Washington State Health Care Authority

Naloxone distribution in emergency departments

SB 5195 Frequently Asked Questions for Clinical Staff

Is naloxone safe and effective when used outside of hospital settings?

Yes, naloxone has been proven to effectively reverse opioid overdoses in community settings administered by people with no medical training. Naloxone will not cause harm if it is administered to someone who is not having an opioid overdose.

Does naloxone distribution encourage drug use?

No, the availability of naloxone does not correlate with an increase in drug use frequency or quantity. In fact, the distribution of naloxone combined with access to harm reduction services has been shown to have a positive impact on substance use behaviors.

Does naloxone help people get better, or does it just allow someone to stay alive and continue using drugs?

Naloxone does both! The value of saving a life is not determined by what we know, assume, like, or dislike about the life saved. Most people who are at risk for an opioid overdose will reduce their risk over time and make positive changes, provided they are alive to do so. By distributing naloxone along with overdose prevention education, you are confirming that the lives of people who experience an opioid overdose are worth saving. Unfortunately, that is not the message that people who use opioids receive. As nurses, we know that caring for people is a part of healing people.

How will this affect me?

Naloxone is a simple way to save lives, which is an ER nurses favorite thing to do. Often, we are struggling with staffing, ratios, COVID… basically not feeling as effective or safe providing care as we should. Having something simple, easy, safe, effective, and lifesaving to do can help reduce burnout and re-establish a sense of purpose.

Offering naloxone and demonstrating you care about people at risk of opioid overdose can immediately shift the relationship you have with that patient. Often people who use opioids experience stigma and shame in their interactions with the healthcare system and may not trust or like us. When you take action to keep them safe you build positive rapport, and that makes their experience more healing and your job more satisfying.

What do I need to do differently?

The education required to dispense naloxone will take about 10-15 minutes and is on top of the other discharge education you must provide. This can be challenging to fit in, especially if you are looking to turn the room over quickly or if the patient is in a hurry to leave. Many patients who need this education will have already received naloxone and may be in withdrawal. Consider discussing offering suboxone for withdrawal management to help the patient continue their medical care and discharge appropriately.

Where can I learn more about reducing the harms related to drug use?

There are a lot of resources out there, and harmreduction.org and stopoverdose.org are two good websites to start learning more. The Washington Department of Health has a drug user health page: https://www.doh.wa.gov/YouandYourFamily/DrugUserHealth. You can also connect with your local syringe services program, as they are experts in your community.

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What words should I use and what words should I avoid when talking about drug use?

The words you use matter. It is important to see your patient as a person, and not as an illness or a behavior. Words like junky, addict, drug-seeker, clean or dirty, etc. are judgmental and cause harm. Use person first language instead, such as “people who use drugs” or “people who inject drugs”.

Drug addiction and drug abuse are also terms that should be avoided, as they often fail to distinguish between drug use, drug dependence, substance use disorder and always fail to recognize the ways in which people can make positive changes without abstaining from use altogether. Substance use disorder or opioid use disorder are appropriate instead.

What are some effective ways to talk with people about overdose risk?

The most important thing is to be non-judgmental, demonstrate caring, ask open ended questions, include their experiences and existing knowledge, and trust them as the experts on their own use.

If you would like more structure, consider the following approach.

1. Build rapport	I would like to take some time to talk about your risk of opioid overdose and naloxone. Can you tell me what you know about naloxone and how to use it?
2. Pros and Cons	What do you do that might put you at risk for overdose? What actions do you currently take to reduce that risk?
3. Provide information and get feedback	I have some additional information on overdose risk and how naloxone works, can we review it together?
4. Assess readiness	So, on a scale of 0 to 10, how prepared do you feel to use naloxone / recognize an overdose / tell other people how to use it on you / etc.
5. Make an action plan	Based on our conversation, what are some options that might work for you to help you stay healthy and safe? What supports do you have for making this change? Those are great ideas. I have a few more that be helpful (link to additional support, programs, telling people where the naloxone is stored, etc.)

How can I help my patients “get sober”?

Most people who use drugs will end up on a path to recovery. Abstinence is only one way to recover from substance use disorder. It is important to move away from sobriety and abstinence models because they are less effective both in terms of reducing mortality and in terms of long-term retention.

Medications for opioid use disorder, such as suboxone and methadone, are associated with a 50% reduction in mortality. Use of medication treatment is not replacing one drug with another and is one way of recovering from opioid use disorder. Recommending medications and proving information on how to get started on them is a great way to help your patients.

Any positive change in how someone uses drugs is another way to start a recovery process. Patients who carry naloxone and reduce overdose risk are making positive change for themselves and others.