ASAM American Society of Addiction Medicine

Public Policy Statement on the Use of Naloxone for the Prevention of Opioid Overdose Deaths

Background

National attention has been drawn to a marked increase over the past two decades in the rate of drug-related overdose deaths, especially those related to prescription and non-prescription opioids. Since the early 1990's, the number of overdose deaths has increased steadily, exceeding first the number of firearm deaths in the U.S and, in 2008, the number of motor vehicle deaths. Drug-related overdose is the leading cause of accidental death in the US and deaths from opioid overdose are a significant contributor to these grim statistics, having quadrupled since 1999. According to the Centers for Disease Control and Prevention (CDC), there were 47,055 lethal drug-related overdoses in 2014, the highest rate of deaths from overdose of any year on record. Deaths from opioid overdose accounted for 62% of those fatalities, with 18,893 overdose deaths related to prescription opioids and 10,574 overdose deaths related to heroin.[i] Contributing significantly to the overdose epidemic are deaths caused by synthetic opioids other than methadone. The number of deaths from all non-methadone synthetic opioids increased by 80% from 2013 to 2014, with roughly 5,500 overdose deaths in 2014. Law enforcement indicates that much of this increase may be due to illegally-made fentanyl. According to data from the National Forensic Laboratory Information System, seizures of fentanyl increased by seven times from 2012 to 2014, with 4,585 fentanyl confiscations in 2014.[ii]

Naloxone is a mu-opioid antagonist with well-established safety and efficacy that can reverse opioid overdose and prevent fatalities. Naloxone treatment of opioid overdose has been in use in hospital settings for decades. Over the last several years and in response to the overdose epidemic in the US, training and distribution of naloxone for the treatment of opioid overdose has been expanded to include emergency medical technicians, police officers, firefighters, correctional officers, and others who might experience or witness opioid overdose such as individuals who use opioids and their families.[iii] SAMHSA supports the use of naloxone for the treatment of opioid overdose by bystanders in their Opioid Overdose Prevention Toolkit.[iv]

Naloxone is a remarkably effective, inexpensive and safe medication. It acts quickly, has no addictive potential, may be dispensed by injection (preferably intramuscular) or nasal application, and has mild side effects (other than precipitating opioid withdrawal) when used at the proper low dosage.

Until relatively recently, only physicians and certain emergency medical personnel were authorized to administer naloxone to resuscitate opioid overdose victims. Nearly every state has now provided legislative authority for others (e.g. lay persons, emergency medical

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technicians and police officers) to administer naloxone in such cases.

However, since the onset of opioid overdose often can be detected early by individuals closely associated with the individual experiencing the overdose (in somewhat the same manner that a diabetic insulin reaction can be detected some time before the individual enters into a coma), reforms have evolved to authorize use of naloxone by lay individuals. Prompt action by a non-professional who observes an individual experiencing early stages of opioid overdose and who administers naloxone before professional first responders are on the scene, greatly increases the probability of survival.

Training in the use of naloxone is comparatively simple, due to the absence of complicated administration requirements or serious reactions, although referral for subsequent medical attention is usually incorporated as part of the administration procedure of government-funded training programs. There are three populations that would benefit most from being provided naloxone: individuals who use opioids who are not in treatment; individuals diagnosed with opioid use disorders and in treatment; and individuals prescribed opioid medication for non-acute pain control. In addition, significant others and companions who come into regular contact with individuals in these populations should be provided naloxone. Revival of an opioid overdose victim—often referred to as a "rescue" via naloxone use "in the field"—is important to achieve as it can be life-saving and the first step in helping an individual connect with ongoing helpful medical services (including addiction treatment if indicated) after treatment of the overdose emergency. Since 2014 the Food and Drug Administration has as approved two new delivery devices for naloxone that can be used by laypersons with virtually no training.

Increased awareness of the opioid overdose epidemic in 2014 led to public pronouncements by the U.S. Attorney General and the National Governors Association, recommending a range of public health and medical interventions, including more widespread availability and use of naloxone to "rescue" overdose victims. In response to the impact of this devastating overdose epidemic, as of 2016, forty-seven states, including the District of Columbia, have passed legislation designed to improve layperson access to naloxone and provide legal immunity to medical professionals who prescribe or dispense naloxone or persons who administer naloxone. Additionally, thirty-five states, including the District of Columbia, have enacted some form of a Good Samaritan or 911 immunity law that provides immunity from low level drug possession and use offenses when a person activates the emergency medical response system after experiencing or observing an opioid overdose. Fourteen states have begun to make naloxone available over the counter at pharmacies for individuals vulnerable to opioid overdose or members of their families, significant others, or companions. In most cases, considerable educational material and training have been developed for each respective program to ensure that those who might administer naloxone in response to an overdose are adequately prepared for safe and effective administration of this antagonist.[v] By 2014 it was reported that more than 150,000 "laypersons" had received naloxone training and rescue kits resulting in more than 26,000 reported overdose reversals.[vi] Studies have found that increasing access to naloxone among people who use drugs is associated with decreases in overdose deaths

and that there is no associated increase in opioid use.[vii]

Recommendations

1. ASAM supports the increased use of naloxone in cases of opioid overdose to prevent or reverse respiratory arrest. Naloxone can be administered quickly and effectively by trained professionals and by lay individuals who observe the initial signs of an opioid overdose and are trained in the proper administration of naloxone.

2. ASAM supports broadened accessibility to naloxone for individuals commonly in a position to initiate early response to evidence of opioid overdose. These individuals would include:

    a. Family members, significant others, companions of people who use or are prescribed opioids, and people who use or are prescribed opioids.
    b. Early responders to calls for emergency medical assistance (EMTs and paramedics)
    c. Clinicians and others who provide services to individuals with substance use disorders in office based or clinic settings
    d. Corrections staff
    e. Law enforcement officers
    f. Staff of state and community-based public and private organizations serving populations at high risk for opioid overdose

3. ASAM encourages the co-prescribing of naloxone for people at risk of overdose, which includes those receiving non-acute opioid treatment for pain and those being treated for opioid use disorder. The prescription should be complemented by appropriate patient and/or family education about the risks of opioid overdose, the signs/symptoms of overdose, the proper use of naloxone for revival of accidental overdose victims, and instructions for referral to emergency care, addiction treatment, and the need for follow-up. Persons provided with naloxone supplies for use in the event of opioid overdose should be offered training and education in the prevention, detection, and appropriate response to an overdose, including the recognition of opioid overdose symptoms, proper technique for administration of the opioid antagonist, either by intramuscular injection or by the nasal mucosa, and essential follow-up procedures, including referral to emergency medical services. This includes people provided with naloxone supplies under a public health program of harm reduction. Laypersons offered prescriptions for naloxone at medical visits, or provided with nasal naloxone delivery devices through public health agencies, should also be provided education on its proper use and the need to refer successfully rescued individuals for further medical care.

4. Federal and state health departments should be encouraged to develop and maintain data tracking systems that capture both fatal and non-fatal overdoses and reversals.

5. States with legislative barriers or resistance to broadened distribution of naloxone for opioid overdose reversal should be encouraged by their state medical societies and health

department officials, addiction treatment providers, and the public to support legislation to eliminate such barriers.

6. All jurisdictions should adopt laws that provide overdose victims and persons assisting with the emergency immunity from prosecution and civil liability should they come in contact with emergency responders. This immunity should apply as well to overdose victims and persons assisting with the emergency who are supervised as part of probation or parole agreements.

7. All jurisdictions should provide adequate funding for the implementation of naloxone distribution and/or co-prescription programs. Access to naloxone should not be inhibited by a lack of funding from the respective jurisdiction.

8. Regulations should be amended to permit access to naloxone at pharmacies either by a standing prescription for eligible individuals or by designating naloxone as an over-the-counter medication. Pharmacists should be encouraged to recommend naloxone when indicated. Insurance regulations should be amended to allow individuals to make use of medication benefits when naloxone is obtained at pharmacies regardless of whether it is obtained by standing prescription or as an over-the-counter medication.

9. Opioid overdose reversal programs should be regarded as a potential gateway to ongoing medical care and opioid addiction treatment if indicated.

10. All addiction treatment agencies, including outpatient and residential facilities, and recovery houses should have on-site supplies of naloxone for "rescue" dosing in cases of opioid overdose that may appear among patients of the agency or others on the agency's grounds. ASAM encourages state regulatory agencies to fund and require the on-site presence of naloxone supplies and methods of medication delivery as a condition of facility licensure for addiction treatment facilities. In addition, addiction treatment agencies and office-based providers should encourage patients with opioid use disorders and significant others of people at risk for overdose to become able to provide naloxone.

11. A range of follow-up services should be available for overdose survivors, including emergency medicine, primary care medicine, addiction treatment services and harm reduction services for those who choose this approach.

12. ASAM supports research into other interventions for the reversal of opioid overdose.

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