

Naloxone Myths and Facts Sheet

The Naloxone Myths Fact Sheet can be utilized by first responders to help understand information surrounding the access and utilization of naloxone, as well as serve as a reference tool when conveying information about naloxone to the public or when responding to overdose calls.

Naloxone Myths	
Popular Misconceptions	Best Evidence
Opioid users will not want naloxone.	The majority of opioid users would accept take-home naloxone from the ED. ¹
If opioid users want naloxone, they can get it on their own because of the standing order.	Significant stigma remains regarding asking for naloxone, in addition to barriers in cost and lack of availability in all pharmacies. ^{2,3,4,5}
Opioid users will be willing to use more potent opioids and/or higher doses if they have naloxone.	Multiple studies indicate that opioid users do not have more confidence when using due to naloxone availability, and habitual users do not want naloxone reversal at any time. ^{6,7}
Opioid users will no longer come to the Emergency Department after an overdose.	Referral rates to EDs remain the same with or without bystander naloxone administration. ^{6,8,9}
Providing naloxone enables substance users to continue using.	Providing naloxone enables people to survive and receive treatment. ^{6,7,8,10}
Someone who overdoses couldn't even use their own naloxone.	Almost all bystander naloxone administered in Allegheny County has been by other opioid users. ¹¹
Naloxone will not last as long as the overdose drug and can be a liability risk.	The vast majority of overdoses that require naloxone do not require repeat dosing, and naloxone administration prevents death. ¹²
Naloxone distribution and administration doesn't seem to really be making a difference in this problem.	Bystander naloxone and Take-Home-Naloxone programs have repeatedly demonstrated mortality reductions. ^{9,10}
Naloxone distribution/administration adds to healthcare and taxpayer expenses.	Analysis of community distribution of naloxone has shown significant decrease in overall societal cost and increase in quality life years. ¹³

References

- 1) Bakhireva, L.N. et al. (2017). Barriers and facilitators to dispensing of intranasal naloxone by pharmacists. *Subst Abus*, 18:0.
- 2) Clark, A.K. et al. (2014). A systematic review of community opioid overdose prevention and naloxone distribution programs. *J Addict Med*, 8(3), 153-63.
- 3) Coffin, P.O. et al. (2013). Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal. *Ann Intern Med*, 158, 1-9.
- 4) Cressman, A.M. et al. (2017). Availability of naloxone in Canadian pharmacies: A population-based survey. *CMAJ*, 5(4), E779-E784.
- 5) Green, T.C et al. (2003). Perpetuating stigma or reducing risk? Perspectives from naloxone consumers and pharmacists on pharmacy-based naloxone in two states. *J Am Pharm Assoc*, 57(2S), S19-S27.
- 6) Heavey, S.C. et al. (2017). ‘I have it just in case’: Naloxone access and changes in opioid use behaviours. *Int J Drug Policy*, 51, 27-35.
- 7) Heindel, G.A. et al. (2017). Rising cost of antidotes in the U.S.: Cost comparison from 2010 to 2015. *Clin Toxicol (Phila)*, 55(5), 360-363.
- 8) Kestler, A. et al. Factors associated with participation in an emergency department-based take-home naloxone program for at-risk opioid users. *Ann Emerg Med*, 69(3), 340-346.
- 9) Piper, T.M. et al. (2008). Evaluation of a naloxone distribution and administration program in New York City. *Subst Use Misuse*, 43(7), 858-70.
- 10) Prevention Point Pittsburgh, Naloxone Cumulative Data: July 2005–June 2015.
- 11) Walley, A.Y. et al. (2013). Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: Interrupted time series analysis. *BMJ*, 346, f174.
- 12) Wheeler, E. et al. (2015). Opioid overdose prevention programs providing naloxone to laypersons—United States. *MMWR Morb Mortal Wkly Rep*, 64(23), 631-635.
- 13) Willman, M.W. et al. (2017). Do heroin overdose patients require observation after receiving naloxone? *Clin Toxicol (Phila)*, 55(2), 81-87.