

**The Bill Blackwood  
Law Enforcement Management Institute of Texas**

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**Equipping Law Enforcement Officers with  
the Opioid Antagonist Naloxone**

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**A Leadership White Paper  
Submitted in Partial Fulfillment  
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## **ABSTRACT**

For the past several years, the nation has been under siege by an opioid crisis that has led to many overdose deaths (O'Donnell et al., 2017). The most common opioids being abused are prescription medications, heroin, and fentanyl. The opioid abusers are not alone in their risk of overdose. Other household members, including children, may accidentally be exposed to opioids present in their surroundings. Police officers are also at high risk of exposure due to their frequent contact with drug users. Exposure can occur through skin contact or by inhaling airborne powdered forms. Naloxone is a drug that immediately reverses the effects of an opioid overdose and can save lives in accidental overdose situations. Naloxone should be carried by all police officers. It is now available as a nasal spray that is very simple to administer, even by non-medical personnel. Legislation has been passed in Texas that permits law enforcement agencies to partner with pharmacies to acquire and carry the medication via a standing order. These partnerships, along with government or community grants, can also help control the cost of equipping all officers with it. If law enforcement officers, who are often the first responders to an overdose situation, are routinely equipped with naloxone, lives can be saved. The life may be a drug abuser who now has another chance, or that of a police officer who has been exposed to opioids while coming to an abuser's aid.

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## INTRODUCTION

In August of 2017, 18 Pittsburg SWAT police officers were exposed to airborne fentanyl while serving a federal drug warrant. The officers experienced symptoms such as dizziness and numbness, typical signs of an opioid overdose. They all received medical treatment and fully recovered ("SWAT Team," 2017). The incident illustrates how highly vulnerable police officers are to accidental opioid exposure and overdose. In October 2017, President Donald Trump declared the opioid crisis that is sweeping the nation a public health emergency (Davis, 2017). Being on the front lines of this epidemic places officers in the unique position of having regular contact with opioids and opioid abusers. High doses of opioids depress breathing, which can lead to brain damage or death (Davis, Carr, Southwell, & Beletsky, 2015). Commonly abused opioids are prescription pain medication, heroin, and fentanyl, among others. Fentanyl is the most dangerous, as it can be easily and cheaply produced, making it much less expensive than heroin. Accidental exposure can occur through skin contact or inhaling the airborne powdered form of the drug (Kulbarsh, 2016). The danger has caused police departments to change procedures for handling substances suspected of being fentanyl. It is also 50 to 100 times more powerful than heroin (O'Donnell, Halpin, Mattson, Goldberger, Gladden, 2017). It is often sold in lieu of or combined with heroin. According to preliminary estimates by the Center for Disease Control and Prevention, deaths from synthetic opioids (fentanyl) increased five times from 2013 to 2016. Overall, more than 60,000 people died from all types of drug overdoses in this nation in 2016 (O'Donnell et al., 2017).

Naloxone hydrochloride is an opioid antagonist that blocks and reverses the effects of an overdose. It throws the overdose victim into withdrawal. It immediately restores the person's ability to breath. It cannot be abused. If it is administered when it is not necessary, there are no negative effects. It is not a controlled substance (Davis et al, 2015). Naloxone is highly effective, readily available, affordable, and easy to administer. According to Albright (2016), the Food and Drug Administration (FDA) first approved naloxone in 1971. Initially it was administered via intramuscular injection, but changing delivery mechanisms have made administration of the prescription medication possible by almost anyone. As delivery methods have become simpler, the drug has been more widely distributed to public health organizations and first responders. In the 90's, some public health organizations began using, without FDA approval, a nasal atomizer for naloxone administration. In 2014, naloxone was approved by the FDA in an auto-injector mechanism under the brand name Evzio™ (Albright, 2016). In 2015, the FDA approved the first nasal spray version of naloxone called Narcan™ (Food and Drug Administration, 2015). The National Institute on Drug Abuse, as cited by Albright (2016), found that the nasal spray was very easy to use by those with no medical training, and was possibly more effective than an injection. In 2010, the Quincy, MA Police Department was the first law enforcement agency to equip their officers with naloxone. It has been used by that department to reverse overdoses more than 500 times since the program began (Ronan, 2016). Since then, numerous innovative programs have been formed all over the nation in which first responders and public health organizations collaborate to get naloxone distributed where it will be most utilized. The medication is distributed to the drug user population; their friends and

family; and first responders. As first responders, police officers should be equipped with naloxone and be prepared to save the life of an overdose victim, an innocent family member of the victim, or a fellow officer who has been accidentally exposed in the line of duty. Although medical personnel are going to be dispatched to an overdose call for service along with police, if officers arrive first they can initiate treatment.

The opioid crisis facing the nation is a public health emergency. Police officers are in the unique position of being on the front lines of responding to opioid overdose situations. Law enforcement agencies should equip all police officers with naloxone because it can reverse the effects of opioid overdoses and save lives.

## **POSITION**

Law enforcement officers should be equipped with naloxone for the simple reason that it saves the lives of overdose victims. It immediately reverses the effects of opioids, so it can also have a positive impact on recovery outcomes in non-fatal overdose situations (Davis et al., 2015). Naloxone is a medication that in emergency situations can buy first responders precious time to get the victim more extensive necessary medical treatment. Naloxone is obviously most commonly used on drug abusers. However, others who live in the same household as a drug abuser, especially young children, are also at risk of accidental exposure due to opioids being present in their surroundings. Drug abusers are frequently careless with the storage of their drugs and paraphernalia. Drug endangered children protocols are commonplace in order to prosecute those who endanger them with the presence of drugs.

Law enforcement policies should prioritize saving children's lives from accidental overdose as well. Police officers, particularly patrol and narcotics officers, are

vulnerable to accidental exposure and overdose. In October of 2017 in Canton, Ohio police officers conducted a traffic stop. They saw a white powdery substance which was later identified as heroin inside the vehicle. After they struggled with the driver to remove him from the vehicle, one of the officers began showing symptoms of overdose and fell to the ground. The officer self-administered naloxone. He and his partner were both transported to the hospital for further treatment (Hall, 2017). In this situation, summoning and waiting for EMTs would have cost the officer valuable time. Their response time could have cost him his life.

Naloxone can be used on police K-9s as well. In October of 2016, three K-9s in Florida were treated with naloxone after inhaling fentanyl (Dreier, 2017). If officers are equipped with naloxone, they can immediately render aid to a fellow officer or K-9 and improve the victim's prognosis. Police officers are trained in basic first aid and CPR. They often carry tourniquets, first aid kits, and even defibrillators. These tools are at officers' disposal in life-threatening emergencies. The current opioid crisis would lead citizens to reasonably expect police officers to carry this life-saving drug as well.

Another reason naloxone needs to be provided to all law enforcement officers is due to their unique position as first responders. The nature of police work puts them in regular contact with a high-risk population of drug abusers and their environments. Patrol officers are often first on the scene of an overdose call for help. Opioids cause injury or death via hypoxia, when the victim's brain is no longer receiving oxygen due to their inability to breathe (Davis et al., 2015). Reversing this effect as soon as possible may prevent brain damage to the victim from lack of oxygen. The first few minutes after officers arrive on scene before emergency medical technicians (EMTs) respond may be

crucial for the victim's survival or recovery. According to Dr. Edwards, "The problem is when an emergency occurs, and you stop breathing, seconds count. The earlier you can administer naloxone, the better your chance of avoiding intubation, the ICU, and death" (as cited by Knopf, 2016, para. 25). In many situations, when EMTs arrive at a location before police, they do not enter a scene before police can ensure it is safe to do so (Kulbarsh, 2015). Officers being equipped with naloxone can be particularly important in rural areas where EMT response times are longer than in urban areas. In these rural areas, medical personnel are likely to have longer response times because they are not out on patrol as are law enforcement officers. Urban areas often have fire departments that also serve as EMTs, but many rural areas depend on volunteer fire departments. The volunteers that staff those departments may not have EMT training, nor are they usually manning a central fire station around the clock. There are societal expectations that police officers who are first on a scene take action. Having naloxone and the training to use it is simple and reasonable.

## **COUNTER ARGUMENTS**

Law enforcement leaders that are opposed to officers carrying naloxone contend that it is a prescription drug that should only be administered by medical personnel. Prescriptions are written for a specific patient, which leads to the common misconception that officers would not be allowed to carry the medication without one. Bexley, Ohio, Chief of Police Rinehart spent a year researching the pros and cons of his officers carrying naloxone. He conferred with local medical personnel during that process. They told him that they arrive at a scene as quickly or sooner than police, and that they should administer the medication since they are trained professionals



(Bournea, 2016). Slade (2017) states that, “Every responder has an essential function to perform at the scene of emergency, and while there is some overlap, when units start driving outside of their lane it inevitably causes them to neglect their primary responsibility” (para. 5). In order to effectively administer naloxone, police officers would have to immediately transition from using the skill set of enforcing laws and maintaining order to that of a medical professional (Slade, 2017).

Officers are already trained in CPR and rescue breathing, which can be done until medical personnel arrive. Preparing officers to administer naloxone would include training them to recognize the signs of an opioid overdose in order to treat them appropriately. Many of those opposed believe that the responsibility of treating medical emergencies should continue to rest with the medical first responders, while police enforce the law and maintain order at a scene.

The Texas legislature rebutted this argument when it passed SB 1462 in 2015. This act amended the Health and Safety Code with Subchapter E. Opioid Antagonists. The act states that a prescriber (medical provider) can issue a standing order to a person or organization that enables them to store and distribute an opioid antagonist, as long as there is no compensation to the person or organization. The law also allows any person to possess the drug, regardless of whether or not they have a prescription for it (Opioid Antagonists, 2015). By utilizing this new law, many law enforcement agencies have partnered with local hospitals or health departments and pharmacies to obtain naloxone for their officers.

Additionally, police officers interact with drug abusers regularly and become proficient at recognizing the signs of abuse and overdose. The newest delivery

methods of naloxone, a nasal spray and auto-injector, make it simple for anyone to administer the medication with little to no training. The state law that allows officers to possess naloxone and the simplicity of administering it negates this counter position.

Another argument against equipping law enforcement with naloxone is the cost to the police agencies. Fire Captain Ralph of Marion, Ohio, voiced his frustration over the high cost of naloxone to his department. Ralph said he depends on donations from health departments to maintain his program, which he describes as “extremely expensive” (Sewell, 2016, para. 11). Within a 12-day window last year, his department responded to 30 overdoses and two deaths (Sewell, 2016). The high cost is often cited as a factor by police administrators who oppose implementing a new naloxone program. Establishing a new program would include manpower costs to establish policies and procedures.

Training all officers would be an additional expense. Especially with the current limited or even shrinking budgets, administrators view the high cost as a primary consideration. Several factors such as competition, FDA approvals, increased demand and changing delivery methods have made the price of naloxone very unstable. The opioid crisis has created such a demand for the medication that prices have increased. Additionally, the recent demand has led to third-party companies that repackage naloxone syringes into “kits” which they then mark up to a price comparable to newer products (Albright, 2016). This pricing instability makes the initial cost for a new program uncertain. These same factors make it challenging to plan long-term budgets to sustain the program.

While this may be true, there are funding sources available other than a police department's normal operating budget. Federal, state, or local health agencies often have grant money available as part of public health initiatives. They are willing to work with police agencies to share the cost. In 2017, the Utah Department of Health began a pilot program in which they budgeted \$236,000 for naloxone to distribute to different agencies throughout the state (Lockhart, 2017). In 2015, naloxone kits were handed out free to the public in Berks County, PA by the Council on Chemical Abuse (Turner, 2015).

Another source of funding is drug money that police departments seize and are awarded in court. Establishing a working relationship with an area pharmacy can result in reduced costs with bulk purchases or long-term contracts. Police administrators must also consider the expenses that are offset by lives saved. For example, a deceased overdose victim imposes investigative costs on the agency. Some of these costs are quite significant, such as an autopsy. If the victim is an on-duty police officer, the medical costs for treatment could be high. Quicker medical intervention with naloxone may result in shorter recovery time after a non-fatal injury from exposure. Should the officer pass away, the line-of-duty death benefits and the expense to replace that officer could be very high.

There is, by many opposed to police officers carrying naloxone, a perceived increased risk of liability when police move outside their primary mission of enforcing laws. The very nature of law enforcement already creates liability issues with the many use of force options officers have available, both lethal and non-lethal. Police administrators do not wish to incur any additional unnecessary risk. Although officers

are trained in basic first aid and CPR, administering prescription medication is an area that police have never entered into before the current opioid crisis. In Somerville, MA, the implementation of a naloxone program was delayed due to negotiations between the police union and the city over concerns about the program. These concerns included officer safety, training, and liability (Ortega, 2014).

The American Journal of Public Health contends that the liability risk is no greater than any other normal police function (as cited in Davis et al., 2015). Officers already carry firearms, batons, tasers, and pepper spray, which they can expect to use at any time. They are trained in the use of force to subdue resisting persons. Any of these actions can result in a lawsuit. More importantly, Texas SB 1462 relieves anyone who is acting in good faith and with reasonable care of any liability. They must believe that the person is suffering an opioid overdose. This relief applies to administration of naloxone, or the omission of administering it (Opioid Antagonists, 2015).

## **RECOMMENDATION**

Society's expectations of modern police officers are quite different from years ago. Police officers are expected to be more well-rounded with more tools at their disposal to handle a wide variety of situations. The "It's not my job" mentality is no longer legitimate. Naloxone is highly effective, safe, and now easier to administer than ever before. Although using this medication is only treating one facet of a much larger drug problem, it is a humane action that gives the overdose victim another chance to receive treatment. With the passage of SB 1462, the Texas legislature cleared a path for anyone who may encounter an opioid overdose victim to possess and use naloxone.

In 2016, the Texas Pharmacy Association issued a standing order for third-party prescriptions for naloxone, and it is available at pharmacies (Hoban, 2016). All law enforcement agencies should explore partnerships with a local hospital, health care provider or health department. The health care partner would be invaluable with ensuring officers receive the proper training. Through collaboration with such an entity, police agencies can develop and implement policies and training to create an efficient, effective naloxone program for the current needs in their community. Departments that decide to equip their officers with this medication should augment their current policy regarding first aid to victims upon arriving at a scene to include administration of naloxone when appropriate. Additionally, new policies would have to be written to address naloxone specifically. Details such as to whom it would be issued, accountability for doses, storage and transportation, and training requirements must be addressed.

The final component is working with an area pharmacy to create a supply chain of the medication. Pharmacy personnel can assist in the logistics of storage and transportation of the medicine. The opioid crisis is currently much worse in some areas of the country than others. In areas where overdoses are not as common, proactively setting up a program like this can allow law enforcement agencies to be prepared if and when the opioid problem suddenly spikes.

As first responders, police officers are in a position to use naloxone and have a significant positive impact on the number of overdose deaths or injuries. The Office of National Drug Control Policy urges law enforcement to equip all officers with naloxone. The director declared that naloxone “should be in the patrol cars of every law

enforcement professional across the nation” (Botticelli, 2013, para. 4). A section of the law enforcement Code of Ethics state that officers are to safeguard lives.

Advancements in the role of police officers in the community and the simplicity with which naloxone can now be used enable officers to uphold those words.

In summary, naloxone should be used by law enforcement officers because it has been proven to save lives. Police officers are often first responders to situations involving opioids and opioid users, so it is only logical that they be equipped with it. There are some who argue that naloxone is a prescription drug that should only be administered by medical personnel. This concern was dismissed when Texas legislators passed a law specifically allowing law enforcement to possess and administer the drug. Other opponents claim that the medication is cost prohibitive for agencies to purchase. However, the cost can be mitigated by grant monies or through partnership with pharmaceutical providers. Detractors might also claim that the use of naloxone by law enforcement exposes them to liability. This argument is negated by common sense: police officers have many tools at their disposal that can open them and their agency up to liability if not used properly. The use of this medication is no different. It does not cause addiction and has the added benefit of not causing harm if it is used when it is not necessary. There is simply no valid reason that public servants should not have this harmless medication at their disposal to assist in life-threatening opioid overdose situations.

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