	Rate
2014-15	Opioid distribution	PMP	NA	Score*
2013	Neonatal Abstinence Syndrome incidence	HCUP	In-hospital births	Rate
2013	Opioid diagnosis presence on Arkansas inpatient discharges	HCUP	Total pop.	Rate
2013	Opioid diagnosis presence on Arkansas hospital discharge with evidence of emergency department utilization	HCUP	Total pop.	Rate
2012-2015	Opiate poisoning	NPDS	NA	Score*
Outcome indicators				
2014-16	Drug overdose deaths (non-specific) based on autopsy results	ASCL	Total pop.	Average rate
2010-14	Overdose deaths (nonspecific)	NCHS	NA	Score*

* Scores were calculated where ranges of rates were the only values available.

Methodology

General

Raw data came in multiple forms:

1. Counts by county
2. Ranges of rates by county
3. Rates by county

Raw data in the form of counts were converted to rates using the same year's denominator where possible. When it was not possible to use a denominator collected during the same timeframe as the indicator's numerator, the most recent denominator available was used. Ranges of rates by county were converted to scores depending on the number of ranges, where one was the lowest score. Raw data that was already a rate were used as is.

The number of years analyzed for each indicator ranged between one to five years. In cases where more than one year was collected, the final rates provided in this report are averages for each indicator across the years that were available.

Correlation analysis and location selection

Indicators with the most influence on the opioid overdose deaths outcome measure were assessed to identify target counties for prevention. Two available indicators representing overdose deaths were selected as primary outcomes. The analytics team considered running linear regressions on all indicators with the primary outcome measures. However, a close examination of the indicators showed that many of them were not normally distributed. For this reason, Spearman correlation analyses were conducted for each indicator with *Drug overdose deaths (nonspecific) based on autopsy results* and *Overdose deaths (nonspecific)* from NCHS. This allowed the analytics team to determine the individual indicators influencing both outcomes. Indicators that were significant and correlated with both overdose death measures, with a probability of <0.05 were selected. Counties were then ranked based on the value for each indicator. Summed ranks were used to identify the 20 counties most at risk.

Analysis

Table 5 shows the five counties with the highest rates/scores for each indicator. For maps that display scores and ranks for all counties please see the Appendix.

Table 5. Top 5 counties for each indicator

Indicators	County	Rate/score
Arrests for selling/manufacturing or possession (*Source: ACIC*)		
Opiate-related – average rate of arrests per 100,000 county population from 2011 to 2015	Sebastian	154.6
	Poinsett	108.2
	Conway	104.0
	Pike	87.7
	Clay	85.7
Heroin-specific – average rate of arrests per 100,000 county population from 2011 to 2015	Jackson	38.60
	Greene	21.68
	Saline	7.97
	Crittenden	7.68
	Randolph	4.58
Treatment admissions for opiates (*Source: ADMIS*)		
Prisoner population – rate of admissions in 2016 per 100,000 county population in 2015. Based on county of residence. (n=57 counties)	Polk	59.4
	Ashley	43.2
	Jackson	34.6
	Crawford	32.4
	Pike	27.7
General population average rate of admissions per 1,000 county population from 2011 to 2015. Based on county of residence.	Miller	3.88
	Union	2.54
	Sebastian	2.30
	Pulaski	2.11
	Garland	1.98
Students using (*Source: APNA*)		

Table 5. Top 5 counties for each indicator

Indicators	County	Rate/score
Heroin (lifetime) – percent of students trying heroin from 2012 to 2016	Marion	1.40
	Baxter	1.30
	Dallas	1.25
	Sharp	1.18
	Sebastian	1.02
Heroin (30-day) – percent of students currently using heroin from 2012 to 2016	Dallas	0.60
	Marion	0.52
	Woodruff	0.48
	Baxter	0.42
	Nevada	0.42
	Union	0.42
Prescription drugs (life-time) – percent of students trying prescription drugs from 2012 to 2016	Sharp	9.3
	Garland	9.2
	Madison	9.1
	Baxter	8.9
	White	8.8
	Cross	8.8
Prescription drugs (30-day) – percent of students using prescription drugs from 2012 to 2016	Madison	4.9
	Cross	4.4
	Monroe	4.4
	Prairie	4.1
	Lincoln	4.1
	Miller	4.1
Parents using (*Source: DCFS*)		
Removal of children due to drug use – percent of removals from home where parental substance use played a role in the decision to remove the child(ren) from 2012 to 2016	Cleburne	86.0
	Independence	79.7
	Conway	72.8
	Montgomery	72.2
	Cleveland	70.8
New mothers testing positive for opiates – rate of mothers who tested positive for an opiate in SFY 2016 per 1,000 live births in 2015 (n = 41 counties)	Crawford	17.7
	Cleveland	13.9
	Lafayette	13.3
	Boone	13.3
	Phillips	12.7
Naloxone administration (*Source: EMS*)		
Naloxone administration – rate of emergency events in SFY 2016 requiring the administration of naloxone per 1,000 county population in 2015. Based on county of incidence. (n = 73 counties)	Searcy	3.3
	Izard	2.9
	Poinsett	2.8
	Madison	2.7
	Hot Spring	2.6
Opioid distribution (*Source: PDMP*)		
	Franklin	4.73

Table 5. Top 5 counties for each indicator

Indicators	County	Rate/score
Opioid distribution – average score across opiate agonists prescribed 2014 and 2015. There were six rate ranges provided in 2014 and five rate ranges provided in 2015.	Sharp	4.73
	Poinsett	4.67
	Logan	4.60
	Scott	4.60
Overdose deaths – rate (*Source: ASCL*)		
Non-specific drug overdose deaths based on autopsy results – average rate of overdose deaths per 100,000 county population from 2014 to 2016	Searcy	33.9
	Sharp	25.6
	Grant	20.2
	Ashley	19.2
	Pulaski	18.9
Overdose deaths – score (*Source: NCHS*)		
Non-specific overdose deaths – average score from 2010 to 2014. There were 11 rate ranges for each year.	Garland	10.8
	Sharp	10.8
	Baxter	10.6
	Izard	10.4
	Fulton	10.4
	Newton	10.4
Opiate Poisoning (*Source: NPDS*)		
Opiate poisonings – rate of poisonings per 1,000 county population in 2012 to 2015	Independence	0.074
	Garland	0.072
	Clay	0.066
	Desha	0.062
	Randolph	0.057
Hospital discharges (*Source: HCUP*)		
Neonatal Abstinence Syndrome (NAS) incidence – rate of discharges that had evidence of NAS being present per 1,000 live in-hospital births in 2013, based on county of residence (n = 28 counties)	Woodruff	27.0
	Jackson	15.9
	Madison	12.0
	Fulton	11.2
	Crawford	9.2
Substance diagnosis presence on Arkansas inpatient discharges – rate of discharges per 1,000 county population in 2013, based on county of residence	Crawford	2.81
	Garland	2.73
	Sebastian	2.31
	Sharp	2.29
	Lonoke	2.25
Substance diagnosis presence on Arkansas hospital discharge with evidence of emergency department utilization – rate of discharges with evidence of ED utilization per 1,000 county population in 2013, based on county of residence (n = 71 counties)	White	1.17
	Searcy	1.12
	Garland	1.09
	Crawford	1.09
	Jackson	1.08

Conclusion and recommendations

The correlation analysis identified five indicators that had the most influence on non-specific overdose deaths: opiate-related arrests, treatment admissions, opioid diagnosis on hospital inpatient discharges, opioid diagnosis on emergency department discharges and opioid distribution by prescription. Correlation coefficients and p-values for each of the five indicators are shown in Table 6.

Table 6. Spearman correlation coefficients between outcome indicators and most selected indicators:

	Overdose deaths (non-specific) from NCHS		Drug overdose deaths (non-specific) based on autopsy results	
	Coefficient	**p-value**	**Coefficient**	**p-value**
Opiate-related arrests for selling/manufacturing or possession	0.32	<0.005	0.25	0.03
Treatment admissions based on county of residence	0.31	0.0067	0.26	0.02
Opioid diagnosis presence on Arkansas inpatient discharges	0.46	<.0001	0.28	0.01
Opioid diagnosis presence on Arkansas hospital discharge with evidence of emergency department utilization	0.32	0.0051	0.26	0.02
Opioid distribution	0.65	<.0001	0.36	0.002

Adding the ascending ranks for the five indicators and two outcome measures provided scores representing the most at-risk counties. See Table 7 for the list of most at-risk counties. Figure 2 shows the scores for each county, where red counties had the highest scores and green counties had the lowest scores.

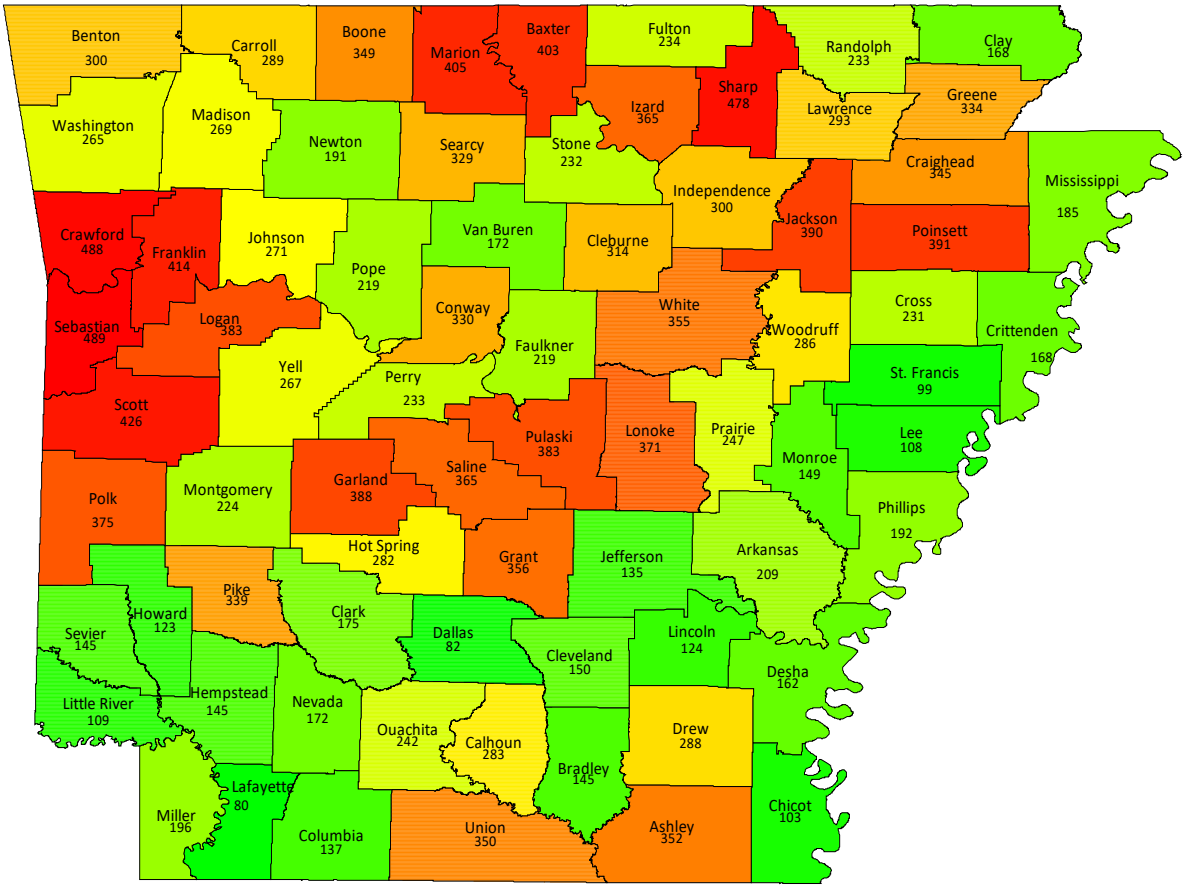
Table 7. Top 20 counties for consideration

Rank	County	Rank	County
1	Sebastian	11	Pulaski
2	Crawford	12	Logan
3	Sharp	13	Polk
4	Scott	14	Lonoke
5	Franklin	15	Saline
6	Marion	16	Izard
7	Baxter	17	Grant
8	Poinsett	18	White
9	Jackson	19	Ashley
10	Garland	20	Union

Below are the current recommendations based on state and county data. It is important to note that capacity for each community needs to be considered prior to final selection:

1. School/college settings. As noted in Table 1, Arkansas youth 12-17 and 18-25 rank 1st and 4th in the nation, respectively. Use before age 25 is associated with opiate addiction - this is a community that the council may consider.
2. Counties in Arkansas Prevention Region 5 (Crawford, Franklin, Logan, Polk Sebastian, and Scott)
3. Sharp, Jackson, Izard, and White counties in Arkansas Prevention Region 3
4. Poinsett and Craighead in Arkansas Prevention Region 4
5. Garland county in Arkansas Prevention Region 8
6. Counties in Arkansas Prevention Region 9 (Pulaski, Saline, Prairie, and Lonoke)
7. Grant, Union, and Ashley counties are in separate Arkansas Prevention Regions; although may warrant cross regional coordination with other communities

Figure 2.
Counties ranked by combined score of influential and outcome indicator ranks
Red indicates counties with high scores



State laws Governing Naloxone Regulation

In 2015, the Arkansas legislature passed Act 122 – the Naloxone Access Act – which allows a health care professional, acting in good faith, to directly or by standing order prescribe and dispense an opioid antagonist, such as naloxone, to:

1. A person at risk of experiencing an opioid-related drug overdose
2. A pain management clinic
3. A harm reduction organization
4. An emergency medical services technician
5. A first responder
6. A law enforcement officer or agency
7. A family member or friend of a person at risk of experiencing an opioid-related drug overdose

The Act also provides immunity from civil or criminal charges and professional sanctions to a person acting in good faith who reasonably believes that another person is experiencing an opioid-related drug overdose. The opioid antagonist administered must have been prescribed and dispensed in accordance with the Arkansas Code Annotated §20-13-1601, as long as that individual obtained the drug through prescription from a health care professional.

A second law passed in 2015. Act 1114, the Joshua Ashley Pauley Act, is a "Good Samaritan" law that provides immunity from arrest, charges or prosecution for anyone in possession of a controlled substance if that individual is seeking medical assistance for his or her self or for another individual experiencing a drug overdose. Immunity is extended if seeking medical attention is the sole reason that law enforcement would know of the possession. It further states that the individual is safe from probation, parole, restraining order or pre-trial condition violation for seeking medical attention for themselves or others. This act was named for a 20-year-old Conway man who died of an overdose. Those with him at the time of his death said they were too afraid to call for help for fear of prosecution.

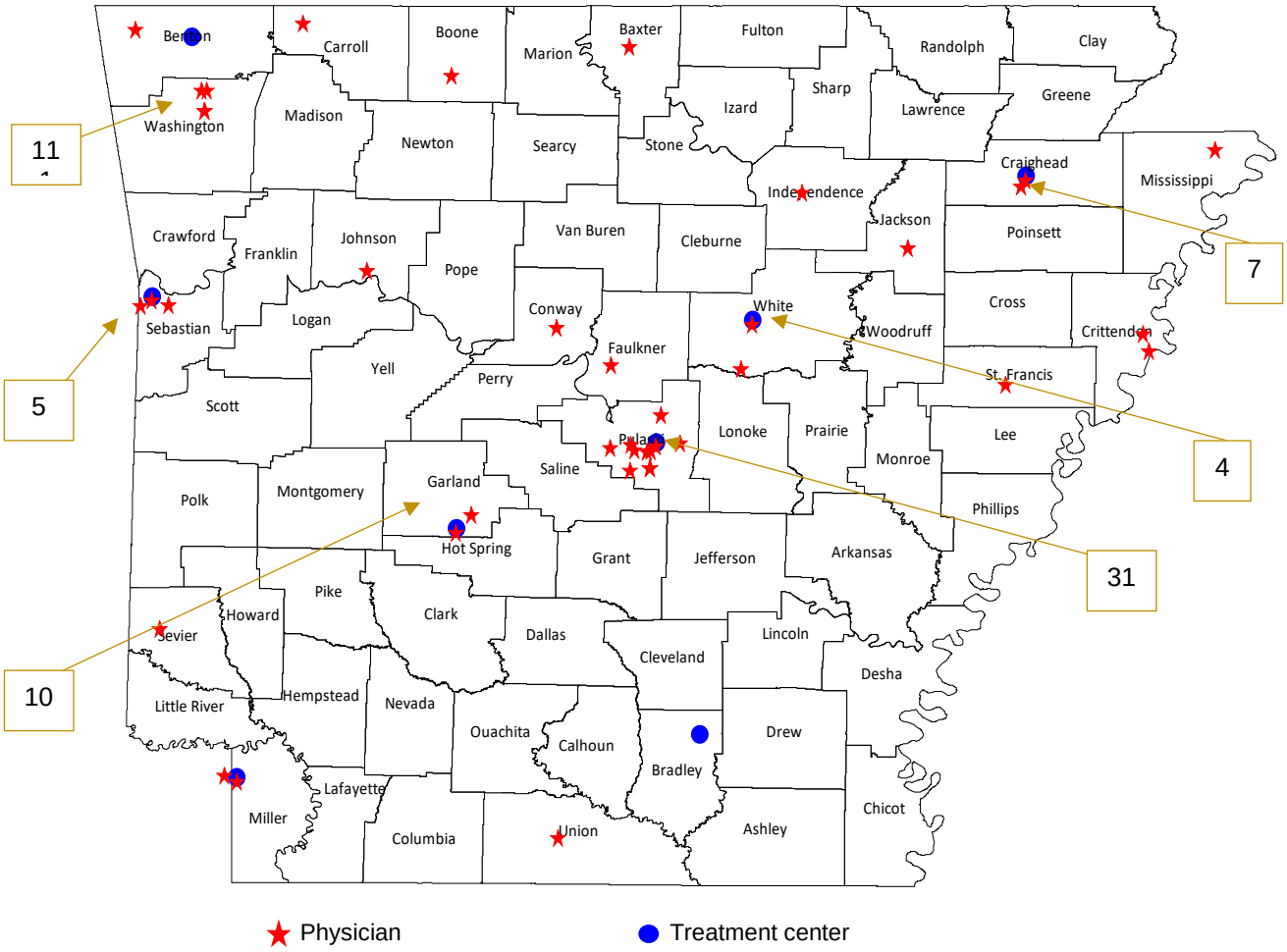
Naloxone Distribution System

Arkansas does not currently have a formalized statewide naloxone distribution system or protocol. Therefore, further summary or gaps in the current system are not available. Areas of greatest need were outlined within previous portions of this report. A naloxone distribution plan specific to this funding is being developed with anticipated finalization and approval within two months.

Appendix

Treatment Capacity Map

Locations of physicians with DEA waiver and funded licensed substance abuse treatment providers

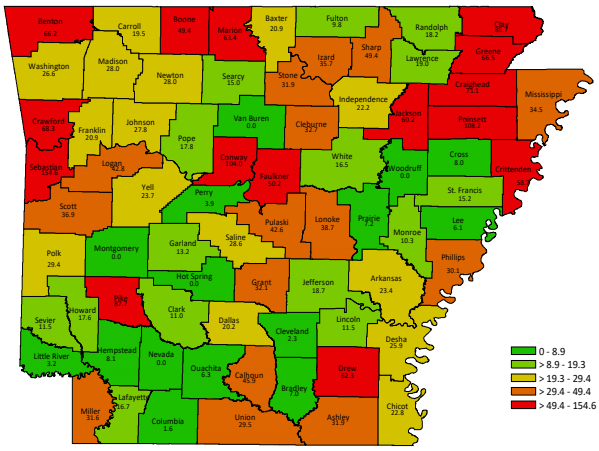


For counties with more than one physician with a waiver at a single zip code, the actual number of physicians for the entire county is given.

Indicator Maps

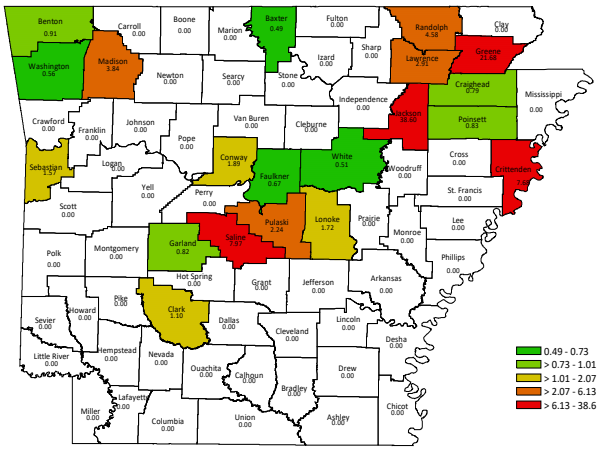
Opiate-related arrests for selling/manufacturing or possession

average rate per 100,000 county population from 2011 to 2015



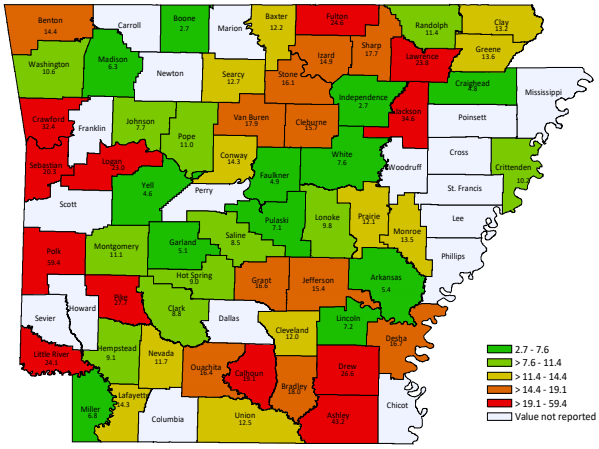
Heroin-specific drug arrests for selling/manufacturing or possession

average rate per 100,000 county population from 2011 to 2015



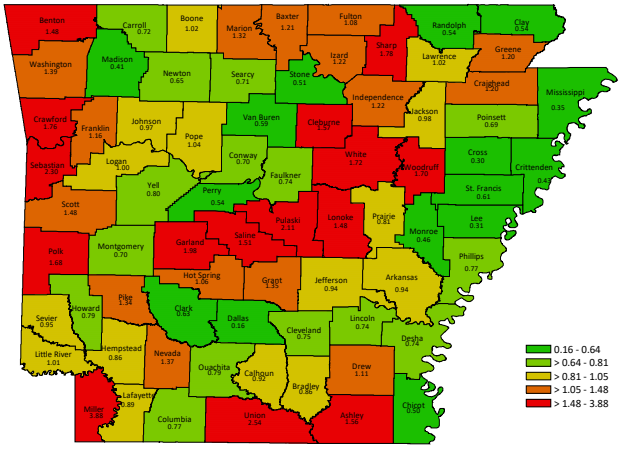
Prisoner treatment admissions for opiates in 2016 based on county of residence

per 100,000 county population in 2015



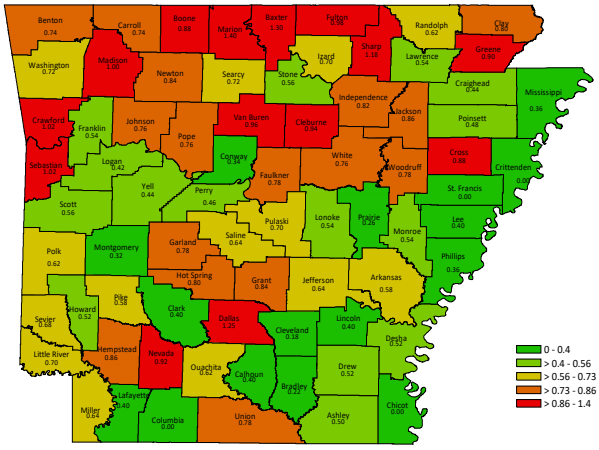
Treatment admissions based on county of residence

average rate per 1,000 county population from 2011 to 2015



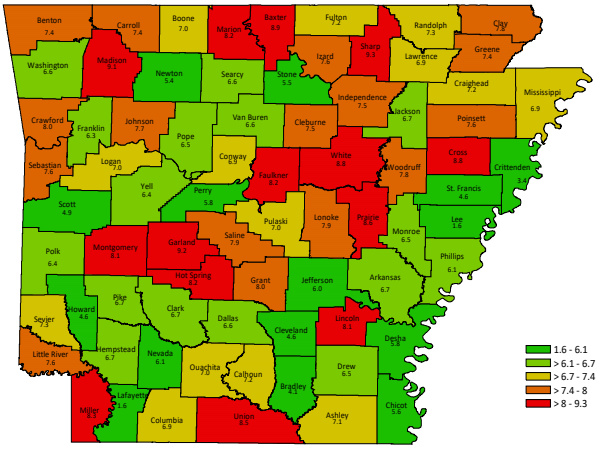
Students using heroin (lifetime)

average percent of students from 2012 to 2016

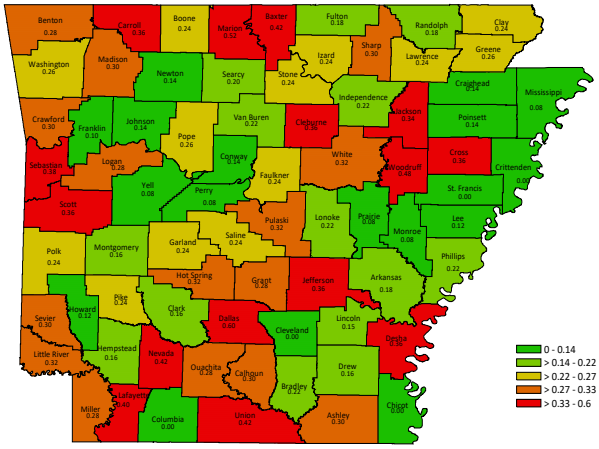


Students using prescription drugs (lifetime)

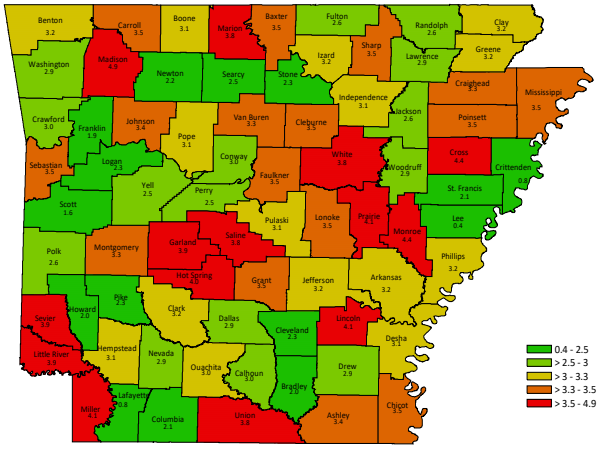
average percent of students from 2012 to 2016



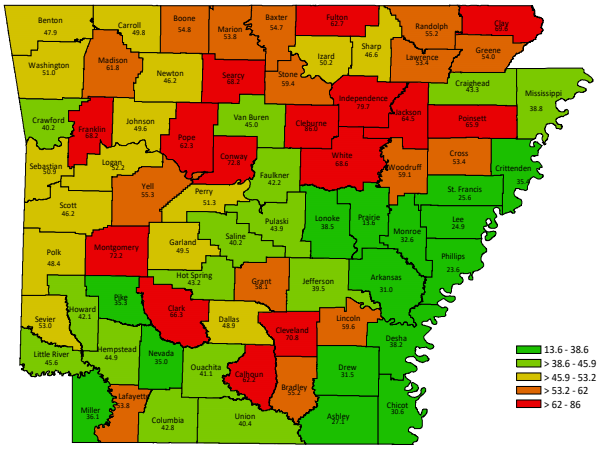
Students using heroin (30-day)
average percent of students from 2012 to 2016



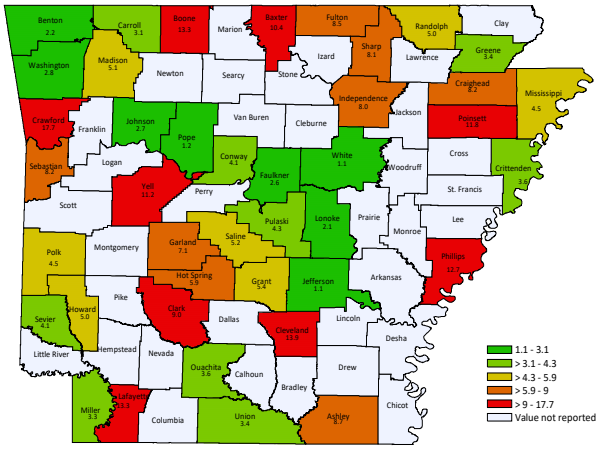
Students using prescription drugs (30-day)
average percent of students from 2012 to 2016



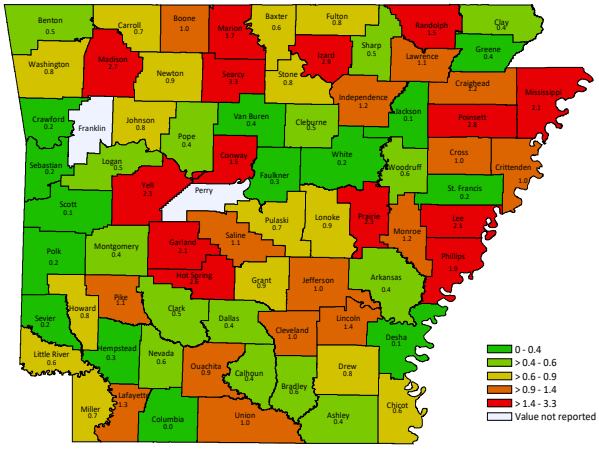
Removal of children due to drug use
average percent of removals from 2012 to 2016



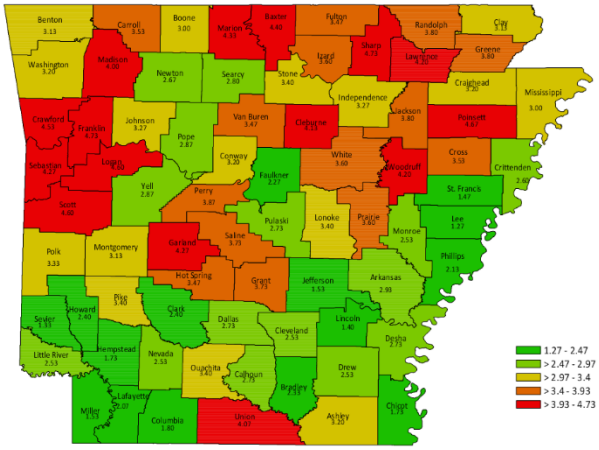
New mothers testing positive for opiates in SFY 2016
per 1,000 live births in 2015



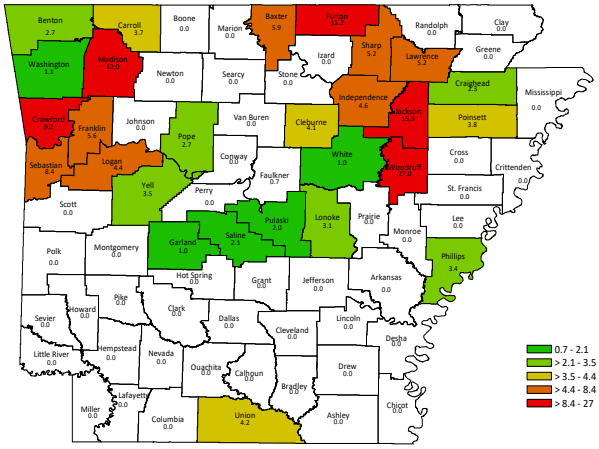
Naloxone administration in SFY 2016
per 1,000 county population in 2015



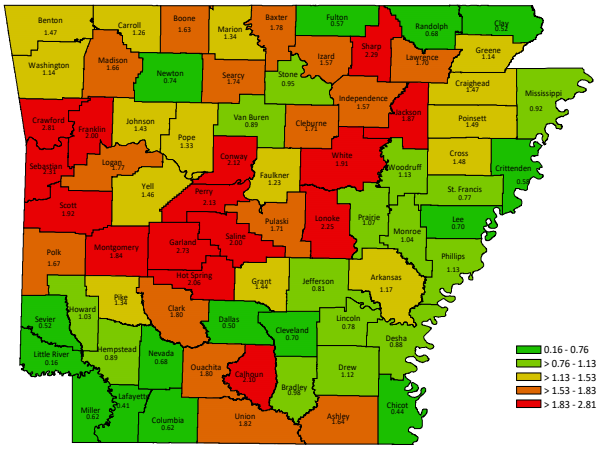
Opioid distribution
average score of 1-6 in 2014 and 2015



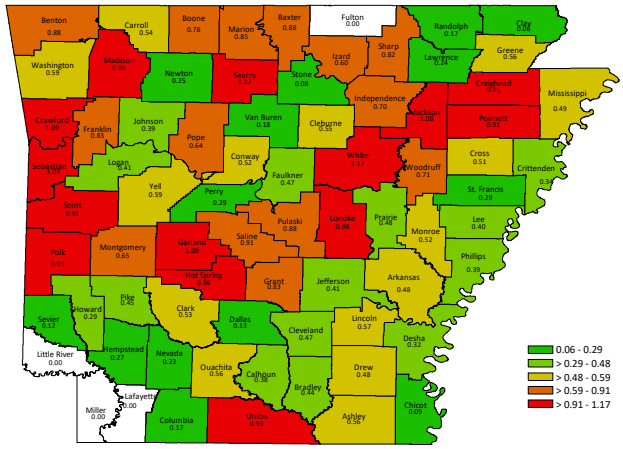
Neonatal Abstinence Syndrome incidence
per 1,000 live in-hospital births in 2013



Opioid diagnosis presence on Arkansas inpatient discharges
per 1,000 county population in 2013



Opioid diagnosis presence on Arkansas hospital discharge with evidence of emergency department utilization
per 1,000 county population in 2013

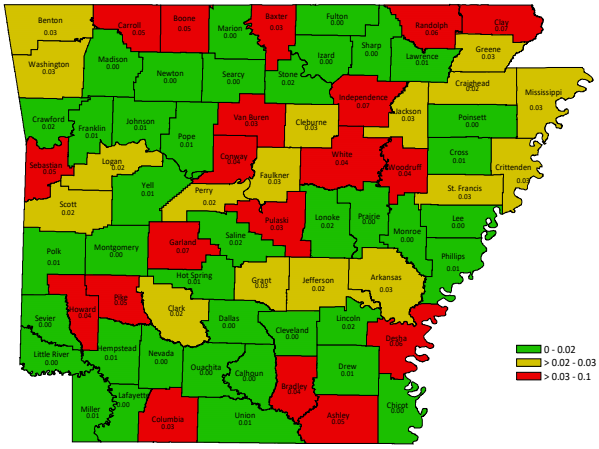


Note – Opioid diagnosis includes the following:

- Opioid dependence
- Combinations of opioid drug with any other drug dependence
- Opioid abuse
- Poisoning by opium (alkaloids), unspecified; heroin; methadone; other opiates and related narcotics
- Poisoning by opiate antagonists
- Accidental poisoning by heroin; methadone; other opiates and related narcotics
- Heroin, methadone, other opiates and related narcotics causing adverse effects in therapeutic use
- Opiate antagonists causing adverse effects in therapeutic use

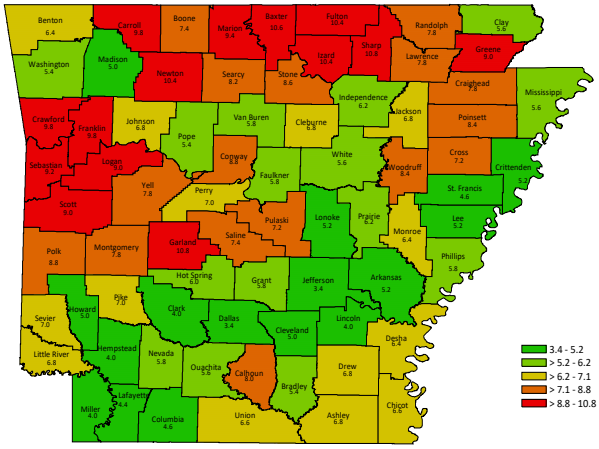
Opiate poisoning

average rate per 1,000 county population in 2012 to 2015



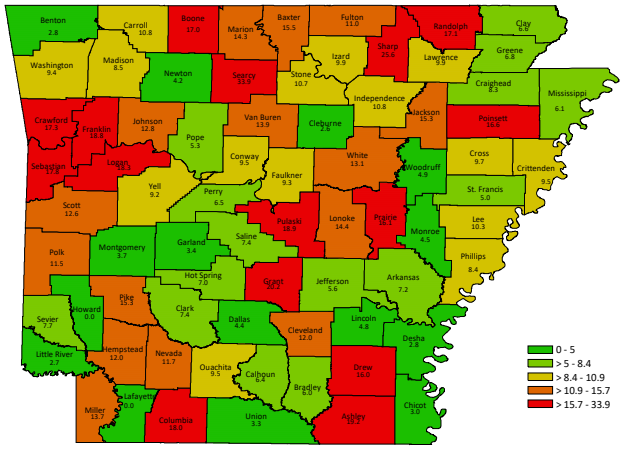
Overdose deaths (non-specific)

average score of 1-11 from 2010 to 2014



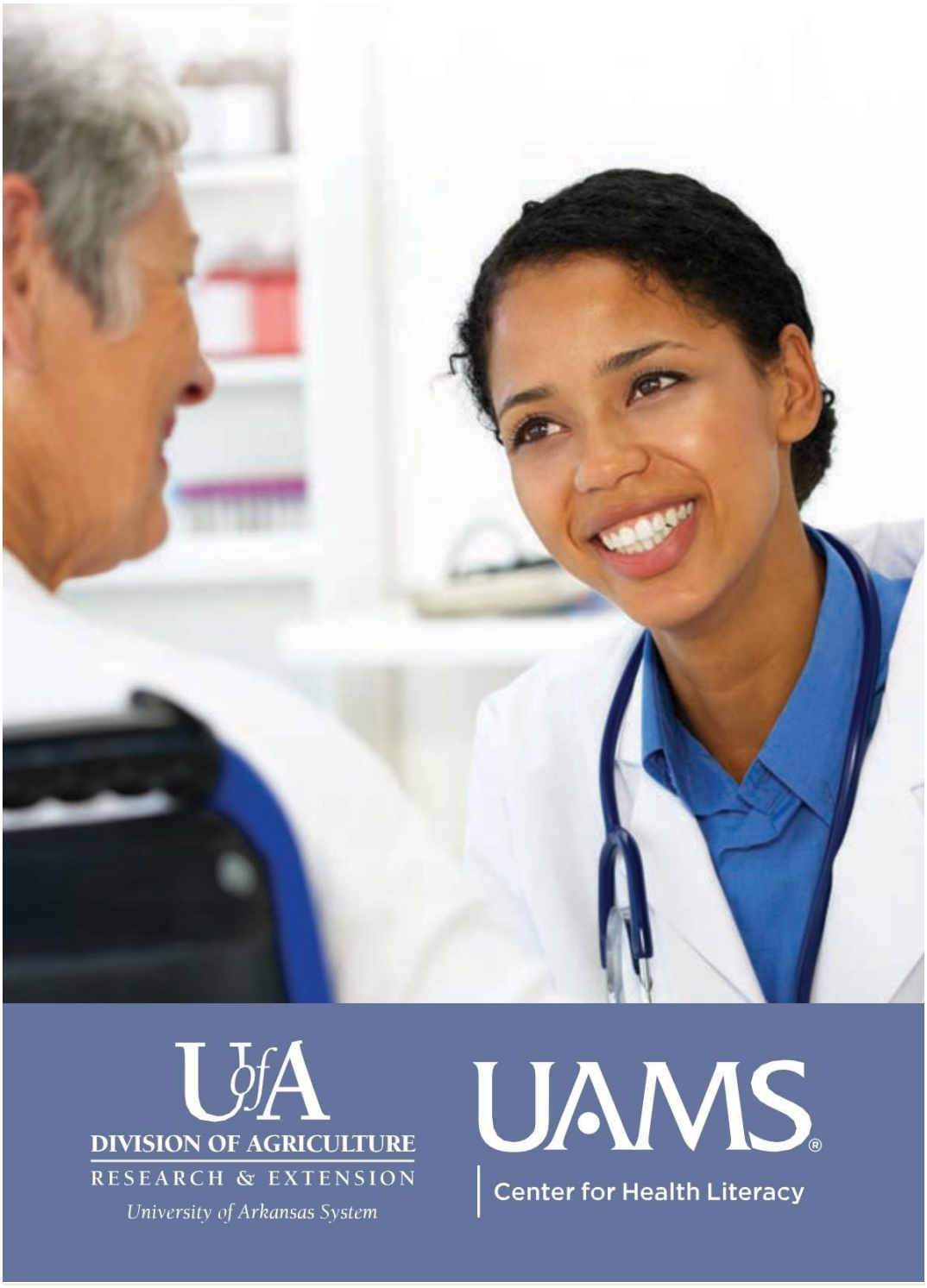
Drug overdose deaths (non-specific) based on autopsy results

average rate per 100,000 county population from 2014 to 2016



***Note: Needs Assessment prepared by AFMC**

Appendix 8: *"How to Talk to Your Doctor" Health Literacy Tool*



1. Remember!

Remember to bring the things you need to read, hear, and talk to your doctor.

4

1. Remember to take to my visit…

- ☐ Insurance card
- ☐ ID card
- ☐ Glasses
- ☐ Hearing aids
- ☐ Helper/Listener
- ☐ Calendar/Schedule
- ☐ This HANDbook
- ☐ Bag of all your meds

Other:

- ☐ _____
- ☐ _____
- ☐ _____

5

2. TWO-minute history

Practice telling your doctor what you need to say in just two minutes.

Write down notes on the next page to help you remember what to say.

6

2. Two-minute history:
My important health problems…

_____

_____

_____

_____

_____

_____

Why I am at this visit...

_____

_____

When my recent problems started...

_____

_____

What I want out of this visit...

_____

_____

7

3. Words

Repeat instructions and information back in your own Words.

Decide how you will start the conversation with your doctor. Pick an example on the next page or write your own.

8

3. How will you repeat instructions and information in your own Words?

- ☐ So here's how I understood you...
- ☐ So when I go home I will...
- ☐ You just told me a lot of information. Let me be sure I got it all...
- ☐ Other:

_____

_____

_____

_____

_____

9

4. FORms

Don't FORget to fill out FORms completely. Ask for help if forms are hard to fill out. Take a list of things that may be in forms.

Write down the information you will need to fill out forms on the next page.

10

4. Information for FORms...

Past health problems (surgeries, sickness, family history):

_____

_____

_____

_____

Doctors I see (name, kind, address, phone #):

_____

_____

_____

_____

Other info I need:

_____

_____

_____

11

5. Med List

Brand or Generic Name of Med:	Description:	Purpose:	Dosage: how much	When taken: days and times
Omeprazole	Pink/Red Capsule	Acid Reflux	10mg	once a day, morning

5. Med List

Brand or Generic Name of Med:	Description:	Purpose:	Dosage: how much	When taken: days and times

How to Talk to Your Doctor

HANDbook

1. Remember
the things you need to take to your visit.

2. Two-minute history
Tell your doctor your health problems in two-minutes.

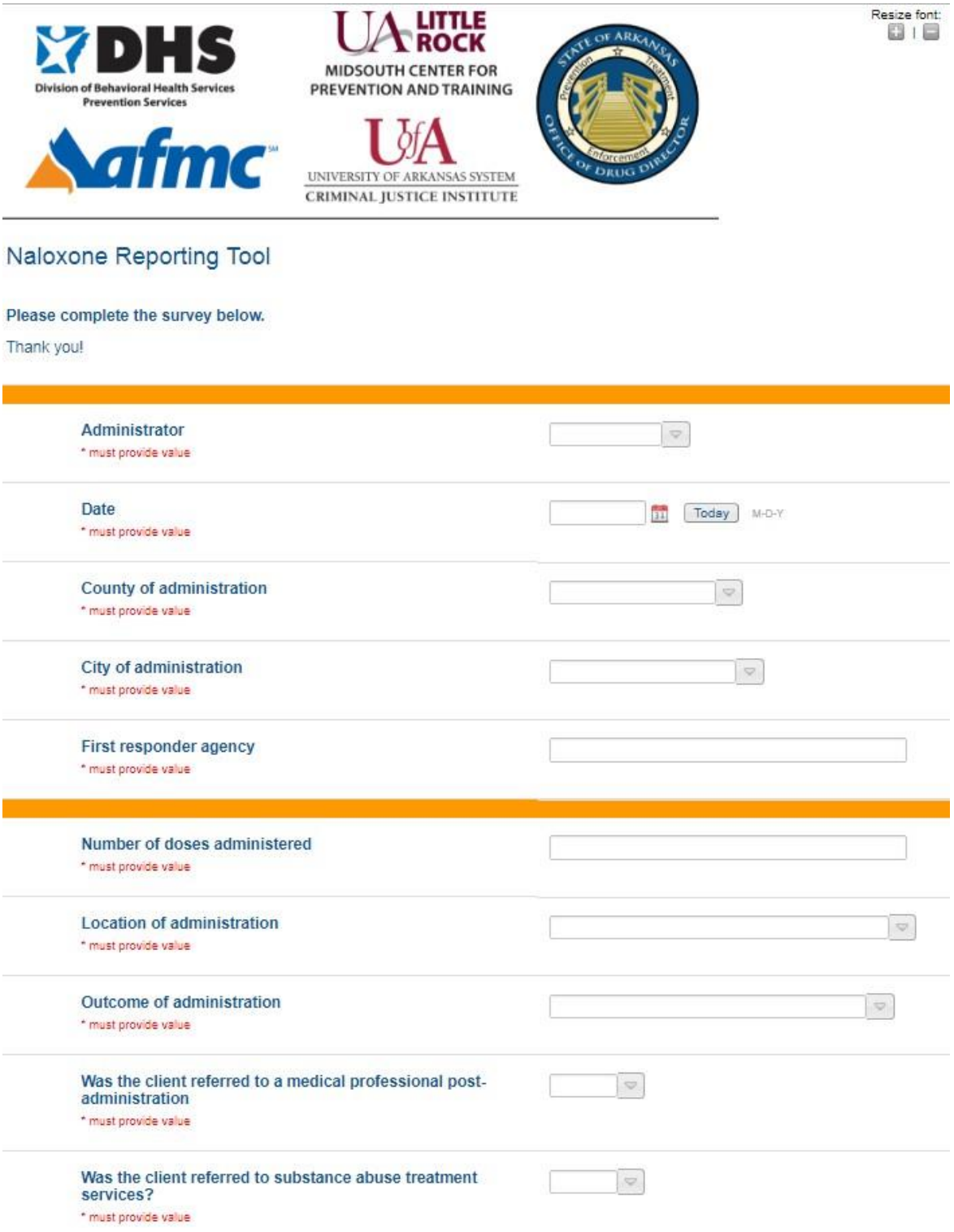
3. Words
Repeat instructions and information back in your own Words.

4. FORms
Don't FORget to fill out all your FORms completely.

5. Take your meds
Take meds as labeled AND take all your meds to your visit.

15

Appendix 9: *Naloxone Reporting Tool*



Resize font:

DHS Division of Behavioral Health Services Prevention Services

UA LITTLE ROCK MIDSOUTH CENTER FOR PREVENTION AND TRAINING

afmc

UofA UNIVERSITY OF ARKANSAS SYSTEM CRIMINAL JUSTICE INSTITUTE

STATE OF ARKANSAS Prevention Treatment Enforcement OFFICE OF DRUG DIRECTOR

Naloxone Reporting Tool

Please complete the survey below.

Thank you!

Administrator
* must provide value

Date
* must provide value
Today M-D-Y

County of administration
* must provide value

City of administration
* must provide value

First responder agency
* must provide value

Number of doses administered
* must provide value

Location of administration
* must provide value

Outcome of administration
* must provide value

Was the client referred to a medical professional post-administration
* must provide value

Was the client referred to substance abuse treatment services?
* must provide value

Substance used

- [ ] Alcohol
- [ ] Amphetamines
- [ ] Barbiturates
- [ ] Benzodiazepine
- [ ] Cocaine (excluding crack cocaine)
- [ ] Crack Cocaine
- [ ] Hallucinogens
- [ ] Heroin
- [ ] Inhalants
- [ ] Marijuana/Hashish
- [ ] Methamphetamine
- [ ] None
- [ ] Non-Rx Methadone
- [ ] Other
- [ ] Other Opiates and Synthetics
- [ ] Other Sedatives of Hypnotics
- [ ] Other Stimulants
- [ ] Over the Counter
- [ ] PCP
- [ ] Tranquilizers
- [ ] Unknown Substances

Demographics of recipient

Date of birth [ ] Today M-D-Y

Race
* must provide value

Ethnicity
* must provide value

Gender
* must provide value

Education

Occupation
https://www.bls.gov/oes/current/oes_stru.htm

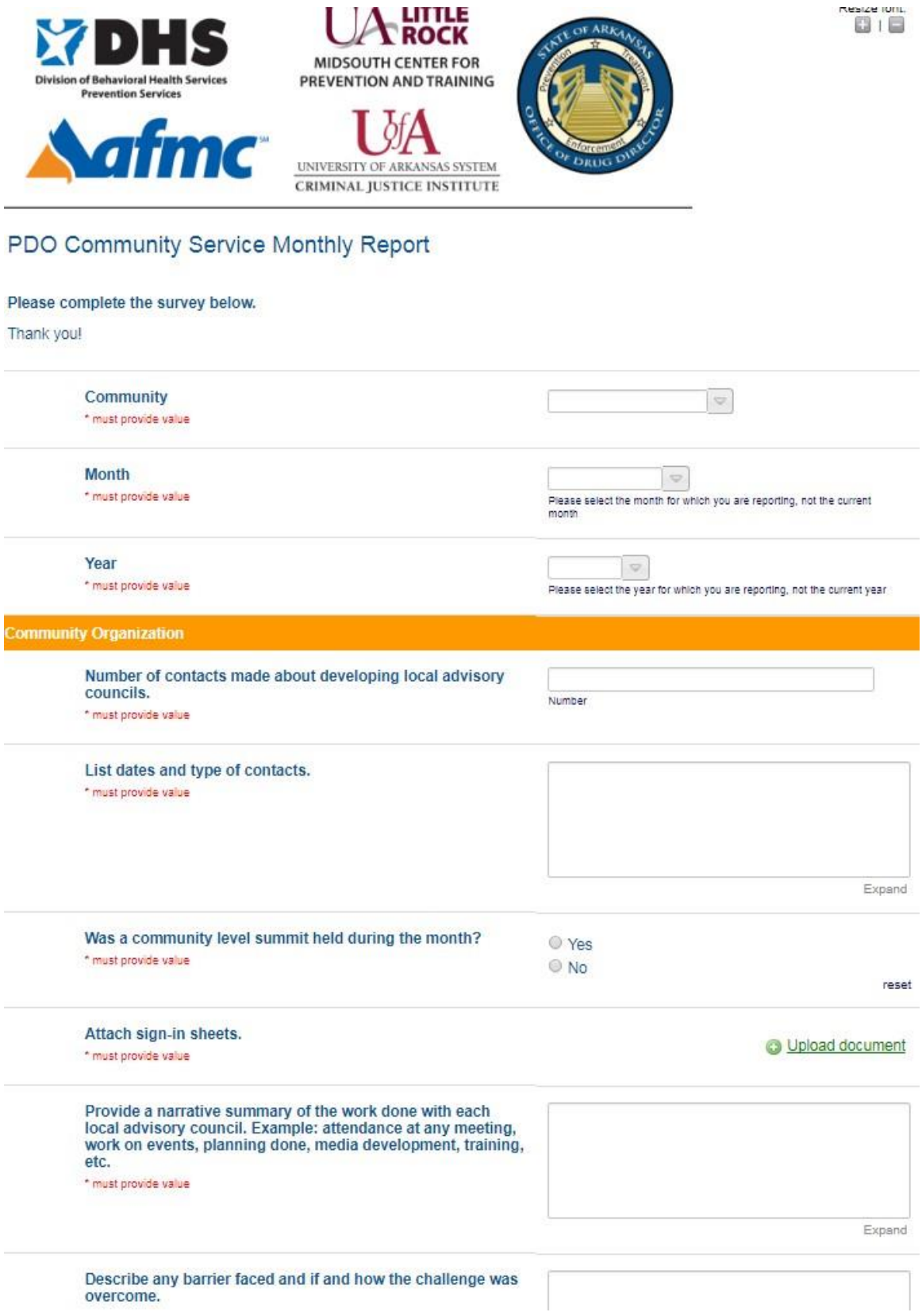
Comments

Other comments/notes about administrations
* must provide value

Expand

Submit

Appendix 10: *PDO Community Service Monthly Report*



DHS Division of Behavioral Health Services Prevention Services

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UofA UNIVERSITY OF ARKANSAS SYSTEM CRIMINAL JUSTICE INSTITUTE

STATE OF ARKANSAS Prevention Treatment Enforcement OFFICE OF DRUG DIRECTOR

Resize font: + | −

PDO Community Service Monthly Report

Please complete the survey below.

Thank you!

Community
* must provide value

Month
* must provide value
Please select the month for which you are reporting, not the current month

Year
* must provide value
Please select the year for which you are reporting, not the current year

Community Organization

Number of contacts made about developing local advisory councils.
* must provide value
Number

List dates and type of contacts.
* must provide value
Expand

Was a community level summit held during the month?
* must provide value
Yes
No
reset

Attach sign-in sheets.
* must provide value
Upload document

Provide a narrative summary of the work done with each local advisory council. Example: attendance at any meeting, work on events, planning done, media development, training, etc.
* must provide value
Expand

Describe any barrier faced and if and how the challenge was overcome.

Naloxone Distribution

Number of doses purchased.
* must provide value
Number

Number of doses distributed by first responders.
* must provide value
Number

Number of doses distributed by treatment centers.
* must provide value

Number of administrations.
* must provide value
Number

Trainings

Number of trainings conducted on opioid overdose death prevention strategies
* must provide value
Number

Number of medical professionals trained on the risks of overprescribing
* must provide value
Number

Number of people reporting learning new information or skills as a result of education/training
* must provide value
Number

Number of people reporting using the information/skills learned
* must provide value
Number

Number of people reporting feeling confident in using the skills learned
* must provide value
Number

Number of individuals accurately recognizing overdose symptoms
* must provide value
Number

First Responder Face to Face Training

Number of law enforcement officers trained.
* must provide value
Number

Number of EMTs trained.
* must provide value
Number

Number of other first responders trained.
* must provide value
Number

Dates and locations of trainings.
* must provide value

Attach sign-in sheets.
* must provide value

Upload document

On-line Refresher Trainings

Number of on-line refreshers.
* must provide value

Number

Training of Trainer to Substance Abuse Centers

Number of training of trainer to substance abuse centers.
* must provide value

Number

Number of substance abuse treatment providers trained.
* must provide value

Number

Number of family members trained.
* must provide value

Number

Dates and location.
* must provide value

Expand

Attach sign-in sheets.
* must provide value

Upload document

Number of first responders who reported in a post training survey that they feel confident in administering naloxone.
* must provide value

Number

Training of Trainer for Layperson Naloxone Administration

Number of individuals trained in training of trainer for layperson naloxone administration.
* must provide value

Number

Dates and locations of trainings.
* must provide value

Expand

Attach sign-in sheets.
* must provide value

Upload document

Number of individuals who reported in a post training survey that they feel confident in providing training to family and supportive individuals.
* must provide value

Number

Training of Trainer for Layperson Naloxone Administration

Number of individuals trained in training of trainer for layperson naloxone administration.
* must provide value

Number

Dates and locations of trainings.
* must provide value

Expand

Attach sign-in sheets.
* must provide value

Upload document

Number of individuals who reported in a post training survey that they feel confident in providing training to family and supportive individuals.
* must provide value

Number

Drug Summit

Number of materials provided to physicians during Drug Summit.
* must provide value

Number

Number of physicians seen during Drug Summit.
* must provide value

Number

Attach agenda and sign-in sheets for Drug Summit.
* must provide value

Upload document

Media Campaign (All media require prior approval by DBHS) Break down by community.

Number of broadcast presentations.
* must provide value

Number

Number of social media posts.
* must provide value

Number

Number of print ads or news stories.
* must provide value

Number

Number of billboards.
* must provide value

Number

Describe any responses to media. Provide demographics of potential audience.
* must provide value

Expand

Health Literacy Promotion

Number of Med Handbooks distributed by community.
* must provide value

Number

Number of events to promote health literacy by community.
* must provide value

Number

Provide narrative detail about event, include date, location, time, demographics, and any promotional materials and sign-in sheets.
* must provide value

Expand

Attach any promotional materials and sign-in sheets.
* must provide value

Upload document

Process Data Collection

Number of contacts with data collection contractor.
* must provide value

Number

Narrative description of contact including type of data shared.
* must provide value

Expand

Submit

Appendix 11: *SAMHSA Opioid Overdose Prevention Toolkit*

FIVE ESSENTIAL STEPS FOR FIRST RESPONDERS

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. In 2014, 28,647 of drug overdose deaths involved some type of opioid, including heroin.[1] U.S. overdose deaths involving prescription opioid analgesics increased to about 19,000 deaths in 2014[2,3] more than three times the number in 2001.[2]

To address the problem, emergency medical personnel, health care professionals, and patients increasingly are being trained in the use of the opioid antagonist naloxone hydrochloride (naloxone), which is the treatment of choice to reverse the potentially fatal respiratory depression caused by opioid overdose. (Note that naloxone has no effect on non-opioid overdoses, such as those involving cocaine, benzodiazepines, or alcohol.)[4]

The steps outlined below are recommended to reduce the number of deaths resulting from opioid overdoses[3,5,6,7,8,9,10,11]

STEP 1: CALL FOR HELP (DIAL 911)

AN OPIOID OVERDOSE NEEDS IMMEDIATE MEDICAL ATTENTION. An essential step is to get someone with medical expertise to see the patient as soon as possible, so if no emergency medical services (EMS) or other trained personnel are on the scene, dial 911 immediately. All you have to say is "Someone is not breathing." Be sure to give a clear address and/or description of your location.

STEP 2: CHECK FOR SIGNS OF OPIOID OVERDOSE

Signs of **OVERDOSE**, which often results in death if not treated, include [4]:

- Extreme sleepiness, inability to awaken verbally or upon sternal rub.
- Breathing problems that can range from slow to shallow breathing in a patient that cannot be awakened.
- Fingernails or lips turning blue/purple.
- Extremely small "pinpoint" pupils.
- Slow heartbeat and/or low blood pressure.

Signs of **OVERMEDICATION**, which may progress to overdose, include: [4]

- Unusual sleepiness, drowsiness, or difficulty staying awake despite loud verbal stimulus or vigorous sternal rub.
- Mental confusion, slurred speech, intoxicated behavior.
- Slow or shallow breathing.
- Extremely small "pinpoint" pupils, although normal size pupils do not exclude opioid overdose.
- Slow heartbeat, low blood pressure.
- Difficulty waking the person from sleep.

Because opioids depress respiratory function and breathing, one telltale sign of a person in a critical medical state is the "death rattle." If a person emits a "death rattle"—an exhaled breath with a very distinct, labored sound coming from the throat—emergency resuscitation will be necessary immediately, as such a sound almost always is a sign that the individual is near death.[8]

STEP 3: SUPPORT THE PERSON'S BREATHING

Ventilatory support is an important intervention and may be life-saving on its own. Patients should be ventilated with oxygen prior to administration of naloxone.[3,5] In situations where oxygen is not available, rescue breathing can be very effective in supporting respiration.[3] Rescue breathing for adults involves the following steps:

- Be sure the person's airway is clear (check that nothing inside the person's mouth or throat is blocking the airway).
- Place one hand on the person's chin, tilt the head back and pinch the nose closed.
- Place your mouth over the person's mouth to make a seal and give 2 slow breaths.
- The person's chest should rise (but not the stomach).
- Follow up with one breath every 5 seconds.

STEP 4: ADMINISTER NALOXONE

Any patient who presents with signs of opioid overdose, or when this is suspected, should be administered naloxone. Naloxone injection is approved by the FDA and has been used for decades by EMS personnel to reverse opioid overdose and resuscitate individuals who have overdosed on opioids.

Naloxone can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection.[8-10] The most rapid onset of action is achieved by intravenous administration, which is recommended in emergency situations.[8] The dose should be titrated to the smallest effective dose that maintains spontaneous normal respiratory drive.

Opioid-naive patients may be given starting doses of up to 2 mg without concern for triggering withdrawal symptoms depending on the route of administration.[3,9,12]

The intramuscular route of administration for naloxone may be suitable for patients with suspected opioid use disorder because it provides a slower onset of action and a prolonged duration of effect, which may minimize rapid onset of withdrawal symptoms.[3,6,13]

DURATION OF EFFECT. The duration of effect of naloxone is 20 to 90 minutes depending on dose and route of administration[5], and overdose symptoms.[8,9,13] The goal of naloxone therapy should be to restore adequate spontaneous breathing, but not necessarily complete arousal.[13]

More than one dose of naloxone may be needed to revive someone who is overdosing. Patients who have taken longer-acting opioids may require further intravenous bolus doses or an infusion of naloxone.[4]

Comfort the person being treated, as withdrawal triggered by naloxone can feel unpleasant. As a result, some persons become agitated or combative when this happens and need help to remain calm.

SAFETY OF NALOXONE. The safety profile of naloxone is remarkably high, especially when used in low doses and titrated to effect.[3,8,12,15] When given to individuals who are not opioid-intoxicated or opioid-dependent, naloxone produces no clinical effects, even at high doses. Moreover, although rapid opioid withdrawal in tolerant patients may be unpleasant, it is not life-threatening.

Naloxone can be used in life-threatening opioid overdose circumstances in pregnant women.[16]

The FDA has approved injectable naloxone, intranasal naloxone (called Narcan® Nasal Spray), and a naloxone auto-injector (called Evzio®[1]). The currently available naloxone kits that include a syringe and naloxone ampules

[1] http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm391465.htm

or vials or a prefilled naloxone syringe and a mucosal atomizer device to enable intranasal delivery require the user to be trained on how to assemble all of the materials and administer the naloxone to the victim. The Narcan Nasal Spray is a pre-filled, needle-free device that requires no assembly, which can deliver a single dose into one nostril. The Evzio auto-injector is injected into the outer thigh to deliver naloxone to the muscle (intramuscular) or under the skin (subcutaneous). Once turned on, the device provides verbal instruction to the user describing how to deliver the medication, similar to automated defibrillators. Both Narcan Nasal Spray and Evzio are packaged in a carton containing two doses, to allow for repeat dosing if needed.

STEP 5: MONITOR THE PERSON'S RESPONSE

All patients should be monitored for recurrence of signs and symptoms of opioid toxicity for at least 4 hours from the last dose of naloxone or discontinuation of the naloxone infusion. Patients who have overdoses on long-acting opioids should have more prolonged monitoring.[3,6]

Most patients respond by returning to spontaneous breathing. The response generally occurs within 3 to 5 minutes of naloxone administration. (Continue rescue breathing while waiting for the naloxone to take effect.)[3,6,13]

Naloxone will continue to work for 30 to 90 minutes, but after that time, overdose symptoms may return.[8,9] Therefore, it is essential to get the person to an emergency department or other source of medical care as quickly as possible, even if he or she revives after the initial dose of naloxone and seems to feel better.

SIGNS OF OPIOID WITHDRAWAL. The signs and symptoms of opioid withdrawal in an individual who is physically dependent on opioids may include, but are not limited to, the following: body aches, diarrhea, tachycardia, fever, runny nose, sneezing, piloerection, sweating, yawning, nausea or vomiting, nervousness, restlessness or irritability, shivering or trembling, abdominal cramps, weakness, and increased blood pressure. In the neonate, opioid withdrawal may also include convulsions, excessive crying, and hyperactive reflexes.[8]

NALOXONE NON-RESPONDERS. If a patient does not respond to naloxone, an alternative explanation for the clinical symptoms should be considered. The most likely explanation is that the person is not overdosing on an opioid but rather some other substance or may even be experiencing a non-overdose medical emergency. A possible explanation to consider is that the individual has overdosed on buprenorphine, a long-acting opioid partial agonist. Because buprenorphine has a higher affinity for the opioid receptors than do other opioids, naloxone may not be effective at reversing the effects of buprenorphine-induced opioid overdose.[9]

In all cases, support of ventilation, oxygenation, and blood pressure should be sufficient to prevent the complications of opioid overdose and should be given priority if the response to naloxone is not prompt.

FIVE ESSENTIAL STEPS FOR FIRST RESPONDERS

SUMMARY

Do's and Don'ts in Responding to Opioid Overdose

- DO support the person's breathing by administering oxygen or performing rescue breathing.
- DO administer naloxone.
- DO put the person in the "recovery position" on the side, if he or she is breathing independently.
- DO stay with the person and keep him/her warm.
- DON'T slap or try to forcefully stimulate the person—it will only cause further injury. If you are unable to wake the person by shouting, rubbing your knuckles on the sternum (center of the chest or rib cage), or light pinching, he or she may be unconscious.
- DON'T put the person into a cold bath or shower. This increases the risk of falling, drowning, or going into shock.
- DON'T inject the person with any substance (saltwater, milk, "speed," heroin, etc.). The only safe and appropriate treatment is naloxone.
- DON'T try to make the person vomit drugs that he or she may have swallowed. Choking or inhaling vomit into the lungs can cause a fatal injury.

NOTE: All naloxone products have an expiration date, so it is important to check the expiration date and obtain replacement naloxone as needed.

ACKNOWLEDGMENTS

Acknowledgments

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