



# ASAM

American Society of Addiction Medicine

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## **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. Since then, the level of deaths has crept steadily upward, exceeding first the number of firearm deaths nationally and, in 2011, the number of motor vehicle deaths nationally. Deaths from opioid overdose are a significant contributor to these grim statistics. And of roughly 17,000 opioid overdose deaths annual, about one third are due to lethality attributable to methadone, the vast majority of which was prescribed not for the management of addiction but for the management of pain.

According to a 2013 annual health trends report from the Centers for Disease Control and Prevention (CDC), death rates from poisoning involving opioid analgesics has more than tripled between 2000 and 2010. Furthermore, the CDC estimates that in 2010, 78% of the 38,329 overdose deaths from all drug overdoses were unintentional (that is, not a result of a planned suicide attempt) and those associated with opioid overdose could have been prevented by the timely administration of an opioid antagonist, such as naloxone.

In response to the impact of these adverse trends, 21 states, including the District of Columbia, have a law related to the use of opioid antagonists for the prevention of opioid overdose. Some authorize the prescription or distribution of opioid antagonists to first responders, EMTs, and/or to individuals vulnerable to opioid overdose or members of their families, significant others, or companions. 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 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....”

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.”

Naloxone, the most commonly used opioid antagonist, is a remarkably effective, inexpensive and safe 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.

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., emergency medical technicians) 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.

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 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. Revival of an 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 allow for future interventions to engage the individual in substance use disorder services. When naloxone is administered by a health professional of any category, there is the opportunity for the revived individual to receive a brief intervention and motivational enhancement to encourage entry into substance use disorder services for evaluation or medically necessary treatment.

In 2014, the federal Food and Drug Administration fast-tracked approval of a new delivery device for naloxone that can be used by lay persons 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” accidental overdose victims. Such victims can include not only illicit opioid users or those who misuse prescription opioids but also children who inadvertently ingest opioid products and patients who are offered supplies of high-dose opioid therapy for a legitimate medical purpose.

Individuals who are witness to the early stages of drug overdose, particularly that resulting from the use of illegal opioids 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 criminal prosecution for illegal possession and use of controlled substances and/or civil liability in the event of the death or permanent injury of the individual who has overdosed. Needless deaths 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 14 states and the District of Columbia 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 “opioid” overdose. Naloxone can be administered quickly and effectively by trained professional and by lay individuals who observe the initial signs of an opioid overdose reaction 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 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. ASAM encourages the establishment/employment of “co-prescription” programs in which prescribers authorizing high-potency long-acting opioids for appropriate medical conditions or prescription supplies with significant total dosage supplies, would simultaneously offer the patient a prescription for naloxone for home use in the event of an overdose situation experienced by the patient or by any others in the household. The prescription would 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, instructions for referral to emergency care and addiction treatment, and the need for safe medication storage and safe medication disposal for home supplies of opioid analgesics.

4. Persons provided with naloxone supplies for use in the event of drug overdose, including known illicit opioid users provided with naloxone supplies under a public health program of harm reduction, 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 cardiac-pulmonary resuscitation (CPR) and referral to emergency medical services. Lay persons 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 referral to treatment.
5. Supervision of professionals trained to dispense naloxone for the treatment of drug overdose should be required and maintained on an ongoing basis, and reports of naloxone use—including incidents of “rescue doses” administered “in the field,” should be tabulated and entered into registries for epidemiological purposes.
6. 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, addiction treatment providers, and the public to support legislation to eliminate such barriers.
7. ASAM recommends that all jurisdictions adopt laws that would provide overdose witnesses immunity from prosecution and civil liability should they contact emergency responders or administer naloxone on behalf of the overdose victim.
8. 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 persons with opioid addiction, 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.
9. Overdose prevention programs should be regarded as a potential gateway to long-term opioid addiction treatment, including the use of medications approved by the FDA for the treatment of opioid addiction, which can enable a person suffering with opioid addiction to resume a productive life pattern.

10. ASAM recommends that all addiction treatment agencies, including outpatient and residential facilities, have on-site supplies of naloxone for “rescue” dosing in cases of accidental opioid overdose that may appear among patients of the agency or others on the agency’s grounds. Proper staff training is indicated, but just as agencies have automated external defibrillators on-site for use to provide life-saving interventions prior to the arrival of first responders, addiction treatment agencies should have the capacity to revive any victims of overdose before first responders may arrive. 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.
11. ASAM supports increased research into the identification and administration of new opioid antagonists and new delivery systems for overdose reversal agents.
12. 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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