Street Drugs As Used By 'Abigail' & Friends

by Douglas Haviland

EMT Objectives

After reading this article, the EMT will be able to:

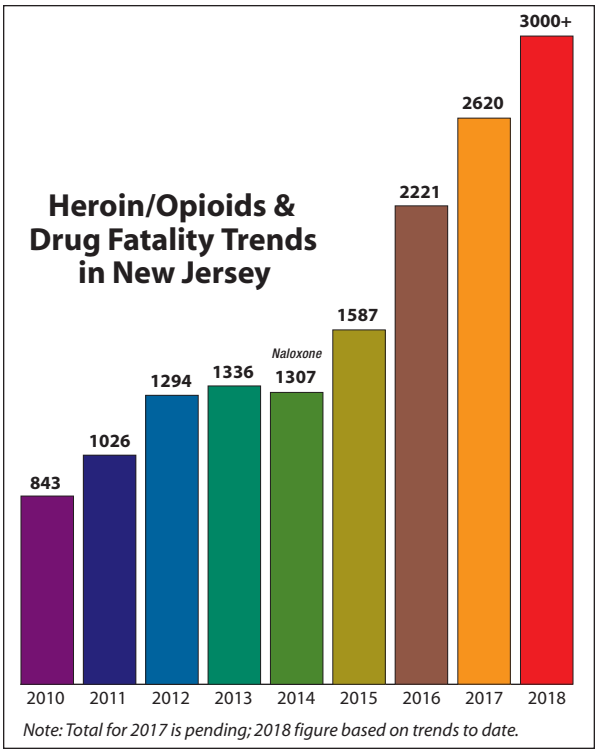
- Identify various types of drugs that alter mental consciousness, their legitimate uses (if any) and the forms in which they may be encountered.
- Describe how Narcan works and the circumstances under which it should (or should not) be used.
- Display a familiarity with Naloxone protocols, including recent changes.
- List the multiple safety concerns associated with an overdose scene.

Introduction

Chances are, as an EMT in New Jersey you've been exposed to the use of illicit drugs. Even if you've never been on an overdose call, you can hardly escape the current media frenzy about our state's "opiate epidemic." Thousands have died of overdoses of opiates such as heroin, Oxycodone or Oxycontin. I have personally responded to more fatal overdoses than I care to recall, as you may have as well.

And the situation is not getting any better, at least not in New Jersey. A recent study showed that, for the first time since the federal government declared the opioid crisis an epidemic in 2011, the number of deaths in the entire country edged downward last year – while in New Jersey overdose fatalities continue to climb. *(See Figure 1)*

Figure 1:



Note: Total for 2017 is pending; 2018 figure based on trends to date.

No Geographic Boundaries

It's hardly news that illicit drugs are not restricted to our inner cities. In fact, many drug abusers are from affluent New Jersey neighborhoods, with prestigious addresses we would all recognize as "well off." The teens and young adults living in these comfortable environs are just as likely to be snared in the world of drugs as urban youth. This is a fact you should recognize; just because your response area is affluent or rural does not exempt your squad from encountering a variety of drugs.

In this article our discussion will be informed from a "front lines" perspective, based on a series of conversations I've had with "Abigail," a 29-year-old recovering opioid user. Like many young adults in New Jersey, Abigail has seen the drug world on the streets and has managed to survive, although often just barely! You will find her life experiences insightful and perhaps a bit shocking.

In Q&A format, what follows is just a portion of those conversations. My questions are marked "***DH***." Interspersed with our discussions are in-depth analyses of the topics that Abigail and I touched upon.

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DH: *Abigail, how old were you when you first experienced opiates[1]?*

Abigail: "Pills at 16, heroin via IV at 18."

DH: *How long did it take for your use of heroin[2] to turn into a habit?*

Abigail: "From the first dose to using it every day took six months."

DH: *How many of your friends have died from overdoses[3]?*

Abigail: "Half, at least 10 a year for eight years."

DH: *How did you manage to avoid this same fate?*

Abigail: "Doing just enough ***not*** to 'get sick'[4], and luck."

1. A **Narcotic** is a drug that produces sleep or altered mental consciousness. The terms "opiate" and "opioid" are often – and incorrectly – used interchangeably. Opiates are drugs derived from opium. Examples include heroin, morphine and codeine. At one time, "opioids" referred only to synthetic opiates (drugs created to emulate opium, but which are different chemically). Some examples of synthetic opioids include the prescription painkillers hydrocodone (Vicodin) and oxycodone (OxyContin), as well as fentanyl and methadone. Now the term "opioid" is used for the entire family of opiates and analogues including natural, synthetic and semi-synthetic.

Whatever their composition, these drugs work by binding to the brain's opioid receptors – the parts of the brain responsible for controlling pain, reward and addictive behaviors.

2. **Heroin** is the most popular opiate, and a Schedule I narcotic under U.S. Federal law (no medicinal purpose, highly abused). It is also known as diamorphine and other street names that go in and out of fashion. Heroin is an opioid commonly used as a recreational drug for its euphoric effects.

Now the term 'opioid' is used for the entire family of opiates including natural, synthetic and semi-synthetic.

3. **Signs Of An Overdose** - Anyone using opioids is at risk of overdose. Signs include: a clammy, pale face; cyanosis; hypoxia; deep snoring or gurgling; bradycardia; no response to physical stimuli.

4. **"Getting Sick"** – In speaking to Abigail I found that drug users have a lingo unto themselves and use terms that can seem confusing. "Getting sick" doesn't literally mean the user is sick as we commonly understand it; it means the user is experiencing the onset of withdrawal symptoms. What struck me most was the user's assumption that I inherently understood what she meant. Personally, I have never experienced heroin nor withdrawal, but I can tell you it induces a dramatic shift in personality. Users denied the drug when they would normally use it can become extremely agitated and desperate.

6. **Methadone** - Methadone is a synthetic opiate that works at the same receptors in the brain as heroin (the mu opioid receptors). Unlike heroin, it has a slow onset and long duration of action when taken as directed. Properly prescribed, methadone is not intoxicating or sedating. It does effectively suppress opiate withdrawal and relieve the debilitating craving that typically causes people to relapse. However, there are downsides. As an opioid, methadone can be addictive. And because it's such a long-acting drug, it can build up in the body and remain in the bloodstream for a long time. It is easy to overdose on methadone due to its strength. Even legitimate use via a prescription can turn into abuse as tolerance develops. According to the CDC, in 2009, methadone contributed to one in three prescription painkiller deaths. As methadone has increasingly been used to treat pain and not just addiction, more of this long-acting opiate has become available to people who abuse drugs.

DH: *How many times have you been in rehab for heroin?*

Abigail: "Twice in rehab in 10 years; five times in detox and once as an outpatient."

DH: *People recovering from heroin often end up relying on other, legal forms of drugs to replace heroin. Have you had any experience with these?*

Abigail: "Two common

5. **Suboxone** – Perhaps the most shocking thing I learned in researching this article concerned the use and abuse of Suboxone. I had never heard of Suboxone, much less understood it.

Suboxone has saved countless lives, lives that would have been lost to heroin, and that was why it was developed. However, Suboxone has led a twisted medical and legal existence.

Suboxone is a mixture of naloxone and buprenorphine. It's typically used in the management of opioid abuse and withdrawal. It can be given to people to facilitate detox, withdrawal and the early stages of opioid abuse recovery, as well as be used in the longer-term – as a maintenance medication to reduce the risk of relapse with more dangerous substances.

Buprenorphine is a ***partial opioid agonist.*** Its moderate activity at the brain's opioid receptors can help to reduce the effects of withdrawing from an opioid such as heroin. As an opioid receptor antagonist, naloxone counteracts opioid overdose but also serves to prevent more potent opioids from fully delivering their euphoric effects. Suboxone is available in tablet form, as well as a sublingual film that dissolves upon insertion under the tongue.

Suboxone is a beneficial medication that aids in the treatment of opioid addiction. However, as an opioid drug, Suboxone abuse and addiction can and does occur. People may buy, sell, or trade their Suboxone, take Suboxone that is not prescribed to them, or take inappropriate doses of Suboxone.

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drugs – Suboxone[5] and methadone[6]."

DH: *Have you ever been "Narcaned" for a overdose?*

Abigail: Yes, by the police. They said I was out of control; they gave me Narcan[7] (via the nasal route) in police headquarters.

DH: *Are heroin users exclusive to that drug, or do they mix other drugs in their routine?*

Abigail: "Mix – anything to get high, Xanax[8] and cocaine[9] are common."

GC: *What is the current street cost of heroin? How much would a typical user take in a given day?*

Any care of patients with suspected opiate overdose should be focused on the 'A-B-Cs.' Narcan is a secondary concern; breathing is primary!

Abigail: "A 'bag' of heroin is $5.00 to $10.00. Its not unheard of to use 50 bags in a day (that's $250.00 to 500.00 a day).

My initial reaction to Abigail's "50 bags a day" remark was that it seemed ludicrous. In speaking to one law enforcement officer he said it was close to impossible. However, in speaking to other users, I found a truth

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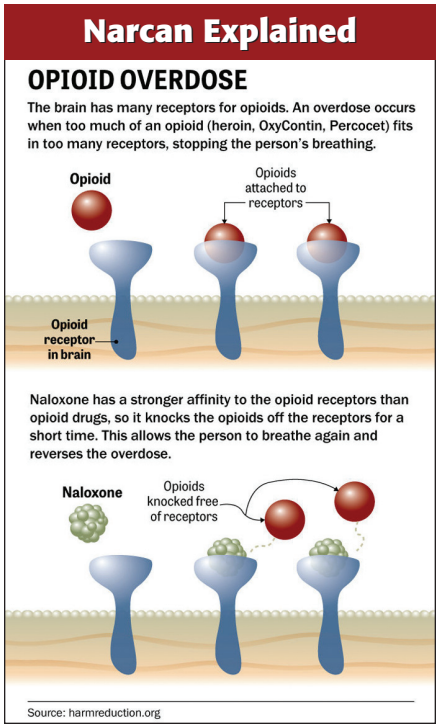
Figure 2:



7. Narcan (naloxone) – Narcan is the brand name for the drug naloxone. Unlike partial agonists like buprenorphine, which partially blocks opioid effects while still providing its own, milder version of them, naloxone is a pure opioid antagonist. This means that naloxone does not produce any opioid effects and instead binds to the brain's opioid receptors *(see Figure 2),* rendering any opioid drugs in a person's system essentially powerless.

While these properties give naloxone the ability to reverse an overdose and save someone's life, this sudden and complete stoppage will initiate immediate and often extremely painful withdrawal symptoms, so it is reserved strictly as an emergency measure.

Narcan can be easily administered via the nasal route (as in Abigail's story) and via an "IM" or injectable pen device similar to an epi-pen. Narcan can reverse the effects of not only prescription opioids, but also drugs like heroin and even fentanyl. It binds to the brain's opioid receptors within two to three minutes. Narcan has no effect on overdoses of substances other than opioids.

There is no such thing as a drug that has no side effects. Side effects of Narcan may include headache, nasal swelling, congestion, inflammation, dryness and increased blood pressure.

However, the most unpleasant and potentially dangerous of the Narcan side effects is a result of its intended use. The rapid reversal of an overdose shocks the body into near immediate drug withdrawal. These withdrawal symptoms may include nausea, dyspnea, diarrhea, stomach cramps, tremors, tachycardia, diaphoresis, muscle aches, flu-like symptoms (fever, chills, weakness) and finally cardiac arrest.

At present, one of the glaring issues with Narcan is its overuse. As illustrated by Abigail's story, Narcan can be given to conscious patients with any opiate use or overdose. However, prehospital use of Narcan should be restricted to ***unconscious*** patients who are not breathing.[10] Narcan should ***not*** be used to gain control of unruly patients! In fact, Narcan is best used in the prehospital setting to block just enough opiate to restore normal breathing, not to wake the patient. Any care of patients with suspected opiate overdose should be focused on the "A-B-Cs." EMS should be first and foremost prepared to "bag" the patient (BVM administration with supplemental oxygen and airway control). Narcan is a secondary concern; breathing is primary! Be careful: In some instances, Narcan will not just wake the patient but cause him to awake in an agitated state. Some patients may vomit and potentially lose airway control. Remember: Breathing is your primary concern, not waking the patient!

8. Xanax - Xanax is the trade name of the prescription drug alprazolam, and is in a category of medications known as benzodiazepines. It comes in several tablet forms and as a concentrated solution. Xanax is typically prescribed to treat anxiety and panic disorders; it is the single most prescribed psychiatric medication in the U.S.

Xanax is especially addictive when misused (taken recreationally or other than as directed). It is commonly abused by those taking it as a sedative. Overusers will appear lethargic, and lack the motivation to engage in normal activities or tasks requiring sustained attention.

9. Cocaine - Glamorized by popular culture and countless 1980s dramas, to many cocaine is a drug of "Reagan era" America. This is misleading. Cocaine use is widespread and drug users often drift between a variety of products such as heroin and cocaine (or often combine them). For this reason, many prehospital personnel frequently confuse the drugs.

Cocaine is a stimulant, as opposed to heroin which is a CNS depressant. Being a stimulant does not necessarily make it safer. While heroin and its pharmacy cousins are deadly due to their inordinate ability to depress vital functions, for certain populations the stimulant effects of cocaine can have cardiac effects that are just as deadly. Users older than 55 are especially in danger.

CEU Article: Street Drugs

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hidden in her remark that had escaped me. The reality is that one bag of heroin[13] is not necessarily equal to a single injection; users can and will prepare and inject multiple bags in one syringe delivery. Users will shoot up to ten bags in one injection and doing the math we can see that could possibly be up to five individual injections (in a given day).

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10. Protocols - All EMTs should be familiar with current NJ State treatment protocols. The opiate overdose protocol received an update with a significant change in September 2017 *(see Figure 4).* Also keep in mind that while NJ does allow naloxone use by EMTs, it requires medical direction and specific in-house agency training. Wording specific to the state protocols are as follows: "Respiration depression, secondary to an opiate overdose, is primarily managed by continuous, attentive airway care and ventilatory support. If available, reversal therapy with naloxone can be secondarily considered ***after*** ventilatory support with the **goal** to increase respiratory effort and increased respirations due to depression."

Other State Protocols for naloxone:

Age: No restrictions. However, the protocols do recommend that for patients under age five, medical direction should be consulted. Keep in mind children can get into

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Figure 4:

NJDOH/Office of Emergency Medical Services - EMT Treatment Protocols

Opiate Overdose

Initial actions:

- Conduct scene size up, primary assessment, & immediate life-saving interventions. Have airway, ventilation & suction devices nearby & ready. Delay the insertion of a lubricated nasopharyngeal airway until **after** the administration of Naloxone to permit absorption.
- Promptly administer oxygen by NRB or BVM at 10-15 liters/minute as needed. If available monitor SpO_2.
- Request Advanced Life Support (ALS) considering their availability & hospital proximity.
- Obtain baseline vital signs, SAMPLE history, & conduct a secondary assessment attentive to respiratory depression, failure, or arrest.

Respiratory depression, secondary to an opiate overdose, is primarily managed by continuous, attentive airway care & ventilatory support. If available, reversal therapy with naloxone can be secondarily considered after ventilatory support with the *goal* to increase respiratory effort and increase respirations due to depression.

Prompt transport is important – DO NOT delay transport to administer this treatment.

Therapy	**Naloxone (Narcan ®)**	
Form	Solution for atomized intranasal administration (IN) Solution for intramuscular (IM) auto-injector administration	
Source	Supplied by OEMS registered & approved EMT/agency under a Medical Director	
Authorization	EMTs operating for a registered agency who successfully complete OEMS approved training while operating under the agency Medical Director's approved protocol.	
Age	No restriction, but for patients under 5 years old on-line consultation with medical control and/or Medical Director protocol is required.	
Indications	Patients with respiratory depression or arrest secondary to known or suspected opiate overdose (as evidenced by pinpoint pupils, depressed mental status, etc.).	
Contraindications	• Hypersensitivity or allergy to naloxone (Narcan ®), nalmefene, or naltrexone • Medication is discolored, cloudy, precipitated, or expired. • Use cautiously with cardiac disease, supraventricular arrhythmia, head trauma, brain tumor, or poly-substance overdose	
Adverse effects	• Agitation/Combative • Nausea • Vomiting • Diarrhea • Tremulousness • Diaphoresis • Tachycardia • Seizures • Dyspnea • Abdominal cramps • Increased Blood Pressure • Cardiac Arrest/Ventricular Fibrillation • Pulmonary Edema	
	The adverse effects following naloxone administration, particularly in chronic opioid users & abusers, may place the patient, emergency personnel & bystanders at risk.	
Administration	**IN & IM auto-injector administration are the only authorized routes for EMTs**	
	Intranasal (IN) Administration	**Intramuscular (IM) auto-injector administration**
	• Assemble and administer medication according to manufacturer instructions and/or local protocol (Naloxone should take effect in 2-5 minutes)	• Administer 0.4mg of Naloxone via IM auto-injector to the lateral thigh according to the manufacturer's recommendations. • Properly dispose of auto-injector in sharps container.
• Maintain vigilant airway care & ventilation support. Be prepared to remove oropharyngeal airway, suction, & use a nasopharyngeal airway if gag reflex returns after medication administration (vomiting and pulmonary edema may occur). • Monitor for agitation, combativeness, and other withdrawal symptoms should reversal occur (typically over 2-5 minutes). • Have AED nearby and ready; misled by a sedated appearance, Ventricular Fibrillation cardiac arrest may develop after treatment.		
Documentation	• Note dose(s) & time(s) of administration & patient response & communicate this during transfer of care to ALS and/or receiving facility staff. • All incidents where an EMT has administered Naloxone shall be reported to OEMS within 24 hours via DOH web-based Naloxone Reporting Form.	

EMTs may administer IN or IM auto-injector naloxone to persons suspected of suffering from an opioid overdose ONLY upon successful completion of training & with the approval of their Medical Director. EMTs may administer an additional dose of IN or IM auto-injector naloxone to persons suspected of suffering from an opioid overdose even if an on scene police officer or lay person has already administered one dose or after contacting their respective Medical Director or NJ Poison Control at 1-800-222-1222 for medical direction.

REMEMBER: WHEN QUESTIONS OR CONCERNS ARISE, CONTACT MEDICAL CONTROL!

September 20, 2017

Protocols *(continued)*

opiates – legal and illegal – in the home. (Do not underestimate an abuser's ability to be careless with drugs, even with small children in the house; parenthood does not displace the desire to use heroin and other opioids.)

Indications: respiratory depression or arrest secondary to known or suspected opiate overdose – pinpoint pupils, depressed mental status.

Contraindications: hypersensitivity, medication is discolored, cloudy, precipitated or expired. Use with caution with known cardiac history, SVT arrhythmia, head trauma, brain tumor, or poly-substance overdose.

Dose: The biggest change in the protocols was the reference to Narcan doseage. Prior editions referenced an EMT level dose of a single 2mg (application) spread over both nares. Law enforcement was allowed higher levels. The latest version makes no mention of a specific dose. This may be due to reportedly higher resistance to Narcan by users consuming higher levels of opioids, or more intense versions such as fentanyl[11]. EMTs are now allowed to administer multiple doses of 1mg per nare. To be clear the latest protocol is open-ended with ***no*** specific maximum dose amount mentioned for EMTs.

DH: *When did you first experience cocaine?*

Abigail: "15" (years of age).

DH: *How is cocaine used on the street?*

Abigail: "Snorted, injected and smoked (in a pipe)."

DH: *What should an EMT look out for in treating a patient with sharps[12] on board?*

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A Few Common Terms

CDS: controlled dangerous substance.

Sharps: common medical term for needles or diabetic lancets

Paraphernalia: items used for preparing and ingesting drugs including needles, spoons, lighters, pipes and packets

Rehab: generally an inpatient stay, 24/7 with supervision, especially for those with severe substance abuse issues. Average stay is 30 days.

Detox: medically supervised purging of the addicts body of toxins (the drugs). Most often the first step in rehab.

IM: intermuscular injection

MAD: nasal applicator for Narcan

Are Those Drugs Real or Fake?

EMTs should be aware that the drugs they encounter at an overdose scene might not be what they appear to be.

"Almost 100 percent of what's being sold out there is counterfeit," said the chief security office for Pfizer, the company that makes prescription Xanax. "They're putting whatever they want into it: fentanyl, boric acid, whatever ingredients are available they'll put into it and sell it as Xanax. If the intent is to kill kids then they're doing a good job of it."

Most buyers simply don't realize they're getting something different than what they intended to purchase, especially when the counterfeit looks exactly like the real thing. Fake Xanax is a good example: it has the "XANAX" label, and has a similar size, shape and color. In fact, the physical characteristics of these pills are so exact, even forensic scientists can't tell they're fake just by looking at them.

More and more news reports are mirroring one that came from the San Francisco area last year, where at least nine people fell prey to fake Xanax pills laced with fentanyl. Three suffered from heart attacks (one fatal) and one from heart failure, while others experienced a major hit to respiratory and nervous system function.

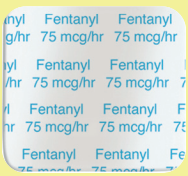
11. Fentanyl - Fentanyl is a synthetic opioid that is often used in conjunction with heroin; street mixtures of the two drugs are common. Fentanyl is at least 75 times more potent than morphine, and fentanyl analogs (such as carfentanil) may be as much as 10,000 times more potent than morphine. Fentanyl and heroin appear identical, but even a small dose of fentanyl can have dramatic effects or can even be fatal.

In its purest form, fentanyl is a white powder or in grains similar in size to grains of salt. It only takes a very small amount of fentanyl to cause a severe or potentially deadly reaction; as little as two milligrams is a lethal dose for most people *(see photo at right).* Consequently, not only are users exposed to danger, but also others who might encounter fentanyl such as first responders and police officers.

In 24 of the nation's largest metropolitan areas, fentanyl-related overdose deaths increased nearly 600 percent from 2014 to 2016, according to county health departments. While many of those overdosing on fentanyl specifically sought to use the drug, officials say overdoses also occur among users who didn't know the powerful opioid was cut into their heroin – or even their cocaine.

Fentanyl's attractiveness lies in its dirt cheap price. If a particular batch of counterfeit pills has two milligrams of fentanyl per pill, approximately 500,000 pills can be manufactured from one kilogram of pure fentanyl. On the street, these pills sell for $10 to $20 each.

In addition to powder, granular and pill form, fentanyl is also sold by prescription as a transdermal patch, commonly under the brand name *Duragesic.* EMS personnel are well-advised to do a thorough head-to-toe exam of suspect patients to locate such patches (there might be more than one). Extreme caution should be taken in removing a patch; gloves are a must. Remember: as long as any patch is left on, the patient is still being medicated.



A Fentanyl patch

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Abigail: "Needles will be hidden in a variety of fashions: in clothing, shoes, sunglass cases and purses. Look for holes in clothes (as access to hiding places). Any of these could contain sharps."

***DH:** Any closing thoughts?*

Abigail: "I wish I knew what I know now when I started!"

Fentanyl is a synthetic opioid that is at least 75 times more potent than morphine.

Catch And Release?

One of the hottest debates of late is a practice that's often called "catch and release." Specifically, this entails administering Narcan to an overdose patient and – once it takes effect and the patient is conscious – asking him or her if they wish to be transported to the hospital. Almost without exception, the patient will decline transport and sign off as an RMA. Certain departments and counties are countering "catch and release" and enforcing a 100% transport rule after administering Narcan to patients who overdose.

Those in favor of transporting, with or without consent, point out that transporting to the hospital will give the drug user an opportunity to be counseled by someone at the healthcare facility. Their hope is that the shocking experience of being transported will bring some sense into them and they will suddenly "see the light" and the gravity of their situation. The user will, with counseling, curtail his habit and be put on the road to recovery.

Those against transporting will point out that all oriented patients have "free will" to refuse, and if we ignore their wishes we open ourselves to potential litigation. We should all be familiar with a patient's right to refuse all or part of care, including ultimate transport.

The entire issue reveals a serious failing in the current climate of unrestrained prehospital use of Narcan by law enforcement and EMS. While there's no question that Narcan has saved thousands of overdose victims, it has also created an aura of "consequence-free" IV drug use. Hardcore IV drug users harbor little fear of death, at least none they will admit to openly.

From an EMS perspective I offer my students the following: If you've taken any patient to the point that you've assisted or administered a drug – aspirin, glucose, nitro, epi-pen or Narcan – you have crossed over a threshold of patient involvement (care) beyond doing vitals and counseling them. My personal belief, especially given the increased level of lethalness of opioids, is to do everything possible to get them to agree to hospital transport. The very real possibility is that the drug – a heroin and fentanyl mix, for example – will remain in the patient's body longer than the Narcan is active in the bloodstream; this can result in another episode of overdose within minutes or hours of your 9-1-1 visit!

Your best course of action may seem odd: namely, don't give Narcan

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12. Sharps - Prehospital personnel should know that drug users commonly use needles – "sharps" – to inject heroin and cocaine into their bloodstreams. These sharps are not just common but were made legal in an effort to prevent disease transmission. In interviewing Abigail she made pointed reference to the confusion over the legal availability of needles in the pharmacy.

Like three million other Americans, Abigail has type 1 diabetes and uses needles multiple times a day. In her teens, Abigail found out how popular her supply of new and "slightly used" needles were. A diabetic who is a drug abuser – surrounded by other drug users – will often recycle the sharps, even with several users. These well-used sharps may be strewn about carelessly or, conversely, carefully hidden.

The New Jersey law decriminalizing needle possession was enacted in 2012. The law provides for the sale of hypodermic syringes or needles in quantities of ten or fewer to anyone 18 or older who presents valid photo identification. The law also provides that if syringes are purchased for criminal intent or unlawful purpose, law enforcement intervention would be triggered.

I sought out several police officers to get their viewpoints on the law. This presented another occasion for me to be shocked. Even veteran officers seemed confused at best at what the law actually says. How law enforcement typically treats a needle possession incident seemed to vary between officers I spoke with; some were unaware that needles can be purchased without a script. One veteran officer offered the most concise observation: "The needle alone would mean little. Other evidence pointing to drug use would give police cause to pursue action."

The bottom line for EMS is to ***always*** use caution and be hyper aware of what one might encounter. As Abigail warned: "needles may be hidden in clothing" and other areas. What I learned was needle sharing is very much alive and well! IV drug users are numbed to the chances of disease transmission since their singular focus is to obtain more of the drug they desire. To them, needles are simply a reusable element within the big picture.

13. Heroin Packets - If you've ever had the misfortune of attending to a heroin overdose death, you may have noticed the presence of the ubiquitous heroin packet. These packets are about the size of a book of matches. The technical name for the bag is "wax glassine bag." Published internet data indicates they contain a single dose of heroin; this dose seems to vary between 33.5 mg to 50 mg or more. Typically they are plain-looking but frequently they have a "brand" stamp.

The brand stamping is particularly common from the Philadelphia area through New Jersey, New York and the northeast. I clearly recall the first time I saw one; it was embossed with a logo identical to the familiar Garden State Parkway or "GSP" logo (the outline of the state inside a circle with text around the circumference). The drug branding is actually an attempt, as with all consumer products, to build loyalty among users to one's brand.

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initially! If your OD victim is unconscious, your main role is to support breathing with a BVM. The BVM ventilation will maintain your patient's life and your patient also will be unable to refuse the transport. Hospital staff can then make a call in the facility to give the Narcan or not.

We have all heard of IV drug users who have been "Narcaned" (had Narcan administered on scene) by EMS two or three different times in a given day or over the period of a week. Such stories should clearly illustrate the nature of the issues at stake. In this author's view, both extremes of the "catch and release" debate are playing moral and political games on the backs of severely ill drug addicts.

Scene Safety

In a recent EMT class I was conducting, an astute student asked: "What should we do if we arrive at the scene of a heroin overdose and there are still drugs and paraphernalia laying around?" My first thought was to say that the priority is the overdose victim; the paraphernalia is not your concern.

However, the presence of that paraphernalia raises another issue that we as EMTs should keep foremost in our minds when approaching an overdose call. That is, we must be wary of the selfish and sometimes barbaric mindset of many drug abusers.

Since your first EMT class, instructors have drummed into your head the concept of "scene safety." I find the term is repeated so frequently, by rote, that we become numb to the meaning of it. And the danger of becoming numb is that a CDS overdose scene is precisely ***not*** the time to let your guard down!

Narcotics users frequently turn to crime – ranging from robbery and credit card fraud to prostitution – to sustain their habit. Criminal behavior is often accompanied by an aggressive or violent mindset, and firearms and other weapons are not unheard of in a drug scene setting.

As Abigail alluded to in her interview, used needles are commonly left strewn about the scene or hidden within clothing or personal possessions. IV drug users are often carriers of various communicable – and sometimes deadly – diseases.

When you combine all of these factors: fentanyl's potency, disease transmission, the potential presence of firearms, criminal behavior, uncertain patient response to Narcan, and unsecured sharps, you can see the ubiquitous overdose is hardly an EMS run to be treated lightly. Yes, the opioid/heroin overdose call is very common, and becoming moreso, but the underlying circumstances leading up to any two of them could be as different as day and night. ***Always remain vigilant and approach each scene with a heightened sense of situational awareness!***

Douglas Haviland *has been involved in emergency services since 1980 and a full EMT instructor since 2005. He teaches for Jersey Shore University Medical Center - Hackensack Meridian. He also trains new instructors in AHA CPR.*