Introduction

Overdose death rates in the U.S. have more than doubled over the past decade, surpassing motor vehicle accidents as the leading cause of injury-related death in the country.¹

According to the Centers for Disease Control and Prevention (CDC), more than 41,000 people died from an accidental or intentional drug overdose in the U.S. in 2011 — an average of 113 deaths every day.² Eighty percent of these deaths (over 33,000) were accidental — and nearly 17,000 of these deaths involved prescription opioids (compared to about 4,400 attributed to heroin).³

Many of these deaths could have been prevented. Proven strategies are available to reduce the harms associated with drug misuse, treat dependence and addiction, improve immediate overdose responses, enhance public safety and prevent fatalities. These strategies include expanding access to the life-saving medicine naloxone and its associated training; improving fact-based drug education for young people that includes an overdose prevention and response component; enacting legal protections that encourage people to call for help for overdose victims; and training people how to prevent, recognize and respond to an overdose.

911 Good Samaritan Limited Immunity Laws

911 Good Samaritan immunity laws provide protection from arrest and prosecution for witnesses who call 911 or seek emergency medical assistance.

The chance of surviving an overdose, like that of surviving a heart attack, depends greatly on how fast one receives medical assistance. Multiple studies show that most deaths actually occur one to three hours after the victim has initially ingested or injected drugs.⁴ The time that elapses before an overdose becomes a fatality presents a vital opportunity to intervene and seek medical help.

Witnesses to heart attacks rarely think twice about calling 911, but witnesses to an overdose often squander precious time hesitating to call for help or, in many cases, simply don’t make the call.⁵ The most common reason people cite for not calling 911 is fear of police involvement.⁶

Severe penalties for possession and use of illicit drugs, including state laws that impose criminal charges on individuals who provide drugs to someone who subsequently dies of an overdose, also intensify the fear that prevents many witnesses from seeking emergency medical help.⁷

An important solution to encourage overdose witnesses to seek medical help is to exempt them from arrest and criminal prosecution through the adoption of 911 Good Samaritan immunity laws.

Such legislation does not protect people from arrest for other offenses, such as selling or trafficking drugs. These policies generally only protect the caller and overdose victim from arrest and/or prosecution for simple drug possession, possession of paraphernalia, and/or being under the influence. Some states, like Utah and Indiana, do not extend any immunity from arrest or prosecution, but do permit the act of seeking medical assistance at the scene of an overdose as a mitigating factor at the time of sentencing.

Laws encouraging overdose witnesses and victims to seek medical attention may also be accompanied by training for law enforcement, EMS and other emergency and public safety personnel.⁸
DPA spearheaded passage of the nation’s first 911 Good Samaritan law in New Mexico in 2007. Since then, nineteen additional states – Alaska, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Louisiana, Maryland, Massachusetts, Minnesota, New Jersey, New York, North Carolina, Rhode Island, Vermont, Washington State and Wisconsin – as well as the District of Columbia have passed such laws.9

Initial results from an evaluation of Washington State’s Good Samaritan law, adopted in 2010, found that 88 percent of people who use opioids said they would be more likely, and less afraid, to call 911 in the event of a future overdose after learning about the law.10

The most current information about the various 911 Good Samaritan policies and laws across the U.S. is collected by the Public Health Law Research program of the Robert Wood Johnson Foundation and can be found at: https://www.networkforphl.org/_asset/qz5pvn/network-naloxone-10-4.pdf. The efficacy and implementation of these laws vary considerably from state to state. It is recommended you research the Good Samaritan policy in your own state.

Risk of criminal prosecution or civil litigation can deter medical professionals, drug users and bystanders from aiding overdose victims. Well-crafted legislation can provide simple protections to alleviate these fears, improve emergency overdose responses and save lives.

Naloxone: An Antidote to Opioid Overdose

Chief among today’s highly effective available practices to halt and reverse the growing toll of accidental opioid overdose fatalities is naloxone hydrochloride (also known as Narcan™), a low-cost drug available generically that was first approved by the FDA in 1971.

Naloxone is an opioid antagonist that blocks the brain cell receptors activated by heroin and other opioids, temporarily restoring normal breathing within two to three minutes of administration. Naloxone works by taking up opioid receptor sites in the brain; it has a higher affinity for these opioid receptor sites and stays bound longer than opioid activators, which bind and release rapidly.11

Naloxone’s only effects are to reverse respiratory failure resulting from an opioid overdose and to cause uncomfortable withdrawal symptoms in the dependent user.12 It has no pharmacological effect if administered to a person who has not taken opioids,13 has no potential for abuse14 and does not lead to increases in drug use.15

Ideally, emergency medical responders are summoned as soon as an overdose is detected. A dose of naloxone is then administered and rescue breathing is initiated if necessary. If the victim has not been revived after two minutes, another dose of naloxone is administered and so on until the naloxone has the desired effect. Naloxone’s effects last for 30 to 75 minutes, allowing time for the arrival of emergency medical assistance.16

Naloxone is most commonly administered via intramuscular injection, but it can also be administered intranasally using an atomizer device that delivers a mist to the nasal mucus membrane.17 This latter form of administration has been used for many years by EMS responders and overdose prevention groups in several states and will soon be available as an FDA-approved delivery device. Several studies have demonstrated that intranasal naloxone can be distributed to potential bystanders and later administered safely and effectively to reverse opioid overdoses.18 This method of administration can be easier for pre-hospital responses to overdose. Most members of law enforcement prefer to carry and use intranasal naloxone to facilitate speed and ease of use.

In April 2014, the FDA approved a handheld intramuscular naloxone auto-injector device called Evzio. Evzio is available by prescription only. The device employs voice prompts to guide the user through the accurate administration of naloxone. It is the first naloxone delivery device to be approved by the FDA specifically for administration by laypeople outside of a healthcare setting.19
Naloxone Saves Lives
Naloxone-availability efforts have been undertaken in cities and states around the country with considerable success:

- The Centers for Disease Control and Prevention (CDC) reports that, between 1996 and 2010, community-based opioid overdose prevention programs were established and began distributing naloxone at nearly 190 locations in 15 states across the country.
- These programs have trained and equipped more than 53,000 people with naloxone, who have successfully reversed more than 10,000 opioid overdoses.  
- Naloxone distribution programs in Massachusetts, for example, successfully trained nearly 3,000 laypeople in the use of naloxone, who reported more than 300 overdose reversals between 2002 and 2009. A 2013 study of these programs published in the British Medical Journal found that opioid overdose death rates were significantly reduced in communities that adopted naloxone programs compared to those that did not.

Because of naloxone’s lifesaving potential, leading health organizations in the U.S. and internationally, have endorsed its expanded access and use by health professionals and/or laypeople, including the American Medical Association, the American Public Health Association, the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control and Prevention, the American Society of Addiction Medicine, the World Health Organization and the United Nations Office on Drugs and Crime.

Twenty-eight states – California, Colorado, Connecticut, Delaware, Georgia, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Minnesota, Missouri, North Carolina, New Mexico, New Jersey, New York, Ohio, Oklahoma, Utah, Rhode Island, Tennessee, Vermont, Virginia, Washington and Wisconsin – as well as the District of Columbia have passed laws providing for some form of access to naloxone access among first responders and/or laypeople.

Naloxone is Cost-Effective
Providing take-home naloxone to opioid users for later administration not only saves lives; it also saves money. A 2013 cost-benefit analysis published in the Annals of Internal Medicine concluded that “Naloxone distribution to heroin users is likely to reduce overdose deaths and is cost-effective, even under markedly conservative assumptions.” Specifically, the study found that one life could be saved for every 164 naloxone kits that are distributed.

“Providing opioid overdose education and naloxone to persons who use drugs and to persons who might be present at an opioid overdose can help reduce opioid overdose mortality, a rapidly growing public health concern.”
– Centers for Disease Control and Prevention, 2012.

Expanding the Availability of Naloxone
Providing take-home naloxone to people who use opioids (and their family, friends and caretakers) for later administration in case of an overdose is a commonsense and cost-effective strategy to significantly reduce opioid overdose deaths.

Several community programs in major metropolitan areas are making important strides in increasing public access to naloxone. A number of syringe exchange programs in major U.S. cities have begun making naloxone available to people who inject illicit drugs. Many overdose prevention programs are paired with syringe exchange programs, creating important linkages between services that can help prevent both accidental overdose and the spread of HIV/AIDS, hepatitis and other infectious diseases among people who inject drugs.

While it’s important to make naloxone available to people who visit syringe exchange programs, it is equally important to ensure naloxone availability to members of the public who use prescription opioids but do not use syringes or visit exchange programs.
Expanding access to naloxone in pharmacies.

A handful of states are beginning to make naloxone more readily available in pharmacies. States such as Rhode Island, New York and Washington permit pharmacists to dispense naloxone to patients, as long as a physician has an agreement with the pharmacy allowing them to do so; while states such as New Mexico have added naloxone to the list of drugs pharmacists are permitted to directly furnish to patients without a prior prescription. In June 2014, New York became the most recent state to reduce consumer barriers to naloxone.28 Additionally, a bill in California (AB 1535) is currently heading toward the governor’s desk for his signature and may be signed into law as early as August 2014.

Studies demonstrate that pharmacy-distribution of naloxone is safe and feasible.30 Moreover, surveys of pharmacists show that they are highly willing to dispense naloxone to patients and other laypeople when permitted to do so – reflecting a growing awareness of the vital role that pharmacists can and must play to prevent opioid overdose.31

In fact, new evidence indicates that even laypeople who have not received naloxone training can still administer it accurately and effectively,32 suggesting that naloxone could potentially be made available as an over-the-counter medication.33

Improving naloxone awareness among physicians and other providers.

Support is growing among some physicians and other health professionals for regularly pairing naloxone with all opioid prescriptions.34 Under this scenario, physicians would routinely write a prescription for naloxone to accompany every prescription for an opioid medication. Such a convention would have the dual benefits of safeguarding the life of the patient and normalizing naloxone by educating the greater public about its function and proper use. Physician education and training in naloxone prescription and use is vital to increase these efforts among providers treating patients at risk of opioid overdose.35

It is particularly important to make naloxone available in methadone clinics, addiction treatment programs, syringe exchange programs, college and university health centers and emergency rooms.36

Improving naloxone access for people being released from prison or jail.

Overdose risk is significantly greater following an extended period of abstinence or reduced use – whether of a voluntary nature, such as spending time in a rehabilitation facility, or involuntary, such as incarceration.37 It is estimated that people who inject heroin have seven times the risk of death from an overdose during the first two weeks after their release from incarceration.38

For example, a study of more than 70,000 individuals released from Washington State prisons found that, during the first two weeks post-release, their overdose rate was nearly 13 times that of the general population.39

Recognizing this elevated risk, overdose education – including naloxone – should be provided to all opioid-dependent people released from prison or jail.40

“I am confident that expanding the availability of naloxone has the potential to save the lives, families and futures of countless people across the nation.”41

Law Enforcement Embraces Naloxone

Law enforcement professionals and correctional personnel should also be trained on how to respond to opioid overdose, including rescue breathing and administration of naloxone. Research supports the expansion of naloxone among police, sheriffs, firefighters and all first-responders.42

There appears to be a growing demand for overdose prevention information among members of the law enforcement community. A survey of law enforcement officers “indicated a desire to be more involved in overdose prevention and response, suggesting the potential for broader law enforcement engagement around this pressing public health crisis.”43

Indeed, an increasing number of law enforcement agencies across the country are now equipping their officers, sheriffs and other personnel with naloxone. By May 2014, over a dozen departments were providing naloxone to law enforcement officers, with several more expected to do so by 2015. Cities where some officers are equipped with naloxone include San Diego, California; Bartlett, Bloomingdale, Downers...
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“someone experiencing an overdose, it can and will
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naloxone. Used in concert with “Good Samaritan”
laws, which grant immunity from criminal
prosecution to those seeking medical help for
someone experiencing an overdose, it can and will
save lives.”
– Office of National Drug Control Policy, 2014

Liability Mitigation and Other Measures to Remove
Barriers to Naloxone Access
According to a 2012 article in the Journal of the
American Medical Association, several barriers stand
in the way of widespread diffusion of naloxone: “the
price of naloxone has sky-rocketed in the context of a
severe shortage; few prescribers are aware of and are
willing to facilitate overdose prevention education and
naloxone access; funding for program activities and
evaluation research remains sparse; and the Food and
Drug Administration (FDA)–approved formulation of
naloxone is suboptimal for out-of-hospital use.”

One key barrier to broader naloxone access in the
U.S. is its status as a prescription drug. Depending
on state law, prescriptions for naloxone must either be
written to individuals who have requested to carry the
drug or may be made by programs operating under
standing orders from a physician.

Even though naloxone is already governed by state
and federal prescription drug laws, some physicians
may be discouraged from distributing naloxone
because of legal concerns. After years of federal
prosecutions against physicians accused of
professional negligence or corruption for prescribing
opioids for pain, doctors supportive of naloxone
availability are understandably concerned about
potential liabilities stemming from any incorrect use of
the drug or from unintended results.

Explicit legal protection for naloxone distribution
programs and/or prescribers is offered by only a
handful of states. This lack of a consistent legal
framework supporting national naloxone availability
casts a shadow of uncertainty over good-faith efforts to
save lives. Though no guarantees exist, several
reviews of existing law have concluded that
prescribing naloxone and providing proper training in its use does
not expose physicians to an unusual risk of medical
liability a long as the physician acts (1) in good faith,
(2) in the course of professional practice and (3) for
legitimate medical purpose.

In California, Governor Arnold Schwarzenegger signed
the Overdose Treatment Liability Act (Senate Bill 767),
which went into effect in 2008. The legislation protects
physicians and healthcare providers who prescribe
take-home naloxone to people at risk of overdose.
Community-based syringe exchange and drug
treatment programs that target people who use opioids
in Los Angeles receive county funding to train clients
on how to prevent an overdose, administer naloxone
and assist with rescue breathing. Clients also receive
information about treatment services and other
resources.

Nevertheless, it remains illegal in most jurisdictions for
physicians to prescribe naloxone to a family member
for use on a loved one who has not seen the doctor. It
is also illegal for the prescription recipient to use
naloxone on another person for whom it was not
prescribed. New Mexico’s Overdose Prevention and
Response Initiative addresses these failings by
explicitly authorizing non-healthcare providers “to
administer an opioid antagonist if they believe in good
faith that the other person is experiencing an opioid
drug overdose and they act with reasonable care.”
Provisions for the legal dispensing, use and/or possession of naloxone can be included in 911 Good Samaritan legislation, as was the case in Washington’s Good Samaritan bill, or as stand-alone legislation. A handful of other states have taken similar action to protect naloxone availability. For example, in 2005, New York State passed a far-reaching law that provides for state regulation of overdose prevention programs, defines the use of naloxone as “first aid” and clarifies that persons who administer naloxone are immune from civil liability or criminal prosecution for the provision of overdose treatment in good faith. The law also directs the state commissioner to publish opioid overdose death and emergency data, an invaluable tool in tracking and responding to accidental drug overdoses.

Experts generally agree that any possible malpractice liability can be reduced by ensuring that those who are given a naloxone overdose kit understand its proper use and that naloxone programs train participants in the full range of overdose responses and maintain thorough documentation.

Experts also point to the routine practice of making lifesaving medications available to third parties trained in emergency management, to the training of family and friends to administer drugs such as glucagon for diabetes or epinephrine for anaphylaxis, both of which have far greater potential for adverse reactions than naloxone, and to the wide latitude provided by federal law for the prescription of drugs for uses beyond those indicated on their labels.

Public Outreach and Education

Providing practical, life-saving information to people who use opioids can dramatically reduce the likelihood of fatal overdose. A major factor in drug overdose incidence in New Mexico, for example, is the mixing of drugs such as opioids with alcohol or cocaine. In response, the state has undertaken an outreach and education initiative to inform people who use drugs about the risks of using multiple substances simultaneously.

The key to combating the rise in overdose among users of pain medications is education – not only for patients, but also for their doctors and caregivers. Pain patients must be adequately informed about the dangers of taking larger and/or more frequent doses of opioid medication than prescribed, and mixing opioids with alcohol or other drugs. Medication-specific risks must be carefully explained, and patients must be given detailed information about dosages, time frames and complementary pain management strategies.

**Recommendations:**

- Enact 911 Good Samaritan immunity laws at all jurisdictional levels to protect overdose witnesses from arrest and prosecution for minor drug law violations.
- Expand access to naloxone among people who use opioids, as well as their friends, family members, caretakers and doctors.
- Promote fact-based drug education for young people about potentially dangerous drug combinations and how to prevent and respond to an overdose.
- Provide education in prevention and overdose reversal to people residing in homeless shelters and to individuals prior to their release from jails, prisons, residential treatment facilities and detoxification programs.
- Increase awareness about overdose prevention, recognition and response among high school and college students.
- Provide overdose prevention, recognition and response education at methadone clinics and all syringe exchange programs.
- Support public education initiatives to foster awareness of any overdose policy reforms and improve cooperation with ambulance and police services.
- Encourage doctors to prescribe naloxone to patients using prescription opioids and better educate their patients about the risks inherent to opioid analgesics.
- Develop and deliver overdose trainings and education campaigns targeted at general- and family-practice physicians, registered nurses, pharmacists and other medical personnel.
- Shield first responders from liability should the use of naloxone prove ineffective.

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2 Center for Disease Control and Prevention (CDC), “Prescription Drug Overdose in the United States: Fact Sheet”.

3 Ibid; John Fauber and Kristina Fiore, “Overdose deaths from opioids, heroin on the rise,” Milwaukee Journal Sentinel, July 2 2014. Evidence indicates that some prescription opioid consumers may have switched to heroin in recent years. Their initiation to heroin use seems to have been precipitated by the relatively cheap price of street heroin compared to prescription opioids, lack of access to prescription opioids – perhaps as a result of states’ efforts to restrict access to such medications – or the difficulties of snorting or injecting new deterrent-resistant formulations of prescription drugs. See e.g., Theodore J. Cicero et al., “The Changing Face of Heroin Use in the United States,” JAMA Psychiatry.
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45 Maya Doe-Simkins et al., “Saved by the nose: bystander-administered intranasal naloxone hydrochloride for opioid overdose; S. Burris, J Norland, and B Edlin, “Legal aspects of providing naloxone to heroin users in the United States.”


47 S. Burris, J Norland, and B Edlin, “Legal aspects of providing naloxone to heroin users in the United States.”

48 Maya Doe-Simkins et al., “Saved by the nose: bystander-administered intranasal naloxone hydrochloride for opioid overdose.”


50 New Mexico Administrative Code 7.32.7.8 “Individual Authorization to Administer Opioid Antagonist” (2001); Persons, other than a licensed health care professional permitted by law to administer an opioid antagonist, are authorized to administer an opioid antagonist to another person if he, in good faith, believes the other person is experiencing an opioid drug overdose and he acts with reasonable care in administering the drug to the other person. It is strongly recommended that any person administering an opioid antagonist to another person immediately call for Emergency Medical Services;”

51 State of New York Codes, Rules and Regulations 10.80.138 Opioid Overdose Prevention Programs; New York State Public Health Law Article 33, Title 1, Sec. 3309.

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56 Ibid.

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