

NOPE

*Naloxone Overdose Prevention
Education Working Group*

**NALOXONE
LEGISLATION
DRAFTING GUIDE**

WHO WE ARE

The Naloxone Overdose Prevention and Education (NOPE) Working Group was formed in 2008 to address issues related to naloxone access in the United States. NOPE currently has over one hundred members, including legal and policy experts, individuals working in naloxone distribution programs, advocates, public health officials, researchers, medical professionals, and others involved in varying aspects of expanding access to naloxone. Members of NOPE have been involved in projects related to naloxone pricing and shortages, advancing policies that include overdose prevention and naloxone, production of advocacy materials like the film *Reach for Me*, maintaining a national database of overdose prevention initiatives, assisting in the implementation of new programs, and advising states on legislative changes related to naloxone, among others. NOPE receives no funding to support its activities.

MODEL NALOXONE LEGISLATION PROVISIONS

DEFINITIONS

1. [Health Care Professional](#)

Sample Language: “Health care professional” includes, but is not limited to, a physician, a physician assistant, or a nurse practitioner, who is authorized to prescribe an opioid antagonist.

2. [Opioid Antagonist](#)

Sample Language: “Opioid antagonist” means any drug that binds to opioid receptors and blocks or disinhibits the effects of opioids acting on those receptors.

3. [Opioid-Related Drug Overdose](#)

Sample Language: “Opioid-related drug overdose” means a condition including, but not limited to, extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death resulting from the consumption or use of an opioid, or another substance with which an opioid was combined, or that a layperson would reasonably believe to be an opioid-related drug overdose that requires medical assistance.

Note that these definitions may be unnecessary. If you choose to include specific definitions in your bill, however, then these definitions are preferred.
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THE FOLLOWING PROVISIONS ARE ESSENTIAL TO INCLUDE IN A LAW FOR IT TO BE EFFECTIVE:

1. [Third-Party Prescription/Standing Order Distribution](#)

Sample Language: Notwithstanding any other law or regulation, a health care professional otherwise authorized to prescribe an opioid antagonist may, directly or by standing order, prescribe, dispense, and distribute an opioid antagonist to a person at risk of experiencing an opioid-related overdose or to a family member, friend, or other person in a position to assist a person at risk of experiencing an opioid-related overdose. Any such prescription shall be regarded as being issued for a legitimate medical purpose in the usual course of professional practice.

This provision authorizes a health care professional to prescribe naloxone for use on a person at risk of opioid overdose, even if the physician has not personally examined that person. It also permits the prescribing practitioner to dispense naloxone to a person other than the person for whom the drug may be used. This practice is not unique; for example, many states explicitly permit such “third party prescription” in the form of expedited partner therapy for sexually transmitted infections. However, state laws often prohibit or discourage it (and prescribers may be unwilling to do it) unless a statute explicitly permits the practice.

The only requirement for receiving a prescription for naloxone that this provision imposes is that the person be “in a position to assist a person at risk of experiencing an opioid-related overdose.” It does not impose any educational, training, or certification requirements on either the doctor or the patient. These additional requirements should be avoided if politically possible. *See Provisions That Should Generally Be Avoided, Training/Education Requirements (pg. 8).*

2. [Prescriber/Dispenser Civil and Criminal Immunity](#)

Sample Language: A health care professional who, acting in good faith and with reasonable care, prescribes or dispenses an opioid antagonist shall not be subject to any criminal or civil liability or any professional disciplinary action for (1) such prescribing or dispensing; and (2) any outcomes resulting from the eventual administration of the opioid antagonist.

This provision provides prescribers assurance of professional, civil, and criminal immunity even if the naloxone prescribed is ultimately used by or for someone else. Because third-party prescription is relatively uncommon, doctors and other health care professionals will likely want to make sure they are protected if they issue a prescription for naloxone to a third-party, even if doing so does not actually pose any special liability risks. While this provision does not provide a *blanket* immunity for health care professionals, it does ensure that prescribers who are acting reasonably will not be punished by their licensing boards, charged with a drug crime, or lose a malpractice civil lawsuit simply because third-party naloxone prescription is an emerging practice.

3. [Possession of Naloxone Lawful](#)

Sample Language: Notwithstanding any other law or regulation, any person may lawfully possess an opioid antagonist.

As written, this provision does not tie lawful possession of naloxone to a prescription and/or authorized distribution program. This is ideal. It is important to encourage people who use drugs and their friends and family to share the information and tools they receive with respect to reversing overdose. If a friend gives a person at risk their naloxone kit, for example, that person should still be protected under the law even if they did not receive a prescription for the kit themselves.

4. [Civil and Criminal Immunity for Administration of Naloxone](#)

Sample Language: A person who, acting in good faith and with reasonable care, administers an opioid antagonist to another person whom the person believes to be suffering an opioid-related drug overdose shall be immune from criminal prosecution, sanction under any professional licensing statute, and civil liability, for acts or omissions resulting from such act.

This provision ensures that *anyone* (whether specifically authorized to administer naloxone or not) who administers naloxone will be immune from professional, civil, and criminal liability. To our knowledge no person administering naloxone has ever been criminally charged or civilly prosecuted for that act, but this provision may provide peace of mind, particularly in the organizational context.

THE FOLLOWING PROVISIONS ARE HIGHLY DESIRABLE, STRENGTHEN THE EFFECTIVENESS OF THE LAW, AND SHOULD BE INCLUDED IF POLITICALLY FEASIBLE:

1. [Permitting EMT-B and EMT-Is to Administer Naloxone](#)

Sample Language: By January 1, 20XX, every Emergency Medical Technician licensed and registered in [the state] shall be authorized and permitted to administer an opioid antagonist as clinically indicated.

In most states, non-Paramedic EMTs are not permitted to administer naloxone. While in many states this can be changed at the regulatory or sub-regulatory levels (particularly if naloxone is available in the intranasal formulation) it is advisable for the statute to mandate this change.

2. [Lay Distribution of Naloxone Via Standing Orders](#)

Sample Language: Notwithstanding any other law or regulation, a person or organization acting under a standing order issued by a health care professional who is otherwise authorized to prescribe an opioid antagonist may store an opioid antagonist without being subject to provisions of [the state pharmacy act] except [those provisions regarding storage of drugs], and may dispense an opioid antagonist so long as such activities are undertaken without charge or compensation.

We believe this is the best method by which to distribute naloxone to as many people as possible, particularly those that do not have access to a primary physician or lack medical insurance.

The Overdose Education and Nasal Naloxone Distribution (OEND) programs in Massachusetts provide one example of the standing order model. A recent study of OEND effectiveness concluded that “opioid overdose death rates were reduced in communities where OEND was implemented” compared to communities without OEND implementation. OEND programs trained 2,912 potential bystanders who reported 327 rescues. This study provides observational evidence that by training potential bystanders to prevent, recognize, and respond to opioid overdoses, OEND (though the standing order model) is an effective intervention. See Alexander Walley et al., *Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis*, 346 *BMJ* 1-12 (2013).

3. [State Insurance Coverage for Naloxone](#)

Sample Language: [The single state agency] is directed to ensure that naloxone hydrochloride for outpatient use is covered by the Medicaid prescription drug program on the same basis as other covered drugs.

This is state specific. Advocates should work with the state Medicaid agency or an attorney familiar with state Medicaid drug law (see contact information below) to determine how best to legislatively provide Medicaid coverage for outpatient naloxone. Not all states have formularies or preferred drug lists, but in those states that do, simply adding naloxone to that list may be sufficient.

4. [Funding for Overdose Prevention and Naloxone Distribution](#)

Sample Language: The [appropriate state agency] shall make grants from funds appropriated pursuant to this section for any of the following purposes:

(a) Drug overdose prevention, recognition, and response, including naloxone administration, education projects;

(b) Drug overdose prevention, recognition, and response, including naloxone administration, training for patients receiving opioids and their families and caregivers;

(c) Naloxone hydrochloride prescription or distribution projects; or

(d) Education and training projects on drug overdose response and treatment, including naloxone administration, for emergency services and law enforcement personnel, including, but not limited to, volunteer fire and emergency services.

There is hereby appropriated from the [specify fund – likely General Fund], in the 20XX-XX fiscal year, (\$X00,000) for the purpose of funding the grants provided in this section.

Additional funds necessary for the implementation of this section in the 20XX-XX fiscal year and in later fiscal years may be included in the budget appropriation for the [appropriate state agency].

This provision is likely a long shot as appropriating funds necessarily makes legislation more difficult to pass. However, it is certainly worth attempting for funding and removing it if it becomes politically necessary to do so for the bill's passage. Another strategy would be to separate this provision from those that do not require appropriations and submit it as a separate and distinct bill. Given current state budgets, provisions with appropriations have great potential to kill the entire bill.

5. [Statewide Surveillance](#)

Sample Language: The [appropriate state agency] shall ascertain, document, and publish an annual report on the number, trends, patterns, and risk factors related to unintentional drug overdose fatalities occurring within the state each year. The report shall also provide information on interventions that would be effective in reducing the rate of fatal or nonfatal drug overdose.

A key obstacle to addressing the opioid overdose epidemic is the paucity of state-wide data on the number, risk factors, and circumstances surrounding opioid overdose fatalities. Surveillance may have associated costs, and, to that extent, may be better off in a separate bill if appropriations are attached to it. Again, appropriations make the bill exponentially more difficult to pass.

6. [Collaborative Practice Agreements/Pharmacy Dispensing](#)

Sample Language: None – State Specific.

State pharmacy provisions generally contain either a collaborative practice agreement provision or state-approved protocols that allow pharmacists to provide certain drugs without a prescription. Collaborative practice agreements permit prescribers to authorize pharmacists to engage in specified activities, including adjusting or initiating drug therapy. In states with state-approved protocols, collaborative practice agreements or similar agreements between physicians and pharmacists are allowed, but modification of existing statutes or regulations may be required to allow pharmacists to dispense prescription drugs without a prescription.

It may also be the case that additional legislation is not required in order to implement collaborative practice agreements between physicians and pharmacies for the provision of naloxone. Authorizing legislation may be required, however, in certain states. For example, California specifically authorized collaborative practice agreements for emergency contraceptive pills (*see* California Business and Professions Code sections 4052(8) and 4052.3) and similar legislation would be required for naloxone.

For legislative drafting assistance with respect to this provision, please see contacts for “Legal/Legislative Drafting” on pg. 17 below.

THE FOLLOWING PROVISIONS ARE OFTEN SUGGESTED BUT CAN BE DETRIMENTAL TO AN EFFECTIVE LAW:

1. [Training and Education Requirements](#)

Mandatory training and education is an unnecessary barrier to accessing naloxone. Prescribers and dispensers are already required by general practice rules to ensure that patients understand what a particular medication does, when and how to use it, etc. Requiring naloxone-specific education stigmatizes the drug and reduces the chances that already-rushed prescribers will bother prescribing it. A lengthy training program for end users may also reduce the chance that they attempt to get naloxone. Moreover, naloxone is extremely safe and easy to use and accordingly should not require a higher training and education threshold than other prescription medications.

If it becomes absolutely necessary for the political survival of a naloxone bill to include training and education requirements, they should be as least onerous as possible, and preferably would not use the word “training,” but would rather state something like the following: “The person receiving naloxone will be instructed on the proper use of the drug and how to recognize an overdose.” Using the phrase “will receive education” or something to that effect leaves it open for interpretation. “Education” could include watching a video, receiving a brochure, or simply a brief discussion with a physician or pharmacist. Ultimately, it is important to avoid state health departments or other agencies mandating stringent and onerous trainings in order to access naloxone. Alternatively, training and education requirements could be mandated through regulations. Though regulations are not easy to change, they can evolve more easily than legislation.

2. [Identifying a Single “Home” for Naloxone Distribution Programs](#)

It is preferable to refrain from identifying a *single* “home,” such as the department of health, for naloxone distribution. There should not be a single point of access to naloxone. The goal should be to make distribution possible through many types of agencies (state, NGO, city, etc.). While health departments can be fine settings for overdose programs, they often face unnecessary restrictions, impose onerous training requirements, and can be risk averse.

3. [Specifying Naloxone Formulations \(i.e., Intranasal\)](#)

Naloxone legislation that specifies intranasal naloxone is unnecessarily limiting. Intranasal naloxone is a non-FDA approved (i.e. non-existent) formulation of naloxone. There is technically no such thing as “intranasal” naloxone, only higher concentration injectable naloxone used off-label intranasally. If something were to happen with the distributor of the luer-lock device or the atomizer (the products that make injectable naloxone intranasal) and either of those products become unavailable and people are unable to acquire “intranasal” naloxone, a law specifying “intranasal” naloxone would essentially be null and void despite the fact that injectable naloxone would be readily available. The higher concentration naloxone used for intranasal administration also tends to be more expensive and would also mean that the state would be supporting one company providing naloxone over another.

4. [Data Collection and Reporting](#)

If there is a way to structure data collection and reporting requirements through existing mechanisms that do not add any additional burden, then it may be okay. However, data collection on programs providing naloxone have the potential to create additional burdens and also to create the impression that naloxone needs a special program just to track it (and devote scarce resources to do the tracking).

****A SAMPLE BILL BASED ON THE PROVISIONS ABOVE IS ATTACHED AS EXHIBIT A.****

RESPONDING TO CRITICISM

1. [Criticism: The Availability of Naloxone Will Encourage Abuse by Drug Users Because They Will be More Likely to Take Larger Doses if They Know Naloxone is Available.](#)

Response: Naloxone puts opioid users into withdrawal—which is a very unpleasant experience—and takes away from the positive euphoria of opioid use. The following studies have accordingly concluded that the availability of naloxone does not encourage people to use more drugs or to use drugs in riskier ways:

- Karen H. Seal et al., *Naloxone Distribution and Cardiopulmonary Resuscitation Training for Injection Drug Users to Prevent Heroin Overdose Death: A Pilot Intervention Study*, 82(2) *Journal of Urban Health* 303–311 (2005) (Participants trained in overdose prevention and use of naloxone increased their knowledge of heroin overdose management, while heroin use decreased).
- Temple University of the Commonwealth System of Higher Education, Beasley School of Law, Project on Harm Reduction in the Health Care System, Memorandum, *Legal Analysis of Switching Naloxone from Prescription to Over the Counter*, July 6, 2005 (Two European studies found no serious adverse effects and observed no increase in risky behavior associated with naloxone availability).
- Scott Burris et al., *Legal Aspects of Providing Naloxone to Heroin Users in the United States*, 12 *The International Journal of Drug Policy* 237-248 (2001) (One survey of heroin users found that few would use more following administration of naloxone).
- Sarz Maxwell et al., *Prescribing Naloxone to Actively Injecting Heroin Users: A Program to Reduce Heroin Overdose Deaths*, 25(3) *Journal of Addictive Diseases* 89-96 (2006) (Participants in naloxone programs reported no interest in increasing dosage or injecting more frequently as a result of naloxone availability).
- Nancy Worthington et al., Research, *Opiate Users' Knowledge About Overdose Prevention and Naloxone In New York City: A Focus Group Study*, 3(19) *Harm Reduction Journal* (2006) (Aversion to effects of naloxone administration in study participants refutes concerns of riskier drug-taking activity in opiate users).
- Karla D. Wagner et al., *Evaluation of an Overdose Prevention and Response Training Program for Injection Drug Users in the Skid Row Area of Los Angeles, CA*, 21(3) *International Journal of Drug Policy* 186-193 (2010) (Overdose prevention and response training programs may be associated with improved overdose response behavior).

In addition, there may be unanticipated benefits of naloxone distribution: a recent study found that witnesses to overdose who administered naloxone were less likely to share syringes than those who did not administer naloxone.¹ This finding points to “the potential wider, positive effects or behavioral modifications that naloxone distribution may have beyond its ability to reduce overdose risk behaviors or reverse an overdose,” such as potentially helping to reduce transmission of hepatitis C and HIV.²

2. Criticism: Drug Users and Other Lay People Are Not Medically Trained and Will Be Unable To Administer Naloxone Properly.

Response: Research studies demonstrate that drug users can effectively recognize an overdose and respond correctly with naloxone:

- Traci C. Green, *Distinguishing Signs of Opioid Overdose and Indication for Naloxone: An Evaluation of Six Overdose Training and Naloxone Distribution Programs in the United States*, 103 *Addiction* 979-989 (2008) (“[T]his study reports initial evidence of the effectiveness of overdose training and naloxone distribution programs in opioid overdose recognition and response. People trained through these programs identify opioid overdoses and indications for naloxone as well as medical experts and consistently scored higher in knowledge of overdose and naloxone indication scenarios than their untrained counterparts.”).

3. Criticism: Naloxone Will Discourage People From Seeking Drug Treatment.

Response: On the contrary, studies demonstrate that naloxone program participants may be more likely to access treatment:

- Karen H. Seal et al., *Naloxone Distribution and Cardiopulmonary Resuscitation Training for Injection Drug Users to Prevent Heroin Overdose Death: A Pilot Intervention Study*, 82(2) *Journal of Urban Health* 303–311 (2005) (Drug treatment entry increased after participation in naloxone distribution and overdose prevention and management program).

Naloxone is a resource that drug users want. By providing it, harm reduction programs can, at the very least, get access to drug users and build relationships with them. This may lead to other health benefits, like HIV testing and treatment, counseling, and drug treatment.

¹ Phillip Coffin et al., *Drug Overdose, Lay Naloxone and HIV Risk Behaviours Among Persons Who Inject Drugs*, Presented at AIDS Conference 2012, Washington, D.C., available at <http://pag.aids2012.org/Abstracts.aspx?AID=7909>. (last accessed March 10, 2013).

² *Opioid Overdose Prevention Training and Community-Based Naloxone Distribution in Ontario*, Ontario Health Promotion E-Bulletin 787, Vol. 2013, No. 787, Feb. 22, 2013, available at <http://www.ohpe.ca/node/14023> (last accessed March 10, 2013).

4. [Criticism: Side Effects From Naloxone Can Be a Threat to the Health and Safety of the Overdose Victim if They Are Not Thereafter Treated by Medical Professionals.](#)

Response: Advocates should point to the following empirical studies which indicate that people who refused to be taken to the hospital after receiving naloxone generally did not experience any adverse health effects:

- G.M. Vilke et al., *Assessment For Deaths in Out-Of-Hospital Heroin Overdose Patients Treated With Naloxone Who Refuse Transport*, 10 *Academy of Emergency Medicine* 893-6 (2003) (998 patients received naloxone in the field and refused further treatment, and “[w]hen compared by age, time, date, sex, location, and ethnicity, there were no cases in which a patient was treated by paramedics with naloxone within 12 hours of being found dead of an opioid overdose”).
- S.S. Rudolph et al., *Prehospital Treatment of Opioid Overdose in Copenhagen—Is It Safe to Discharge On-Scene?*, 82 *Resuscitation* 1414-8 (2011) (“We found 4762 cases of acute opioid overdose. In 3245 cases positive identification was obtained. Over this ten year period fourteen patients who were released on-scene after having been treated with naloxone died within 48 h, but only in 3 of these we found a rebound opioid toxicity to be the likely cause of death, corresponding to 0.13% of those 2241 released on scene who were identified.”).

INSTITUTIONAL SUPPORTERS OF NALOXONE PROGRAMS AND/OR NALOXONE LEGISLATION

1. [National Organizational Support for Peer-Delivered Naloxone Programs](#)

The following organizations support peer delivered naloxone programs, but not necessarily any particular legislation:

- American Medical Association

<http://www.ama-assn.org/ama/pub/news/news/2012-06-19-ama-adopts-new-policies.page>

- American Society of Addiction Medicine

<http://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2011/12/15/use-of-naloxone-for-the-prevention-of-drug-overdose-deaths>

- Office of National Drug Control Policy

<http://www.whitehouse.gov/ondcp/drugpolicyreform>

- US Conference of Mayors

http://www.usmayors.org/resolutions/76th_conference/chhs_16.asp

- National Coalition Against Prescription Drug Abuse

http://leginfo.ca.gov/pub/13-14/bill/asm/ab_0601-0650/ab_635_cfa_20130617_134746_sen_comm.html

- American Public Health Association

<http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1443>

- United Nations Office on Drugs and Crime

http://www.unodc.org/documents/commissions/CND-Res-2011to2019/CND-Res-2012/Resolution_55_7.pdf

- National Alliance of State and Territorial AIDS Directors

http://www.nastad.org/Docs/014907_NASTAD%20Statement%20of%20Commitment%20Drug%20User%20Health%20August%205%202011.pdf

2. [State Examples of Organizational Support for Naloxone Legislation](#)

The following list is provided to give you some ideas of who to approach for support for naloxone legislation in your state, and includes organizational endorsers of state naloxone legislation that were recently helpful in gaining support of legislators. This is not an exhaustive list of supporters, and does not include the many harm reduction organizations, drug policy organizations, AIDS service organizations, and drug user organizations that did most of the lobbying and support, but rather, the endorsers useful in demonstrating mainstream institutional support.

California Endorsers

- California Society of Addiction Medicine
- California Attorneys for Criminal Justice
- California Association of Alcohol and Drug Program Executives, Inc. (CAADPE)
- California Opioid Maintenance Providers
- California Public Defenders Association
- Civil Justice Association of California (CJAC)
- City and County of San Francisco
- County Alcohol and Drug Program Administrators Association of California (CADPAAC)
- Medical Board of California

Oregon Endorsers

- County Health Departments
- Oregon Primary Care Association

Colorado Endorsers

- Colorado Medical Society
- Colorado Department of Public Health and Environment
- Colorado Behavioral Healthcare Council
- Colorado Psychiatric Society

North Carolina Endorsers

- North Carolina Sheriff Association
- North Carolina Medical Board
- Injury and Violence Prevention Branch of the state's Division of Public Health
- Drug Control Unit, NC DHHS, Justice Innovations Team (runs state's Prescription Drug Monitoring Program)
- Community Care of North Carolina (Medicaid authority)
- Governors Institute on Substance Abuse
- North Carolina Child Fatality Task Force

New Jersey Endorsers

- New Jersey State Nurses Association
- Lutheran Office of Governmental Ministry
- New Jersey Deputy Fire Chiefs Association
- National Council on Alcoholism and Drug Dependence—New Jersey
- National Association of Social Workers—New Jersey
- New Jersey Hospital Association
- Health Professionals and Allied Employees

New York Endorsers

- Medical Society of the State of New York
- New York Society of Addiction Medicine
- New York State Office of Alcohol and Substance Abuse Services
- New York State Department of Health
- New York City Department of Health and Mental Health
- Nassau County Office of Mental Health
- NYC Department of Homeless Services

Illinois Endorsers

- Chicago Coalition for the Homeless
- Illinois Alcoholism and Drug Dependence Association
- Illinois Public Health Association
- Illinois Nurses Association
- Roosevelt University's Illinois Consortium on Drug Policy

TIPS FOR LEGISLATIVE ADVOCACY³

This guide provides you with model legislation for responding to the opioid overdose crisis in your state by increasing access to naloxone. But, obviously, the proposed legislation cannot make an impact until it gets signed into law. Below are some steps for how you can effectively advocate for the model legislation to be introduced and passed in your state.

1. [Get to Know Your State's Legislative Process](#)

Every state has its own process for creating laws, but all states follow this general path:

First, a member of the legislature must introduce a bill. With the exception of Nebraska, all states have two legislative chambers, known in most states as the house and senate. Any member of either state body can introduce a bill. Very often, bills are introduced by both a member of the house and a member of the senate at the same time.

Once introduced, the bill is then referred to a legislative committee for further review. Bills with multiple components typically must be considered by multiple committees. For example, drug overdose legislation is often referred to committees dealing with issues of public health, or the judiciary, or both.

Once referred to committee, the committee chairperson will determine when and if a bill should be considered by that committee. If a committee considers the bill, it will often do so after hearing testimony from experts and members of the public. A bill that is not considered by the committee to which it is assigned is considered to “die in committee,” meaning it does not move on to the next step in becoming a law.

If the bill passes the committee, it will often be referred to another relevant committee to repeat the same process.

Once the bill passes all relevant committees, the majority leader (e.g., speaker of the house, senate president, or senate president pro tempore) will determine whether it should be voted on by the entire legislative chamber. This is often known as being brought to the floor for a vote.

Very often bills are amended in committee or on the floor of the legislature, meaning that their original language is changed to effectuate a compromise among the legislators and enhance its likelihood of passing.

If the bill passes the first chamber, it typically must be reintroduced in the second legislative chamber. For example, if a bill originally was introduced in the senate and passes that chamber, it next must be introduced in the house, and vice versa.

Once the bill is reintroduced in the second chamber, it then may be referred to committee. Some states have joint committees between both legislative chambers, so the bill only has to go

³ Adapted from *Legal Interventions to Prevent Opioid Overdose Deaths: Guide to Model Legislation*, Prepared for the Drug Policy Alliance by Northeastern University School of Law, Class of 2015, Legal Skills in Social Context, Social Justice Program.

through one committee related to the issue. For example, Massachusetts has a Joint Committee on Mental Health and Substance Abuse, comprised of members of both the House and the Senate. Other states have separate committees for the house and senate. For example, a bill related to mental health in New York most likely would have to be considered by both the Senate's Mental Health and Developmental Disabilities Committee and the Assembly's Mental Health Committee.

The next step is for the majority leader to determine whether the bill should go up for a vote on the floor of the second legislative chamber. If so, the legislators will vote on the bill.

If the bill passes the floor, its next stop usually is the governor's desk for signing. If the governor signs the bill, it becomes law.

However, in most states, the governor has the power to veto or kill a bill even after it is passed by the legislature. Some states allow governors to veto a single section of the legislation, an action referred to as a line item veto. Often, one or both chambers of the legislature can override this veto with a two-thirds vote.

Usually if the governor does not sign the bill but does not veto it either, the bill will become law by default after a certain period of time has elapsed.

2. [Gather Persuasive Information About the Opioid Overdose Crisis in Your State](#)

A key to advocacy is being able to effectively discuss the problem you are trying to solve in a way that is meaningful and relevant to your audience. National statistics about the opioid overdose crisis may be persuasive, but nowhere near as compelling as information you can share about your own state or community. You need to convince the decision makers that this is not only a problem on a national level, but that it directly impacts a significant number of people in your state. How many people die of opioid overdose in your state each year? How does the opioid overdose death rate compare to the rates of other common causes of death in your state, such as car accidents or heart disease?

Statistics specific to your community are even more helpful. Legislators are especially concerned about issues that impact their constituents. If you can show your legislator that opioid overdose is a problem that relates directly to their district, you are more likely to convince them to support meaningful change. While statistics can be powerful, legislators may be more responsive to personal stories or testimonies (see number 6 below).

3. [Identify a Potential Sponsor in the State Legislature](#)

No legislation can be introduced without a sponsor. If you are an individual or a community-based group, your first step may be to approach the legislators who represent your district. Alternatively, you may wish to identify legislators who may already be leaders on issues related to drug reform, public health, drug treatment, and harm reduction. Visit your state legislature's website and find out the name of the legislative committee or committees that deal with healthcare or public health issues. Review the names of the legislators on that committee. If they have web pages on the legislature's site or their own web pages, visit them. Google them or look them up on your local newspaper's website. Identify which of these legislators

have championed legislation on similar issues in the past or who stressed public health or drug reform issues in their campaigns. It is also worth trying to identify legislators who have been personally affected by overdose. Finally, if no obvious legislators emerge in your search, you also may wish to identify a community in your state which you know has the highest rates of opioid overdose deaths. Contact the legislators from those communities, as this may be a major concern for their district.

4. [Identify Local Supporters](#)

Successful legislative campaigns often have a coalition of supporters behind them. Consider what community groups, social service agencies, and advocacy organizations in your state may have a stake in getting the opioid overdose legislation passed. This may include direct service providers, mental health and medical professional groups, faith-based recovery organizations, academics at local universities, and social change and mutual aid organizations. Encourage these groups to contact their legislators.

5. [Anticipate Your Opposition](#)

It also is critical to identify potential areas of opposition in your state. In some states, physician and nurses groups, trial and consumer attorneys, pharmacy boards, and state departments of alcohol/drugs have been resistant to similar types of legislation depending on the provisions included or not included. It is helpful to predict where you may hit roadblocks so you can have arguments prepared in advance (see “Responding to Criticism” section above).

6. [Recognize the Power of Personal Testimony](#)

Listening to the story of a constituent who lost a child to opioid overdose or a local emergency room nurse who regularly sees patients die from opioid overdose can be exceedingly powerful for a legislator. If you know of such stories, use them.

7. [Launch a Strategic Legislative Advocacy Campaign](#)

Effective strategic legislative advocacy campaigns are based on numerical calculations. First, find out the number of votes you need in each committee for the legislation to pass (once the legislation passes committee, you should do the same for each chamber). Usually, it is 50% of legislators (minus abstentions) plus one. Next, calculate the number of legislators on the committee whom you *know* will support the bill. Then calculate the difference between that number and the number of votes you need (or the number of votes you would like the bill to receive, if you are looking for a number greater than a majority). You may wish to add to that number, to account for possible absences at the time of the vote or changes of heart. The resulting number tells you how many legislators you will need to persuade so that the legislation passes with a majority.

As you can see, you do not need to convince *every* legislator to vote for your bill to guarantee passage. It is best to identify those legislators who are most apt to vote for the legislation, but have not indicated how they will vote yet. These are persuadable legislators. The best way to identify whether a legislator is apt to support your bill is to look at their past votes on similar issues, particularly as they relate to substance abuse and public health issues. If the legislator

was recently elected and does not have a voting history, consider statements made during the campaign. Votes made while the new legislator served in a previously elected office (e.g. city council) may also be informative.

Target your lobbying to all or most of these persuadable legislators. Identify community supporters in persuadable legislators' districts. Bring these constituents to meet with the persuadable legislators at the State House or in their district offices. Canvas persuadable legislators' districts to obtain constituents' signatures for letter writing and postcard campaigns. Encourage constituents in these districts to call their legislators.

Keep a running tally of all of the legislators on the committee (or chamber, once the legislation passes committee) and how they have indicated they will vote: Are they supporters, persuadables, or opponents? Even after you reach your target number, continue to lobby remaining persuadable legislators, and do not forget to thank those who have committed their support prior to the vote.

TIPS FOR MEDIA ADVOCACY

Please see Exhibit B, drafted by the Drug Policy Alliance.

CONTACTS

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GOOD SAMARITAN LEGISLATION

To the extent you are seeking to introduce a comprehensive overdose prevention bill with both Naloxone and Good Samaritan (i.e., providing immunity from drug arrest/charges when seeking medical assistance in the event of an overdose) provisions, or will be introducing a Good Samaritan bill separately, please contact either Lindsay LaSalle or Corey Davis (above) for Good Samaritan drafting guidance.

EXHIBIT A

DRAFT “OVERDOSE PREVENTION AND EMERGENCY RESPONSE ACT”

The [_____] hereby enacts as follows:

Section 1. The [_____ Code/Act] is amended by adding a section to read:

Section [_____]. Immunity for persons who prescribe, possess, and/or administer an opioid antagonist during an opioid-related drug overdose.

(a) The following definitions apply throughout this section:

(1) “Health care professional” includes, but is not limited to, a physician, a physician assistant, or a nurse practitioner, who is authorized to prescribe an opioid antagonist.

(2) “Opioid antagonist” means any drug that binds to opioid receptors and blocks or disinhibits the effects of opioids acting on those receptors.

(3) “Opioid-related drug overdose” means a condition including, but not limited to, extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death resulting from the consumption or use of an opioid, or another substance with which an opioid was combined, or that a layperson would reasonably believe to be an opioid-related drug overdose that requires medical assistance.

(b) Notwithstanding any other law or regulation, a health care professional otherwise authorized to prescribe an opioid antagonist may, directly or by standing order, prescribe, dispense, and distribute an opioid antagonist to a person at risk of experiencing an opioid-related overdose or to a family member, friend, or other person in a position to assist a person at risk of experiencing an opioid-related overdose. Any such prescription shall be regarded as being issued for a legitimate medical purpose in the usual course of professional practice.

(c) A health care professional who, acting in good faith and with reasonable care, prescribes or dispenses an opioid antagonist shall not be subject to any criminal or civil liability or any professional disciplinary action for (1) such prescribing or dispensing; and (2) any outcomes resulting from the eventual administration of the opioid antagonist.

(d) Notwithstanding any other law or regulation, any person may lawfully possess an opioid antagonist.

(e) A person who, acting in good faith and with reasonable care, administers an opioid antagonist to another person whom the person believes to be suffering an opioid-related drug overdose shall be immune from criminal prosecution, sanction under any professional licensing statute, and civil liability, for acts or omissions resulting from such act.

Section 2. The [_____ Code/Act] is amended by adding a section to read:

Section [_____]. Authorizing administration of naloxone hydrochloride by emergency personnel.

(a) By January 1, 20XX, every Emergency Medical Technician licensed and registered in [the state] shall be authorized and permitted to administer an opioid antagonist as clinically indicated.

Section 3. The [_____ Code/Act] is amended by adding a section to read:

Section [_____]. Medicaid coverage for naloxone hydrochloride.

(a) [The single state agency] is directed to ensure that naloxone hydrochloride for outpatient use is covered by the Medicaid prescription drug program on the same basis as other covered drugs..

Section 4. The [_____ Code/Act] is amended by adding a section to read:

Section [_____]. Exemption from pharmacy [list requirement here (i.e., permit, license, etc.)] for prescription order for naloxone hydrochloride.

(a) Notwithstanding any other law or regulation, a person or organization acting under a standing order issued by a health care professional who is otherwise authorized to prescribe an opioid antagonist may store an opioid antagonist without being subject to provisions of [the state pharmacy act] except [those provisions regarding storage of drugs], and may dispense an opioid antagonist so long as such activities are undertaken without charge or compensation.

Section 5. The [_____ Code/Act] is amended by adding a section to read:

Section [_____]. Report on unintentional drug overdose.

(a) The [appropriate state agency] shall ascertain, document, and publish an annual report on the number, trends, patterns, and risk factors related to unintentional drug overdose fatalities occurring within the state each year. The report shall also provide information on interventions that would be effective in reducing the rate of fatal or nonfatal drug overdose.

Section [_____]. Grants for drug overdose projects including naloxone hydrochloride.

The [appropriate state agency] shall make grants from funds appropriated pursuant to this section for any of the following purposes:

(a) Drug overdose prevention, recognition, and response, including naloxone administration, education projects;

(b) Drug overdose prevention, recognition, and response, including naloxone administration, training for patients receiving opioids and their families and caregivers;

(c) Naloxone hydrochloride prescription or distribution projects; or

(d) Education and training projects on drug overdose response and treatment, including naloxone administration, for emergency services and law enforcement personnel, including, but not limited to, volunteer fire and emergency services.

There is hereby appropriated from the [specify fund – likely General Fund], in the 20XX-XX fiscal year, (\$X00,000) for the purpose of funding the grants provided in this section. Additional funds necessary for the implementation of this section in the 20XX-XX fiscal year and in later fiscal years may be included in the budget appropriation for the [appropriate state agency].

DRAFT

EXHIBIT B

Tip Sheet: 10 Steps to Getting Press



1. Identify what's "newsworthy." There is a big difference between an issue and a news story. We can assist the media in covering issues that are important to us by letting them know when a related "story" emerges. What makes something newsworthy? Controversy, anniversaries, civil disobedience, human interest, strange bedfellows, superlatives (first, biggest, etc.) If a topic isn't newsworthy – no matter how important – they probably won't cover it.

2. Develop written materials. The first thing a reporter is likely to ask when you call them to pitch a story is: "Do you have anything in writing?" Help make their job as easy as possible by developing brief, easy-to-read materials. Especially important is a 1-2 page media advisory or press release with details of an event or news story. The style and content should resemble a simple newspaper story, with strong headlines, facts and quotes. Other background materials can be helpful, including fact sheets, spokespeople bios or report summaries.

3. Develop a targeted media list. It is important to think about which reporters will be interested in your story. Are they reporters who cover health? Politics? Entertainment? Is it a local or a national story? Is it a story that's good for newspaper, radio and/or television? From there, develop a list of reporters' names and numbers to call.

4. Keep an eye on your email. To quickly send your materials to a reporter, it's important to keep an eye on your email when making pitch calls. If a reporter wants to see something right away, it won't help to send them something several hours later.

5. Identify strategic spokespeople. The messenger is often just as important as the message when it comes to the media. It is also crucial that spokespeople are articulate and knowledgeable on the issue, and easily reach-able by reporters on deadline. (Not having a cell phone can

sometimes mean not being included in a story!!) Remember – reporters are not your friends. Be careful and strategic when doing interviews.

6. Practice your telephone pitch. Reporters get hundreds of calls a day. What's likely to make a reporter not hang up on you, or immediately delete your message, is if you develop a well focused, 30-second pitch that highlights the essence of your news story. Once you hook them, you can describe in more detail why you are calling and how you can get them more information. Practice leaving messages on your own voicemail. Don't forget to leave your phone number if you leave a message.

7. Never lie or exaggerate. It is important that reporters feel they can trust the information you give them. If they find out you are lying or exaggerating, it will greatly hurt your chances of being able to pitch them a story again.

8. Don't take no for an answer. Pitching is not dating. If a reporter says no, try another reporter, or call them again when you have a different story. If you get one out of ten reporters to write about your story, that is a huge success!

9. Use the media to get more media. If a good article comes out on your issue, send it to other reporters who might also be interested. Oftentimes newspapers will be more interested in op-ed pieces if the topic has been in the recent news. Articles and op-eds can also lead to radio interviews, and local stories can lead to national stories, if they're seen by the right editors/producers.

10. Say thank you. Developing friendly relationships with reporters is helpful when trying to pitch news stories. They appreciate thanks, and will be more likely to return your phone call the next time around.