Opioids: Frequently Asked Questions

Originally Published: September 2017
Updated November 2017

On October 26, the Secretary of the Department of Health and Human Services (HHS) declared the opioid[1] crisis a "public health emergency." This type of declaration allows federal and state agencies to waive certain funding requirements, make temporary staff assignments, modify certain practices, and modify deadlines. Prior to the federal declaration, six states declared a formal emergency, public health emergency, or made a similar type of pronouncement to address this public health crisis at the state level. Several states are currently using the Centers for Medicare & Medicaid coverage and reimbursement policy to tackle the epidemic. The most current data available from the Centers for Disease Control and Prevention (CDC 2016) indicates that:

- 91 Americans die every day from an opioid overdose;
- The number of opioid-related overdose deaths have quadrupled since 1999 (a statistic closely aligned with the amount of prescription opioids sold in the U.S. in the same timeframe); and
- Synthetic opioid death rates (which include Illegally-produced fentanyl) increased by 72% between 2014 and 2015 (CDC 2016).

The impact of the crisis is far reaching and not limited to deaths. Emergency departments are reporting large numbers of opioid-related visits, Emergency Medical Services (EMS) agencies across the country are answering many more narcotic related calls, and questions and calls for policy and protective recommendations abound. Additionally, narcotic treatment programs can be disrupted by disasters with severe consequences for patients.

This ASPR TRACIE fact sheet was developed to provide answers to some of the most frequently asked questions that affect our audience (e.g., regional ASPR staff, healthcare coalitions, healthcare entities, healthcare providers, emergency managers, and public health practitioners). It does not represent official agency policy, nor is it meant to be all-encompassing, but rather it serves as a snapshot of the challenges facing the healthcare emergency field at this time. We welcome you to reach out to us if you have additional

[1] For the purposes of this fact sheet, the term "opioid" refers to prescription opioids, (illegally produced) fentanyl, heroin, and any combination thereof.

questions or recommended resources for our Subject Matter Expert Cadre to consider for inclusion.

Q: Why are we seeing so many deaths in the past few years when heroin has been around a long time?

A: Heroin has become much cheaper and far easier to access than prescription narcotics. Because so many people in the United States have become addicted through prescribed narcotics, the number of users has skyrocketed. Unfortunately, ”heroin” may vary greatly in potency and often isn’t heroin at all, but rather may contain fentanyl or other synthetic opioid derivatives that are easier and cheaper to make than heroin but are much more potent.

Q: How do patients die from narcotics?

A: Narcotics suppress the drive to breathe, and the respiratory rate slows or stops, depriving the brain of oxygen. If this situation isn’t reversed within minutes, death will result. Rarely users will die from other complications such as aspirating vomit or from fluid leaking into the lungs.

Q: Who can give naloxone (Narcan)?

A: Naloxone is a narcotic reversal agent that has traditionally been given by advanced life support paramedics or in hospitals. Thanks to new programs and grants, special legal authority now allows basic life support paramedics and law enforcement to be equipped with and trained to administer naloxone. The success of intranasal administration facilitated these changes since administering naloxone in this form does not require injection or intravenous access. Additionally, many states allow the public to purchase naloxone and there are programs that provide naloxone to users through providers, treatment programs, and retail pharmacies.

Q: Does naloxone always work?

A: No. With many of the new synthetic drugs a very high dose of nalaxone is required – far beyond what is available in standard kits or even in many emergency departments. Some of the synthetic drugs just don’t seem to respond at all to treatment, though that may be because not enough naloxone was available to reverse the effects. Also, if naloxone is not used quickly enough, the brain may have already suffered irreversible damage from lack of oxygen. Naloxone cannot reverse opioid-induced cardiac arrest. Also, the naloxone reversal of narcotic effect in a frequent user can cause a rapid and severe withdrawal syndrome including vomiting, tremor, and severe anxiety.

Q: What does a formal declaration of a public health emergency, emergency, or other similar type of declaration mean with regards to the opioid public health crisis?

A: It means different things at different levels of government and depending on the specific type of declaration that is made. At the federal level, a public health emergency declaration by the HHS Secretary allows certain authorities to be used to respond to a particular public health

emergency. However, the HHS Secretary has broad authority to respond to public health crises whether or not a formal public health emergency is declared. At the state and local level, general emergency and public health emergency laws vary widely but may allow release or reallocation of resources such as staff or funds, suspend selected liability laws, and otherwise support necessary response measures. Formal emergency declarations are different than political proclamations that don't convey specific emergency authorities, though state and local governments should look at their emergency powers and determine if it is in their best interests to invoke these.

Q: What is the role of a healthcare coalition in the crisis?

A: Healthcare coalitions are perfectly positioned to play a coordinating role since this issue affects EMS, hospitals, public health, and emergency management. Coordination of efforts, messaging, information sharing, and advocacy can support critical response efforts over time. Because this is a longer-term event, the coalition can provide an ongoing role in supporting response, and provide critical liaison to emergency management, including determining if the policy and legal support that can be provided by local emergency declarations justifies their use in this situation. The opioid crisis also provides coalitions the opportunity to engage other stakeholders —particularly the behavioral health and chemical dependency community. Both of these stakeholder groups can be of tremendous value to the coalition during a disaster. Coalitions can also foster planning with opioid treatment programs to guarantee their patients have access to care and medications after disasters.

Q: What role does emergency management play in this crisis?

A: Coordination of stakeholder and public information, consideration of emergency declarations, analysis of legal aspects of responder protection, civil and criminal liability issues, and incident action planning support are key roles of emergency management in this crisis.

Q: What role does EMS play?

A: EMS responders need to be trained to provide support for patients who are not breathing (or not breathing effectively) both with naloxone as well as by providing oxygen and ventilation. Knowing to give larger doses of naloxone as needed is essential.

Q: Is there any risk to providers from synthetic narcotics?

A: Though there have been several reports of law enforcement (and other responder) exposure and accidental overdoses, at present none of these that occurred *during patient care activities* have been confirmed due to narcotic effect. Most issues have occurred with handling of larger quantities of powder during crime scene processing at manufacturing locations. Most calls will not involve any visible powder and use of usual nitrile gloves and standard precautions will be sufficient (and is important during any patient care activities). Responders should *not* withhold life-saving patient care due to theoretical concerns about powder exposure as the risk is very

low, but should understand that the risk increases with increasing amounts of powder present and that higher levels of protection are needed when processing lab and crime scenes. Liquid exposures are also possible, particularly at manufacturing locations. The National Institute for Occupational Safety and Health (NIOSH) recently released guidelines that distinguish different levels of protection based on the risk. Since powder does not cross intact skin, a responder would need to breathe in airborne particles or ingest material to be affected.

Q: What if there is powder present on a patient?

A: If powder is present during patient care, it should not be brushed or shaken off clothing. An N95 mask should provide responders with adequate protection, and should be donned as soon as powder is detected. While NIOSH recommends responders wear a P100 mask, in actuality, the protection factor for a 95 and 100 rated mask is the same. The "P" designation means that the mask is oil-proof. A related national position statement was just published by the American College of Medical Toxicology and American Academy of Clinical Toxicology. This statement was also endorsed by The National Association of EMS Physicians. If a department does not have N95 masks / filters available, simple medical masks offer some benefit but there is significant variation in their filtering abilities and so they cannot be officially recommended.

Q: What role do hospital staff play?

A: In addition to providing emergency medical care and support to these patients, hospitals need to observe them until it is clear they are safe. Sometimes the naloxone wears off before the opioids do, putting the patient back in grave danger. Further, hospital staff should be able to refer patients to chemical dependency counseling programs and ideally assist the patient with naloxone or other resources on discharge (with the caveat that naloxone may not work in these doses to reverse some of the drugs out there and should not be regarded as a "safety net").

Q: What is the role of public health in the opioid crisis?

A: Because this is a public health issue, roles include defining the scope of the problem locally and determining target groups for messaging and interventions (such as information dissemination, treatment support, programs that attempt to limit risk through needle exchanges, naloxone programs, and other interventions). Public health should also be coordinating public messaging around these issues in conjunction with a joint information system if one is utilized in the community.

Q: What are some barriers to solving the problem?

A: Narcotic addiction is extremely difficult to cure. Severe withdrawal symptoms prevent most addicted persons from quitting on their own and cause them to continuously seek out narcotics. The availability of cheap illegal narcotics and ongoing prescribing of powerful prescription medicines does not help.

Most physicians are not licensed to prescribe methadone or suboxone—drugs that can be used to manage narcotic addiction—and do not know how to manage the patient's other needs during treatment. Limited authorized care providers and limited treatment program options often mean that patients do not have access to necessary medicines and support, making them very likely to keep using. Intensive social support is usually necessary to prevent relapse when the patient returns to their usual social group. Because the majority of these patients are on public insurance programs and have limited resources, it can be very difficult to access adequate treatment assistance and coordinate transportation to appointments and medicine pick-up. Finally, legally ordered treatment is a rarity; despite the concerns of many families for their addicted loved ones, it is very difficult in most states to commit a patient for opioid dependency treatment.

Q: What are some issues that arise during disaster with opioid treatment programs?

A: Following disasters with infrastructure disruption (e.g., flooding, hurricanes, and blizzards) access to treatment clinics can be a problem. This was particularly an issue after Hurricane Sandy and has been reported after Hurricane Harvey as well. Most methadone treatment programs require their patients to visit the clinic *every day* for their dose. When the clinics are unable to open, patients will go into withdrawal. Most providers cannot prescribe methadone, so the patients wind up suffering. Some clinics have plans for alternate dispensing sites and methods during disasters but without planning, this vulnerable group of patients is at risk for withdrawal or relapse if they use other narcotics to prevent withdrawal symptoms.

I. Resources for Responders Exposed to Fentanyl at Crime Scenes

American College of Medical Toxicology (ACMT) and American Academy of Clinical Toxicology. (2017). Position Statement: Preventing Occupational Fentanyl and Fentanyl Analog Exposure to Emergency Responders.

This statement provides information and guidance for first responders in the following categories: inhalation exposure risk, dermal exposure risk, ocular-facial exposure risk, and naloxone. Recommendations regarding precautions are provided for each type of risk as well as naloxone administration and airway management.

Blevins, M. (2017). Fentanyl Lab Cleanup & the Growing Need for Educated Remediators. Restoration & Remediation Magazine.

The author of this article describes the complexity of the cleanup process for fentanyl, and what cleanup staff can staff should be on the lookout for as it relates to their safety.

Government of British Columbia, Justice Institute of British Columbia, Canadian Association of Chiefs of Police, et al. (2017). Fentanyl Safety for First Responders.

While not specific to the U.S., this webpage includes helpful information regarding handling suspected drugs (including how to conduct a risk assessment of the scene) by level of risk. Tips for disposing equipment are included, as are helpful photos.

Graves, K. (2016). Fentanyl Exposure: 5 Safety Tips for Cops. PoliceOne.com.

The author explains the dangers associated with exposure to fentanyl and shares tips for responders to protect themselves. He encourages law enforcement conducting a raid to treat each raid as if it were a drug lab and don protective gear (including respirators) ahead of time.

International Association of Chiefs of Police. (2016). Increasing Safety for Law Enforcement Personnel and First Responders in Response to the Dangers of Fentanyl.

This statement—released by the International Association of Chiefs of Police (IACP)—provides information on fentanyl, including statistics, Drug Enforcement Administration-related activities, and ways in which the IACP strives to protect law enforcement and community members from the fentanyl crisis.

Law Enforcement Learning. (n.d.). Fentanyl Safety, Decontamination and Identification. (Accessed 9/28/2017. NOTE: There is a fee to register for this course.)

This online course is intended for law enforcement members who may come across fentanyl in their daily activities. Participants will learn more about: personal protective equipment related to possession of drug cases, street sales, and lab/bulk sales case; the

signs and symptoms of fentanyl exposure; the routes of exposure that lead to fentanyl overdoses for first responders; self-protection from fentanyl exposure when working undercover; decontamination steps; risk assessments for "man down" calls (that can help prevent fentanyl contamination); and the history, dosage units and types of fentanyl that are on the street today.

National Association of Emergency Services Physicians. (2017). EMS Physicians Endorse Toxicology Groups' Opioid Safety Precautions Guidance.

With this release, the association endorses the statement made by the American College of Medical Toxicology and American Academy of Clinical Toxicology that summarized safety precautions for first responders in opioid overdose situations.

National Institute of Standards and Technology. (2017). Fentanyl Can Sicken First Responders—Researchers Offer a Solution.

The author explains how first responders and evidence examiners can use screening technologies to reduce the risk of accidental exposure to synthetic opioids.

The White House. (2017). Fentanyl: Safety Recommendations for First Responders.

This factsheet summarizes how first responders can protect themselves from exposure and provides steps to follow when exposure occurs / negative health effects are observed.

Wiebe, M. (2017). Fentanyl: The Next Trend in Illicit Drug Lab Cleanup. Restoration & Remediation Magazine.

The author of this article provides an overview of fentanyl, its origin and production process, the dangers of cross-contamination, the remediation process, and educational/ awareness information.

II. General Resources for First Responders

Bureau of Justice Assistance National Training and Technical Assistance Center. (2017). Law Enforcement Naloxone Toolkit.

This toolkit was designed to help law enforcement agencies develop their own naloxone program. It includes sample templates that can be downloaded and customized.

Indian Health Services. (n.d.). First Responders (Opioid Resources). (Accessed 9/28/2017.)

The video and "First Responder Naloxone Training Toolkit" on this page can help first responders learn more about naloxone procurement and storage and administration.

King, B.S., Musolin, K., and Choi, J. (2013). Evaluation of Potential Employee Exposures during Crime and Death Investigations at a County Coroner's Office. The National Institute for Occupational Safety and Health.

In October 2011 and January 2012, NIOSH evaluated coroner's office in Ohio to determine if conditions and work practices at the facility were posing a health hazard to employees. This report provides information on the methods used by NIOSH during the evaluation, and their findings after the site visit. Evaluators found that some exposures to formaldehyde in the autopsy suite exceeded recommended exposure levels. Also lead contamination of surfaces in the firearms section and drug particle contamination of surfaces in the drug evidence laboratory may have posed health hazards. Recommendations were provided to improve work conditions and minimize exposures.

National Institute of Occupational Safety and Health. (2016). Fentanyl: Preventing Occupational Exposure to Emergency Responders. Centers for Disease Control and Prevention.

Resources on this webpage include information on responder exposure risks, the use of personal protective equipment, and trends related to the illegal use of fentanyl across the U.S.

New Hampshire Department of Health and Human Services. (n.d.). Carfentanil and First Responders. (Accessed 9/28/2017.)

This tip sheet includes guidelines for first responders that can help them avoid exposure and revive people who have overdosed using naloxone. Graphics regarding donning and doffing protective gloves are also included.

New York State Division of Criminal Justice Services. (2014). Opioid Overdose and Intranasal Naloxone Training for Law Enforcement.

In 2014, The New York State Division of Criminal Justice Services (DCJS), in collaboration with several partners, offered a statewide opioid overdose reversal training initiative for law enforcement officers. Training included the identification of opioid overdoses and the administration of the medication.

North Carolina Office of EMS. (n.d.). Opioid Overdose Prevention for Law Enforcement and First Responders. (Accessed 9/28/2017.)

This PowerPoint presentation was developed to help the public safety community recognize and treat suspected opioid overdoses. It includes state-specific information and helpful general information.

Substance Abuse and Mental Health Services Administration. (2013). Opioid Overdose Toolkit: Five Essential Steps for First Responders.

This document provides recommended steps to reduce the number of deaths resulting from opioid overdoses.

U.S. Department of Health and Human Services. (2017). Opioids: Law Enforcement Resources.

The resources on this webpage can help law enforcement and other first responders gain a better understanding of the opioid epidemic and related laws, policies, and programs.

Vinehout, J. (n.d.). New York Police Officers on Their Use of Naloxone. (Accessed 9/28/2017.) Harm Reduction Coalition.

This video features New York City police officers sharing their experiences using and administering naloxone to prevent fatal opioid overdoses.

Massachusetts Technical Assistance Partnership for Prevention. (n.d.). First Responder Naloxone Technical Assistance. (Accessed 9/28/2017.)

This webpage provides information on the opioid overdose epidemic in Massachusetts, and the grants awarded by the State Department of Public Health (DPH) for Police and Fire Departments to carry and administer naloxone, an opioid overdose antidote, in municipalities that are most affected by this epidemic. It also includes information on accessing naloxone for non-DPH funded First Responder departments, such as information on accessing the Bulk Purchasing Program, training resources, and sample policies and data collection forms.

III. General Opioid Resources

Arizona Department of Health Services. (2017). Opioid Action Plan.

This report outlines the steps the State of Arizona will take to reduce opioid-related deaths. It can be used as a strategic plan, recommendation brief, and scorecard (to measure monthly progress towards meeting the goals identified by stakeholders).

Cross, A. (2017). Flood of Opioid-Addicted Babies Prompts UK, Other Hospitals to Try a New Strategy of Keeping Them with Their Mothers in the Hospital. Kentucky Health News.

The author writes that 15 out of every 1,000 babies born in the State of Kentucky are addicted to opioids, and explains that keeping babies with their mothers can ease infants' withdrawal and shorten hospital stays.

Georgia Bureau of Investigation. (2017). GBI Issues Synthetic Opioids Alert.

This public safety alert lists the number of deaths related to fentanyl, the number of cases the Bureau has investigated to date, symptoms associated with use and overdose,

and emphasizes the need for first responders to use extreme caution when handling items that may be contaminated with the drug.

Langford, J., Abraham, A., Johnson, A., et al. (2017). Prescription Opioids and Heroin Epidemic in Georgia: A White Paper.

This state-specific white paper provides an overview of the opioid and heroin epidemic, specifies issues specific to Georgia (e.g., overdose reversal and controlling access to opioids), and includes a section on proposed legislation.

Mammoser, G. (2017). 'Gray Death' is the Latest Dangerous Street Drug. Healthline News.

The author explains how powerful painkillers (e.g., fentanyl, carfentanil, and U-47700) are being combined to create this "cocktail."

National Academy of Medicine. (2017). First, Do No Harm: Marshaling Clinician Leadership to Counter the Opioid Epidemic.

The authors summarize the opioid crisis and highlight the roles of clinicians, "both as primary 'gatekeepers' for the appropriate use of these drugs and as first responders to the consequences of their misuse."

National Library of Medicine. (2017). Opiate Addiction and Treatment. U.S. Department of Health and Human Services.

This webpage includes links to resources regarding opioid addiction, overdose, treating addiction, pregnancy and opioid use (and neonatal abstinence syndrome), recovery, and other helpful topics.

The National Academies of Sciences, Engineering, and Medicine. (2017). Confronting Pain Management and the Opioid Epidemic.

This comprehensive report addresses the opioid epidemic and shares strategies for pain management. It includes case studies and tips for health professional organizations, research sponsors, state agencies, and federal agencies. It also includes a social media toolkit that can be used to promote the report to health professionals and the general public.

The Network for Public Health Law. (2017). Legal Interventions to Reduce Overdose Mortality: Naloxone Access and Overdose Good Samaritan Laws.

All 50 states and the District of Columbia have changed their laws regarding access to naloxone; this factsheet explains how medical professionals who prescribe/dispense it and laypeople who administer it may have civil, criminal, and disciplinary immunity.

Substance Abuse and Mental Health Services Administration. (2016). Naloxone. U.S. Department of Health and Human Services.

This page explains naloxone, its side effects, and how it can be used to treat opioid overdose.

Substance Abuse and Mental Health Services Administration. (2016). SAMHSA Opioid Overdose Prevention Toolkit. U.S. Department of Health and Human Services.

This toolkit was designed to help communities prevent opioid-related overdoses and deaths and includes sections for community members, first responders, prescribers, and patients and family members. The final section focuses on recovering from an overdose.

U.S. Department of Health and Human Services. (2017). Opioids: The Prescription Drug & Heroin Overdose Epidemic.

This webpage includes general information regarding the opioid epidemic; users can click on tabs to find out more about prevention, treatment and recovery, and overdose response. There are also separate tabs for health and law enforcement professionals.

U.S. Food and Drug Administration. (2017). Risk Evaluation and Mitigation Strategy (REMS) for Extended-Release and Long-Acting Opioid Analgesics.

This webpage includes links to resources that explain how the FDA plans to update the Risk Evaluation and Mitigation Strategy for these types of analgesics.