NATIONAL SAFETY COUNCIL

Position/Policy Statement

Naloxone

Comment: This document has an inconsistent smaller font that other Policy/Position documents. It should be standardized.

Policy/Position

The National Safety Council (NSC) supports individual states continuing to address legal barriers to prescribing, dispensing, obtaining, possessing, and administering naloxone for the reversal of opioid overdose. Naloxone is an opioid antagonist that temporarily reverses the effects of opioid medications. Naloxone is not a controlled substance as it has no misuse potential.[1,2,3] {reference 2 link is not working}

~~NSC passed a policy position (#116) in November of 2014 addressing the role of naloxone in combatting the opioid epidemic, calling primarily for enhanced Good Samaritan laws and thirdparty prescriptions, increased insurance coverage and increased data reporting. There is still room for improvement of in all of these areas.~~ There is an emerging need for evidence-based naloxone education and distribution programs~~,~~[4] with additional ~~available~~ information ~~regarding the efficacy of~~ from community-based take home naloxone programs[5,6] ~~and the~~ with demonstrated impact of co-prescribing naloxone ~~when a patient is prescribed opioids~~.[7,8] Aiming to highlight the role the workplace can play in preventing and addressing opioid overdose,[9] this policy ~~replaces policy #116 with expanded and~~ incorporated new evidence-based recommendations.

~~Specifically,~~ NSC supports:

1. Increasing legal protections – modifying laws to permit family members, friends, employers, first responders and other persons who may be in the position to ~~treat~~ alleviate life-threatening

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[1] https://www.drugabuse.gov/publications/drugfacts/naloxone
[2] https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-reversal-naloxone-narcan-evzio
[3] https://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/understanding-naloxone/
[4] https://ldi.upenn.edu/brief/expanding-access-naloxone-review-distribution-strategies
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5071734/
[6] https://pubmed.ncbi.nlm.nih.gov/23372174/
[7] https://www.hhs.gov/opioids/sites/default/files/2018-12/naloxone-coprescribing-guidance.pdf
[8] https://ajph.aphapublications.org/doi/10.2105/AJPH.2020.305620 [9]
https://www.nsc.org/opioidsatwork

signs of an overdose ~~to~~ from access and ~~administer~~ administration of ~~the medication~~ naloxone ~~through third party or non-patient specific prescription orders.~~ by:

a. Modifying laws to provide civil and criminal immunity to health care professionals, law enforcement officials, medical first responders, and nonmedical first responders (including peers, bystanders, employers, the overdose victim and other 'Good Samaritans' who deploy naloxone or call for help in an overdose emergency)~~.~~;

b. Minimizing barriers and ensuring that pharmacists can dispense naloxone through a standing order, statewide protocol, a pharmacist prescription, or without a prescription at all~~.~~;

c. Increasing the role that pharmacists provide in educating patients, friends and family regarding opioid overdose and naloxone, and providing pharmacist education not only on naloxone, but also on applicable regulations to minimize prescribing barriers.

2. Increasing insurance coverage – requiring states, insurers, and other relevant payers to ensure that naloxone is covered by insurance plans, including public plans. Also encourage Human Resources/Health Plan Administrators to ensure ~~it's~~ it is covered in benefits plans~~.~~;

3. Improving data collection – ensuring comprehensive data collection on the full spectrum of naloxone-related metrics (e.g., dispensing, administration, etc.), and applying that data to ensure overdose-related interventions are appropriate for the state or local community~~.~~;

4. Supporting community-based take-home naloxone distribution programs for people who use opioids~~.~~;

5. Facilitating naloxone access at worksites, including on airplanes, trains, buses, and on other modes of transportation~~.~~;

6. Requiring or supporting co-prescribing of naloxone with ~~prescription of~~ opioid medication~~(s)~~ when medically appropriate~~.~~;

7. Expanding and enhancing research and development of evidence-based overdose education and naloxone distribution programs~~.~~;

8. Improving support mechanisms after naloxone is deployed.

Naloxone is an effective tool to save lives in cases of opioid overdoses. Implementing proven prevention and treatment strategies are also necessary to end the opioid epidemic. Please see NSC ~~policies~~ policy on Substance Use Disorder Treatment and Recovery and Prevention, Education and Public Awareness to learn more about NSC's position on these issues.

Background

Naloxone is a drug that can temporarily stop many of the life-threatening effects of opioid overdoses~~, can help restore~~ by helping restoring sufficient breathing and reverse the sedation and unconsciousness that are common during an opioid overdose. It is available in multiple formulations. Naloxone only works on overdoses from opioids, including prescription ~~painkillers~~ opioids, heroin, and synthetic opioids such as fentanyl ~~and related drugs~~.[9] If administered to a person who is not experiencing an opioid overdose, it will not ~~impact~~ harm them.

For first responders, opioid~~s~~ users, and the people around them (e.g., family, friends, bystanders), the ability to recognize and respond to an opioid overdose with naloxone will save lives. It cannot reverse overdoses caused by other substances (~~for example,~~ e.g., stimulants, alcohol or benzodiazepines). Increasing access to and availability of naloxone is essential. Research shows that overdose education and

[9] https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/naloxone

naloxone distribution, when made available to community members, results in fewer overdose deaths.[10,11] Additionally, making naloxone more accessible does not increase opioid use – in fact, studies suggest that increased naloxone distribution and education ~~actually~~ reduces the use of opioids and increases users' desire to seek addiction treatment.[12]

Access to ~~the medication~~ naloxone is limited in many jurisdictions by state laws that limit third party prescriptions, health insurance coverage that does not cover ~~the medication~~ naloxone ~~and/or the nasal application device~~, and laws that punish overdose bystanders who call for help in good faith. Forty states and the District of Columbia have already revised their laws to increase access to naloxone and address the civil and criminal liability issues in some ~~fashion~~ manner.[13]

Recommendations

There are several ways in which NSC recommends modifying laws to increase provision of, access to, and administration of naloxone.

1. Increasing Legal Protections

States should modify and enhance laws to permit family members, friends, employers, first responders, and other persons who may be in the position to treat an overdose to access and administer the medication through third-party or non-patient-specific prescription orders. Examples of this include:

- Modifying state law to provide civil and criminal immunity to health care professionals, law enforcement officials, medical first responders, peers, bystanders, employers, the overdose victim, and other 'Good Samaritans' who deploy naloxone or call for help in an overdose emergency.

Research shows that the most common reason people do not call 911 in the event of an overdose is fear of police involvement~~,~~.[14] {reference 14 link is not working} ~~and~~ "Good Samaritan" laws provide critical protection and immunity. ~~At this point (January 2021),~~ ~~40~~ Forty states and the District of Columbia have enacted some form of a Good Samaritan or 911 drug immunity law~~,~~ as a mechanism to encourage people to seek out medical attention when an overdose is suspected.[15] {reference 15 link is not working}

Though not standardized nationally, these laws frequently provide protection from prosecution for low-level drug offenses, like the sale or use of a controlled substance or paraphernalia. Some states have expanded their laws to provide broader protections, including covering arrest, probation or parole violations and more. Vermont's Good Samaritan law is the most expansive, providing immunity for any drug-related offense, including drug sales.[16] {reference 16 link is not working} Good Samaritan laws protect the person administering ~~the~~ naloxone from medical liability, as well as any bystander response to medical emergency, as long as they are acting in good faith in responding to an opioid overdose.[17]

Not all Good Samaritan laws protect health care professionals, law enforcement officials, medical first responders, peers, bystanders, the overdose victim, and other 'Good Samaritans' to the same extent. States should consider evolving existing laws to include:

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[10] Walley Alexander Y, Xuan Ziming, Hackman H Holly, Quinn Emily, Doe-Simkins Maya, Sorensen-Alawad Amy et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis BMJ 2013; 346 :f174

[11] Opioid Overdose Prevention Programs Providing Naloxone to Laypersons - United States, 2014. (2015, June 19). Retrieved August 1, 2019, from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6423a2.htm

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661437/

[13] https://www.ncsl.org/research/civil-and-criminal-justice/drug-overdose-immunity-good-samaritan-laws.aspx

[14] https://www.researchgate.net/publication/7742372_Circumstances_of_witnessed_drug_overdose_in_New_York_City_implications_for_intervention/file/d912f50ef220035400.pdf?ev=pub_ext_doc_dl&docViewer=true

[15] https://www.ncsl.org/research/civil-and-criminal-justice/drug-overdose-immunity-good-samaritan-laws.aspx

[16] https://www.researchgate.net/publication/7742372_Circumstances_of_witnessed_drug_overdose_in_New_York_City_implications_for_intervention/file/d912f50ef220035400.pdf?ev=pub_ext_doc_dl&docViewer=true

[17] https://namsdl.org/wp-content/uploads/Good-Samaritan-Overdose-Prevention-Statutes.pdf [19] https://mnprc.org/wp-content/uploads/2019/01/good-samaritan-law-tool.pdf

- Explicit protection of the overdose victim as well as the person who calls 911 and / or administers naloxone (many states do not extend legal immunity to the overdose victim)

- Removing conditions and requirements that actively dis-incentivize bystanders from calling 911, such as full disclosure of personal information for all individuals involved, providing immunity for only a limited number of people on the scene, requiring treatment within a certain time frame, and / or limiting the number of times an individual can be eligible for immunity.[19] {reference 19 link is not specific enough}

States should encourage increased awareness of Good Samaritan laws with target populations, including law enforcement officers, to ensure these protections will be utilized to their full extent. Law enforcement officers should be trained on the specific protections offered by the law as well as the health and safety benefits of upholding immunity protections. Public education campaigns should focus on people using opioids (both ~~as~~ prescribed and ~~illicitly~~ illicit) and recognize that many people who are at risk of opioid overdose may be skeptical ~~and / or~~ and/or distrust that the law will help them.[18] This will take time to change, but is a necessary step to reducing overdose fatalities and increasing ~~utilization~~ use of Good Samaritan laws.

Community pharmacists are the most widely accessible healthcare professionals, with more than 90% of Americans living within 5 miles of a community pharmacy.[19] Because of this, pharmacists can have a significant impact on reducing the number of fatal opioid overdoses. The Centers for Disease Control and Prevention (CDC) has recognized the pharmacist's importance in communicating with both patients and prescribers to mitigate the risks associated with opioid misuse.[20] States should:

- Minimize barriers and ensure that pharmacists can dispense naloxone through a standing order [which enable non-medical organizations and programs to distribute naloxone under the prescribing authority of a state-level medical professional[21]], {reference 21 link is not working} statewide protocol, a pharmacist prescription, or without a prescription at all.

- Support pharmacists by providing education not only on naloxone, but also on applicable regulations, and increase their role in providing education for patients, friends and family regarding opioid overdose and naloxone.

To maximize pharmacists' efforts, all 50 U.S. states and the District of Columbia have expanded pharmacists' legal abilities to furnish naloxone.[22] More than half allow the dispensing of naloxone pursuant to a standing order. Other states have provided pharmacists with

prescriptive authority through a collaborative-practice agreement to initiate prescriptions for naloxone, ~~and~~ while a few states {suggest a listing of those states} allow for the dispensing of naloxone without a prescription.[23,24]

Allowing pharmacists to dispense naloxone (in accordance with physician approved protocols) without a prescription has been successful. The implementation of an Ohio law allowing pharmacists to dispense naloxone without a prescription was associated with a significant increase in naloxone dispensing rates, especially in low-employment counties. This is of particular importance as unemployment rates were highly correlated with the magnitude of the opioid crisis.[25] A 3.8% increase in opioid per capita sales and a 4.6% increase in opioid overdose–related death rates with every 1% increase in a county's

[18] Ibid
[19] National Association of Chain Drug Stores. Pharmacy. The face of neighborhood health care in America. www.nacds.org/
[20] https://www.cdc.gov/drugoverdose/pdf/pharmacists_brochure-a.pdf
[21] https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/10/expanded-access-to-naloxone-cancurb-opioid-overdose-deaths
[22] https://www.uspharmacist.com/article/an-overview-of-naloxone-for-pharmacists
[23] https://naspa.us/resource/naloxone-access-community-pharmacies/
[24] https://pubmed.ncbi.nlm.nih.gov/28073688/
[25] https://aspe.hhs.gov/system/files/pdf/259261/ASPEEconomicOpportunityOpioidCrisis.pdf

unemployment rate was observed.[26] The number of naloxone orders dispensed after the state law was implemented increased by 2328%. {How did this impacted the overdose-related death rate?} The naloxone dispensing rate per month per county increased by 18% in the Ohio Medicaid populations, compared with high-employment counties.[27] Regardless of the existence of standing orders, states should provide the ability for pharmacists to dispense naloxone without a prescription.

However, even with increased access, there are still barriers that need to be addressed. Increasing education and awareness around naloxone to pharmacists is critical. A 2018 study[28] found that less than one in three pharmacists scored highly on a knowledge assessment of naloxone~~,~~ and that over half were not comfortable prescribing {pharmacists prescribing?} naloxone. Increased knowledge and understanding of naloxone is significantly correlated with wiliness to dispense it~~, and~~ given the reach of pharmacists and their potential to increase the amount of naloxone in a given community, this is important to address.[29] Additionally, the majority of participants indicated that additional training, such as information about naloxone, identifying patients in need, etc., would increase the likelihood that they'd be willing to dispense naloxone, and that it would be helpful for the pharmacy as a whole.

Another barrier to pharmacists prescribing naloxone is limited pharmacy availability and variabilities in out-of-pocket costs for naloxone.[30] There is a reported lack of clarity about who can be covered, for example, if there is a minimum age requirement.[31] States should provide pharmacist education that addresses not only naloxone itself, but also addresses misconceptions, to increase pharmacist capacity and willingness to prescribe naloxone.

2. Increasing Insurance Coverage

States, insurers and other relevant payers must ensure that naloxone is covered by insurance plans, including public plans. Coverage of naloxone varies widely by insurance plans, and is not required.[32] For example, it varies depending on if it's being administered (i.e. the individual is covered if naloxone is administered while in medical care) versus prescribed (i.e. an individual wants naloxone to take home).[33] Some plans will not cover naloxone unless it is tied to a particular enrollee – a barrier for those engaging in illicit drug use who need anonymity.[34] Human Resources and health plan administrators should proactively address these issues when implementing employee benefit programs. Lastly, there are some life insurance plans that have denied coverage to people with a prescription for naloxone, which is a barrier for both Good Samaritans and people at risk for overdose.

These disparities in coverage are critical to address, given ~~than~~ the low-end cost for the naloxone nasal spray Narcan® is approximately $140, and the naloxone auto-injector Evzio® is approximately $4,000.[35] Both price points can be prohibitive. Though naloxone is available more cheaply as a manual combination syringe and vial injectable solution, it is not typically offered as a prescription option from a pharmacy.

One tool that can be used to address these disparities is Medicaid expansion, which NSC supports in policy position #162, Medicaid Support for Mental Health and Substance Use Disorder. More than half of people with an opioid use disorder (OUD) have incomes below 200% of the federal poverty line.[36] {reference 36

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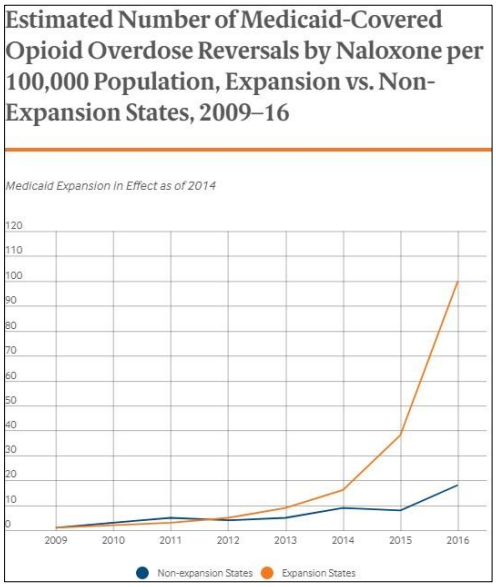
[26] https://www.sciencedirect.com/science/article/abs/pii/S0167629617303387?via%3Dihub
[27] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2759842
[28] https://pubmed.ncbi.nlm.nih.gov/30006187/
[29] Ibid
[30] https://pubmed.ncbi.nlm.nih.gov/30585876/
[31] https://pubmed.ncbi.nlm.nih.gov/31540779/
[32] https://health.clevelandclinic.org/is-naloxone-narcan-sold-over-the-counter/
[33] https://prescribetoprevent.org/wp2015/wp-content/uploads/naloxone_medicaid_report_gwu.pdf
[34] https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-naloxone-coverage-provided-forfamily-members-or-friends-obtaining-naloxone-prescription-on-enrollees-behalf/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[35] https://health.clevelandclinic.org/is-naloxone-narcan-sold-over-the-counter/
[36] https://www.commonwealthfund.org/blog/2017/medicaid-expands-access-lifesaving-naloxone [39] https://onlinelibrary.wiley.com/doi/abs/10.1111/add.14634?author_access_token=c785smzr9a7BqXjvfJWvota6bR2k8jH0KrdpFOxC65Cjw6d-4bYe-TjBsb0m5APm4Nd1RFZd8YZoIBNlX3j1qb2fbDX6NKa_htuUgVhZZrfxpECtFt2JGrY1t9o1ASW

link is not working} Medicaid expansion, which took effect as the opioid epidemic ballooned~~,~~ and provided insurance coverage to people at highest risk of ~~opioid use disorder (~~OUD~~)~~ – lower-income, younger adults. It ~~– and~~ has been highly effective because it made naloxone available and affordable to individuals who ~~are~~ were most likely to be on-site when an overdose ~~occurs~~ occurred. Expansion states dramatically increased their Medicaid-covered naloxone prescriptions. In 2016, states that did not expand Medicaid averaged 83.1 Medicaid-covered prescriptions per
100,000 enrollees, while expansion states averaged nearly four-times that amount – 215.6 per 100,000 enrollees. On average, naloxone saves one life for every 14 prescriptions written, which means expansion states potentially saved an additional 22.7 {Is this correct? Seems too low. Graph below needs to be updated. Graph data for 2016 notes tens of OD reversals per 100,000 population} lives per year per state.[39]



- Individual states should mandate, through legislative action, that all insurance plans that offer prescription coverage – including private plans ~~– to~~ offer prescription coverage of naloxone.[37]

An example of this is a 2016 law passed in Rhode Island~~,~~ which ~~requires~~ required every individual and group health insurance plan with prescription coverage to cover naloxone, even if it was intended for use on someone other than the insured.[38]

States can increase access to naloxone and reduce costs by negotiating with manufacturers for bulk purchase at a reduced price, which can offset costs for naloxone distribution to local agencies, including emergency response, law enforcement, health departments, community-based organizations and others. [39] {reference 39 is missing online} This can help get naloxone to people who are un- or underinsured.

3. Improving Data Collection

In general, data collection is critical in developing effective policies, practices and solutions to prevent intentional and unintentional injuries and illnesses from the workplace to anyplace. ~~The National Safety Council~~ NSC supports these broad efforts in policy position #137, focused on research and data collection. {should be a single hyperlink} Robust data collection systems help identify shifts in trends and patterns indicating the emergence of new injury issues and concerns.

Having accurate, current data that pertains to the opioid crisis is a key tool in the development of national, state, and local strategies. This is visible in the Department of Health and Human Services (HHS) five-point

[37] https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/10/expanded-access-to-naloxone-cancurb-opioid-overdose-deaths
[38] http://webserver.rilin.state.ri.us/BillText16/HouseText16/H7710.htm
[39] https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/10/expanded-access-to-naloxone-cancurb-opioid-overdose-deaths

strategy for addressing the significant social and public costs associated with the opioid crisis, in which data collection is a key part, as the ability to link data — combining data from two or more sources to study the same individual, facility, organization, event, or geographic area — often makes it possible to enhance the value of the information obtained beyond what is available from any single source.[40]

In the case of naloxone, there are variety of sources where data collection should be performed to best target naloxone distribution efforts, education and awareness campaigns, and ~~fund~~ funding. Data linkages are most commonly used to examine the effects of state naloxone policies or overdose education and naloxone distribution (OEND) programs on opioid overdose. The HHS Data Sources and Data-Linking Strategies to Support Research to Address the Opioid Crisis report {should be a single hyperlink} has a table that explains in-depth potential data sources (see below):

{What is IQVIA? Should be defined}

Data Type	Commonly Used Sources	Commonly Used Measures
Commercial Insurance Claims	IQVIA	Naloxone prescriptions through retail pharmacy channels Prescriber specialty Patient age, gender
Mortality Data	CDC Wide-ranging Online Data for Epidemiologic Research (CDC WONDER) National Vital Statistics System Mortality Multiple Cause of Death (NVSS MCOD)	Opioid analgesic overdose deaths Heroin overdose deaths Synthetic opioid overdose deaths
OEND Program Data	Massachusetts Opioid Overdose Prevention Pilot Program Harm Reduction Coalition	Reported number of overdose reversals Number of naloxone administrations Number of persons trained and naloxone kits distributed Knowledge about how to respond to a witnessed overdose and administer naloxone
EMS Data	National Emergency Medical Services Information System (NEMSIS)	EMS naloxone administration
Policy Data	Prescription Drug Abuse Policy System (PDAPS) Network of Public Health Law Legal databases	Good Samaritan laws Naloxone access laws
Hospital Emergency Department Data	TBD	Use of naloxone and associated outcome

[40] https://aspe.hhs.gov/system/files/pdf/259641/OpioidDataLinkage.pdf

{Any new information for Hospital Emergency Department Data? Table has TBD}

However, data collection can be a challenge for states and local health authorities, for a variety of reasons. These may include data costs ~~and / or~~ and/or lack of funding, staff time, lack of compatible formats for data comparison and combination across systems, and a lack of willingness to share data.

One way to address these barriers, aside from increasing funding, is to participate in the CDC Overdose Data to Action (OD2A) program, and to use those data to inform public health response and prevention activities.[41] The OD2A is a cooperative agreement between the CDC and jurisdictions (comprised of states, territories, counties, and city health departments) that aims to increase the timeliness and comprehensiveness of data, enabling participants to monitor and gather data about the scope and nature of the overdose problem, including:

- Collecting and disseminating emergency department data on suspected overdoses categorized as "all drug," "all opioid," "heroin," and "all stimulant";
- Collecting and disseminating descriptions of drug overdose death circumstances using death certificates, toxicology reports, and medical examiner/coroner reports;
- Implementing innovative surveillance activities to support interventions.

Another data source to focus on is the Overdose Detection Mapping Application Program (ODMAP). ODMAP provides near real-time suspected overdose surveillance data across jurisdictions to support public safety and public health efforts to mobilize an immediate response to a sudden increase, or spike in overdose events. It links first responders and relevant record management systems to a mapping tool to track overdoses to stimulate real-time response and strategic analysis across jurisdictions. This also helps identify geographic areas of high need and allows for accurate resource targeting.

These activities allow jurisdictions to expand comprehensive data collection and to tailor their surveillance efforts to specific needs. The establishment of a state or local authority solely responsible for managing data collection related to opioid overdose and naloxone may help address concerns surrounding data compatibility ~~and~~ while ~~encourage~~ encouraging data sharing. States should consider mandating data sharing to the current appropriate authority from all parties in the above table.

4. Supporting Community-Based Take-Home Naloxone Distribution Programs for People who Use Opioids

Overdose education and naloxone distribution (OEND) programs train laypersons to respond during overdose events and provide access to naloxone. Early adopters of this model began in the mid-1990s, becoming more widespread as the opioid crisis grew in the late 2000s, with a wide variety of organizations participating in OEND efforts~~.~~, such as syringe exchange programs, homeless shelters, emergency medical services, social service agencies, libraries, emergency departments, health care providers, and substance use disorder (SUD) treatment programs. A literature review[42] of observational studies and economic models suggests that OEND programs prevent deaths and are cost-effective. As an example, Massachusetts communities with an OEND program had lower opioid overdose death rates than communities without.[46]

However, stigma, lack of reach, funding and cost barriers, staffing, legal, regulatory and client-related problems provide barriers for OEND programs. States can mitigate these barriers by seeking federal funding ~~and / or~~ and/or providing state funding to ensure OENDs can purchase enough naloxone and provide increased access. As mentioned earlier, negotiating and purchasing naloxone in bulk can help mitigate the costs to the state. Accompanying legal actions were also described earlier in this policy position. States can likewise focus on destigmatizing opioid use and overdose via public education campaigns.

[41] https://www.cdc.gov/drugoverdose/OD2A/

[42] https://ldi.upenn.edu/brief/expanding-access-naloxone-review-distribution-strategies [46] https://www.ncbi.nlm.nih.gov/pubmed/23372174

These programs are most successful if they provide naloxone directly to those who are actively using opioids and at the highest risk for opioid overdose. To address problems with reach, states should authorize OENDs to distribute naloxone in their standing orders, via both in-person and mail delivery~~, in order~~ to reach people who may not be able to access a naloxone distribution site. Programs that support people who are being discharged from correctional and treatment facilities, who are at a higher risk for overdose,[43,44] should also be included, even if they do not have a formal OEND.

5. Facilitating Naloxone Access at Worksites

Opioid overdoses are occurring in workplaces. The Bureau of Labor Statistics (BLS) reported that overdose deaths at work from non-medical use of drugs or alcohol increased by at least 38% annually between 2013 and 2016. The 217 workplace overdose deaths reported in 2016 accounted for 4.2% of occupational injury deaths that year, compared with 1.8% in 2013.[45] Workplaces that serve the public (~~i.e.~~ e.g., libraries, hotels, restaurants, parks) may also have visitors who overdose while onsite.

Employers should consider:

- ~~including~~ Including naloxone in first aid supplies, including first aid supplies that are government regulated~~,~~;
- ~~providing~~ Providing naloxone training to first responders~~,~~;
- ~~teaching~~ Teaching employees how to recognize the signs and symptoms of an overdose.[46]

Fatal opioid overdoses in the workplace are rising: the rate of workplace overdose ~~fatality~~ fatalities increased annually between 2011 and 2019.[47] Any opioid user – which may include employees, visitors or passersby – is at risk for an opioid overdose. Occupations with higher rates of work-related injuries and illnesses, as well as those with lower availability of paid sick leave and lower job security, have higher opioid overdose death rates.

Workplaces have a critical role to play in combatting the overdose crisis, as 70% of people with ~~a~~ an SUD are employed.[52] If deemed feasible, provision of naloxone in the workplace is essential. Workplaces often have concerns about legality and liability of workplace naloxone programs.[48] States should provide clarity on workplace questions and concerns and work to remove other barriers identified by employers.

6. Supporting Co-Prescribing of Naloxone with Prescription of Opioid Medication(s)

Scientific consensus guidance documents {Identify which ones} support the prescription of naloxone to people who might be at risk for experiencing opioid overdose. This includes patients who are already prescribed opioid medications as well as opioid-naïve patients. Despite efforts to train and encourage prescribers to prescribe naloxone to patients at increased risk of overdose, existing stigma as well as a range of provider-specific and structural challenges, such as naloxone stocking, have limited ~~the uptake of~~ naloxone co-prescribing.[49] A 2005 to 2016 study showed that only 1.5% of commercially insured patients at high risk of overdose received prescription naloxone, suggesting that regulatory efforts might be needed to bring pharmacy naloxone distribution in line with expert consensus and official guidelines.[50]

One option is to mandate naloxone co-prescribing with prescription of any opioid for individuals at increased risk of overdose, with particular attention paid to those with prescriptions for both opioid and benzodiazepine medications. Recent analysis of states that examined naloxone prescribing before and

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[43] https://doi.org/10.2105/AJPH.2018.304514
[44] https://www.nap.edu/catalog/25310/medications-for-opioid-use-disorder-save-lives
[45] https://www.cdc.gov/niosh/docs/2019-101/pdfs/2019-101.pdf?id=10.26616/NIOSHPUB2019101
[46] https://www.nsc.org/getmedia/2b1616a1-c8a6-4c8c-b56b-1aa32f395bd5/naloxone-in-the-workplace.pdf.aspx
[47] https://safety.blr.com/workplace-safety-news/safety-administration/OSHA-Occupational-Safety-and-Health-Administration/BLS-Workplace-Fatalities-Rose-in-2019/ [52] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf
[48] https://www.nsc.org/getmedia/2b1616a1-c8a6-4c8c-b56b-1aa32f395bd5/naloxone-in-the-workplace.pdf.aspx
[49] https://ajph.aphapublications.org/doi/10.2105/AJPH.2020.305620
[50] https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2732332

after implementation of a naloxone prescribing mandate found that the mandates increased pharmacy naloxone provision 255% ~~from 90 days before to after implementation~~. This approach appeared to engage more prescribers, complement ongoing naloxone provisions under pharmacy standing orders, and expand geographic reach. Mandating naloxone ~~the~~ prescribing ~~of naloxone~~ quickly expanded naloxone access to more people in more places.[51] This result was replicated at retail pharmacies in all 50 states and the District of Columbia~~, in which~~ where having a legal mandate for naloxone co-prescription was associated with approximately 7.75 times more dispensed naloxone prescriptions compared with those not having the requirements.[52] Other states should consider mandating ~~the~~ co-prescription of naloxone to individuals at increased risk of overdose as identified during medical screenings, physician-patient conversations, patient history of opioid use or overdose, or other mechanisms that may arise during the course of medical care.

Physicians may be concerned about legality and liability when it comes to naloxone co-prescribing.[53] The legal risk associated with prescribing naloxone is no higher than that associated with any other medication and is lower than many. Where a prescriber determines in ~~his or her~~ their clinical judgment that a patient is at risk of overdose, co-prescribing naloxone is a reasonable and prudent clinical and legal decision. No clinician should fail or refuse to issue such a prescription based on liability concerns.[54] States should clarify any questions on legality or liability to appropriately address such concerns and increase physician co-prescribing. Additionally, physician training on naloxone can help mitigate concerns about naloxone itself and other questions on substance use and addiction.[55]

7. Expanding and Enhancing Research and Development of Overdose Education and Naloxone Distribution (OEND) Programs

NSC supports research efforts, funding and grant programs, and other relevant mechanisms to expand novel OEND programs, as well as evaluate and increase the effectiveness and reach of existing programs. More research can be done to determine the most efficient and effective ways to get naloxone to the people who need it most, and to reduce barriers. Special attention should be paid to the role that stigma plays as a barrier to naloxone distribution and utilization. This stigma can manifest when prescribing, dispensing, or carrying naloxone. Education and awareness via the OEND program is critical to reducing stigma.

8. Improving Support Systems After Naloxone is Deployed

The patient experience after naloxone administration can be difficult, traumatic, and confusing. However, this can be a good opportunity for providing a variety of support services, including linking to treatment services and peer recovery support services. This means that first responders and emergency departments (ED) are a critical part of the process as they work to get individuals stabilized and discharged. Studies have shown that patients are more likely to engage in treatment and reduce their opioid use when treatment is initiated in the ED.[61]

NSC supports increasing services that:

- Provide naloxone when patients are discharged from an opioid-overdose related ED visit;
- Facilitate transition to treatment and recovery (if desired);
- Enhance abilities of people administering naloxone (e.g., physicians and other medical professionals, law enforcement, first responders) to engage patients.

In particular, NSC supports implementation of the peer-support services model. This is an evidence-based model that can streamline this process, and has ~~shown~~ proven to be effective in increasing social supports and patient engagement and well-being. A peer-support provider, recovery coach or certified {by what

[51] https://ajph.aphapublications.org/doi/10.2105/AJPH.2020.305620
[52] https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2736179
[53] https://link.springer.com/content/pdf/10.1007/s11524-006-9120-z.pdf
[54] https://www.tandfonline.com/doi/full/10.1080/08897077.2016.1238431
[55] https://journals.lww.com/jphmp/Abstract/2018/07000/A_Survey_of_Prescribers__Attitudes,_Knowledge,.4.aspx [61] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4527523/

organization?} peer-support specialist is uniquely qualified to offer support and encouragement because of their lived experience. Peer support providers, recovery coaches and certified peer support specialists may also offer services outside of emergency department settings including destinations where an individual may have experienced an opioid overdose including and not limited to EMT services, first responders, public health departments, probation and parole offices, law enforcement, and treatment and/or recovery centers.

Conclusion

Naloxone is a medication that can be safely administered by — and prescribed, dispensed, and distributed to — people who are at risk of overdose or who may witness an overdose in a variety of settings. Removing barriers to naloxone accessibility should be a top priority in order to reduce the number of opioid overdose deaths across the country. 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 to save lives.

Comment: Reference numbering in Word format is awkward to work with. All references should identify the year of publication. Weblinks should specify date of publication or when last accessed. Content highlighted in yellow needs to be updated.

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This position statement reflects the opinions of the National Safety Council but not necessarily those of each member organization.

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