



Prescription Painkillers

Prescription Painkillers – A National Epidemic

Over the past two decades, drug overdose deaths have steadily increased and are now the main cause of injury death in the United States.¹ Each day in the United States, 105 people die from drug overdose (over 36,000 fatal drug overdoses per year) and another 6,748 people are treated in emergency departments for misusing or abusing drugs.^{2,3} Moreover, almost 9 out of every 10 poisoning deaths are caused by drugs.⁴

Prescription painkiller (“opioid”) use is a large and growing threat; since 1999, nationwide prescription painkiller use has increased by 300%. During this same period, prescription painkiller related deaths have increased by 400%.⁵ Roughly 15,000 drug overdose deaths each year are caused by opioids.⁶

Opioids cause many people to experience euphoric feelings that could induce people to take them without a prescription. In 2010, more than 1 in 20 people in the United States reported using opioids non-medically.⁷ Similar rates were reported in Maryland, as approximately 3.9% of Marylanders aged 12 or older reported having used prescription pain relievers for nonmedical reasons in 2010-2011.⁸ Nonmedical prescription painkiller use constitutes abuse.

Historically, Maryland has largely reflected the national trend in unintended poisonings and abuse of prescription painkillers. However, the 2012 data reflects a change in course. Unintentional poisonings has been the leading cause of injury death in Maryland since 2008, and from 2007-2012 more than 40% of all overdose deaths in Maryland involved one or more prescription opioid.⁹ Additionally, Maryland experienced a 15% spike in drug and alcohol intoxicated deaths in 2012 (761 deaths in 2012, up from 663 in 2011). Despite these results, the number of prescription opioid related deaths decreased by 12% (dropping to 293 deaths in 2012 after

¹ Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control: Data & Statistics (WISQARS), *10 Leading Causes of Injury Deaths by Age Group Highlighting Unintentional Injury Deaths, United States, 2013*. <http://www.cdc.gov/injury/images/lc-charts/leading-causes-of-injury-deaths-highlighting-unintentional-injury-2013-a.gif> (last visited January 13, 2017).

² “Drugs” in this context include both legal and illegal drugs. Pharmaceutical (prescription painkillers, benzodiazepines, and anti-anxiety and insomnia medications, to name a few) drugs are among the most common drugs involved in overdoses.

³ The Network for Public Health Law, *Legal Interventions to Reduce Overdose Mortality: Naloxone Access and Overdose Good Samaritan Laws (“The Network – Drug Overdose Prevention and Harm Reduction”)* 2014. Available online, <https://www.networkforphl.org/asset/gz5pvn/network-naloxone-10-4.pdf>.

⁴ Centers for Disease Control and Prevention, National Centers for Health Statistics (NCHS), *NCHS Data Brief: Drug-poisoning Death Involving Opioid Analgesics: United States, 1999-2011*, No. 166, September 2014. Available online, www.cdc.gov/nchs/data/databriefs/db166.pdf.

⁵ Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control, *Home and Recreational Safety: Policy Impact: Prescription Painkiller Overdoses (“CDC Policy Impact: Prescription Painkiller Overdoses”)*, 2013. Available online, <https://www.cdc.gov/drugoverdose/pubs/index.html>.

⁶ Centers for Disease Control and Prevention, National Centers for Health Statistics (NCHS), *NCHS Data Brief: Drug-poisoning Death Involving Opioid Analgesics: United States, 1999-2011*, No. 166, September 2014. Available online, www.cdc.gov/nchs/data/databriefs/db166.pdf.

⁷ Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control, Division of Unintentional Injury Prevention, *CDC Vital Signs*, November 2011. Available online, <http://www.cdc.gov/vitalsigns/pdf/2011-11-vitalsigns.pdf>.

⁸ Centers for Disease Control and Prevention, *CDC Policy Impact: Prescription Painkiller Overdoses*, 2013. Available online: <http://www.cdc.gov/HomeandRecreationalSafety/pdf/PolicyImpact-PrescriptionPainkillerOD.pdf>

⁹ Maryland Department of Health and Mental Hygiene, *State’s Prescription Drug Monitoring Program Launches for Healthcare providers (“MD PDMP Report”)*, <http://dhmh.maryland.gov/newsroom/Pages/State%E2%80%99s-Prescription-Drug-Monitoring-Program-Launches-for-Healthcare-Providers.aspx>. (last visited January 13, 2017).

350 deaths in 2011).¹⁰ This promising result might indicate that the steps Maryland has taken to address the harmful effects of prescription painkiller abuse are effective. Moreover, the results may be proof that there are effective means to combat this epidemic.

What are Prescription Painkillers, and How do They Work?

Opioid prescription painkillers, like heroin, are derived from the opium poppy; they work by binding receptors in the brain to decrease the perception of pain. Common examples of opioids include Vicodin, OxyCotin, Opana, and methadone. These drugs cause many people to experience euphoric feelings, although they also possess chemical mechanisms that can trigger physical dependence and lead to addiction.¹¹

Opioid use can be fatal. They can cause sedation that slows a person's breathing. A person who is abusing opioids is prone to taking larger doses to feel their euphoric effect and reduce withdrawal symptoms. Ingesting a large enough dose of an opioid can cause a person to stop breathing.¹² If this process is not reversed within a few minutes, a person's lack of oxygen begins to kill their brain.

Groups at the Highest Risk of Overdose

While opioid abuse is a widespread problem that every community faces, certain groups are more susceptible to overdose from prescription painkillers than others. High risk groups include men (especially those age 45-49), Native American Indians/Alaska Natives, and Caucasians.¹³ Additionally, researchers have identified individual risk factors for opioid overdose. Specifically, individuals with a prior history of mental illness or substance abuse and people on Medicaid are prevalent in drug overdose statistics. Moreover, studies have shown correlation between prescription painkiller abuse and age. The non-medical use of prescription drugs is highest among young adults (aged 18 to 25).¹⁴

Several factors have contributed to this result. Prescription painkillers are readily available—one of the highest risk factors for substance abuse among youths—from the medicine cabinet, a family member, or a friend. According to the 2012 National Survey on Drug Use and Health, with respect to people 12 or older who in the last year used pain relievers non-medically:

54.0 percent got the pain relievers they used from a friend or relative for free. Nearly 1 in 5 (19.7 percent) received them through a prescription from one doctor (which was higher than the 17.4 percent in 2009-2010). Another 10.9 percent bought them from a friend or relative. In addition, 4.0 percent of these nonmedical users in 2011-2012 took pain relievers from a friend or relative without asking. An annual average of 4.3 percent got pain relievers from a drug dealer or other stranger; 1.8 percent got pain relievers from more than one doctor; 0.8 percent stole pain relievers from a doctor's office, clinic, hospital, or pharmacy (which was higher than the 0.2 percent in 2009-2010); and 0.2 percent bought the pain relievers on the internet.¹⁵

A recent national study is revealing. The study found a significant link between nonmedical use of opioids and heroin use. According to the study, "82.6% of frequent nonmedical users who also used heroin in the past year reported nonmedical use of opioid pain relievers prior to heroin initiation"¹⁶—an indication that prescription painkiller abuse may lead to heroin use. Maryland statistics support this study. From 2007 through September 2014 (the most recent data available), generally, when overdose deaths from opioid painkillers decline, overdose deaths from heroin increase in Maryland.¹⁷ This trend suggests that as fewer people abuse (and overdose on) opioid painkillers, more people use (and overdose on) heroin.

¹⁰ Maryland Department of Health and Mental Hygiene, Drug and Alcohol Intoxication Deaths in Maryland, 2007-2012 ("MD Drug and Alcohol Report"). Last updated: July 2013. Last visited: January 13, 2017. Available online: <http://dhmh.maryland.gov/vsa/documents/report.pdf>

¹¹ Centers for Disease Control and Prevention, *CDC Policy Impact: Prescription Painkiller Overdoses*, 2011. Available online, <https://www.cdc.gov/drugoverdose/pdf/policyimpact-prescriptionpainkillerod-a.pdf>.

¹² *Id.*

¹³ Margaret Warner, et al., *Drug poisoning deaths in the United States, 1980–2008*. NCHS data brief, no 81., 2011.

¹⁴ National Institutes of Health, National Institute on Drug Abuse, *Abuse of Prescription Drugs Affects Young Adults the Most*, 2013. Available online, http://d14rmgtrwzf5a.cloudfront.net/sites/default/files/infographic-young-adults_0.pdf.

¹⁵ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings*, 2013. Available online, <http://archive.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.htm>.

¹⁶ Drug and Alcohol Dependence. ScienceDirect, Volume 132, Issues 1-2, pages 95-100. Last updated: September, 2013. Last visited: January 13, 2017. Available online: <http://www.sciencedirect.com/science/article/pii/S0376871613000197>

¹⁷ Maryland Department of Health and Mental Hygiene, Vital Statistics Administration, *2014 Quarterly Report – Third Quarter*. Available online, http://bha.dhmh.maryland.gov/OVERDOSE_PREVENTION/Documents/2014.12.18%20-%20OD%203rd%20quarter%202014_posted%20online.pdf.

How Maryland has Addressed the Issue

Several strategies and interventions can be pursued by government to prevent prescription drug overdoses. Maryland has taken several of these important steps:

Maryland's Prescription Drug Monitoring Program ("Maryland's PDMP"). Maryland has adopted a PDMP. The program was adopted into law in 2011 and the PDMP became operational on October 28, 2013.¹⁸ Established in the Department of Health and Mental Hygiene ("DHMH"), the Maryland PDMP monitors the prescribing and dispensing of prescription painkillers (along with other controlled substances) by all prescribers and dispensers in the state.¹⁹ DHMH is required to provide prescribers and dispensers with the necessary technology software system, but DHMH may not impose costs upon users of the system.²⁰

Maryland's PDMP has been revised with the passage of bills in recent legislative sessions, including the 2015 PDMP Required Disclosures²¹, 2014 PDMP Sunset Extension Program Evaluation²² and the 2013 Disclosure of Prescription Drug Monitoring Program Data²³ bills.

The 2015 legislation expanded the entities to which the PDMP shall disclose prescription monitoring data to include the state Board of Physicians, and certain state fatality and medical review teams.²⁴ This change will go into effect October 1, 2015.

The 2014 bill, among other things, empowered the PDMP's administrator to (1) disclose data to administrators of other state's PDMPs provided they agree to use the data in a manner consistent with the Maryland program; and (2) request and receive data from other state's PDMPs.²⁵

The 2013 Disclosure of Prescription Drug Monitoring Program Data bill required that the PDMP must disclose data to the DHMH Division of Drug Control for the purpose of furthering an existing bona fide individual investigation.²⁶

Overdose Response Program (Naloxone). Maryland's Overdose Response Program is geared towards reducing unintentional, life-threatening poisonings related to the ingestion of opioids, including both illicit drugs (i.e. heroin) and pharmaceutical opioid analgesics.²⁷ The Maryland statutes addressing the Overdose Response Program (Health-General Article §13-3101 through §13-3109) significantly expands access to naloxone. Naloxone is a medication that safely reverses the effects of an opioid overdose, such as overdoses caused by prescription painkillers and heroin. Naloxone has been used by emergency medical technicians for over forty years because the medication effectively counteracts the effect of an opioid overdose, has no effect if administered to a person not experiencing an opioid overdose, does not cause addiction, and rarely causes an allergic reaction.²⁸

The Overdose Response Program expands access to naloxone to individuals likely to have the opportunity to assist someone experiencing an overdose. Specifically, the program allows people to complete a training program that would authorize the individual to receive a prescription for naloxone and administer the medication,²⁹ and authorizes DHMH to approve certification and training programs.³⁰

¹⁸ Md. Code Ann., Health-Gen § 21-2A-01.

¹⁹ Md. Code Ann., Health-Gen § 21-2A-03; COMAR 10.47.07.04.

²⁰ Md. Code Ann., Health-Gen § 21-2A-04(b).

²¹ SB757 (2015). Prescription Drug Monitoring Program – Required Disclosures. Available online, <http://mgaleg.maryland.gov/2015RS/bills/sb/sb0757T.pdf>.

²² Chapter 92 of the Acts of Maryland (2014). Prescription Drug Monitoring Program – Sunset Extension and Program Evaluation. This Bill changed Md. Code Ann., Health-Gen §21-2a-06(b)(7), (g), and (h).

²³ Chapter 177 of the Acts of Maryland (2013).

Prescription Drug Monitoring Program – Disclosure of Prescription Monitoring Data. Available online, http://mgaleg.maryland.gov/2013RS/Chapters_noln/CH_177_sb0080t.pdf

²⁴ SB757 (2015). Prescription Drug Monitoring Program – Required Disclosures. Available online, <http://mgaleg.maryland.gov/2015RS/bills/sb/sb0757T.pdf>

²⁵ Chapter 2 of the Acts of Maryland (2014). Prescription Drug Monitoring Program – Sunset Extension and Program Evaluation. This Bill changed Md. Code Ann., Health-Gen §21-2a-06(b)(7), (g), and (h). Available online, http://mgaleg.maryland.gov/2014RS/chapters_noln/Ch_92_hb0255T.pdf.

²⁶ Chapter 177 of the Acts of Maryland (2013).

Prescription Drug Monitoring Program – Disclosure of Prescription Monitoring Data. Available online, http://mgaleg.maryland.gov/2013RS/Chapters_noln/CH_177_sb0080t.pdf.

²⁷ Md. Code Ann., Health-Gen § 13-3102.

Md. Code Ann., Health-Gen § 13-3107.

²⁸ The Network – Drug Overdose Prevention and Harm Reduction, 2014. Available online, https://www.networkforphl.org/_asset/qz5pvn/network-naloxone-10-4.pdf.

²⁹ Md. Code Ann., Health-Gen § 13-3104.

³⁰ Md. Code Ann., Health-Gen § 13-3103.

The goal of the program is to reduce the morbidity and mortality from opioid overdoses by providing lay people the opportunity to inject naloxone, and thus counter the effects of an opioid overdose, as quickly as possible once a person is identified as experiencing an overdose.

Overdose Good Samaritan Bill. Chapter 401 of the Acts of Maryland (2014), effective October 1, 2014, provides limited immunity for those seeking, providing or assisting with medical assistance for person experiencing a medical emergency as a result of using drugs or alcohol.³¹ Immunity from prosecution is also provided to those seeking medical assistance, as well as for those experiencing medical emergencies, if the evidence for the criminal prosecution was obtained solely as a result of the seeking of medical assistance.³²

Recommended Approaches

Prescription Drug Monitoring Programs. The purpose of these programs is to detect suspicious activity early so as to prevent prolonged prescription drug abuse. As a baseline, these systems typically permit a prescriber or pharmacist to access information regarding a patient's controlled substance prescription history, thus reducing "doctor shopping" (doctor shopping is when an individual obtains multiple prescriptions from several providers). Some PDMPs also collect information regarding prescribers, helping regulators identify prescription patterns that abusers might exploit.³³

Studies have demonstrated that PDMP, when fully utilized, can be effective. For example:

A 2010 study found that when PDMP data were used in an emergency room, 41% of cases had altered prescribing after the clinician reviewed PDMP data – with 61% of the patients receiving fewer or no opioid pain medications than had been originally planned by the physician prior to reviewing the PDMP data, and 39% receiving more opioid medication than previously planned because the physician was able to confirm the patient did not have a recent history of controlled substance use.³⁴

PDMPs can also benefit practitioners and third party payers because of the information they provide about patients' use of controlled substances. A 2010 Wisconsin cost-benefit analysis of PDMPs demonstrates that PDMPs, by decreasing prescription drug abuse and diversion, may save states millions of dollars.³⁵

Studies of the effectiveness of PDMPs have produced both positive and neutral (but not negative) results. Some studies conclude that PDMPs are effective and may be linked with decreases in drug abuse, doctor shopping, and the per-capita supply of prescription drugs. However, other studies posit that PDMPs are ineffective because prescribers do not use them or are unaware of them.³⁶ Moreover, these programs have not been as effective as they could be due to impediments that hinder prescribers and dispensers from accessing PDMP information.³⁷ Impediments include the absence of a requirement to use such information, limitations on members of the care team that can access PDMP systems, incomplete data reporting, lack of standardized input methods intrastate, and inadequate interstate information sharing.

Currently, forty-nine states (all but Missouri), the District of Columbia, and Guam have implemented PDMPs.³⁸ State PDMPs vary in what they do and how they function. Most state PDMPs provide prescription history reports online and on-demand to prescribers and dispensers.³⁹

³¹ Chapter 401 of the Acts of Maryland (2014). Available online at http://mgaleg.maryland.gov/2014RS/chapters_nolin/Ch_401_hb0416T.pdf. (Last visited: January 13, 2017).

³² *Id.*

³³ Centers for Disease Control and Prevention, *CDC Policy Impact: Prescription Painkiller Overdoses*, 2013. Available online: <http://www.cdc.gov/HomeandRecreationalSafety/pdf/PolicyImpact-PrescriptionPainkillerOD.pdf>.

³⁴ Office of National Drug Control Policy, Executive Office of the President. *Fact Sheet, April 8, 2011.*

http://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/pdmp_fact_sheet_4-8-11.pdf (last visited January 13, 2017).

Primary Source: Baehren DF, Marco, CA, Droz DE, et al. A Statewide Prescription Monitoring Program Affects Emergency Department Prescribing Behaviors. *Annals of Emergency Medicine*. 56(1): 9-23. 2010.

³⁵ Dunkin, C. et al., *Cost-Benefit analysis of a prescription drug monitoring program in Wisconsin*, LaFayette School of Public Affairs (LaFayette), 6, Dec., 2010. Available online, http://cbkb.org/wp-content/uploads/2012/07/Prescription_Drugs_2010.pdf.

³⁶ Jennifer Ellick and Linda Stahr, Department of Legislative Services: Preliminary Evaluation of the Prescription Drug Monitoring Program, 2013 (page 5). Available online, http://dls.state.md.us/data/polanasubare/polanasubare_sunrev/2013-Preliminary-Evaluation-of-the-Prescription-Drug-Monitoring-Program.pdf.

³⁷ MITRE Corporation, *Enhancing Access to Prescription Drug Monitoring Programs Using Health Information Technology: Work Group Recommendations*. Prepared for: Office of the National Coordinator for Health Information Technology, in partnership with the Substance Abuse and Mental Health Services Administration; Version 1.1, 2012. Available online, http://www.healthit.gov/sites/default/files/pdmp_work_group_recommendations-1.pdf.

³⁸ Brandeis University, *Prescription Drug Monitoring Frequently Asked Questions*, http://www.pdmpassist.org/pdf/pdmp_faq_2014_print.pdf (last viewed January 13, 2017).

The PDMP Center of Excellence at Brandeis University (“COE”) has created a list of sixty potential “best practices” that have been linked with fully realizing PDMP effectiveness.⁴⁰ Among these practices are sharing of information between PDMPs and requiring prescribers and dispensers to use their PDMP. Maryland’s PDMP, when compared with these studies, is favorable with respect to the scope of drugs monitored, the information a dispenser must submit, the monitored data’s confidentiality, the easy to use platform, and integration with Maryland’s health information exchange.⁴¹ Additionally, Maryland now also allows its PDMP administrator to give and receive data to other state’s PDMPs. However, Maryland’s PDMP is lacking in the areas of unsolicited reporting, required enrollment or use, and stable funding. The timeliness of Maryland PDMP data reporting (currently three days) is average: while it falls within the “acceptable” seven day interval, it is not “real time” (as several other states are trending towards).⁴²

Required Registration or Use May Enhance Effectiveness. In the future, Maryland could enhance its PDMP by requiring prescribers and dispensers to use it.⁴³ Several states have enacted more stringent PDMPs that proactively transmit patient prescription history reports or electronic alerts to prescribers and dispensers to identify patients of concern. In fact, twenty-four states have legislation mandating that prescribers (and sometimes dispensers) use their PDMP in certain situations.⁴⁴ For example, in Kentucky, prescribers must check the PDMP when initially prescribing any drug containing hydrocodone. Additionally, (notwithstanding certain exceptions, such as during an emergency situation, following surgery, and for patients in hospitals in long-term care facilities) prescribers must query the PDMP every three months for a patient and review the information before prescribing any additional hydrocodone.⁴⁵ Many experts in the field view Kentucky’s PDMP as the “gold standard.”⁴⁶

Unsolicited PDMP Reporting. Maryland, in contrast to most PDMPs (which produce unsolicited and solicited reports), only generates reports in response to specific inquiries. One model act, rather than identifying a specific threshold number to be used, instructs PDMPs to review prescription data that “appears to indicate if a person may be obtaining prescriptions in a manner that may represent misuse or abuse of controlled substances” and “identify information that appears to indicate if a violation of law or breach of professional standards may have occurred.”⁴⁷ Studies have demonstrated that unsolicited reporting raises program awareness and might prompt prescribers and dispensers to make solicited data requests. As such, Maryland should explore the possibility of unsolicited reporting.

Instituting Real-Time Data Collection and Reporting Capability. Maryland could also benefit from requiring that prescription data be reported in a timelier manner. The Maryland PDMP requires that prescription data be reported within three business days of dispensing. While this satisfies the Model Act’s recommendation (seven days), the COE recommends that the best practices would mandate real time data collection. At present, at least two states (Oklahoma and New York⁴⁸) require real-time data collection, while several others (such as Kentucky) require daily collection.⁴⁹ Reporting delays might hinder the identification of doctor shopping and drug abuse, so an upgrade of the system to enable real-time reporting is a worthwhile consideration.

³⁹ ASTHO. *Prescription Drug Monitoring Programs: Tools for Education, Epidemiological Surveillance, Prevention, and Early Intervention*, <http://www.astho.org/Rx/Brandeis-PDMP-Report/> (last visited January 13, 2017).

⁴⁰ Prescription Drug Monitoring Program Center of Excellence at Brandeis University. *Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices*, 2012. Available online, <http://www.pdmpassist.org/content/coe-releases-updated-briefing-pdmp-effectiveness>.

⁴¹ Jennifer Ellick and Linda Stahr, Department of Legislative Services: Preliminary Evaluation of the Prescription Drug Monitoring Program, 2013 (page 6). Available online, http://dls.state.md.us/data/polanasubare/polanasubare_sunrev/2013-Preliminary-Evaluation-of-the-Prescription-Drug-Monitoring-Program.pdf.

⁴² *Id.*

⁴³ During Maryland’s 2015 legislative session, House Bill 3 was introduced but did not pass out of committee. The bill would have required providers to query the database before prescribing or dispensing a monitored prescription drug to the patient. The bill had a \$1.7 million fiscal note (http://mgaleg.maryland.gov/2015RS/fnotes/bil_0003/hb0003.pdf), and received an unfavorable report from the House Health and Government Operations Committee. Available online: <http://mgaleg.maryland.gov/2015RS/bills/hb/hb0003F.pdf>.

⁴⁴ The twenty-four states here are: Arizona, Colorado, Delaware, Georgia, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania (effective June 30, 2015), Rhode Island, Tennessee, Vermont, Virginia, Washington, and West Virginia. NAMSDL, *Prescription Monitoring Programs – State Law and Policy Profiles*. Available online, <http://www.namsdl.org/library/192FBC8C-65BE-F4BB-A881B9E6F05C3035/>.

⁴⁵ Ken. Rev. Stat. 218A.172

⁴⁶ SAMHSA, *Kentucky Meets the Gold Standard for Prescription Drug Monitoring Programs*, 2013, <https://www.samhsa.gov/capt/tools-learning-resources/kentucky-meets-gold-standard-prescription-drug-monitoring-programs>. (last visited January 13, 2017).

⁴⁷ Alliance of States with Prescription Monitoring Programs, *Prescription Monitoring Program Model Act 2010 Revision*, 2010, <http://www.nascsa.org/nascsaPMP/ASPMPModelAct2010.pdf> (last visited January 13, 2017).

⁴⁸ According to the NAMSDL, “New York requires the submission of data in real time by statute, but that has been interpreted by regulation to mean no later than 24 hours after the substance has been delivered.” NAMSDL, *Annual Review of Prescription Monitoring Programs*, 2014. Available online, <http://www.namsdl.org/IssuesandEvents/2014%20Annual%20Review%20of%20Prescription%20Monitoring%20Programs.pdf>.

⁴⁹ *Id.*

Overdose Response Programs and the Administration of Naloxone. Thirty-two states, as well as the District of Columbia, have passed laws to make it easier for professionals to prescribe and laypersons to administer naloxone statewide.⁵⁰ Massachusetts is an example of an effective program: the Commonwealth has trained over 2,900 people who are potential overdose bystanders.⁵¹ An evaluation of the program reported that opioid overdose death rates were significantly lower in communities that implemented this program.⁵²

Good Samaritan Laws. Twenty-four states, as well as the District of Columbia, have amended their Good Samaritan laws to limit the liability of a person who summons help in the event of an overdose. These Good Samaritan laws are effective measures at reducing morbidity and mortality because witnesses to an overdose are incentivized to contact emergency services as soon as possible after witnessing an overdose. In fact, Maryland law permits courts to consider whether the bystander sought medical assistance may be used as a mitigating factor in a criminal prosecution.⁵³

Prescription Limits. Some states, such as New York and New Jersey impose limits based on dosage amounts.⁵⁴ New York requires that prescribers and dispensers must consult the PDMP before prescribing or dispensing prescription painkillers such as hydrocodone for more than five days' supply.⁵⁵ Accordingly, Maryland might consider prescription limits in the future.

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⁵⁰ The Network for Public Health Law, *Legal Interventions to Reduce Overdose Mortality: Naloxone Access and Overdose Good Samaritan Laws*, 2014., http://www.networkforphl.org/_asset/qz5pvn/network-naloxone-10-4.pdf (Last visited January 13, 2017).

⁵¹ *Id.*

⁵² *Id.*

⁵³ Md. Code Crim. Proc. § 1-210.

⁵⁴ N.Y. Comp. Codes R. & Regs. Title 10, § 80.67; N.J. Stat. Ann. § 45:9-22.19.

⁵⁵ N.Y. Comp. Codes R. & Regs. Title 10, § 80.