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# Lessons Learned from the Expansion of Naloxone Access in Massachusetts and North Carolina

*Corey S. Davis, Alexander Y. Walley, and Colleen M. Bridger*

## Background

States are rapidly modifying law and policy to increase access to the opioid antidote naloxone, and the provision of naloxone rescue kits (NRK) for use in the event of overdose is becoming increasingly common.<sup>1</sup> As of late 2014 the majority of states had passed laws increasing naloxone access, and nearly as many have modified emergency responder scope of practice protocols to permit Emergency Medical Technicians (EMTs) and law enforcement officers to administer the medication.<sup>2</sup> While the text of these laws is generally similar, their implementation varies among states.

This article outlines experiences and lessons learned from two diverse states, Massachusetts and North Carolina. In Massachusetts naloxone access initiatives were well underway before formal legislative action occurred, while in North Carolina the passage of a naloxone access law served as a catalyst for the creation of new programs and facilitated the scale-up of existing ones. In both states legislative action was necessary to permit the prescription and dispensing of naloxone to the friends and family members of people who use opioids, a key legal change.

## Lessons Learned from Two Diverse States

### *Massachusetts*

In Massachusetts, several programmatic, legislative, and regulatory innovations have expanded access to

overdose prevention education and NRK distribution. The key legal component of much of this rollout has been the issuance of standing orders that permit naloxone to be distributed without direct interaction between the prescriber and the person receiving the medication.

Community overdose prevention education programs that include the distribution of NRKs began in Massachusetts in 2006. These programs, started in response to a local surge in opioid-related overdose deaths, were initially directed towards people who inject heroin in Boston and the neighboring city of Cambridge. The NRKs were based on those used by the local EMS service and included two doses of medication, two nasal atomizers, and instructions on how to assemble the naloxone delivery device and administer the medication. In 2007, the program was expanded to four other community-based agencies by the Massachusetts Department of Public Health (MDPH), with further expansion from 2009 through 2014 to include 16 agencies across the state.

In August 2012, the Massachusetts Legislature passed a law that permits the prescription of naloxone to “a family member, friend or other person in a position to assist a person at risk of experiencing an opiate-related overdose” (often referred to as “third-party” prescriptions), and permits individuals to administer naloxone to a person experiencing an overdose. The law also provides protection from charge and prosecution for victims and bystanders who summon emergency assistance in the event of an overdose (often referred to as “Good Samaritan” provisions).<sup>3</sup> In March 2014, Massachusetts Governor Deval Patrick further enhanced these efforts by declaring a public health emergency that led to regulations permitting

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**Corey S. Davis, J.D., M.S.P.H.,** is the Deputy Director of the Southeastern Region of the Network for Public Health Law and a Staff Attorney for the National Health Law Program. **Alexander Y. Walley, M.D., M.S.,** is an Assistant Professor of Medicine and Program Director of the Addiction Medicine Fellows Program at Boston University School of Medicine. **Colleen M. Bridger, Ph.D., M.P.H.,** is the Health Director in Orange County, NC.

all first responders to carry naloxone under a medical director's supervision, and in July 2014 a law took effect that permits pharmacists to furnish NRKs pursuant to a standing prescription order.<sup>4</sup>

There are currently four types of naloxone standing orders in place in Massachusetts: (1) a statewide order issued as part of the MDPH overdose prevention pilot program that permits the distribution

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of NRKs by public health workers; (2) a statewide protocol adopted by the MDPH's Office of Emergency Medical Services that permits EMTs and first responders to administer naloxone for opioid overdose; (3) a prescriber-issued standing order for pharmacists to furnish NRKs without a patient-specific prescription; and (4) hospital standing orders that allow a hospital pharmacy to furnish NRKs to patients upon discharge.

Perhaps the most comprehensive of these programs is one in which trained community health workers distribute NRKs statewide under a standing order issued by the MDPH program's medical director. These kits are distributed in a broad array of venues including inpatient detoxification programs, syringe access programs, drop-in HIV prevention centers, methadone maintenance clinics, addiction treatment programs, emergency departments, homeless shelters, and community meetings. Police officers and firefighters in six Massachusetts towns have been trained and equipped to administer naloxone during an overdose under the same standing order.<sup>5</sup>

By late 2014 over 30,000 individuals in Massachusetts had been trained and equipped to administer naloxone and over 3,500 successful reversals have been reported. Together, the four standing order programs and associated training and education initiatives have greatly increased community access to naloxone, likely reducing rates of opioid overdose death.<sup>6</sup>

### *North Carolina*

While community groups have been distributing naloxone to people at risk of opioid overdose in North Carolina since 2010, these initiatives were limited in part by lack of third-party prescription authority and ambiguity regarding the scope of standing prescription orders.<sup>7</sup> This changed in 2013, when the North Carolina General Assembly nearly unanimously passed a law designed to increase naloxone access. Like the Massachusetts law, this legislation permits prescribers to issue prescriptions for third parties, and protects both the prescriber and administrator from civil and criminal liability. It also provides protection from criminal charges for the overdose victim and bystanders who act in good faith to summon emergency responders, and explicitly permits the prescription of naloxone via standing order.<sup>8</sup>

In 2014 the Orange County Health Department (Department) became the first health department in the state to implement a standing order-based naloxone distribution program. The county Board of Health had identified reducing unintentional drug overdose deaths as a priority after the Department's Community Health Assessment revealed a 300% increase in unintentional prescription drug overdose deaths. The Department became involved with a community coalition focused on the issue. While the community coalition worked to implement community education, diversion control and provider education interventions, the Department has focused on harm reduction initiatives. Based on positive reports from other areas, including Massachusetts, the Board of Health directed the Department to begin offering NRKs at no charge to opioid patients as well as friends and family members of individuals at risk of opioid overdose through a standing order issued by the Department's medical director.

This program quickly met with an unexpected hurdle in the form of a North Carolina Board of Pharmacy regulation that limited the medications that public health nurses are permitted to dispense under a standing order. The county Health Director, the director from a nearby health department, representatives from the state health department, and staff from the state Board of Pharmacy held informal conversations to discuss the effect of the rule in limiting the effect of the recently passed law. Within months the Department petitioned the state Board of Pharmacy to add naloxone to the list of approved medications. The Board of Pharmacy acted swiftly, suspending the existing rule and fast-tracking the addition of naloxone to the public health nurse formulary.

The Department then worked to ensure a standardized approach for training and dispensing, and developed a standing order that was shared throughout the state. Once the naloxone was ordered and the NRKs were put together and ready for dispensing, the final hurdle was getting the word out that the free NRKs were available. The Department is currently working with numerous partners to publicize the program and develop an inventory and reporting system to be able to track overdose reversals associated with the kits.

Nonprofit organizations also quickly began working to expand naloxone access. The North Carolina Harm Reduction Coalition, a statewide nonprofit, distributed more than 7,500 NRKs in the first 20 months after the law went into effect, and received more than 325 reports that the kits were used to reverse an overdose. In part spurred by the success of these efforts, state health officials have taken actions to increase access to naloxone in other venues. The state Department of Public Health developed a web-based training that can be accessed by any public health nurse in the state, and Project Lazarus, a comprehensive community-based overdose prevention intervention that includes the distribution of NRKs, has been funded to expand statewide. Additionally, the state Office of Emergency Medical Services (EMS) modified the statewide EMS scope of practice to include the administration of naloxone by all first responders, including law enforcement officers, acting under a standing order issued by the county EMS medical director.<sup>9</sup> Several lessons were learned through the process of passing overdose prevention legislation and implementing naloxone access programs in North Carolina. First, “other states are doing it” is not always a persuasive argument. The great work being done in Massachusetts was not compelling to some of the more conservative elected decision makers in the state — although most of these elected officials eventually supported the law, perhaps partly because it was endorsed by law enforcement actors including the influential state Sheriffs Association.<sup>10</sup> Second, not all harm reduction messages resonate as well as “seat belts save lives.” Even some public health officials in the state continue to hold the false belief that naloxone access enables addiction. Finally, it was discovered that some first responders are unfamiliar with the evidence base supporting the expanded use of naloxone, although initial response among first responders newly equipped with naloxone has been positive.

## Conclusion

Both Massachusetts and North Carolina have made great progress in increasing access to naloxone, of which changes to law and policy have been a critical

factor. However, while legal change may be a necessary component of increased access, it is not sufficient. Several barriers remain in both states. First, health care providers often do not see the prescription and provision of naloxone as part of their duty to patients and their families. Substantial work is needed to educate and engage frontline providers including prescribers, pharmacists, nurses, first responders, and social workers in the importance of naloxone in reducing overdose risk (one example of a free online multidisciplinary program can be found at [opioidprescribing.com](http://opioidprescribing.com)). Second, existing naloxone formulations either require assembly (intranasal), pose a risk of needle stick injury (intramuscular), or carry a high cost (Evzio auto-injector). Formulations that are affordable, require little training, and are easily accessible are urgently needed. Insurance coverage for NRKs (which are highly cost effective) should also be a priority.<sup>11</sup> Finally, naloxone’s status as a prescription medication reduces NRK access and its potential to save lives. The likely benefits of making NRKs available over-the-counter warrant consideration as a promising next step in overdose prevention.

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