



Expanded Access to Naloxone Can Curb Opioid Overdose Deaths

Changes to prescribing laws to improve availability of the overdose reversal drug can reduce fatalities

Overview

Although the opioid crisis has resulted in approximately 450,000 deaths since 1999, evidence shows that increasing the availability of naloxone—a prescription medication that reverses the respiratory depression caused by an opioid overdose—reduces the rate of opioid overdose deaths.¹ Naloxone can be safely administered to prevent overdose-related injuries and death not only by medical professionals but also by lay people who witness an overdose.² And it's been shown that increasing access to naloxone does not increase nonmedical opioid use.³

All U.S. states have enacted at least one law that expands access to naloxone.⁴ However, the scope of these laws differs, and not all of them ensure that naloxone can get into the hands of people most likely to experience or witness an opioid overdose. Some states have taken more innovative approaches to increase access to naloxone beyond the pharmacy: for example, by permitting naloxone distribution in community-based and corrections settings to people who use drugs and to their family and friends.

This brief examines approaches state policymakers, such as legislators and health agency directors, can take to make naloxone widely available to people at risk of experiencing or witnessing an overdose. This includes laws and policies that:

- Increase traditional prescriptions for naloxone.
 - Require health care providers to co-prescribe naloxone for patients receiving high-dose opioids, or opioids combined with benzodiazepines, due to the high risk of overdose from these drugs.
 - Allow providers to prescribe naloxone to third parties who may witness an overdose (i.e., family and friends of people who use opioids).
- Remove the need for individual prescriptions by allowing naloxone to be dispensed without a patient-specific prescription.
- Allow and equip law enforcement officers to carry and administer naloxone.
- Provide to people at risk of overdose who are leaving hospital, treatment, or corrections settings.
 - Encourage hospital emergency departments to provide or prescribe naloxone to people with an opioid-related illness or injury who are at risk of overdose.
 - Require all treatment facilities that receive public funding to prescribe or dispense naloxone to patients upon discharge.
 - Require distribution of naloxone to people being released from corrections settings whose history of opioid use puts them at high risk of overdose.
- Increase community distribution.
 - Permit local agencies and organizations to distribute naloxone to community members who may be likely to witness an overdose.
 - Enact 911 Good Samaritan laws that provide immunity to people who experience or witness an overdose to encourage them to call 911 for help without fear of arrest.
- Reduce costs for individuals and state governments.
 - Mandate coverage in public and private insurance plans to reduce the cost of naloxone for people accessing it through a prescription.
 - Negotiate with naloxone manufacturers for bulk purchase at lower costs to decrease the price burden on state agencies and organizations distributing naloxone.

Increase access to naloxone through traditional prescriptions

Providers who prescribe or dispense naloxone can play a role in expanding the number of people who receive it. States can enact policies that require or allow physicians and other prescribers to write individual naloxone prescriptions to patients who use opioids and to their friends and family.

Prescribe naloxone along with high-dose opioids

The Centers for Disease Control and Prevention (CDC) recommends that clinicians co-prescribe naloxone to patients who are at high risk of overdose, such as those who have a high-dose opioid prescription or are concurrently prescribed any combination of opioids and benzodiazepines.⁵ After states began following these guidelines in 2017, rates of co-prescribing naloxone among these patient populations increased, with the highest co-prescription rates in states that formally implemented co-prescribing regulations.⁶

For example, in 2017 the Virginia Board of Medicine enacted regulations requiring that any patient treated with opioids for acute pain also be prescribed naloxone.⁷ Compared with the year prior to enacting the regulations, Medicare Part D claims data in 2017 showed a 2,650 percent increase in prescription claims for co-prescribed opioid and naloxone in Virginia. While co-prescribing rates increased nationally during this time, Virginia's rate was the highest across the country.⁸ Furthermore, a study of five states with required co-prescribing, including Virginia, found the dispensation of naloxone grew by 255 percent in the 90 days following implementation of the mandate compared with the 90 days prior.⁹

Implementing such naloxone co-prescribing programs typically involves training primary care providers in how to identify at-risk patients—which providers indicate they are willing to do—and educating patients on how and when to use naloxone. Moreover, patients report feeling safer after receiving naloxone education and prescriptions.¹⁰

Allow third-party prescribing of naloxone

Family and friends of people who use opioids, as well as people at organizations that provide services to this population, are more likely than the general public to witness an opioid overdose, even if they themselves are not at risk. Though medications typically are prescribed for use by the patient, states can authorize physicians and others to prescribe naloxone to third parties, such as family, friends, or service providers, who intend to use the naloxone on someone else.¹¹ As of July 2018, the most recent date for which reliable data is available, 49 states have passed laws permitting third-party prescribing of naloxone.¹²

Dispense naloxone without a patient-specific prescription

Although naloxone is a prescription medication, as of December 2018, 48 states had enacted laws that eliminate the need for a doctor to write a prescription.¹³ Standing orders, protocol orders, collaborative practice agreements, and pharmacist prescriptive authority laws all authorize dispensation of naloxone without a patient-specific prescription:¹⁴

- **Standing orders** authorize pharmacies or other places permitted by the law (e.g., community organizations) to dispense naloxone through the prescribing authority of a state-level medical professional (e.g., secretary of health and human services). Importantly, standing orders can include language that allows dispensation or distribution of naloxone in nonpharmacy settings, making the drug more widely available in the community.
- **Protocol orders** authorize pharmacies to dispense naloxone through the prescribing authority of a state board of health or licensing board.
- **Collaborative practice agreements** authorize specific pharmacies or pharmacy chains in the state to dispense the drug through a formal agreement with a prescriber.
- **Pharmacist prescriptive authority laws** allow pharmacists to dispense naloxone under their own prescriptive authority, without an order or agreement from another prescriber or agency.¹⁵

Once a standing order, protocol order, collaborative practice agreement, or pharmacist prescriptive authority law is in place, anyone at risk of experiencing or witnessing an overdose (or who meets other criteria outlined in the law) is able to receive naloxone from a pharmacy without first going to a doctor.

Increase naloxone access and administration among law enforcement officers

Law enforcement officers are often the first to respond to 911 calls regarding possible overdoses. But many police departments still do not equip their officers with naloxone, even though law enforcement officers can be successfully trained to recognize the signs of an overdose and properly administer naloxone.¹⁶ States can enact policies that prepare and allow these uniformed responders to administer naloxone immediately upon arrival at the scene of an overdose. Police officers can hold and administer naloxone through local or state medication standing orders or naloxone access laws and generally do not face liability for administering naloxone.¹⁷

States can develop training programs with local partners, as did the Quincy, Massachusetts, police department (QPD), when it started the first law enforcement naloxone program in the country. In 2010, following a previous-year spike in opioid overdose deaths, QPD partnered with the Massachusetts Department of Public Health to train all police officers to recognize the signs of an overdose and administer naloxone. In the year after the program was implemented, Quincy's overdose death rate decreased by 66 percent.¹⁸ Between 2010 and 2016, QPD officers reversed more than 500 opioid overdoses, and the program is now a nationally recognized model for equipping law enforcement with naloxone.¹⁹

Broaden naloxone access to individuals discharged from hospital, corrections, and treatment settings

People with a current or prior history of opioids use often come in contact with hospitals, treatment programs, and the criminal justice system, and are at risk of overdose when discharged from these settings into the community.²⁰ States can enact policies to ensure that hospitals, emergency departments, treatment facilities, jails, and prisons provide naloxone to those at risk of overdose upon release.

Provide naloxone through emergency departments

Frequent emergency department (ED) visits are common among people who use drugs, and are associated with a higher risk of subsequent opioid overdose; accordingly, EDs are a logical setting to dispense naloxone.²¹ When given the training and support to do so, ED physicians are willing to provide naloxone to patients at risk of an overdose.²² Furthermore, one study of an urban ED found that more than two-thirds of patients who use opioids were accepting of take-home naloxone, particularly if they had witnessed an overdose or believed they were at risk for one, indicating that distribution in this setting reaches the target population.²³

States can encourage hospital provision of naloxone by developing standards of care for patients at risk of opioid overdose. In 2017, the Rhode Island Department of Health and Department of Behavioral Healthcare, Developmental Disabilities and Hospitals developed and released standards of care that every ED and hospital in the state follows when treating overdose and opioid use disorder.²⁴ Every hospital met the minimum standard of care by June 2018, which includes dispensing or prescribing naloxone to at-risk patients—those being treated for overdose, prescribed high-dose opioids, co-prescribed opioids and benzodiazepines, or have histories of opioid misuse or use disorders—and providing education on administering naloxone prior to discharge. Evaluation of the hospitals' implementation of the standards of care found that they were more likely to offer and provide naloxone than before.²⁵

Additionally, ED visits for nonfatal overdoses are increasing, which—some data suggests—may be partially due to expanded access to naloxone.²⁶ States should consider adopting practices that provide referrals and initiate treatment in the emergency department for patients who have experienced an overdose.

Distribute naloxone to people discharged from corrections settings

People recently released from correctional settings who have a history of opioid use are at high risk of experiencing an overdose, likely due to a lower drug tolerance after a period of abstinence.²⁷ When such individuals are discharged from prison or jail, officials should provide them with naloxone, or a prescription for it.

States can permit such corrections-based naloxone distribution through their naloxone access laws, and purchase the naloxone using state or federal opioid response grant funds and local opioid overdose prevention funds, or obtain it by partnering their corrections agencies with community organizations that provide naloxone. In 2015, New York State's Department of Health and Department of Corrections and Community Supervision partnered with the Harm Reduction Coalition (HRC), a nonprofit organization, to develop an Overdose Education and Naloxone Distribution (OEND) program, which they piloted in the Queensboro Correctional Facility. HRC prepared corrections staff to provide training on overdose education and naloxone administration to all people scheduled for release from incarceration within 90 days. All OEND training participants in the facility were given a naloxone kit to be kept with their personal property and could choose whether to take it upon release. From the start of the program in 2015 through the beginning of 2018, more than 6,000 individuals released from Queensboro Correctional Facility received naloxone kits, with at least 14 documented overdose reversals. By June 2017, all 54 New York state prisons were providing OEND training and naloxone kits.²⁸

Distribute naloxone to people discharged from inpatient and outpatient treatment programs

People exiting drug treatment programs may also have a lower opioid tolerance than when they entered that puts them at risk for overdose, especially if treatment is abstinence-based or does not include medications for opioid use disorder.²⁹ Given this risk, all people departing treatment settings should be equipped with naloxone. States can require treatment facilities that receive public funding to prescribe or dispense naloxone upon discharge without affecting program budgets; the cost of naloxone can typically be covered by the patient's insurance as part of treatment.³⁰

Expand naloxone access and encourage its use in the community

People who use drugs, and their family and friends, are most likely to witness an overdose, and therefore are in the best position to respond immediately to an overdose. States can enact policies that permit and encourage naloxone distribution to, and administration by, lay people.

Distribute naloxone to community members who may witness an overdose

A survey from 2014 found 140 community organizations across the United States had established 644 local OEND sites to provide naloxone to individuals, particularly those at high risk of witnessing an overdose such as people who use drugs and their families and friends.³¹ From 1996 to 2014, 136 of these organizations reported training over 152,000 people to identify an overdose and administer naloxone, and documented nearly 26,500 overdose reversals.³² Such naloxone distribution programs are successful because they are able to directly reach people in active drug use who are at highest risk for overdose.³³ To ensure that community organizations can establish these programs, states should authorize them to distribute naloxone in their standing orders, via both in-person provision and mail delivery, in order to reach people who may not be able to access a naloxone distribution site.

For example, the Massachusetts Department of Public Health funds and oversees the state OEND program. A standing order issued by the medical director in 2007 permitted nonmedical staff to train community members on naloxone's use and also distribute it.³⁴ Between 2007 and 2009, local agencies and organizations that provide services to people who use drugs established 19 OEND programs to train laypeople to recognize the signs of an overdose and administer naloxone. The OEND programs also distributed naloxone rescue kits to all training participants. Evaluation of overdose death rates from 2002 through 2009 showed significantly reduced rates in the 19 communities with OEND programs, versus those without one.³⁵

Enact 911 Good Samaritan laws

Ideally, the person who administers naloxone should call for medical assistance and stay with the individual who has overdosed to ensure that he or she receives prompt medical attention.³⁶ However, as people who use drugs are the most likely to witness an overdose, they may fear that providing or calling for help would put themselves legally at risk for being at the scene while using or possessing drugs or related paraphernalia.

911 Good Samaritan laws provide limited immunity to people who call for emergency medical services or administer naloxone, and to other bystanders of an overdose, to encourage them to seek help without fear of arrest or prosecution for drug-related crimes.³⁷ State enactment of a Good Samaritan law is associated with a 15 percent reduction in the incidence of opioid overdose deaths compared with before the law was in place, according to a 2014 study of 21 states that had already passed such a law.³⁸ CDC recommends that such laws offer protection from criminal or supervision violation charges, warrant searches, and property seizure to everyone at the scene of an overdose, including the person experiencing the overdose, the person seeking care or administering naloxone, and any other bystanders.³⁹

As of 2018, 46 states and the District of Columbia had passed Good Samaritan laws.⁴⁰ Vermont's law is one of the most comprehensive in the country: While most such laws provide limited immunity for minor drug-related crimes for the person experiencing an overdose and the individual who calls for medical attention, Vermont's includes limited immunity for any crime under the Controlled Substances Act, to any bystander at the scene, or within close proximity to the scene of an overdose.⁴¹ However, when it comes to the range of offenses—and the people on the scene—covered by immunity, Good Samaritan laws vary from state to state, and are rarely as comprehensive as Vermont's or as CDC's guidance.⁴²

Increase access to naloxone by reducing its cost

While all state Medicaid programs currently cover naloxone, individual states can also mandate, through legislative action, that all insurance plans that offer prescription coverage include coverage of naloxone. In 2016, for example, Rhode Island passed a law requiring every individual and group health insurance plan with prescription coverage to provide coverage of naloxone,⁴³ even if it is intended for use on someone other than the insured.⁴⁴

States can also negotiate with manufacturers to bulk purchase naloxone at a reduced price. Massachusetts negotiated with a pharmaceutical wholesaler to offer its municipalities a discounted bulk purchasing option through the State Office of Pharmacy Services to provide naloxone to local agencies (e.g., emergency response, law enforcement, health departments, education).⁴⁵ The Massachusetts legislature in 2015 also established the Municipal Naloxone Bulk Purchase Trust Fund, comprising revenue from municipalities, settlement money from prescription opioid manufacturer lawsuits, and, more recently, money appropriated from the legislature.⁴⁶ The bill offsets the costs of naloxone for fire and police department programs;⁴⁷ in 2018, the legislation was amended to allow nonprofit organizations to also participate in the trust fund program.⁴⁸ As of 2017, 143 municipalities, 10 school districts, and two sheriff's departments had used the fund to purchase naloxone.⁴⁹

Conclusion

Naloxone can be safely administered by—and prescribed, dispensed, and distributed to—people at risk of overdose or who may witness an overdose in a variety of settings. States and communities have made legal and regulatory changes to increase the availability and accessibility of naloxone, and policymakers should look to these successful initiatives as a guide to further expand naloxone access. Removing barriers to naloxone accessibility should be a main priority in order to reduce the number of opioid overdose deaths across the country.

Endnotes

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