A New Patrol Paradigm: Police Officers Carrying Naloxone (Narcan[1]) and Reversing Overdoses

BY SGT. WILLIAM DOHERTY, FLORAL PARK POLICE DEPARTMENT

Sgt. William Doherty

About the author: Sgt. Doherty was a police officer in the New York City Police Department from 1998-2000. He transferred to the Floral Park Police Department (Nassau County) in 2000 where he is currently a patrol supervisor and a certified General Topics Police Instructor. He was a New York State certified Emergency Medical Technician – Critical Care (EMT-CC) from 1997-2010. He is a 2007 graduate of Pace University School of Law and is admitted to practice law in the State of New York.

INTRODUCTION

Police department responses to medical emergencies are nothing new to our field. Depending on the size of the police department, patrol officers may respond to hundreds or thousands of medical aided cases per year. Among the most frequent of these assignments is that of the "unconscious person." Aided persons can become unconscious for a wide variety of reasons, and a common one is due to opioid overdose. Frequently police are first to arrive at the scene of an overdose. Sometimes, police will get there long before emergency medical services, depending on the service area.

According to the New York State Department of Health (NYSDOH), drug overdose deaths throughout the State have risen from 1,395 in 2010 to 1,848 in 2012—an increase of more than 30 percent.[2] Opioid painkillers were involved in 879 of these deaths in 2012.[3] In 2012, heroin was involved in 478 of the State's overdose deaths, an increase of over 180 percent from two years earlier.[4]

According to the New York State Attorney General's office, 40 percent of overdose deaths nationwide are from overdoses of opioid painkillers.[5] These drugs include oxycodone, hydrocodone and others that may be prescribed for lawful reasons. Sometimes the overdose is deliberate; sometimes the overdose is a tragic accident. Overdoses are also common with illicit drugs such as heroin. During the decade following the year 2000, heroin overdoses increased 55 percent.[6] In New York State alone, 2,051 people died from a fatal opioid overdose in 2011. That statistic was twice the number of fatal overdoses reported in 2004.[7] New York City saw fatal heroin overdoses skyrocket 84 percent from 2010 to 2012.[8]

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>
> – NYS Attorney General's Office

Police officers serve on the front lines of fatal overdoses. A poll of veteran police officers would be unlikely to find one who has never responded to an overdose where the aided person had either already died or was near death. One of the avenues through which police officers are able to combat fatal overdoses is by being equipped with an opioid antagonist drug called naloxone. Naloxone is an easy-to-administer medication that can be legally carried and administered by appropriately trained police officers in New York State.

As with many new, and untraditional tools available for police officers there are barriers to entry into the departmental cache of resources. Whether it is funding for the materials or funding for the necessary training, new initiatives may meet unintended resistance. The New York State Department of Health, working with the Division of Criminal Justice Services (DCJS), has undertaken efforts to overcome these barriers as has the New York State Attorney General's office, through its Community Overdose Prevention (C.O.P.) program. Assistance of these state agencies, coupled with some innovative thinking on the part of police departments, has enabled our profession to play a larger role in saving the lives of these New Yorkers.

This article is meant solely to be a primer for the police executive who may be interested in this initiative. It is not meant to replace training in any of the topics herein. For complete information and training materials, the reader should refer to some of the sources listed below along with their local training academies, etc.

WHAT ARE OPIOIDS?

The term "opiate" is applied to any drug derived from the opium poppy. Morphine, codeine and heroin are examples of opiates. The term "opioid" is used to include these opiates as well as synthesized drugs which behave in the same way as opiates.[9] These synthesized opioids include hydrocodone (Vicodin), oxycodone (OxyContin), oxymorphone hydrochloride (Opana), and many others.

The effects of opioids in the brain can be threefold: 1) they have an analgesic—or pain-killing—effect; this is generally why opioids are *prescribed*, 2) they create euphoria—or a feeling of being

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high; this is generally why opioids are *abused* and 3) opioids suppress the person's drive to breathe. The drugs will tell the brain that the person can breathe less than it normally would. This becomes a problem when prolonged exposure causes the brain to signal the body to stop breathing or to breathe so little that the aided person becomes hypoxic (lacking oxygen in the blood system). A cascade effect results in brain damage, respiratory arrest, cardiac arrest and ultimately, death.

WHAT IS NALOXONE[10]?

Naloxone is a medication that has been used in hospitals and the pre-hospital emergency medical setting for more than 40 years. It is an opioid antagonist. This means that it works to block the effect of opioids on the brain.

If the reader can take a moment to hearken back to the days of high school or college biology class, something called "Receptor Theory" may help. Basically, when any substance, whether it is prescribed medicine or some unintentionally ingested substance, enters the bloodstream it seeks a receptor in the person's brain. If there is a perfect fit, the substance or medicine's effects begin to work. Opioids seek the receptor they are designed for and when they find them, the effects take hold. When an opioid antagonist is administered to an aided, that medicine (e.g. naloxone) literally *antagonizes* the opioid's bind with its particular brain receptors. The naloxone will bounce the opioid off the receptor, chemically speaking. A good way to think of this is that the naloxone "steals the parking space[11]" of the opioid in the person's brain.

The next logical question for a police officer is: "How can an officer administer a medication such as naloxone if he or she is not a paramedic or other type of medical provider?" That answer will come in two parts, one practical and one legislative.

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THE PRACTICAL ADMINISTRATION OF NALOXONE

Some background information may be in order. Generally speaking, naloxone would be administered intravenously (through a vein) using a catheter and needle. Other administration routes, some more technical and antiseptic, are available to the trained medical provider as well. These administration routes might be the right option when there is trauma present, or no venous access. However, these options are not available to a non-emergency medical certified responder. With the advent of nasal atomizers, that has changed. Naloxone can be provided to properly trained police officers in a kit that comes with what is called an atomizer. The atomizer is a small conical piece of foam that fits in an aided person's nostril. Most drugs that can be administered intravenously can be administered intra-nasally. The septum between the nostrils, and the surfaces within the nasal passages, provides a medium through which a substance can effectively enter the bloodstream. Whether it is an illicit substance (e.g. snorting cocaine or heroin) or a worthy one such as naloxone, this is an easy route to the person's bloodstream. In the case of the police officer's naloxone atomizer, there is no sharp needle involved and no puncture into the victim's skin. The atomizer lessens the possibility of body substance exposure to the police officer. However, universal precautions such as latex gloves are always an imperative.

Intranasal administration of naloxone is also a relatively rapidly reacting entry into the aided person's bloodstream. The training regimen developed by DCJS directs police officers to spray about half of the vial of naloxone (approximately 1ml) into each nostril of the aided person. If all goes well, the drug should bring a person out of the overdose relatively soon. There are tactical considerations that are important as well. Remember that the officer who administered this life saving medication has broken the aided person's high and aideds are sometimes combative afterward. Results tend to be quick, when the aided that has overdosed has not yet gone into cardiac arrest. However, police officers trained to use naloxone should also be trained in CPR and AED usage because they often go together in these situations. For a complete instructional guide, the reader is advised to visit the DCJS website where a training guide is available for download.

WHEN TO USE NALOXONE[12]

As stated above, opioids suppress a person's drive to breathe. The drugs will tell the brain that the person can breathe less than it normally would. This becomes a problem when prolonged exposure to the opioid causes the brain to signal the person to stop breathing or to breathe so little that the aided person becomes hypoxic (lacking oxygen in the blood system). A deadly cascade effect results: brain damage, respiratory arrest, cardiac arrest and, ultimately, death.

All public safety responses to an opioid overdose should include verification that EMS has been summoned. Intervention in an opioid overdose by public safety personnel does not supplant the role of EMS. It complements it by allowing for a timely, life-saving response prior to the arrival of EMS. However, EMS still must be called.

The DCJS training regimen suggests that when the trained police officer encounters an unconscious (or semi-conscious) aided and an opioid overdose is suspected, breathing status should immediately be assessed and a painful stimulus is in order. If the person is not responsive, rub the person's sternum in such a way as to wake them. Sometimes this sternum rub is sufficient to bring the aided person back to a responsive state. If that does not work and the person is breathing normally or rapidly, DCJS suggests that the aided person be turned on his or her side in the "recovery position" so as to maintain an open airway. The additional benefit of this is that if the aided person vomits his or her airway is less likely to be impaired or blocked as a result. If the aided person is breathing less than 10 times per minute and is unresponsive, naloxone should be administered. If the aided person is unresponsive and is not breathing or is gasping, naloxone should be administered and CPR should be initiated[13].

If administered timely, naloxone can save the life of an aided person who has overdosed on opioids. However, if the person has overdosed on another substance that has caused them to stop breathing, naloxone is not likely to harm them[14]. Additionally, the

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early administration of CPR in the proper circumstances has saved countless lives.

LEGISLATIVE FRAMEWORK

Although naloxone is not a controlled drug, it does require a prescription or order be in place for it to be provided. This is no different than for any other prescription medication. As such, a legislative avenue to get this invaluable tool into the hands of non-traditional healthcare providers (such as police officers on patrol) was necessary.

The New York State legislature found that "prescriptions for opioids, particularly oxycodone and hydrocodone have skyrocketed."[15] Additionally, citing the Centers for Disease Control and Prevention's statistics, the legislature reported that every 19 minutes someone overdoses, either intentionally or accidentally, in the United States.[16] They also reported that because heroin has become cheaper than prescription opioids, "heroin addiction has increased fourfold since 2011."[17]

In 2006, New York State's Opioid Overdose Law (Public Health Law Section 3309) went into effect which implicitly permitted the prescribing of naloxone to non-medical individuals, including police officers, who were potential witnesses to an opioid overdose. This prescribing was done solely through opioid overdose programs which registered with the State Health Department pursuant to 10 NYCRR 80.138. In June of 2014, the New York State legislature enacted bill number S6477B-2013, which was signed into law as Chapter 42 of the Laws of 2014 by Governor Cuomo. This bill amended New York State Public Health Law §3309[18] to allow, among other things, non-patient specific prescriptions for the opioid antagonist naloxone. This important change allows prescribers—who must still be affiliated with registered overdose programs—to issue a standing order which covers all trained personnel within a police department. The standing order may also delegate to a General Topics Police Instructor or another non-medical person the role of actually furnishing the naloxone to one's colleagues.

Among other pertinent highlights of this law are the ability of local and state agencies such as police departments to participate in opioid prevention programs, the ability of public safety officers to carry and dispense naloxone, non-patient specific prescriptions for naloxone to be issued to organizations or agencies and agency-wide sharing of naloxone for officers under the "common organizational or workforce bond" requirement of the implementing rules.[19]

The importance of the non-patient specific prescription availability should be understood. This allows participating agencies to provide their naloxone-trained officers with shared access to naloxone kits. The naloxone kits are dispensed to the participating agency, which then permits the officers to have access and use of the naloxone kits. The practical advantage of this, according to DCJS, is that a department might choose to equip their patrol cars with a naloxone kit, rather than requiring each individual officer to carry his or her own.[20]

The 2014 changes to the regulations expanded the entities eligible to maintain their own registered opioid overdose programs. A public safety agency may now register with the State Health Department.[21] A public safety agency, however, does not need to become a registered program in order for its personnel to be trained and provisioned with naloxone. It may choose instead to work with a local registered program—perhaps a county health department, a drug treatment program, another law enforcement agency—and have its officers trained through that program.

THE GOOD SAMARITAN LAW ANEW

This information is particularly pertinent to police officers who may encounter a drug overdose or someone who has sought aid. "[P]ursuant to Chapter 154 of the Laws of 2011, a person who in good faith seeks care for himself or another… and who is experiencing a drug or alcohol overdose or other life threatening medical emergency, shall not be charged or prosecuted for a controlled substance or marihuana offense, or possession of alcohol or drug paraphernalia…" if the contraband substance came to the attention of the police while the person was seeking or receiving health care.[22] This covers someone on whose behalf a good faith request for aid is made as well. Basically, if the police officer responds because someone called for help (whether it is someone in the room, or the actual aided person him or herself) the police should not make a drug-related arrest of either party even if there are drugs or paraphernalia present. The motivation behind these changes was that the state wants to encourage people who may be suffering overdoses or problematic medical reactions to drugs (or witnessing someone else suffering from them) to call for help rather than refrain from seeking help out of fear of arrest and prosecution. These protections do not apply to possession offenses at the A-1 felony level.[23] These protections also do not apply to situations where drugs are provided for sale "for consideration or other benefit or gain." [24]

NEW YORK STATE DEPARTMENT OF HEALTH'S REGISTERED OPIOID OVERDOSE PROGRAMS[25]

There are more than 200 opioid overdose prevention programs throughout the State registered with the Department of Health. A growing number of these are law enforcement agencies or other eligible organizations that are willing to work with public safety agencies for purposes of supporting their overdose efforts. The Department of Health provides naloxone at no cost to registered programs. A link to the online directory of current programs may be found at www.health.ny.gov/overdose.

NYSDOH has worked closely with DCJS, the Harm Reduction Coalition and the Albany Medical Center in the development of the DCJS-authorized overdose curriculum, which takes approximately 60 to 90 minutes to deliver. These partners also rolled out a series of regional trainings, most of which use a train-the-trainer approach so that General Topics Police Instructors could provide the bulk of the overdose training going forward.

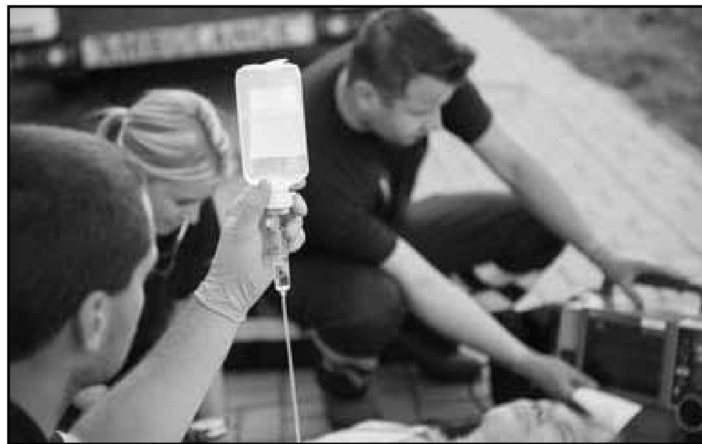

Photo credit: pond5/CandyBoxImages

THE NEW YORK STATE ATTORNEY GENERAL COMMUNITY OVERDOSE PREVENTION (C.O.P.) PROGRAM

The Attorney General's C.O.P. program offered funding to reimburse police departments for training costs (both manpower costs and materials costs) if the departments participated in the program.[26] The program allowed participating departments to be

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reimbursed for training their members as well as for purchasing naloxone kits for those police officers who were trained. This alleviated one hurdle for many departments who suffer from perennially tight purse strings. Again, the training lasts approximately 60 to 90 minutes and provides the trained officers with the ability to carry the naloxone kits as yet another tool on their proverbial tool belt.

NALOXONE AT WORK

The Floral Park Police Department has been participating in this program for approximately one year and has already used naloxone once successfully. The officer who used it is a 27 year veteran who successfully reversed an opioid overdose and brought back an aided person from the brink of disaster.[27] Since June of 2014, naloxone has been administered 194 times by law enforcement personnel, based on reports sent to the Health Department. Of these, there was a response to naloxone among 138 individuals. In nearly 90% of the naloxone administrations, a police officer was the first on the scene. In one reported case, naloxone was successfully administered within one hour after the rescuing officer was trained.[28] Since 2010, the Quincy (MA) Police Department has successfully reversed over 208 opioid overdoses.[29] As of May 2012, the Suffolk County (NY) Police Department reported over 32 successful opioid overdoses.[30] The Lummi Nation (WA) Police Department also reported several successful opioid overdoses.[31] These are just an unscientific sampling of success stories.

"Since June of 2014, naloxone has been administered 194 times by law enforcement personnel... Of these, there was a response to naloxone among 138 individuals."

CONCLUSION

As with all medical emergencies, EMS must be summoned and medical treatment must be obtained for aided persons. The information in this article is meant to provide police executives with broad-stroke information, which may then promote their interest in the topic. Proper medical training for police officers is imperative and individual research into the topic should be done by the reader.

The author has been most fortunate to gain a great deal of information and help from Mark Hammer of the New York State Department of Health in regards to this initiative.[32] He offers his assistance to agencies, and agencies desirous of participating would do well to contact him. As police officers we are often presented with new tools that are supposed to enhance our effectiveness or make us work smarter or more efficiently. Body cameras, various firearms, Tasers and body armor were not always commonplace for police officers. However, they are as ubiquitous now as star-shaped shields once were in the 19th Century. While police officers may (I stress ***may***, because this is not a given) be resistant to change, in the case of naloxone we should all be aware of how this effective tool can actually make our tours of duty easier. A life saved is one that may not need a police car to be out of service at a DOA; a life saved is one whose family will almost certainly now have an exceptionally favorable view of the police; and more importantly, the saving of a life is the very embodiment of what we all, in one way or another, swear to do: *To Serve and Protect*.

[1]Narcan is a Registered Trademark of Endo Pharmaceuticals, Inc., Chadds Ford, Pennsylvania 19317, Source: http://www.drugs.com/pro/narcan.html. Any other brand names used are trademarks of their respective manufacturers.
[2]Source: Division of HIV, STD and HCV Prevention, AIDS Institute, New York State Department of Health.
[3]*Id.*
[4]*Id.*
[5]Source: N.Y.S. Attorney General Office memorandum dated April 3, 2014, inviting law enforcement agencies to participation in the Community Overdose Prevention (C.O.P.) program.
[6]*Id.*
[7]*Id*
[3]*Id.*
[9]Naloxone will not work on drugs such as cocaine or methamphetamine that are not opiates.
[10]Naloxone is the generic name for the well-known opioid antagonist Narcan. Just as acetaminophen is to Tylenol, Naloxone is to Narcan.
[11]This anecdote is found in the DCJS training materials.
[12]For a complete training regimen and guide, see the DCJS website and attend the proper training course. this article is not meant to be an exhaustive treatment of how to use Nalaxone, but is only an introduction to how the drug can work to save lives in our communities.
[13]The above is all part of the training regimen provided by DCJS and is included in their available downloads.
[14]As with all drugs, side effects are possible. Proper training should address this topic. DCJS training materials state that no negative health outcomes have been reported after years of experience in several state and cities. See generally Opioid Overdose and Intranasal Naloxone Training for Law Enforcement Trainer's Guide.
[15]*See generally* bill jacket for L. 2014, Ch. 42.
[16]*Id.*
[17]*Id.*
[18]*See generally* N.Y.S. PHL §3309.
[19]10 NYCRR §80.138.
[20]NYS DCJS Opiod Overdose and Intranasal Nalaxone for Law Enforcement Trainer's Guide (August 2014), Appendix B: Administrative Guide, p. 4.
[21]Other eligible entities include prescribers (physicians, nurse practitioners and physician assistants); health care facilities; drug treatment programs; local and state government agencies; not-for-profit community-based organizations; colleges, universities and trade schools; and pharmacies.
[22]NYS DCJS memorandum of January 28, 2013 to statewide law enforcement agencies detailing the Good Samaritan 911 Law.
[23]Such as CPCS 1st (PL 220.21), CSCS 1st (PL 220.43), operating as a major trafficker (PL 220.77)
[24]*See generally* NYS DCJS memorandum of January 28, 2013 *supra.*
[25]Source: Mark Hammer of the New York State Department of Health.
[26]It should be noted that initially $5,000,000 was available and departments were asked to initially apply for funding by June 3, 2014. More information is available at http://ag.ny.gov/press-release/ag-schneiderman-announces-more-100-lives-saved-community-overdose-prevention-cop.
[27]Reference herein to any spcific commercial products, process, or service by trade name, trademark, manufacturer, or otherwise, does not necessarily constitute or emply its endorsement, recommendation, or favoring by the author or Floral Park Police Department (FPPD). The views and opinions of authors expressed herein do not necessarily state or reflect those of the FPPD and shall not be used for advertising or product endorsement purposes.
[28]Source: Mark Hammer, New York State Department of Health.
[29]*See generally* https://www.bjatraining.org/naloxone/what-are-some-success-stories-law-enforcement-overdose-reversal-programs.
[30]*Id.*
[31]*Id.*
[32]*Mr. Hammer is the Director of Program Integration and Special Projects, Division of HIV, STD and HCV Prevention, AIDS Institute, New York State Department of Health. Inquiries regarding the New York States opioid overdose program may be directed to him at (212) 417-4669 or at overdose@health.ny.gov. He welcomes any inquiries.*