ASAM
American Society of Addiction Medicine

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

Background

National attention has been drawn to a marked increase since the early 1990s in the rate of deaths from drug overdose, from both prescription and non-prescription drugs. The level of deaths has crept steadily upward and, for the first time, exceeded the number of firearm deaths nationally in 2004.[1] The CDC estimated that 67% of over 33,000 drug overdose deaths in 2005 were unintentional (that is, not a result of a planned suicide attempt) and could have been prevented by the timely administration of an opioid antagonist, such as naloxone.[2]

In response to the impact of these adverse trends, some states and communities have initiated pilot programs (North Carolina) or legislation authorizing the prescription or distribution of opioid antagonists, particularly naloxone, to first responders, EMTs, and/or to individuals vulnerable to opioid overdose or members of their families, significant others, or companions (California, Massachusetts, New Mexico, New York, Washington, Wisconsin). In most cases, considerable educational material and training has 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. State medical societies (North Carolina, Massachusetts, New York) have been lending support to several of these initiatives. The Chicago Recovery Alliance (CRA) since 2000 has provided naloxone directly to participants in its clean injection/HIV/AIDS health service, with standardized instruction on prevention, treatment and aftercare of drug overdose. The CRA has assisted with the development of similar programs in many cities in the U.S. and worldwide, and its website provides extensive informational material for U.S. and foreign naloxone distribution programs. The New York State Department of Health has had a fully developed public "Opioid Overdose Prevention" program in operation since October 2006 which offers training as "Trained Overdose Responders" to "All adults who are interested in becoming TORs…."[3]

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[1] CDC. QuickStats: Age-Adjusted Death Rates for Leading Causes of Injury Death, by Year – United States, 1979-2004. MMWR 2006; 55(50): 1363.

[2] H.R. 2855. Drug Overdose Reduction Act. June 12, 2009

[3] New York State Department of Health. Opioid Overdose Prevention Guidelines for Policies and Procedures. Oct. 31, 2006

While some naloxone distribution programs have been limited to address the needs of patients receiving prescription opioid analgesic treatment for cancer or non-cancerous painful health conditions, others (California, Illinois, New York) have been opened to individuals considered vulnerable to overdose as a result of unauthorized/illicit opioid use. An early 2007 evaluation of the New York State program stated that "Preliminary reports from [several city] programs have documented lifesaving events through peer administration without observed adverse effects, and increased overdose awareness and preparedness among opiate users in the programs."[4]

Naloxone, the most commonly used opioid antagonist, is a remarkably effective, inexpensive (estimated $0.27 per dose), and safe prescription opioid antagonist agent used for decades in the treatment of opioid overdose. It acts quickly, is non-addictive, may be dispensed by injection (preferably intramuscular) or nasal application, and has mild side effects when used at the proper low dosage.[5] Training in its use is comparatively simple, due to the absence of complicated administration requirements or serious reactions, although reference for subsequent medical attention is usually incorporated as part of the step-by-step administration procedure of government-funded programs. Naloxone can be provided to health care professionals and paraprofessionals for use when indicated, or it can be dispensed directly to non-professionals (e.g., through a public health department) as part of a program of drug overdose prevention; or it can be prescribed by physicians and dispensed via retail pharmacies in jurisdictions where programs have been established to provide for such a method of placing naloxone in the hands of individuals who can save lives by timely administration of this overdose reversal agent.

Currently, paramedics and emergency room staff are authorized to administer naloxone to resuscitate drug overdose victims. Some states have provided legislative authority for others (e.g., EMTs) to administer naloxone in such cases. However, since the onset of drug 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), some reforms have authorized 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 an opioid antagonist before professional 'first responders' are on the scene, greatly increases the probability of survival. Failure to act early can lead to respiratory arrest, at which point reversal of the reaction becomes much more difficult, requiring emergency hospitalization and medical attention.

Individuals who are witness to the early stages of drug overdose, particularly that resulting from the use of illegal opiates such as heroin or illegally obtained prescription opioids, often are reluctant to call 911 or transport the individual to an emergency room in a timely manner, for fear of subsequent prosecution for illegal possession and use of

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[4] Piper et al. "Overdose prevention for injection drug users: Lessons learned from naloxone training and distribution programs in New York City." *Harm Reduction Journal* 2007, 4:3.

[5] Naloxone may precipitate withdrawal symptoms in a patient dependent on opiates; the severity of the symptoms will depend on the dose and route of administration of naloxone, with a lower dose leading to milder symptoms.

controlled substances and/or charges of responsibility in the event of the death or permanent injury of the individual who has overdosed. Needless deaths result which could be averted by the immediate availability of the antagonist agent at an early stage of the reaction. Legislation (so-called "911 laws") providing callers immunity from prosecution in these circumstances is in place in New Mexico and under consideration in some other jurisdictions.

Recommendations

1. ASAM supports the increased use of naloxone in cases of unintentional opioid overdose, in light of the fact that naloxone has been proven to be an effective, fast-acting, inexpensive and non-addictive opioid antagonist with minimal side effects, when used at the proper dosage, for preventing the often fatal respiratory arrest which characterizes the advanced stages of prescription or illegal drug overdose. Naloxone can be administered quickly and effectively by trained professional and lay individuals who observe the initial signs of an opioid overdose reaction.

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

   a. Early responders to calls for emergency medical assistance (EMTs and paramedics)
   b. Corrections officers
   c. Law enforcement officers
   d. Staff of state and community-based public and private organizations serving populations at high risk for drug overdose
   e. Family members, significant others, companions

3. Authorized dispensers of naloxone for use in the event of drug overdose should be required to undergo training and education in the prevention, detection, and appropriate response to drug overdose, including the recognition of opioid overdose symptoms, proper technique for administration of the opioid antagonist, either by intramuscular injection or by nasal inhalation, positioning of the victim, and essential follow-up procedures, including referral to emergency medical services.

4. Supervision of individuals trained to dispense naloxone for the treatment of drug overdose should be required and maintained on an ongoing basis, and reports of naloxone use should be required and recorded carefully by the agency dispensing the antagonist.

5. States with legislative barriers or resistance to broadened distribution of naloxone for opioid overdose prevention should be encouraged by their state medical societies and health department officials to support legislation to eliminate such barriers.[6]

[6] [Passed] In April 2006, a New York State law regarding opioid overdose prevention now authorizes the state health commissioner to establish standards for overdose prevention programs and the use of

6. State and local areas which contemplate the creation of a drug overdose opioid antagonist program as described in previous paragraphs should weigh the advantages of initiating an ongoing educational program designed to dispel potential misunderstandings among the lay public, as well as the healthcare profession, about the efficacy of programs supplying naloxone and training to opioid addicts, their families, and/or their significant others. Such programs should emphasize the goal of saving lives over negative reactions to increased "needle use" and other objections.

7. Overdose prevention programs should be regarded as a potential gateway to long-term opioid addiction treatment, including substitution therapy (OST) with carefully controlled agents such as methadone and buprenorphine, which can enable a heroin or other opiate addict to resume a productive life pattern.

8. ASAM supports increased research into the identification and administration of new opiate antagonists.

9. ASAM supports increased reporting and data analysis of the prevention, treatment, and outcome of opioid overdose events, including those which are fatal and non-fatal, intentional and unintentional, and based on legal or illegal prescription or illicit opioid drug use nationally and by individual state or territory.

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naloxone by non-medical staff in the case of an overdose. This law was unanimously passed in the House and Senate and supported by the Medical Society of the State of New York.

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