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February 11, 2014

The Honorable Kathleen Sebelius
US Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Sebelius:

I applaud the White House's announcement today urging law enforcement authorities around the country to equip first responders with naloxone to treat individuals who have overdosed. Prescription drug and heroin abuse is plaguing our communities, and our police, sheriffs, fire departments, and families are on the frontlines of this battle to save our communities and take back our streets from the scourge of painkiller and opioid addiction.

Massachusetts has had great success with pilot programs designed to provide naloxone to those most likely to witness or be first on the scene to an overdose. In late 2010, the Massachusetts Department of Public Health (DPH), police and fire departments in several communities and mental health/addiction organizations partnered to train and equip police officers to resuscitate overdose victims using nasal naloxone. As of October 2013, the departments have reported over 300 overdose reversals. This program is viewed quite favorably by our law enforcement officials. I have heard from Massachusetts sheriffs about the success of these naloxone programs, which they believe should be continued and expanded. Massachusetts's naloxone program is held up nationally as an example of success.[1]

The partnership with law and fire departments built on earlier experiences with naloxone distribution In 2007, Massachusetts DPH joined with the Bureau of Substance Abuse Services and the Office of HIV/AIDS (OHA) to train the most common 'first responders'—opioid users and likely bystanders (other users, their families and friends, and related service providers) to administer naloxone. Free distribution of naloxone kits is accomplished through existing OHA vendor sites in fifteen cities in Massachusetts and through "Learn to Cope" parent support meetings in 10 cities and towns across the

[1] R. Gil Kerlikowske. "Prescription Drug Abuse, the National Perspective." Presentation to meeting of the Association of State and Territorial Health Officials September, 2013 http://www.astho.org/Annual-Meeting-2013/Presentations/R-Gil-Kerlikowske-Prescription-Drug-Presidents-Challenge-Session/

Commonwealth. As of October 2013, there have been approximately 2,300 overdose reversals by bystanders. There has been a decrease in overdose-related deaths in the participating communities.[2]

Given the worrisome increase of opioid abuse and the terrible burden to communities of preventable deaths from overdose and the great successes demonstrated in Massachusetts, I am eager to see bystander and first-responder nasal naloxone programs expanded in Massachusetts and also across the nation. In light of this, I respectfully ask that you respond to the following questions:

1. What funding and resources does HHS currently use to assist and support state or local community naloxone programs? How are these funds distributed and utilized to support training, technical assistance, and evaluation? To what extent can these funds be used to offset the cost of purchasing naloxone?

2. What tools and assistance does HHS have available to help states and localities project and prepare for the cost of expanded naloxone distribution programs for emergency responders and law enforcement officials? What tools does HHS have available to assist states in determining appropriate training and distribution protocols for naloxone?

3. What additional resources would HHS need to assist states in expanding naloxone programs so that local law enforcement and emergency responders are trained and equipped with naloxone for administration? Please provide any estimates or data that you have available.

4. Has HHS explored ways to expand naloxone availability to include training and distribution to public bystanders, such as the families of opioid users? Has the Department evaluated whether such naloxone training and distribution programs could be incorporated as a part of broader health programs, such as community health center services, Ryan White services, or addiction treatment programs? What additional resources would be needed to assist in the expansion of bystander naloxone distribution programs?

5. How does HHS work with the various agencies that comprise HHS, such as the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to support expansion of naloxone programs? How does HHS work across other departments and offices outside of HHS, such as the Department of Justice, and the White House Office of National Drug Control Policy? What more is needed to promote inter-departmental planning and engagement? What roles do non-HHS entities play in supporting expansion of naloxone?

6. On a national level, what data collection systems exist to monitor and evaluate the implementation and impact of increased naloxone availability and use? What additional tools or resources are needed to track progress and impact from these programs?

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[2] Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis

7. Has HHS evaluated whether there exist state or local laws that may serve as a barrier for expansion of naloxone programs for emergency responders and low enforcement officials? What about expansion for distribution to public bystanders? Please describe.

Sincerely,

Edward J. Markey

Edward J. Markey
United States Senator

cc: R. Gil Kerlikowske, Director, White House Office of National Drug Control Policy