Beware of Heaping More Bad Opioid Policy on Top of Failing Opioid Policy

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There is an opioid crisis in the United States, and Arizona lawmakers are considering proposals to address this growing problem.

Policymakers looking to address the problem head-on should focus on reducing harm and death and leave doctors to care for their patients in pain. There are two good measures that can be enacted on the state level that are "low hanging fruit."

Naloxone has been in use since 1971 as an antidote for opioid overdoses. First responders across the nation have used the drug to reverse at least 26,500 overdoses between 1996 and 2014. Unfortunately, despite the fact that naloxone is not a controlled substance and has been used by laymen with minimal training, it is still classified as a prescription drug by the Food and Drug Administration. All 50 states and the District of Columbia have devised work-arounds so that either pharmacists can prescribe naloxone or they and other designated personnel are given a "standing order" by a state's chief medical officer to dispense the drug.

But studies have shown that, due to the stigma attached to opioid use, and because some states prohibit dispensing naloxone to friends or relatives of opioid users, the drug is not being obtained or used anywhere near its full potential. If it was reclassified as "over-the-counter" then opioid users and their loved ones can more discretely and privately purchase the antidote off the shelf. This would be a real lifesaver.

Recognizing this fact, Australian authorities made naloxone available OTC in 2016. It has been OTC in Italy for decades. The FDA has already publically expressed a willingness to consider reclassifying naloxone to over-the-counter, and has asked manufacturers to submit petitions for reclassification. But FDA regulations also allow "any interested party" to petition for reclassification. The state of Arizona, one of the front lines of the overdose crisis, is certainly an interested party. The legislature can draft a petition to the FDA requesting a reclassification review.

The legislature can also pass a "Good Samaritan Law," already enacted in 40 states and the District of Columbia, that assures witnesses of drug overdoses that they will not be arrested or prosecuted for drug possession or drug use if they call first responders to rescue an overdose victim. Studies show these laws have reduced overdose deaths as drug users were more likely to summon emergency personnel when they witnessed an overdose.

However, care must be taken in the drafting of such a law. In some states with Good Samaritan laws, police arrest witnesses who called for help and charge them with aggravated battery if they helped the victim inject, and sometimes with manslaughter if the victim dies. This not only runs counter to the spirit of the Good Samaritan law, but undermines it as well. Once news spreads that a witness was arrested after calling for help, expect such calls to stop. A properly crafted Good Samaritan law should explicitly protect witnesses from such arrests and prosecution.

After these relatively easy and uncontroversial steps are taken, legislators can then look at ways to facilitate the development of needle exchange programs or, better yet, supervised injection facilities, both of which are endorsed by the CDC and operate for decades throughout the developed world, in hundreds of locations, reducing overdoses, the spread of disease, and in many cases guiding drug users into treatment programs.

What lawmakers should *not* do is add insult to injury by imposing a one-size-fits-all limit on the amount of opioids prescribed to people in pain. This will only make matters worse and is not evidence-based. Researchers from Brigham and Women's Hospital, the University of Utah, and the University of Alabama, writing in the June 2017 journal *Substance Abuse,* point out that the rush to limit prescriptions was based upon 2016 CDC guidelines which were based upon only limited data and therefore recommended an **individualized** assessment of harm against benefit when prescribing pain medication to patients. The few limited studies upon which the CDC based its advice "did not clarify risk of long-term dependence or addiction due to short term exposure." The authors went on to say, "Unduly broad inferences drawn from this study have fueled sentiment that short-term opioid exposure is a major contributor to addiction," and said of efforts to restrict the prescription opioid supply, "Such efforts are likely to obtain less traction now that other opioids such as heroin and illicitly manufactured fentanyl have come to dominate the crisis…" and "with increasing anecdotal reports of harm to patients summarily cut off from opioids, there is some reason for concern."

And on January 17, 2018 a Harvard study was released that retrospectively analyzed over 1 million Aetna Insurance patients between 2008 and 2016 who were "opioid naïve" and were prescribed opioids postoperatively for pain. [See the article, "Study of Postsurgical Patients Shows Addiction to Pain Pills Is Rare" at *Reason*.] While they found a correlation between the rate of "misuse" (all "misuse" codes including addiction) with subsequent prescription refills, there was an overall incidence of all categories of opioid "misuse" of just 0.6%, with a 0.2% incidence in those patients one year after surgery.

Lawmakers are right to be distressed by the drumbeat of bad news about the rising overdose rate—increasingly due to heroin and fentanyl. But they should resist the strong temptation to "do something" when it is not evidence-based. They should heed the medical dictum, "First do no harm."

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