Positioning Statement **Senate Bill 459**:

Establishing Opioid Overdose Prevention and 911 Good Samaritan Policies for Nevada

PHASA
Public Health Alliance for Safety Access

Drug overdose deaths are a major public health and safety issue in Nevada and the U.S. According to the Centers for Disease Control and Prevention (2012), Nevada is in the highest quartile of overdose death rates in the U.S. In 2013, there were 507 drug-related deaths in Nevada according to data from the National Vital Statistics Database. The rate of drug related deaths in Nevada doubled from 8.9 per 100,000 in 1999 to 17.5 per 100,000 in 2013.

In the U.S., deaths from overdose now exceed the annual rate of deaths caused by homicide and vehicle collisions. The majority of drug overdose deaths in the U.S. involve prescription or illicit opioids. In the U.S., the rate of prescription opioid related deaths quadrupled from 1999 to 2011.

This is a national epidemic that is being addressed at both the local and national level. At the federal level, President Obama has earmarked $133 million in his FY 2016 budget request to address the epidemic of heroin use, prescription drug abuse, and overdose deaths.

At the local level, the Public Health Alliance for Safety Access (PHASA, established 2011), an advocacy group for policy, system and environmental changes that promote the health and well being of all Nevadans, is working to support effective, public-health minded policies to reduce the burden of overdose deaths in Nevada. PHASA applauds the work of Governor Sandoval, bringing forth Senate Bill 459 as sponsored by the Health and Human Services Committee This will establish opioid overdose prevention and 911 Good Samaritan policies for Nevada. PHASA supports our Governor in his fight to end opioid overdose deaths in Nevada.

As of 2014, 28 states across the U.S. have passed laws to expand access to naloxone, the life-saving medication that can be used by bystanders to reverse the potentially fatal effects of an opioid overdose. As of 2010, more than 50,000 people in the US have been trained to use naloxone, and have used naloxone more than 10,000 times to respond to overdoses in their communities. In addition, 22 states have passed 911 Good Samaritan laws, which encourage witnesses to call for emergency medical help in the event of a drug overdose.

In accordance with other states and organizing bodies that seek to pass effective, public health-minded reform to reduce drug overdose deaths, PHASA recommends that the following provisions be included in Nevada's drug overdose prevention legislation:

Naloxone Access Provisions

1. Authorization for health care professionals with existing prescribing authority to prescribe and dispense naloxone, directly or by standing order, to people at risk of experiencing an opioid-related overdose, or to a family member, friend, or other person in a position to assist.
2. Protection from criminal, civil, or professional liability for health care professionals who prescribe or dispense naloxone
3. Assurance that the possession of naloxone is lawful
4. Protection from civil and criminal liability for any individual who possesses naloxone and/or acts in good faith to administer naloxone to an overdose victim
5. Authorization for basic EMTs to administer naloxone
6. Guidance for the inclusion of naloxone on the Medicaid Preferred Drug List

7. Authorization for persons or organizations acting under a standing order issued by a health care professional to store and dispense naloxone
8. Collection of data on drug overdose numbers, rates, trends, patterns, and risk factors in Nevada
9. Provisions of grants from existing resources to support drug overdose prevention and naloxone access

911 Good Samaritan Provisions

Protection from arrest, charge, prosecution, conviction, or forfeiture resulting from commission of drug-related crimes, violation of a restraining order, or violation of probation or parole, if the evidence for the arrest, charge, prosecution, conviction, seizure or penalty was gained as a result of seeking medical assistance for a person experiencing a drug or alcohol overdose or other medical emergency.

We further suggest that the following provisions be avoided in Nevada's law, due to their potential to weaken the effectiveness of the law:

1. Any mandates regarding the quantity, duration, timing, location, context, or other details of providing training and education on overdose prevention and naloxone.

Why should this not be included? Due to the diversity in educational needs of individuals at risk, their friends and family members, and the variety of circumstances related to each clinical encounter, mandating universal training requirements will limit the ability of health care professionals and public health departments to exercise due care when educating their patients and will create barriers to providing and accessing effective prevention resources. Training and education should be conducted based on the professional judgment of the health care professionals and program staff.

2. The identification of a single entity (e.g., a health department, community based organization, or clinical entity) that is entirely responsible for the implementation of overdose prevention activities.

Why should this not be included? Due to the diversity of need throughout Nevada and unique circumstances of communities in different areas of the state, identifying a single "home" for overdose prevention would unduly burden a single entity with a large programmatic mandate and would create barriers to accessing effective prevention resources. Decisions about how and where to provide overdose prevention services should be left to the community stakeholders and the entities providing the services.

3. Any mandate regarding the specific formulation or route of administration for naloxone

Why should this not be included? The changing nature of the pharmaceutical industry means that there is constant flux in the availability and pricing of different formulations of naloxone (i.e., higher concentration used to administer intranasally vs. lower concentration used for intramuscular administration). Creating a mandate for the use of a single formulation or route of administration would unduly burden consumers, providers, and programs, while potentially limiting access if the mandated formulation became unavailable.

Adapted from the Naloxone Overdose Prevention Education Working Group: Naloxone Legislation Drafting Guide