

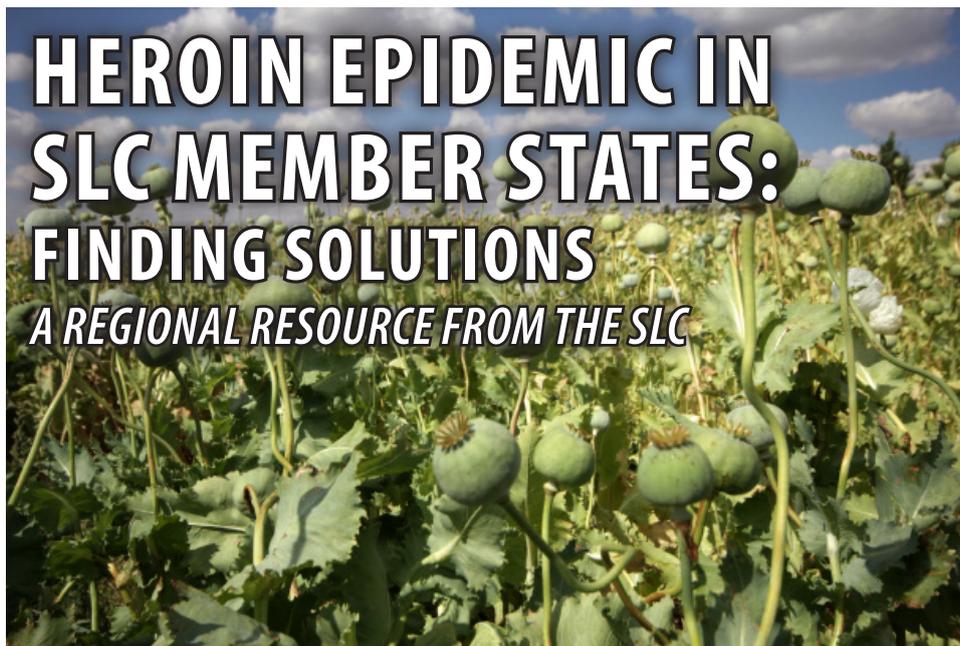


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HEROIN EPIDEMIC IN SLC MEMBER STATES: FINDING SOLUTIONS

A REGIONAL RESOURCE FROM THE SLC



Following a number of distressing revelations, including a 1969 study linking crime and heroin addiction and a 1971 report on the growing heroin epidemic among U.S. service members in Vietnam, President Nixon declared a war on drugs.¹

More than four decades after Nixon named drug abuse “public enemy number one,” the nation continues to struggle with drug addiction.² Each year since 1999, the United States has seen a steady rise in the number of deaths from prescription opioid overdose.³ This rise in deaths corresponds with a four-fold increase of opioid painkiller prescriptions written between 1999 and 2013.⁴ As states began targeting those overprescribing these drugs in an effort to reverse this trend, access to prescription opioids became more difficult for individuals already abusing them. These new impediments to access, coupled with the rising cost of prescription drugs and enterprising drug traffickers and dealers, led many prescription opioid abusers to a more easily accessible and cost-efficient substitute—heroin.^A With prescription opioid addicts 40 times more likely to become addicted to heroin, states now are facing another public health crisis.⁵

^A Heroin is a highly addictive Schedule I controlled substance processed from morphine extracted from poppy plants. Typically sold as white or brown powder or black sticky goo, heroin can be injected, smoked, or snorted to produce a quick euphoric effect. Regular use of the drug builds up a tolerance that, over time, requires higher doses to yield the same effects. (2015 DEA Drugs of Abuse Resource Guide)

Although heroin has remained a public health threat since first rising to cultural popularity in the early 20th century, its recent re-emergence spans a much broader swath of society. A July 2015 report released by the Centers for Disease Control and Prevention (CDC) found that the groups most at risk for a heroin addiction include non-Hispanic whites, 18 to 25 year-olds, and people living in large metropolitan areas.⁶ While men remain the largest users of heroin, it also was reported that use among women has doubled in the last decade.⁷ Eighty percent of heroin users who began using in the 1960s reported that heroin was the first drug they had ever used. By contrast, 75 percent of heroin users who began using in the 2000s report that their first drug use began with prescription opioids.⁸ In light of reports that healthcare providers in the Southern region wrote more prescriptions for opioid painkillers than anywhere else in the country, this fact is particularly alarming for the member states of the Southern Legislative Conference (SLC).⁹ In one SLC state, almost three times as many prescriptions were written per person as compared to the nation’s lowest prescribing state.¹⁰

In 2013 alone, 43,982 deaths were attributed to drug poisoning, 8,257^B of which involved heroin.¹¹ As drug poisoning has surged to become the number one cause

^B The actual number of heroin-related deaths may be higher, but the rapid rate at which heroin metabolizes into morphine can result in a misclassification of which drug caused the death.

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of injury-related deaths in the United States, drug overdose deaths involving heroin more than tripled between 2007 and 2013.¹² By 2014, 36 states had recorded at least one year in which heroin and prescription drug overdoses claimed the lives of more people than car accidents.¹³

While the heroin epidemic largely has been concentrated in the Northeast, Appalachian, and Midwest regions of the country, substance abuse is an issue that crosses multiple areas of public policy, including behavioral and public health, criminal justice, and social services. As the South continues to lead the way in criminal justice reform, lessons from the plight of other regions allow SLC lawmakers to build on their efforts to combat prescription drug abuse and take a proactive stance in the heroin epidemic. In recent years, this awareness has led many SLC states to pass laws which expand availability and access to drugs that can help treat an opioid overdose and provide limited immunity from prosecution for individuals who seek medical assistance for themselves or another person experiencing an opioid overdose.

This *SLC Regional Resource* examines what the SLC member states are doing to combat the heroin epidemic and what policies and/or practices can be implemented to mitigate its side effects and ensure a long-term solution.

AN EFFECTIVE HEROIN STRATEGY

As noted by Jack Killorin, director of the Atlanta-Carolinas High Intensity Drug Trafficking Area, “the abuse of pharmaceuticals and heroin use are intertwined;” consequently, many of the policies being implemented should work in tandem to address both issues.¹⁴ States in the SLC region and nationwide already have begun important work in response to the prescription drug epidemic, but there remains more that can be done. Although not every state with an established prescription drug monitoring program requires its use, Missouri is the only state in the country that has not enacted a prescription drug monitoring program.¹⁵

As with most issues facing the states, there is no one-size-fits-all solution to address the growing heroin problem. However, many experts agree that an effective

response includes a combination of policies that focuses on treatment, prevention, and enforcement.^{16,17} The most common elements of an effective heroin strategy include a combination of provisions related to (1) naloxone access and training; (2) Good Samaritan immunity; (3) needle and syringe exchange programs and decriminalization; (4) medication-assisted treatment; (5) access to treatment; and (6) treatment alternatives to incarceration. While not intended to be a comprehensive overview of what each SLC state is doing in each of these areas, this *Regional Resource* examines recent legislative efforts that support an effective strategy to combat this problem.

Naloxone Access

Naloxone, also called Narcan, is an FDA-approved opioid antagonist^C that can be administered to an individual experiencing an opioid^D overdose to neutralize the effects of heroin or other opioids and reverse the overdose. The drug, which does not produce a high, has saved thousands of lives. First approved by the FDA in 1971, naloxone usually requires a prescription and can be injected intravenously or administered through the nose. In addition to proving effective at saving lives, naloxone also is a tool for improved community response and officer safety. Although naloxone has been used for decades to reverse opioid overdoses, only recently have states begun to allow physicians to prescribe, and pharmacists to dispense, the drug without fear of civil, criminal, or professional repercussions. Additionally, the recent push to expand access to naloxone has enabled physicians to prescribe the drug directly, or by standing order,^E to an individual

^C An opioid antagonist is a drug that quickly binds to the same nerve receptors as opioids to block or prevent their activation by opioids in the system. Naloxone will have no effect if administered to someone who has not taken prescription or illegal opioids.

^D By definition, the term opiate refers to drugs derived from naturally occurring sources (heroin), and the term opioid refers to synthetic and semi-synthetic drugs that produce a similar effect (prescription drugs). In recent years, the term opioid has been used to refer to all drugs that bind to opioid-receptors to produce a euphoric effect. The terms are used interchangeably throughout to reflect the statutory language in each state.

^E A standing order is an order that prescribers write to allow a prescription medication to be dispensed to patients they have not examined based on meeting a certain set of criteria. In the case of naloxone, standing orders commonly are provided to

at risk of experiencing an overdose or to a third-party, including family, friends, and other individuals, who may be in a position to assist during an opioid overdose. Although what defines acting in good faith and the training requirements for prescribers, dispensers, and administrators of naloxone and other opioid antagonists vary by state, every state with a naloxone access law provides some level of immunity to those individuals. As of October 2015, 44 states, including all 15 SLC member states, have enacted laws that, to some degree, expand access to naloxone and other opioid antagonists.¹⁸ However, even within some of these 44 states, expanded access only is available to first responders, not laypersons.

Good Samaritan Laws

Good Samaritan laws are statutes that provide legal protection to individuals who assist in the event of an emergency. Traditionally, these laws have been a means of encouraging bystanders to assist others in emergency situations without fear of being held liable for any additional or exacerbated injuries their well-intentioned assistance might cause. In recent years, Good Samaritan laws have been enacted as a life-saving tool for drug overdose victims by encouraging individuals to seek medical assistance for themselves or another person experiencing an overdose,^F without fear of being arrested, charged, or prosecuted for a drug-related crime. Under most Good Samaritan provisions in the SLC states, individuals experiencing an opioid-related drug overdose, and/or a third party who, in good faith, seeks emergency medical assistance on their behalf, will be immune from criminal charges for possession of a controlled substance and/or possession of drug paraphernalia if the evidence for those charges is the result of seeking medical assistance. The variation among these laws relates to what qualifies as “seeking medical assistance” for immunity purposes. As of October 2015, 34 states have enacted laws that provide some immunity for seeking emergency medical assistance during a drug overdose.¹⁹

community-based organizations so they can distribute the drug to anyone who may be in a position to reverse a drug overdose.

^F In many states, Good Samaritan protections are not limited to opioids; rather they apply generally to controlled substances. In some instances, this protection also is extended to underage individuals who have consumed alcohol.

Needle and Syringe Exchange and Decriminalization

Needle and syringe exchange programs, or syringe service programs (SSPs), provide free and new hypodermic needles and sterile syringes to drug users in exchange for used ones. According to the CDC, in 2013, 7 percent of the more than 47,000 HIV diagnoses, and 10 percent of the more than 26,000 AIDS diagnoses, in the United States were attributed to injection drug use (IDU).²⁰ Providing access to clean and sterile syringes has proven to be one of the most effective and cost-efficient^G means of preventing the spread of blood-borne diseases among intravenous drug users without increasing drug use.²¹ While SSPs provide access to new syringes and safely dispose of used syringes, they also can act as a “bridge to treatment and prevention services.”²² In many instances, SSPs also provide naloxone for use in an opioid overdose, testing and counseling for HIV and hepatitis C, on-site medical care, and information and referrals to treatment for substance use disorders.²³

Despite evidence demonstrating the success of SSPs, attitudes toward these programs vary widely. The 2014 National Survey of Syringe Exchange Programs found 204 programs operating in 116 cities and 33 states, although not every state with SSPs has a corresponding law to allow them.^H In 2015, the SLC states of Kentucky and West Virginia joined those ranks. Research shows SSPs that receive public funding have more success at reducing incidences of HIV and maintaining already low incidence rates.²⁴ With a ban on expending federal funds on SSPs dating back to 1988, oversight and funding largely has fallen on the shoulders of local and state governments.

Not only do SSPs provide public health benefits for users, they also protect law enforcement and other public safety officials from the dangers of inadvertent needlesticks.²⁵ Most often, these occupational hazards

^G Research estimates that the perpetual lifetime cost of treating an HIV-positive person is between \$385,200 and \$618,900, compared to the estimated cost of 52-cents per syringe for SSPs.

^H While it will not be addressed in this *Regional Resource*, states also have provided access to clean and sterile syringes by allowing over-the-counter sales with or without a prescription.

occur during the search of a person or his or her belongings, with one often-cited study estimating that as many as one in three officers will have a needlestick during their career.²⁶ While SSPs can help reduce the chances that a needlestick will result in infection, decriminalizing their possession can help reduce the occurrence of a needlestick altogether. To provide this additional protection to law enforcement officers, states can fully decriminalize their possession by removing hypodermic needles and syringes from the definition of “drug paraphernalia” or partially decriminalize their possession by providing a limited immunity in certain search situations. The latter allows a subject to notify law enforcement of the presence of potentially dangerous needles or other sharp objects prior to them or their possessions being searched. This pre-search notification or affirmative response to law enforcement inquiry can provide immunity from applicable drug-related charges stemming from such possession. To provide the most incentive to individuals to participate in syringe exchange programs or admit to possession of such objects, it is important that immunity be provided for possession of drug paraphernalia and for possession of a controlled substance as it relates to trace amounts that may be found in the syringe.^I

Medication-Assisted Treatment

Medication-Assisted Treatment (MAT) is an evidence-based treatment for opioid addiction that focuses on treating the whole patient through a combined use of behavioral therapy and medications. Methadone has been the most widely used medication to treat opioid dependence for decades. In 2002, the FDA also approved buprenorphine with and without naloxone. Both are maintenance medications that reduce cravings for heroin and other opioid drugs and prevent or curb withdrawal symptoms for addicts without producing the euphoric high of opioids. Methadone, which only can be dispensed by federal and state regulated opioid treatment programs, generally is effective only for as long as it is taken. Buprenor-

^I In order for these provisions to be most effective, at-risk populations also must be educated about the relevant decriminalization and/or immunity laws. This education could pose considerable challenges, as these populations may be difficult to reach through typical public communications. Thus, treatment centers may be best equipped to disseminate this information to at-risk individuals.

phine, which only can be prescribed or dispensed by a specially trained and certified physician,^J has less potential to be abused than methadone, but also is generally more expensive per dose. Except under limited circumstances, such as pregnancy and naloxone-aversion, buprenorphine with naloxone is recommended. Suboxone is a common buprenorphine/naloxone combination. In 2010, the FDA approved extended-release injectable naltrexone for use as a tool to prevent relapse. Unlike methadone and buprenorphine, naltrexone is not a controlled substance and can be prescribed without special training or certification. Like naloxone, naltrexone is an opioid antagonist. Vivitrol is a common brand of naltrexone.

Despite widespread support and evidence of success in treating opioid dependence, MAT is not a tool that has been widely embraced.²⁷ In fact, many drug court programs prohibit opioid-dependent participants from utilizing medication-assisted treatment. Likewise, insurance, including Medicaid, may not cover MAT or may place limits on treatment for substance use disorders^K and how much it will cover.

Access to Treatment

The federal Mental Health Parity Act of 1996 (MHPA) enacted provisions to prohibit large group health plans from imposing annual or lifetime dollar limits on mental health benefits that were more restrictive than the limitations placed on medical and surgical benefits.²⁸ In 2008, the federal Mental Health Parity and Addiction Equality Act (MHPAEA) extended the parity requirement to include treatments for substance use disorders. Under the MHPAEA, health insurance plans that elect to provide coverage for mental health and substance use disorders must provide the same level of benefits as for traditional medical and surgical disorders and

^J Federal law limits certified physicians to treating no more than 100 patients at a time.

^K Recent changes to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) combine the categories of substance abuse and substance dependence into the single category of substance use disorder. Substance use disorders are measured based on their level of severity ranging from mild to severe, and each specific substance is considered a separate use disorder. For the purposes of this *Regional Resource*, the terms “substance abuse” and “substance use disorder” are used interchangeably, with the terminology used in each section mimicking the original source.

diseases.^L These parity requirements prohibit, among other things, financial restrictions that impose higher co-pays or deductibles and more restrictive treatment limitations on the frequency or duration of services for mental health and substance use disorders. While these requirements set a baseline for states that choose to adopt their own parity laws, they do not mandate that health plans provide mental health or substance use disorder treatments and services; they apply only to plans that elect to provide these services in addition to medical and surgical benefits.

In 2010, the federal Affordable Care Act built on the MHPAEA by requiring non-grandfathered plans in the individual and small group markets to provide parity coverage for mental health and substance use disorders as one of 10 Essential Health Benefits (EHB) beginning January 2014.²⁹

Even when insurance provides coverage of treatment and services for substance use disorders, one of the largest obstacles many face is accessing these services. A national shortage of behavioral health providers leaves many with insufficient options for receiving the care they need. Relatively low salaries and reimbursement rates have led many providers to focus their practices on the more lucrative healthcare fields. By one estimate, the addiction services field will need to fill more than 330,000 jobs by 2020, just to keep up with the growing demand.³⁰

Treatment Alternatives to Incarceration

Data from the U.S. Department of Justice shows that incarcerated offenders overwhelmingly are more likely to have a history of heroin use than the general population.^M Reducing criminal activity, incarceration, and

^L Federal regulations implementing mental health parity under MHPAEA for some group plans, qualified health plans under the ACA, and Medicaid non-managed care benchmark and benchmark equivalent plans were finalized in November 2013. However, these rules do not extend to insurance provided through Medicaid managed care and the Children's Health Insurance Program (CHIP). The Center for Medicaid and Medicare Services (CMS) issued rule proposals in April 2015 to extend parity requirements to these federal-state programs; a final rule has not yet been issued.

^M Based on 2004 data, the most recent year for which data is available, approximately 8 percent of state prisoners reported

recidivism are just some of the positive impacts that can result from effective drug abuse policies. Following years of study on the intersection between criminal justice and drug abuse, the National Institute on Drug Abuse (NIDA) found that drug abuse treatment for offenders is the "most effective course for interrupting the drug abuse/criminal justice cycle."³¹ However, effective treatment must address the individual needs of each offender and requires a continuum of care that begins in prison and continues after release through community-based treatment programs. For those not incarcerated, drug courts, diversion programs, and treatment conditions for pretrial release and probation have shown to be effective. Accordingly, NIDA reports that outcomes for individuals who enter treatment under legal pressure can be as good as, or even better than, those who are not under legal pressure to obtain treatment.³² For many, a successful treatment program will include medical, psychological, and social services to address the concurrent problems drug-abusing offenders often face.

Harm Reduction

Collectively, these policies embrace the public health philosophy of harm reduction. Harm reduction strategies seek to reduce the negative consequences associated with certain harmful behaviors. In doing so, the approach works toward addressing a larger issue by mitigating the severity of equally harmful side effects. For example, policies that expand naloxone access and those that encourage reporting overdose-related medical emergencies can help reduce the number of overdose-related deaths; needle and syringe exchange programs help reduce the spread of HIV and hepatitis C among intravenous drug users; medication-assisted treatment helps reduce cravings for heroin and other opioids while improving the stability and functionality of opioid addicts; and providing treatment and alternatives to incarceration help reduce recidivism of certain repeat offenders by addressing the underlying issues.

using heroin or other opiates in the month before their offense. At the same time, less than one-half of 1 percent of the general population reported using heroin or opiates within the past month that year. (PEW, Public Safety Aspects of the Heroin Abuse Epidemic)

RECENT ACTION IN THE SLC MEMBER STATES

Alabama

Naloxone Access

In 2015, Alabama enacted House Bill 208 (HB 208) to expand access to opioid antagonists approved by the FDA for the treatment of an opioid overdose. Under HB 208, a licensed physician or dentist, acting in good faith, can prescribe an opioid antagonist to a person at risk of experiencing an opiate-related overdose. The prescription, which may be direct or by standing order, also can be given to a family member, friend, or other individual, including law enforcement, who is in a position to assist the person experiencing the overdose. As an indicator of good faith, the prescribing physician or dentist may require a written statement that provides a factual basis for the individual's risk and the person's relationship to the at-risk individual. The Bill also authorizes pharmacists to dispense the drug pursuant to a prescription.

Additionally, under HB 208, a third-party individual who receives an opioid antagonist prescription and believes, in good faith, that another person is experiencing an opiate-related overdose, can administer the drug. The Bill imposes a duty of reasonable care when administering the drug, which can be evidenced by the receipt of basic instructions and information on how to administer the opioid antagonist.

If acting in accordance with these laws, prescribing physicians or dentists, dispensing pharmacists, and third-party administrators are immune from civil and criminal liability. Alabama does not provide explicit protections against professional discipline for prescribers or dispensers of opioid antagonists.

First Responders

House Bill 208 directs the Alabama Department of Public Health to approve a training curriculum for law enforcement officers who elect to carry and administer opioid antagonists.

Good Samaritan Immunity

In addition to expanding access to opioid antagonists, HB 208 also provides immunity from prosecution for a misdemeanor controlled substance offense if law enforcement became aware of the offense solely because the individual was seeking medical assistance for another person. To qualify for this immunity, the individual must act in good faith, upon a reasonable belief that he or she was the first to call for assistance; must use his or her own name when contacting authorities; and must remain with the person needing medical assistance until help has arrived. Alabama law does not specify that this immunity extends to the person for whom medical assistance was sought or to someone seeking their own medical assistance. It also should be noted that Alabama's Good Samaritan protection only applies to misdemeanor offenses and does not extend to felony controlled substance offenses like most other SLC states.

Arkansas

Naloxone Access

In 2015, Arkansas enacted Senate Bill 880 (SB 880), also known as the Naloxone Access Act, to expand access to potentially life-saving opioid antagonists. Under SB 880, a healthcare professional acting in good faith can prescribe, directly or by standing order, and dispense an opioid antagonist to: (1) a person at risk of experiencing an opioid-related drug overdose; (2) a family member or friend of an at-risk person; (3) a pain management clinic; (4) a harm reduction organization; (5) an emergency medical technician; (6) a first responder; or (7) a law enforcement officer or agency. An individual acting in good faith may administer the prescribed opioid antagonist if he or she reasonably believes that another person is experiencing an opioid-related overdose.

The Act also provides immunity from civil and criminal liability and from professional sanctions to the prescribing healthcare professional, the dispensing healthcare professional or pharmacist who acts in good faith and in compliance with the appropriate standard of care, and an individual other than a healthcare professional who administers the antagonist.

Arkansas does not set out any training requirements for prescribers, dispensers, or administrators of naloxone and other opioid antagonists.

Good Samaritan Immunity

In 2015, Arkansas also enacted Senate Bill 543, known as the Joshua Ashley-Pauley Act. The Act provides immunity from arrest, charge, or prosecution for possession of a controlled substance if the evidence for the charge is solely the result of the individual seeking medical assistance, in good faith, for himself or herself, or another person who is experiencing a drug overdose. The act of “seeking medical assistance” includes contacting or assisting in contacting 911, law enforcement, or poison control, and providing care to a person believed to be experiencing a drug overdose. Arkansas does not specifically require individuals to give their name to qualify for immunity. If related to seeking medical assistance, Arkansas also provides immunity from penalties for violating a protective or restraining order or sanctions for violating a condition of pretrial release, probation, or parole, for possession of a controlled substance.

These provisions do not provide immunity from any charge other than possession of a controlled substance. Additionally, they do not prohibit the seizure and admissibility of protected evidence in other criminal proceedings nor the detention of an immune individual in relation to another investigation or offense.

Syringe Exchange Programs

Although Arkansas does not have a statute directly authorizing syringe exchange programs, it is possible to interpret a portion of the Naloxone Access Act as an indirect authorization for their existence. Arkansas is one of two SLC states that specifically allows a prescription for naloxone to be given to a harm reduction organization. Under the Act, “harm reduction organization” is defined as an organization that provides direct assistance and services such as syringe exchanges, counseling, homeless services, advocacy, and drug treatment and screening to individuals at risk of experiencing a drug overdose. Despite this statutory reference to syringe exchanges, it should be noted that hy-

podermic syringes, “used, intended for use, or designed for use in... injecting a controlled substance...” remain classified as drug paraphernalia.³³

Florida

Naloxone Access

In 2015, Florida enacted House Bill 751 (HB 751), also known as the Emergency Treatment and Recovery Act, to expand access to emergency opioid antagonists for patients and caregivers and to encourage their prescription by authorized healthcare practitioners. In furtherance of this goal, HB 751 authorizes healthcare practitioners to prescribe the drug to an at-risk individual or caregiver^N and authorizes healthcare practitioners and pharmacists to dispense the drug pursuant to that prescription. While the Act does authorize third-party prescriptions, it does not specifically authorize standing orders. When dispensing the drug, it must be appropriately labeled with instructions for use. The Act further authorizes emergency responders to possess, store, and administer emergency opioid antagonists as clinically indicated.

When a physician is not immediately available, an at-risk individual or caregiver who is authorized to possess and store approved emergency antagonists can administer the drug to someone believed, in good faith, to be experiencing an opioid overdose, regardless of whether the victim has a prescription for the drug.

The Act provides civil immunity to individuals who possess, administer, prescribe, dispense, or store an approved emergency opioid antagonist from any civil damages that result from gratuitously, and in good faith, rendering emergency care. Likewise, a healthcare practitioner or pharmacist acting in good faith and exercising reasonable care is immune from civil or criminal liability and professional discipline that may result from prescribing or dispensing an emergency opioid antagonist. Florida does not explicitly provide criminal or professional immunity for administration of opioid antagonists.

^N Florida defines “caregiver” as a family member, friend, or person in a position to have recurring contact with a person at risk of experiencing an opioid overdose.

Good Samaritan Immunity

In 2012, Florida became the first SLC member state to provide protection for reporting a drug-related overdose with the enactment of Senate Bill 278, the 911 Good Samaritan Act.³⁴ Under the Act, an individual who, in good faith, seeks medical assistance for someone experiencing a drug-related overdose cannot be charged with, prosecuted, or penalized for possession of a controlled substance if the evidence was obtained as a result of doing so. Likewise, a person experiencing an overdose who is in need of medical assistance cannot be charged, prosecuted, or penalized for possession of a controlled substance if the evidence was obtained as a result of the overdose and need for medical assistance.

The immunity protection from prosecution cannot be used as grounds for suppression of evidence in other criminal prosecutions; however, it can be used as mitigating evidence. Under Florida's sentencing guidelines, evidence of a good faith effort to obtain or provide medical assistance for an individual experiencing a drug-related overdose can be considered as mitigating circumstances to reasonably justify deviation from the minimum established sentence for a felony offense.³⁵

Medication-Assisted Treatment and Criminal Justice

In Fiscal Year 2015, the Florida Legislature appropriated \$3 million (\$1 million in recurring funds and \$2 million in nonrecurring funds) for injectable extended-release naltrexone to treat alcohol- and opioid-addicted offenders in court-ordered community-based drug treatment programs.³⁶ In Fiscal Year 2016, the Legislature increased its commitment to medication-assisted treatment in the criminal justice system with a \$3 million appropriation of recurring general funds for naltrexone to treat alcohol- and opioid-addicted individuals in the criminal justice system, individuals who have a high likelihood of criminal justice involvement, or individuals in court-ordered community-based drug treatment.³⁷ With a single dose of Vivitrol^o estimated to cost about \$1,000, the funds allow offenders to obtain the medication for free.³⁸

^o Vivitrol is the brand name for injectable extended-release naltrexone.

In both fiscal years, an additional \$500,000 in recurring funds was appropriated for naltrexone treatment within the state Department of Corrections.

Georgia

Naloxone Access

In 2014, Georgia enacted House Bill 965 (HB 965) to expand access to naloxone. Under HB 965, a licensed physician, acting in good faith and in compliance with the applicable standard of care, may prescribe an opioid antagonist to a person at risk of experiencing an opioid-related overdose, or to a pain management clinic, first responder, harm reduction organization, family member, friend, or other person in a position to assist the at-risk individual. The prescribed opioid antagonist is to be used in accordance with protocols specified by the physician. Pursuant to a physician's prescription, a pharmacist, acting in good faith and in compliance with the applicable standard of care, may dispense opioid antagonists. Likewise, a person acting in good faith and with reasonable care may administer the prescribed drug, in accordance with prescriber protocols, to another person believed to be experiencing an opioid-related overdose.

The Bill provides immunity from civil and criminal liability and professional sanctions to the prescribing or dispensing physician or pharmacist who acts in good faith and in compliance with the appropriate standard of care. This immunity also extends to any person acting in good faith, other than a physician, who administers the antagonist.

Georgia does not set any training requirements for prescribers, dispensers, or administrators of naloxone and other opioid antagonists.

First Responders

House Bill 965 also authorizes first responders to administer or provide an opioid antagonist for the purpose of saving the life of a person experiencing an opioid overdose. The statute defines "first responder" as any person or agency who provides on-site care until the arrival of a duly licensed ambulance service including, but not limited to, persons who routinely respond to calls for assistance through an affiliation with law enforcement agencies, fire departments, and

rescue agencies. All law enforcement agencies, fire departments, rescue agencies, and other similar entities are required to notify the appropriate emergency medical service system that its personnel possess and maintain opioid antagonists. All first responders who have access to or maintain an opioid antagonist must receive training deemed appropriate by the state Department of Public Health.³⁹ Additionally, first responders must make available a report of administering or providing an opioid antagonist to the licensed ambulance service that transports the patient.

Under the Bill, a first responder who, gratuitously, and in good faith, renders emergency care or treatment by administering or providing an opioid antagonist will not be liable for any resulting civil damages from that care or treatment, or as a result of any act or failure to act in providing or arranging for further medical treatment, absent gross negligence or an intent to harm.

In accordance with existing Georgia law, a licensed pharmacy in the state can issue opioid antagonists to first responders under a contract with the director of an emergency service provider.⁴⁰ Additionally, a manual of policies and procedures for the safe handling, storage, labeling, and record keeping of all drugs must be written, approved, and signed by the medical director of an emergency service provider and the pharmacist in charge of an issuing pharmacy. Annually, a pharmacist from the contracting pharmacy must physically inspect the drugs to determine compliance with appropriate policies and procedures for the handling, storage, labeling, and record keeping of all drugs. A written record of all drugs issued to the medical director of an emergency service provider must be maintained by the issuing pharmacy and emergency service provider. Within 72 hours of using a drug, the emergency service provider is to transmit a written record to the issuing pharmacy to provide proper control and accountability of the drugs. In accordance with the law, all outdated, expired, unused, or unusable drugs shall be returned to the issuing pharmacy for proper disposition.

Additionally, HB 965 authorizes emergency medical technicians, paramedics, and certified cardiac tech-

nicians to administer opioid antagonists pursuant to their existing professional certification.

Good Samaritan Immunity

In a webinar hosted by the Southern Legislative Conference, Robert Childs, director of the North Carolina Harm Reduction Coalition, described Georgia's Good Samaritan law as the "gold standard" for the Southern region, and one that "should be replicated by other states."⁴¹

The Georgia 9-1-1 Medical Amnesty Law, also enacted in 2014 as part of HB 965, provides immunity from arrest or prosecution for a drug violation^P to any person who, in good faith, seeks medical assistance for another person experiencing or believed to be experiencing a drug overdose, if the evidence is obtained solely as a result of seeking medical assistance. Likewise, the law provides protection from related penalties for violating a protective or restraining order or sanctions for violating a condition of pretrial release, probation, or parole.

This immunity extends to an individual experiencing an overdose who seeks medical assistance or is the subject of a third party's request. The act of "seeking medical assistance" includes contacting or assisting in contacting 911, law enforcement, or poison control, and providing care to the person while awaiting the arrival of medical assistance. These provisions do not provide immunity from any charge other than possession of a controlled substance. They also do not prohibit the seizure and admissibility of protected evidence in other criminal proceedings nor the detention of an immune individual in relation to another investigation or offense.

Syringe Exchange Programs

Like Arkansas, Georgia does not have a statute directly authorizing syringe exchange programs; however, the state's naloxone access law could be interpreted as indirect authorization. Similarly, in Georgia, a licensed physician can issue a prescription for opioid antago-

^P A drug violation includes possession below certain amounts of a controlled substance or marijuana or possession and use of drug-related objects.

nists to a harm reduction organization, the definition of which includes services “such as syringe exchanges.” While Georgia’s definition of “drug-related object” does not specifically reference hypodermic syringes or needles, they reasonably would be considered to meet the classification as something intended “to introduce” a dangerous drug or controlled substance into the human body.⁴²

Kentucky

Suffering from one of the highest rates of heroin usage and hepatitis C in the country, Kentucky took significant steps to fight the heroin epidemic during the 2015 legislative session. The focus of Senate Bill 192 (SB 192) is to help addicts receive the treatment and recovery necessary to overcome a substance use disorder. To accomplish this goal, SB 192 authorizes a variety of tools to provide immediate and long-term treatment to individuals, including the incarcerated and pregnant. Hoping to prevent others from becoming addicts, the Bill also imposes harsher penalties for those who provide heroin to others.

Then-House Judiciary Committee chairman, Representative John Tilley, called the Bill a “truly bipartisan effort... [with a] three-pronged approach: prevention, treatment, and targeting of traffickers.”⁴³

Naloxone Access

In 2013, Kentucky enacted House Bill 366, which expanded access to naloxone by allowing licensed healthcare providers to prescribe, directly or by standing order, or dispense the drug to an at-risk individual capable of administering the drug for an emergency opioid overdose.⁴⁴ In 2015, with SB 192, Kentucky expanded this access further to allow the drug to be prescribed or dispensed to a person other than the at-risk individual, or to an agency.^Q As under the 2013 law, a licensed healthcare provider who acts in good faith will not be subject to professional discipline or related adverse actions as a result of providing, dispensing, or omitting to do so. Under the amended law, this professional immunity also extends to a pharmacist certified for dispensing naloxone.

^Q An agency includes a peace officer, jailer, firefighter, paramedic, EMT, or authorized school employee.

The person or agency deemed capable of administering the drug by a licensed healthcare provider is authorized, under SB 192, to receive a prescription for naloxone, possess the drug and any necessary equipment, and administer the drug to an individual suffering from an apparent overdose. A naloxone prescription provided directly to an individual at risk of suffering an opioid overdose may also authorize administration by a third party so long as the instructions include a requirement for the third-party administrator to immediately notify the appropriate local public safety authority to the situation.

A person who, in good faith, administers naloxone under these provisions will be immune from civil and criminal liability unless the personal injury is the result of gross negligence or willful and wanton misconduct.

The board of each local public school district and governing body of each private or parochial school or district can authorize a school to keep naloxone on the premises and regulate its administration to any individual suffering from an apparent opiate-related overdose. Local schools and school districts are directed to collaborate with state and local health entities to develop clinical protocols addressing the supply of naloxone kept at schools and advise on clinical administration of the drug.

Training

Senate Bill 192 directs the Kentucky Board of Pharmacy to establish requirements for the certification, education, operation, and protocol related to pharmacists dispensing naloxone. The regulations promulgating these requirements must (a) require that any dispensing only be done in accordance with a physician-approved protocol and specify the minimum required components of that protocol; (b) include a mandatory education requirement on the mechanism and circumstances for the administration of naloxone for the person to whom the drug is dispensed; and (c) require that a record of the dispensing be made available to a physician who signed the protocol, if the physician so desires. In addition to these required regulation provisions, the Board also may promulgate rules to establish a supplemental educational or training component for

a pharmacist seeking naloxone certification and may limit the forms of naloxone and means of administration that can be dispensed by a pharmacist.

In addition to training for pharmacists, SB 192 directs the state Department of Criminal Justice Training to offer voluntary in-service training for law enforcement officers that includes instructional materials on the detection and interdiction of heroin trafficking, the dynamics of heroin abuse, and available treatment options for addicts.

Good Samaritan Immunity

Under SB 192, an individual will be immune from prosecution for possession of a controlled substance or drug paraphernalia if he or she, in good faith, seeks medical assistance for a drug overdose and the evidence resulted from the overdose and necessary medical assistance. The immunity applies to both the individual requiring medical assistance and to the individual who seeks medical assistance. The latter must remain with the overdose victim until the requested assistance is provided.

A law enforcement officer also will be immune from civil or criminal liability for false arrest or imprisonment if an arrest based on probable cause is made in violation of these Good Samaritan provisions.

If the person requesting medical assistance provides appropriate contact information, it should be reported to the local health department. Subsequently, the health department must contact the individual to offer referrals regarding substance abuse treatment, if appropriate.

Emergency Overdose Treatment Referrals

In addition to providing immunity from prosecution for possession of a controlled substance or drug paraphernalia, an individual seeking assistance at a hospital emergency department for an overdose also can receive assistance in procuring treatment for a substance use disorder. Senate Bill 192 requires that the person be informed of known, local treatment services for substance use disorders. Subject to permission from the individual or the individual's legal representative, the hospital can connect the individual with treatment

by contacting an available program on his or her behalf. Additionally, a local community mental health center may provide on-call services in the hospital emergency department to distribute information on treatment services for substance use disorder and connect an individual who was treated for a drug overdose with those services.

Syringe Exchange Programs and Partial Decriminalization

In addition to an increase in heroin use, Kentucky also has seen an uptick in cases of hepatitis C and HIV. According to the CDC, the commonwealth has the highest rate of reported hepatitis C cases in the country.⁴⁵ In 2013, the most recent year for which data is available, the CDC reports the national average to be 0.7 cases per 100,000 people; comparatively, the rate of reported hepatitis C cases in Kentucky in 2013 was 5.1 cases per 100,000 people.⁴⁶ In response to this alarming trend, SB 192 also authorized local health departments to operate hypodermic needle and syringe exchanges as part of a substance abuse treatment program. To operate an exchange program, the local department of health must receive consent from the local board of health and the legislative body in the city or county where the program will operate. Under the Bill, exchanged items will not be considered drug paraphernalia while located at the program site.

Additionally, SB 192 provides some immunity from prosecution for possession of a controlled substance or drug paraphernalia as they relate to needles and other sharp objects. Prior to searching an individual and his or her premises or vehicle, a peace officer^R can inquire as to the presence of any needles or other sharp objects that could cut or puncture the officer while searching the area. If the subject of the search admits to the presence of such objects prior to the search, charges or prosecution for possession of drug paraphernalia or for possession of trace amounts of a controlled substance on the object will not be incurred. However, this exemption does not extend to any other drug paraphernalia or controlled substances that may be present and discovered during the search.

^R The definition of peace officer varies by state, but generally includes any employee of the state or other public agency with the authority to make arrests.

Following the enactment of SB 192, the Louisville Department of Public Health and Wellness began operating the commonwealth's first needle exchange program in June 2015. The program, which operates six days a week at the health department's downtown headquarters, is funded mostly by the local government.

Although health officials budgeted for 500 participants during the program's first year, the first four months of operations far exceeded expectations:

- » 822 individuals participated in the program, with 325 of those returning at least once;
- » 55 individuals were referred to an on-site certified substance abuse counselor;
- » 103 individuals were voluntarily tested for HIV, with none testing positive; and
- » 36 individuals were voluntarily tested for hepatitis C, with approximately 14.4 testing positive.

In response to the program's success, Louisville health officials are expanding the program to include a satellite needle exchange site at a fire station in southwestern Louisville. The community exchange site began operating one day a week in October 2015.

A second exchange program was approved in Lexington-Fayette County, which began operating in September 2015.

Effectiveness of Substance Abuse Treatment

Contingent on available funding, SB 192 directs the Cabinet for Health and Family Services and the Office of Drug Control Policy to initiate a pilot program to analyze the outcomes and effectiveness of substance abuse treatment services in Kentucky. Data will be analyzed to determine practices that reduce frequency of relapse, provide better outcomes for patients, hold patients accountable, and control health costs related to substance abuse. This analysis is intended to help ensure the commonwealth is addressing appropriate risk and protective factors for substance abuse in a defined population; using approaches that have shown to be effective; intervening early at important stages and transitions; intervening in appropriate settings

and domains; and managing programs effectively. At a minimum, the data will come from the state Department for Medicaid Services, Department of Workers' Claims, and KASPER, the commonwealth's controlled substance electronic monitoring system.

The Cabinet for Health and Family Services and Office of Drug Control Policy must issue a joint report to the Legislative Research Commission and Office of the Governor by December 31, 2016, on the findings of the pilot program. The report is to include recommendations based on those findings for optimizing substance abuse treatment services and recommendations on the continued use of analytics to augment Kentucky's approach to fighting substance abuse in the future.

Expanded Treatment Options

Under SB 192, individuals addicted to heroin and other opioids now will have access to treatment options that previously were not available. Perhaps the most significant change is the authorization of medication-assisted treatment. Prior to the enactment of SB 192, recovery options in the commonwealth typically were limited to 12-step or abstinence-only programs.

Senate Bill 192 requires the state Department of Medicaid Services to provide benefits for a broad array of treatment options for those with heroin and other substance use disorders and to expand the behavioral health network to allow providers to offer services within their licensure category. Medicaid managed care organizations are directed to authorize treatment for each diagnosis related to substance use disorder and co-occurring mental health/substance use disorders and to approve coverage and payment for an appropriate level of continued care. Beginning January 1, 2016, the Department of Medicaid Services will be required to provide an annual report to the Legislative Research Commission detailing the number of substance use disorder treatment providers; types of services offered by each provider; geographic distribution of providers; and a summary of expenditures on substance use disorder treatment provided by Medicaid. Additionally, Kentucky now exempts certain residential substance use disorder treatment programs from its Certificate of Need requirements.

Another treatment option available under SB 192 is a faith-based residential treatment program. Certain offenders charged with a controlled substance felony offense now may be able to utilize a faith-based residential treatment program in lieu of substance use disorder treatment, if the cost of the program is less than the treatment that otherwise would be provided. To participate, the offender must sign a commitment to comply with the terms of the program.

Neonatal Abstinence Syndrome

A particular focus of Senate Bill 192 provides substance abuse treatment for pregnant women. The legislation requires substance abuse treatment and recovery service providers who receive state funds to give priority for accessing those services to pregnant women. Likewise, those providers may not refuse access to appropriate services solely due to a woman's pregnancy.

Under SB 192, a petition may not be filed to terminate the parental rights of a woman solely on the basis of her use of a non-prescribed controlled substance during pregnancy if she enrolls in, and maintains substantial compliance with, a substance abuse treatment or recovery program and a regimen of prenatal care as recommended by her healthcare practitioner throughout the remainder of the pregnancy. After a woman has completed treatment, or six months of substantial program compliance after giving birth, whichever is earlier, the court must seal any records relating to a positive test for a non-prescribed controlled substance. The sealed records may not be used in any future criminal prosecution or petition to terminate parental rights.

Corrections Reinvestment in Substance Abuse Treatment

In 2011, Kentucky adopted a series of criminal justice reforms as part of its justice reinvestment initiative. Among the provisions enacted in the 2011 Public Safety and Offender Accountability Act (House Bill 463), the Department of Corrections is required to measure and document the cost savings resulting from these reforms and reinvest a portion of those savings as directed by statute. Furthermore, in addition to the 25 percent already being distributed to the local corrections

assistance fund, SB 192 of 2015 directs that 50 percent of the savings, up to \$10 million in 2015-2016, be allotted to specific substance abuse programs and resources: evidence-based treatment programs in county or regional jails and local detention centers; additional treatment resources at community mental health centers; addressing neonatal abstinence syndrome through community residential treatment services for pregnant women; traditional treatment programs provided by the Kentucky Agency for Substance Abuse Policy; purchasing an FDA-approved extended-release treatment for medically assisted treatment programs; developing additional individualized alternative sentencing plans; and enhancing the use of rocket docket prosecutions^S in controlled substance cases.

Increased Penalties for Heroin Trafficking

Coupled with the effort to improve access to treatment for substance use disorders, Kentucky also amplified efforts to crackdown on the suppliers of heroin. Senate Bill 192 created a new felony for importing heroin and first-degree aggravated trafficking in a controlled substance. The offense of importing heroin is defined as "knowingly and unlawfully transporting, by any means, any quantity of heroin into the commonwealth with the intent to sell or distribute the drug." Knowingly and unlawfully trafficking 100 or more grams of heroin constitutes the crime of first-degree aggravated trafficking in a controlled substance. An individual convicted of either crime must serve at least 50 percent of the sentence imposed before being eligible for probation, shock probation,^T conditional discharge, or parole.

The Bill also expands the scope and increases the sentence for the existing crime of first-degree trafficking of a controlled substance. First, the Bill adds

^S A rocket docket refers to the speedy disposition of cases and controversies by a court or tribunal, often by strictly adhering to the law pertaining to filing deadlines and other procedural matters.

^T Shock probation is a sentencing strategy under which a judge orders a convicted offender to prison for a short period of time before suspending the remainder of the sentence in favor of probation. The intended outcome is that the initial shock of experiencing prison will provide an effective deterrent from recidivism.

fentanyl^U to the list of controlled substances included in the crime of trafficking. Second, the Bill imposes increased sentencing requirements for trafficking of heroin. When less than 2 grams of heroin is discovered and the offense is committed while possessing more than one item of paraphernalia, then the convicted individual must serve at least 50 percent of the sentence imposed before being released on parole, if the totality of the circumstances indicates that the trafficking was a criminal activity. Likewise, the conviction for all offenses of selling 2 or more grams of heroin, and second or subsequent offenses for less than 2 grams of heroin, requires at least 50 percent of the sentence is served before being eligible for any form of early release. The new “50-percent-served” requirements do not apply for first-degree trafficking of controlled substances other than heroin.

In addition to these crimes, SB 192 provides that any offender convicted of homicide or fetal homicide in which the victim’s death was the result of an overdose of a Schedule I controlled substance, including heroin, must serve at least 50 percent of their sentence prior to being eligible for early release.

Louisiana

Naloxone Access

In 2015, Louisiana enacted House Bill 210 (HB 210) to expand access to opioid antagonists for the treatment of a controlled substance overdose. Under HB 210, a licensed medical practitioner can, directly or by standing order, prescribe or dispense an opioid antagonist without having examined the individual to whom it will be administered if two conditions are met: (1) the drug is prescribed or dispensed for administration through an FDA-approved device and (2) the practitioner provides the individual receiving and administering the drug with all training required by the state Department of Health and Hospitals (DHH). Likewise, a licensed pharmacist may dispense an opioid antagonist pursuant to the direct or standing prescription of a licensed medical

^U Fentanyl is a synthetic opioid typically used for treating pain in cancer patients and extreme chronic pain. Classified as a Schedule II controlled substance, fentanyl is 100 times stronger than morphine and 30 to 40 times stronger than heroin. Fentanyl has begun to surface in heroin mixtures, increasing the potency and risk of overdose for the already deadly drug.

practitioner. A licensed medical practitioner or pharmacist who prescribes or dispenses an opioid antagonist in good faith is immune from civil or criminal liability or professional discipline resulting from the act or omission.

The Bill also extends civil and criminal immunity to an individual who, in good faith, administers an opioid antagonist to a person reasonably believed to be undergoing an opioid-related drug overdose, absent gross negligence or willful and wanton misconduct in administering the drug.

Training

House Bill 210 directs the DHH to establish training requirements for individuals who receive and administer an opioid antagonist to ensure safe and proper administration of the drug. The training, which is to be provided by the prescribing or dispensing practitioner, must, at a minimum, address: (1) techniques on how to recognize an opioid-related overdose; (2) standards and procedures for storage and administration of opioid antagonists; and (3) emergency follow-up procedures, including the requirement to summon emergency services either immediately before or immediately after administering the drug. The Bill also directs the DHH to promulgate a set of best practices for use by licensed medical practitioners in prescribing and dispensing opioid antagonists. These best practices must address many of the same items required in the training for laypersons who receive and administer the drug.

First Responders

Prior to expanding access to opioid antagonists for third-party individuals in 2015, Louisiana enacted a pair of bills in 2014 to expand access to the drug for first responders: House Bill 754 (HB 754), under the Public Health and Safety Title, and Senate Bill 422 (SB 422), under the Criminal Law Title.

Under HB 754, a first responder may receive a prescription for an opioid antagonist, maintain possession of the drug, and administer it to anyone believed to be undergoing an opioid-related drug overdose. The Bill defines “first responder” as a peace officer, firefighter, or an EMS practitioner. Prior to receiving a prescription, the first responder must complete the necessary

training to safely and properly administer the drug. Additionally, a record must be kept of each instance in which the drug was administered. A first responder who administers an opioid antagonist to a person believed to be experiencing an opioid-related drug overdose is immune from civil, criminal, and professional liability or discipline for any outcomes resulting from the administration of the drug, absent gross negligence or willful and wanton misconduct.

House Bill 754 authorizes a law enforcement agency or fire department to enter into a written agreement for affiliation with an ambulance service provider or physician for the purpose of obtaining a supply of an opioid antagonist or to obtain the training necessary to safely and properly administer the drug.

Similarly, SB 422 authorizes first responders to administer an opioid antagonist, without a prescription, upon encountering an individual exhibiting signs of an opiate overdose. Likewise, prior to administration, the first responder must complete the necessary training on safe and proper administration of the drug. A notable deviation from HB 754 is that SB 422 defines “first responder” as a law enforcement official, emergency medical technician, firefighter, or medical personnel at secondary schools and institutions of higher education. Additionally, there is no explicit requirement to maintain records of administering the drug. Furthermore, SB 422 provides immunity only from civil liability to a first responder who administers an opioid antagonist in a manner consistent with addressing opiate overdose. This immunity extends to civil damages that result from any act or omission in rendering care, or as a result of any act or failure to act to provide or arrange for further medical treatment or care for the person involved in the emergency, absent gross negligence or willful and wanton misconduct.

Under both 2014 bills, the training for first responders must, at a minimum, cover techniques on how to recognize symptoms of an opioid-related overdose; standards and procedures for the storage and administration of an opioid antagonist; and emergency follow-up procedures. Additionally, the state Department of

Public Safety and Corrections is directed to develop and promulgate a set of best practices for use by a fire department or law enforcement agency. Those best practices should include, but are not limited to, training necessary to safely and properly administer an opioid antagonist; standards and procedures for storage and administration of the drug; and emergency follow-up procedures.

Good Samaritan Immunity

Senate Bill 422 also provides immunity from prosecution or penalty for possession of a controlled substance under certain circumstances. A person who experiences a drug-related overdose and is in need of medical assistance shall not be charged, prosecuted, or penalized for possession of a controlled substance if the evidence was obtained as a result of the overdose and need for medical assistance. Likewise, a third party who, in good faith, seeks medical assistance for another individual experiencing an overdose is immune from prosecution or penalization for possession of a controlled dangerous substance if the evidence is obtained as a result of seeking the medical assistance. A notable exception in Louisiana’s Good Samaritan law is that third-party immunity does not apply if the person illegally provided or administered a controlled substance to the individual needing medical assistance.

Increased Penalties for Heroin Distribution

In 2014, Senate Bill 87 was enacted to increase the minimum sentence for distribution or possession with intent to distribute Schedule I narcotic drugs from five to 10 years. Similarly, the state also increased the minimum number of years that must be served prior to being eligible for probation or a suspended sentence from five to 10 years. No changes were made to the maximum sentence of imprisonment, which remained 50 years, and the maximum fine, \$50,000. At the same time, the state established stiffer penalties if the Schedule I narcotic is heroin or a mixture or substance containing a detectable amount of heroin or its analogues. The penalties for conviction of a first offense for distribution or possession with intent to distribute remained the same, but for second or subsequent heroin-related offenses, the maximum sentence was increased from 50 years to 99 years.

Mississippi

Naloxone Access

In 2015, Mississippi enacted House Bill 692 (HB 692), known as the Emergency Response and Overdose Prevention Act. Under the Act, a licensed practitioner may, in good faith and in compliance with the applicable standard of care, prescribe, directly or by standing order, an opioid antagonist to a person at risk of experiencing an opioid-related overdose. The practitioner also may issue a prescription to a registered pain management clinic, family member, friend, or other person in a position to assist the at-risk individual. Pursuant to a prescription, a pharmacist, acting in good faith and in compliance with the applicable standard of care, may dispense opioid antagonists.

Following the receipt of a prescribed opioid antagonist, an individual, acting in good faith and with reasonable care, may administer the drug to a person believed to be experiencing an opioid-related overdose. Additionally, HB 692 authorizes emergency medical technicians, acting in good faith, to administer opioid antagonists as clinically indicated.

A prescribing practitioner, dispensing pharmacist, administering EMT, or third-party administrator, acting in accordance with these provisions, is immune from any civil or criminal liability, or any professional sanctions, where applicable.

Good Samaritan Immunity

House Bill 692 also enacted the Mississippi Medical Emergency Good Samaritan Act. The Act provides immunity from arrest and prosecution for a drug violation to any person who, in good faith, seeks medical assistance for someone experiencing a drug overdose if there is evidence that the person is under the influence or in possession of a controlled substance. This immunity also extends to the individual for whom the third party sought medical assistance or for an individual who, in good faith, is seeking medical assistance. The term “seeking medical assistance” is defined by the Act as contacting or assisting in contacting 911, law enforcement, or poison control, or providing care to a person experiencing or believed to be experiencing a drug overdose while awaiting the arrival of medical

assistance to aid the person. Under this immunity, an individual also cannot be subject to penalties for violation of a protective or restraining order, sanctions for violations of pretrial release, probation, or parole conditions based on a drug violation, or certain property forfeiture for a drug violation. In the SLC region, Mississippi is the only state that extends this Good Samaritan immunity to civil forfeiture. The immunity does not limit admissibility of evidence in connection with the investigation or prosecution of a crime for a defendant who does not qualify for the immunity or for other crimes committed by a qualified person; limit the seizure of evidence or contraband otherwise permitted by law; or abridge the authority of law enforcement to detain or take into custody a person in the course of an investigation or to effectuate an arrest for any other offense. Unlike other SLC states, Mississippi law does not state that the immunity applies only if the evidence is the result of seeking medical assistance.

Missouri

Of the 15 SLC member states, Missouri is the only state that has not yet enacted provisions to authorize naloxone access for laypersons; however, in 2015, legislation was under consideration that would have allowed this access.

First Responders

In 2014, Missouri enacted House Bill 2040, which authorizes qualified first responders to obtain and administer naloxone to a person suffering from an apparent narcotic or opiate-related overdose. A “qualified first responder” includes state and local law enforcement agencies, fire department or district personnel, and licensed emergency medical technicians with a licensed ambulance service. Qualified first responders must receive training on recognition of, and responding to, an overdose, as well as administration of naloxone to an overdose victim.

The Bill authorizes any licensed drug distributor or pharmacy in the state to sell naloxone to qualified first responder agencies, allowing the agency to have a stock of the drug for administration.

In 2015, House Bill 538, which passed the House but did not receive a vote in the Senate, would have allowed

anyone age 18 or older to obtain naloxone from a licensed pharmacist or pharmacy technician. The Bill also would have provided civil, criminal, and professional immunity to dispensers and administrators of opioid antagonists.

Good Samaritan Immunity

Missouri has not enacted laws to provide immunity to Good Samaritans or overdose victims who seek emergency medical assistance during a drug overdose.

North Carolina

In 2013, North Carolina became the first Southern state to adopt laws authorizing expanded access to opioid antagonists for opiate-related overdoses and limited immunity for Good Samaritans, with the enactment of Senate Bill 20 (SB 20). In the same year, the state also enacted a partial syringe decriminalization law. In 2015, North Carolina refined those laws and expanded the scope of its response to the heroin epidemic in Senate Bill 154 (SB 154).

Naloxone Access

In 2013, SB 20 authorized practitioners, acting in good faith and exercising reasonable care, to prescribe, directly or by standing order, an opioid antagonist to a person at risk of experiencing a drug-related overdose or to a family member, friend, or other person in a position to assist an at-risk individual.⁴⁷ As an indicator of good faith, the practitioner can require a written statement supporting the conclusion that the person receiving a prescription is indeed at-risk or in a position to assist an at-risk individual. Under the law, a person who receives a prescription can administer the drug, using reasonable care, to another person based on a good faith belief that the individual is experiencing a drug-related overdose. Evidence of using reasonable care includes the receipt of basic instruction and information on how to administer the opioid antagonist. Under SB 20, which remains current law, prescribing practitioners and third-party administrators of an opioid antagonist are immune from civil or criminal liability for these authorized actions.

In 2015, SB 154 amended the state's naloxone access statute to authorize pharmacists to dispense an opioid antagonist pursuant to a valid prescription. The Bill

also extends immunity from civil and criminal liability to dispensing pharmacists.

In Fiscal Year 2015-2016, North Carolina appropriated \$50,000 for use by law enforcement agencies and the North Carolina Harm Reduction Coalition to purchase naloxone.⁴⁸

Good Samaritan Immunity

Although North Carolina established limited immunity for Good Samaritans and overdose victims in 2013, SB 154 amended those provisions to clarify the scope of protection. Under the new law, which became effective August 1, 2015, an individual who seeks medical assistance for a person experiencing a drug-related overdose has limited immunity from prosecution for misdemeanor possession of a controlled substance, felony possession of cocaine or heroin, and violation possession of drug paraphernalia. For immunity to apply, all of the following conditions must be met: (1) the person sought medical assistance for an individual experiencing a drug-related overdose by contacting 911, a law enforcement officer, or emergency medical services personnel; (2) the person acted in good faith when seeking medical assistance and reasonably believed that he or she was the first to call for assistance; (3) the person provided his or her own name to 911 or law enforcement upon arrival; (4) the medical assistance was not sought during the execution of an arrest warrant, search warrant, or other lawful search; and (5) evidence for prosecution of the offense was obtained as a result of the person seeking medical assistance. The immunity also extends to the individual for whom medical assistance was sought. Additionally, the immunity protects both parties from arrest or revocation for violating conditions of pretrial release, probation, parole, or post-release.

A law enforcement officer who, acting in good faith, arrests or charges a person immune under these Good Samaritan provisions is not subject to civil liability for the arrest or filing of charges.

Partial Syringe Decriminalization and Disposal

In 2013, North Carolina enacted provisions that partially decriminalized the possession of hypodermic needles. Under the law, prior to searching a person or

his or her premises or vehicle, an officer can inquire about the possession or presence of a hypodermic needle or other sharp objects that could cut or puncture the officer during the course of the search. If the individual alerts the officer of the presence of a hypodermic needle or other sharp object prior to the search, then the individual may not be charged or prosecuted for possession of drug paraphernalia for those objects. In 2015, North Carolina enacted House Bill 712, which expands this immunity by also including prosecution for residual amounts of a controlled substance contained in the needle or sharp object.

House Bill 712 also established a pilot program for disposing of used needles and hypodermic syringes. The one-year pilot program, in consultation with and collaboration between the State Bureau of Investigation and the North Carolina Harm Reduction Coalition, will begin in two counties to provide biohazard disposal receptacles for used hypodermic needles and syringes. The program also will provide limited immunity for participants from possession of drug paraphernalia and residual amounts of a controlled substance in the disposed needle or syringe. The State Bureau of Investigation must report to the appropriate legislative oversight committees on the results of the pilot program after one year. If the program is deemed to have been successful, then it may continue in the original counties for another year and expand to two additional counties, for a total of four.

Oklahoma

Naloxone Access

With the enactment of House Bill 1782 (HB 1782) in 2013, Oklahoma became the first SLC member state to authorize access to opioid antagonists for individuals at risk of experiencing an overdose. Under the law, a first responder can administer the drug when encountering an individual exhibiting signs of an overdose. The first responder, which includes law enforcement officials, EMTs, firefighters, and medical personnel at secondary schools and institutions of higher education, is not required to have a prescription to administer the drug, and is covered by the state's general Good Samaritan Act.⁴⁹ The same legislation also authorizes a provider, upon request, to prescribe an opioid antagonist to an individual for use when encountering

a family member exhibiting signs of an opiate overdose. Information on how to identify the symptoms of an overdose, instructions on basic resuscitation techniques, instructions for proper naloxone administration, and the importance of calling 911 for help also must be provided with the prescription. Additional provisions of HB 1782 specify that the administering family member is covered under the state's general Good Samaritan Act.

In 2014, Oklahoma continued to expand access to naloxone with House Bill 2666 by allowing the drug to be dispensed or sold by a pharmacy without a prescription under the supervision of a licensed pharmacist.

In 2014, legislation (Senate Bill 433) was under consideration to provide limited liability against civil damages arising as a result of administering an opioid antagonist, in good faith, based on a reasonable belief or actual knowledge that the victim is experiencing an opioid drug overdose. A version of the Bill passed the Senate but did not receive a vote in the House.

Good Samaritan Immunity

Although legislation has been introduced in recent years,⁵⁰ Oklahoma has not enacted Good Samaritan laws specifically related to the administration of an opioid antagonist or immunity from prosecution related to seeking medical assistance for oneself or another person experiencing an opioid overdose.

South Carolina

Naloxone Access

In 2015, South Carolina enacted House Bill 3083 (HB 3083), known as the South Carolina Overdose Prevention Act. Under the Act, a prescriber, acting in good faith and exercising reasonable care, may issue a written prescription for an opioid antidote to a person at risk of experiencing an opioid-related overdose or a caregiver^v for that person. The prescriber also must provide the person or caregiver with overdose information that addresses: (1) opioid overdose prevention

^v "Caregiver" is defined as a person who is not at risk of an overdose but who, in the judgment of a physician, may be in a position to assist another individual during an overdose, and who has received the required patient overdose information on the indications for and administration of the opioid antidote.

and recognition; (2) opioid antidote dosage and administration; (3) the importance of calling 911 for medical assistance with an opioid overdose; and (4) care for an overdose victim after administration of the antidote. The prescriber must document in the medical record that this information has been provided. The Act also authorizes a prescriber, acting in good faith and exercising reasonable care, to issue a standing order for a first responder to possess an opioid antidote. A pharmacist, acting in good faith and exercising reasonable care, may dispense an opioid antidote pursuant to a prescriber's written prescription or standing order. Neither the prescriber nor pharmacist who prescribes or dispenses an opioid antidote according to these provisions will be subject to civil or criminal liability or professional discipline as a result of an act or omission.

Likewise, in an emergency, a caregiver who has received the requisite opioid overdose information may administer an opioid antidote to a person they believe, in good faith, is experiencing an opioid overdose. If administered in accordance with these provisions, the caregiver will not be subject to civil or criminal liability.

First Responders

House Bill 3083 also expands first responder access to naloxone and other similar drugs approved by the FDA for treatment of an opioid overdose. The Act defines "first responder" as an emergency medical services provider, law enforcement officer, or a fire department worker directly engaged in examining, treating, or directing persons during an emergency. Under HB 3083, a first responder must comply with all applicable requirements for possession, administration, and disposal of an opioid antidote and administration device and may administer the antidote in an emergency if the first responder believes, in good faith, that the person is experiencing an opioid overdose. If acting in accordance with these provisions, the first responder will not be subject to civil or criminal liability or professional discipline as a result of an act or omission. In addition to authorizing first responders to obtain an opioid antidote, the Act authorizes the state Department of Health and Environmental Control to promulgate regulations to implement these provisions, including appropriate training for first responders who carry or have access to an opioid antidote.

Good Samaritan Immunity

Although legislation has been introduced in recent years,⁵¹ South Carolina currently does not have a statute that provides immunity from prosecution to those seeking medical assistance for themselves or for another person experiencing an opioid overdose.

Tennessee

Naloxone Access

In 2014, Tennessee enacted Senate Bill 1631 (SB 1631) to expand access to opioid antagonists. In good faith and exercising reasonable care, a licensed healthcare practitioner is authorized, under the law, to prescribe an opioid antagonist, either directly or by standing order. The prescription can be issued to someone at risk of experiencing an opiate-related overdose or to a family member, friend, or other person in a position to assist the at-risk individual. To establish good faith, the prescribing healthcare practitioner can require a written communication from the recipient that provides a factual basis for concluding that the individual is at risk or is in a position to assist the at-risk individual.

An individual who receives a prescription for an opioid antagonist can administer the drug, using reasonable care, to another person believed to be experiencing an opioid-related drug overdose. Evidence showing the use of reasonable care in administering the drug includes the receipt of basic instruction and information on how to administer the opioid antagonist, including successful completion of the state's online overdose prevention education program.

Absent gross negligence or willful misconduct, the licensed healthcare practitioner who prescribes or dispenses an opioid antagonist and any person who administers the drug are immune from civil liability for these actions. Likewise, a licensed healthcare practitioner who prescribes, dispenses, or administers an opioid antagonist is immune from disciplinary or adverse administrative actions.

Training

Under SB 1631, the commissioner of the Tennessee Department of Health (TDOH) is directed to create and maintain an online education program to educate laypersons and the general public on the appro-

appropriate techniques and administration of opioid antagonists and follow-up procedures for dealing with an opioid-related drug overdose.

First Responders

In 2015, Tennessee enacted Senate Bill 871 (SB 871), known as the Addiction Treatment Act, which directs the TDOH commissioner to provide training recommendations for first responders on the appropriate use of opioid antagonists, including provisions concerning the appropriate supply of the drug for administration by first responders.

Good Samaritan Immunity

Under the Act, anyone who, in good faith, seeks medical assistance for an individual believed to be experiencing a drug overdose shall not be arrested, charged, or prosecuted for a drug violation based on evidence that is the result of seeking medical assistance. This immunity also extends to the overdose victim if he or she makes the call for help or is the subject of another's call. The immunity also prohibits protected individuals from being subject to penalties for violation of a permanent or temporary protective order or restraining order or sanctions for violation of conditions of pretrial release, probation, or parole based on a drug violation. Evidence of first aid or other medical assistance provided to someone experiencing a drug overdose can be used as a mitigating factor in a criminal prosecution for which immunity is not provided.

These immunity provisions do not limit the admissibility of any evidence in connection with the investigation or criminal prosecution of a defendant who does not qualify for immunity or other crimes committed by an immune individual. Likewise, they do not prohibit the seizure and admissibility of protected evidence in other criminal proceedings nor the detention of an immune individual in relation to another investigation or offense.

Partial Syringe Decriminalization

In 2015, Tennessee also enacted Senate Bill 924 to provide partial immunity for the possession of drug paraphernalia. Under the Bill, prior to searching a person or person's premises or vehicle, an officer can inquire about the possession or presence of a hypodermic

needle or other sharp object that could cut or puncture the officer during the course of the search. If the individual alerts the officer of the presence of a qualifying object prior to the search, then the individual may not be charged or prosecuted for possession of drug paraphernalia for the needle or sharp object. Unlike the other SLC states with similar provisions, Tennessee does not extend this immunity to residual or trace amounts of a controlled substance on the needle or other sharp object.

Medication-Assisted Treatment

Under the Addiction Treatment Act, Tennessee placed limits on the authorized use of buprenorphine for treatment of opioid addiction as part of a medication-assisted treatment program.^w The drug only can be prescribed by certain licensed healthcare providers; however, healthcare providers who otherwise are permitted to prescribe Schedule II or Schedule III drugs can participate in the assessment and management of the patients. Prescribers who treat a patient with a daily dose of 16 milligrams^x for more than 30 consecutive days are required to document the reasons for prescribing a higher dosage in the patient's medical record. In the event that an opioid-dependent patient requires more than 20 milligrams of buprenorphine for more than 30 consecutive days of treatment, a licensed addiction specialist must be used for management of the patient's treatment plan. The Board of Medical Examiners and Board of Osteopathic Examination are directed under the Act to establish qualification requirements for licensed addiction specialists.

Texas

Naloxone Access

In 2015, Texas enacted Senate Bill 1462 (SB 1462) to expand access to opioid antagonists for the treatment of opioid-related overdoses. Under SB 1462, a prescriber may prescribe, directly or by standing order, an opioid antagonist to a person at risk of an opioid-related

^w Consistent with FDA recommendations, buprenorphine mono, also known as buprenorphine without naloxone, may be used as an alternative, but only for treatment of patients who are pregnant, nursing, or have a history of an adverse reaction or hypersensitivity to naloxone.

^x 16 milligrams is the standard buprenorphine dosage when used as part of a medication-assisted treatment program.

overdose, or to a family member, friend, or other person in a position to assist the at-risk individual. Any prescription written under these provisions is considered to be issued for a legitimate medical purpose. Under a valid prescription, a pharmacist is authorized to dispense an opioid antagonist. A prescriber or pharmacist who, acting in good faith and with reasonable care, prescribes or dispenses an opioid antagonist, or chooses not to do so, is immune from any civil or criminal liability or professional discipline.

The Bill also provides that any person can possess an opioid antagonist, regardless of whether he or she holds a prescription for the drug. Additionally, an individual, acting in good faith and with reasonable care, who administers or does not administer an opioid antagonist to someone believed to be suffering an opioid-related overdose will not be subject to criminal or civil liability or professional sanctions for any act or omission resulting from the administration or failure to administer.

The Bill also authorizes emergency service personnel to administer an opioid antagonist, as clinically indicated.

Good Samaritan Immunity

In 2015, the Legislature passed House Bill 225 (HB 225) to provide some protection to individuals who seek emergency medical assistance in response to a possible overdose. Unlike Good Samaritan legislation in most states, HB 225 only would have provided a defense to prosecution to the individual, rather than immunity from prosecution. However, the Bill subsequently was vetoed due to the governor's assessment that it did "not include adequate provisions to prevent its misuse by habitual drug abusers and drug dealers."⁵² House Bill 225 also included naloxone access provisions identical to those enacted in SB 1462Y and, in addition, authorized the state Health and Human Services Commission to issue grants for drug overdose prevention and education, and opioid antagonist prescription or distribution projects.

^Y The veto for House Bill 225 was issued on June 1, 2015, while Senate Bill 1462 was signed by the governor on June 18, 2015.

Virginia

Governor's Task Force on Prescription Drug and Heroin Abuse

In September 2014, Governor McAuliffe established the Governor's Task Force on Prescription Drug and Heroin Abuse to make recommendations for short-term and long-term measures to tackle addiction and abuse of prescription drugs and heroin, using best practices and evidence-based strategies. Focusing on five key areas, the overall goal of the Task Force was to seek measures that would reduce deaths from prescription drug and heroin abuse within five years. Task Force recommendations, which were to include metrics for tracking progress, were aligned with the following five areas: (1) education; (2) treatment; (3) data and monitoring; (4) drug storage and disposal; and (5) enforcement. A final implementation plan was issued by the Task Force on June 30, 2015, with 51 recommendations across the five key areas.⁵³

Naloxone Access

In 2013, Virginia enacted legislation that, for the first time, provided laypersons access to naloxone. Under House Bill 1672, the state Department of Behavioral Health and Developmental Services led a pilot project in the Richmond metropolitan region and the rural southwestern region of the commonwealth that allowed practitioners to provide a naloxone prescription to a family member or friend for use during an opiate overdose. Pilot participants were allowed to possess and administer naloxone to counteract the effects of an overdose and were not liable for civil damages resulting from a good faith administration of the drug. Results and recommendations from the pilot program, which the Department named REVIVE!, were provided to the General Assembly in December 2014. Recommendations from the program were to expand naloxone access statewide, provide criminal immunity to laypersons who contact law enforcement after administering the drug, and provide additional funding for naloxone and the REVIVE! program to enable statewide implementation.⁵⁴

Following recommendations of the Task Force, the General Assembly enacted House Bill 1458 (HB 1458) during the 2015 session. The Bill allows a pharmacist to dispense an opioid antagonist pursuant to an oral, written, or standing order from a prescriber in accordance with protocols developed by the commonwealth's Board of Pharmacy. Echoing recommendations of the pilot project, HB 1458 expands access to naloxone to individuals statewide. An individual who receives naloxone or other opioid antagonist can possess and administer the drug to someone believed to be experiencing or about to experience a life-threatening opiate overdose. Additionally, HB 1458 provides immunity from civil damages to anyone who, in good faith, prescribes, dispenses, or administers naloxone.

Under HB 1458, law enforcement officers and firefighters also are authorized to possess and administer opioid antagonists, after the completion of a training program.

Good Samaritan Defense

In 2015, Virginia also enacted Senate Bill 892 to encourage the safe reporting of an overdose. Under the Bill, an individual who, in good faith, seeks or obtains emergency medical assistance in the event of an overdose may have an affirmative defense to prosecution for possession of a controlled substance or possession of controlled paraphernalia. The affirmative defense applies only if the individual reports the overdose to a firefighter, emergency medical services personnel, law enforcement officer, or emergency 911 system; remains at the location with the overdose victim until a law enforcement officer responds to the report or cooperates with law enforcement if an officer does not respond; if requested, substantially cooperates in any investigation of any other criminal offense reasonably related to the controlled substance that resulted in the overdose; and if the evidence for the offense was obtained as a result of seeking or obtaining emergency medical attention. Notably, Virginia law provides an affirmative defense to prosecution rather than immunity from arrest, charge, or prosecution similar to most Good Samaritan laws.

West Virginia

Recent reports indicate that West Virginia has the highest rate of drug overdose deaths in the country, a number the state has seen increase by more than 600 percent since 1999.⁵⁵ In an effort to address this problem, lawmakers enacted a series of bills in 2015 to expand access to opioid antagonists, encourage reporting of a drug overdose, and provide addiction treatment to offenders in the criminal justice system. In conjunction with the Legislature, these most recent actions are a continuation of Governor Tomblin's efforts to reform the state's criminal justice system and address a prescription opioid epidemic.

Naloxone Access

In 2015, West Virginia enacted Senate Bill 335 (SB 335), known as the Access to Opioid Antagonists Act, to expand access to opioid antagonists by allowing licensed healthcare providers to give a prescription for the drug to persons at risk of experiencing an opiate-related overdose. A prescription also may be given to a relative, friend, or caregiver in a position to assist an at-risk individual. Notably, West Virginia does not specify that this prescription may be by standing order. Under the Act, the prescribing healthcare provider also is required to provide any person or entity receiving the prescription with educational materials related to overdose prevention, treatment programs, and the administration of the prescribed opioid antagonist.

The licensed healthcare provider, acting in good faith, who prescribes an opioid antagonist or dispenses and distributes the drug under a prescription, will not be subject to civil or criminal penalties, absent gross negligence or willful misconduct. A proper prescription for an opioid antagonist is presumed to be issued for a legitimate medical purpose in the usual course of professional practice unless a preponderance of the evidence indicates otherwise.

The Act also provides civil and criminal immunity to an individual who possesses an opioid antagonist and, in good faith, administers or fails to administer the drug to a person believed to be suffering from an opioid-related overdose. To avoid further overdose-related complications, anyone who administers an opioid antagonist is required, subsequently,

to seek additional medical treatment for the person to whom the drug was administered. This immunity does not extend to liability or prosecution resulting from gross negligence or willful misconduct.

First Responders

A licensed healthcare provider also may prescribe an opioid antagonist, directly or by standing order, to a first responder;^z however, the first responder must successfully complete the requisite training to possess and administer the drug. Under SB 335, a trained first responder must consult with an emergency medical service officer in charge before administering an opioid antagonist unless uncontrollable circumstances prevent the first responder from doing so, or if there is not enough time for a consultation based on conditions of the emergency. A trained first responder who, in good faith, administers an opioid antagonist according to the medical consultation provisions will not be subject to civil or criminal penalties related to the administration of the drug. This immunity does not extend to liability or prosecution resulting from gross negligence or willful misconduct.

The Act directs the state Office of Emergency Medical Services to establish standards for initial responder certification, approval of opioid overdose prevention and treatment programs, and protocols for refusal to transport.

Education and Training

In addition to existing continuing education requirements for drug diversion training and training on best practices for prescribing controlled substances, SB 335 also requires certain licensed medical professionals who prescribe, administer, or dispense a controlled substance to complete training on prescribing and administering an opioid antagonist. Individuals licensed to practice medicine and surgery, podiatry, dentistry, optometry, osteopathy, registered professional nursing, and each person licensed as a pharmacist, advanced nurse practitioner, licensed practical nurse, or physician assistant must complete these continuing education requirements within one year of receiving an initial license or certification or as a prerequisite for renewal if held for longer than a year. The require-

^z West Virginia refers to first responders as initial responders.

ments can be waived for license renewal if the medical professional submits a certification to the appropriate licensing board attesting that he or she has not prescribed, administered, or dispensed a controlled substance during the entire applicable reporting period.

Annual Reporting for Opioid Antagonists

The state Office of Emergency Medical Services is required to collect data on each administration of an opioid antagonist by a first responder and report annually on: the number of training programs operating in an Office-designated training center; the number of individuals who received training to administer an opioid antagonist; the number of individuals to whom an initial responder administered an opioid antagonist; the number of individuals who received the drug and were revived or not revived; and the cause of death for those to whom an initial responder administered an opioid antagonist but was not revived.

Each licensed healthcare provider is required to submit data to the state Board of Pharmacy on an annual basis regarding the number of opioid prescriptions written in the preceding calendar year. When reporting the data, the provider must indicate whether the prescription was written to an initial responder; an individual at risk of experiencing an opiate-related overdose; a relative, friend, or caregiver of an at-risk individual; or a person in a position to assist an at-risk individual. The data is to be compiled and reported annually by the Board to the Legislative Oversight Commission on Health and Human Resources Accountability and the state Bureau for Behavioral Health and Health Facilities.

Good Samaritan Immunity

In 2015, West Virginia enacted Senate Bill 523 (SB 523), the Alcohol and Drug Overdose Prevention and Clemency Act, to “encourage citizens to intervene in drug...overdose situations by seeking potentially life-saving emergency medical assistance for others without fear of being subject to certain criminal penalties.” Under the Act, an individual who, in good faith and in a timely manner, seeks emergency medical assistance for a person who reasonably appears to be experiencing an overdose may be immune from criminal liability for knowingly or intentionally possessing

a controlled substance or imitation controlled substance without a prescription. Under this immunity, an individual also is not subject to any sanction for a violation of a condition of pretrial release, probation, furlough, or parole. To be eligible for immunity, the individual must remain with the overdose victim until the emergency medical assistance is provided; identify him or herself, if requested by emergency medical assistance personnel or law enforcement; and cooperate with and provide any relevant information requested that is needed to treat the victim. During the sentencing phase of a criminal proceeding that was instituted based on conduct or evidence obtained as a result of seeking emergency medical assistance for another person, evidence of this act can be considered as a mitigating factor when immunity is not granted. Immunity from criminal prosecution does not preclude any civil claims that may be asserted.

Unique to West Virginia's Good Samaritan law, the immunity does not automatically extend to the person for whom emergency medical assistance was sought. To be eligible for criminal immunity, the person must participate in, comply with, and complete a court-approved substance abuse treatment or recovery program. However, SB 523 also provides several alternative sentencing and clemency options that the court may consider, including, but not limited to, deferred prosecution; pretrial diversion; drug court adjudication; weekend jail program; work program; or community service program.

Absent willful, wanton, or reckless misconduct, law enforcement personnel are immune from civil liability for citing or arresting a person who is later determined to qualify for Good Samaritan immunity.

Syringe Exchanges

In 2015, the state Department of Health and Human Resources (DHHR) began offering grants for implementation and technical assistance to local governments for one-year needle exchange pilot programs. On September 1, 2015, the Cabell-Huntington Health Department began operating the state's first program.⁵⁶ In addition to collecting and exchanging used syringes, the program also provides harm-reduction services, including testing for hepatitis or HIV, providing vaccinations for

hepatitis B, and connecting individuals with treatment counselors and services. Following successful implementation of the Cabell-Huntington program, other programs also have been approved in Wheeling-Ohio County and in the capital city of Charleston.^{57, 58}

Addiction Treatment Pilot Program

Under House Bill 2880 (2015), the DHHR will conduct a pilot program to provide addiction treatment, including medication-assisted treatment,^{AA} to selected opioid-dependent offenders in the criminal justice system. The DHHR is authorized to invite the Supreme Court of Appeals of West Virginia and the state Division of Corrections to participate in the pilot.^{AB}

If the Court's Adult Drug Court Program takes part in the pilot, then individual drug court participants who have been clinically assessed and diagnosed with opioid addiction may be selected to enroll in the pilot program. Likewise, if the Division of Corrections takes part in the pilot, then the Division will select high-risk individuals, as determined by the Level of Service/Case Management Inventory assessment, within its custody to participate in the pilot. Individuals selected to participate in the pilot by the Court or the Division of Corrections must be eligible for Medicaid, or for a state, federal, or private grant, or other funding sources that will provide for the full payment of the treatment necessary to participate in the pilot.

After enrolling in the pilot program, participants must comply with all program requirements, including: (1) receiving treatment based on an integrated service delivery model with coordination of care by a prescriber and addiction services providers; (2) submit-

^{AA} A drug may be used for medication-assisted treatment as part of the pilot program only if it has been approved by the FDA for use in the prevention of relapse to opioid dependence and in conjunction with psychosocial support appropriate to a patient's needs.

^{AB} The version of HB 2880 originally passed by the West Virginia Legislature directed the Supreme Court of Appeals to conduct the pilot program. Citing constitutional concerns about the mandate delegating executive powers to the judicial branch, Governor Tomblin vetoed the original version. To address the governor's veto objections, HB 2880 was amended to provide that the pilot program would be conducted by the state Department of Health and Human Resources, with the Court as a possible participant.

ting to professional, comprehensive substance abuse and mental health diagnostic assessments to determine whether substance abuse treatment and monitoring would be beneficial; (3) receiving the necessary treatments, based on such assessments, from the treatment provider; (4) submitting individualized goals and objectives to the treatment provider; (5) receiving non-narcotic, long-acting antagonistic therapy included in the pilot program's medication-assisted treatment; and (6) participating in other types of therapies, including psychosocial therapies, for both substance abuse and any other co-occurring disorders. The Court will approve treatment providers consistent with its own policies and procedures to provide the aforementioned services for pilot program participants.

By July 1, 2017, using 12 months of data, the DHHR is to report on the total number of participants, number of participants successfully completing the program; offenses for which program participants have been convicted or committed; recidivism rates of participants; potential cost savings or expenditures; a statistical analysis determining the program's effectiveness; and any other pertinent information.

RECENT FEDERAL ACTIONS

Syringe Exchanges

In 1988, the federal government initiated a ban on the use of federal funds to support syringe exchange programs. Although the ban was lifted temporarily in 2009, it was reinstated as part of Congressional budget negotiations in 2011 and remains in effect today.⁵⁹

Heroin Response Strategy

In August 2015, the White House Office of National Drug Control Policy (ONDCP) announced \$13.4 million in funding for High Intensity Drug Trafficking Areas (HIDTA), \$5 million of which is directed toward a range of efforts to reduce the trafficking, distribution, and use of heroin. Notably, ONDCP announced a new \$2.5 million initiative called the Heroin Response Strategy.⁶⁰ The goal of the Strategy is to improve communications between public health and public safety officials to facilitate overdose prevention. Five regional HIDTAs across 15 states in the epicenter of the heroin epidemic, including the SLC states of Kentucky, Tennessee, Virginia, and West Virginia, will receive

a portion of the funds. Public health coordinators at each HIDTA will share information on overdose trends in the area, while public safety coordinators will keep public health officials abreast of heroin making its way around the region. Using this real-time information, law enforcement can better prepare for a potential influx of overdose incidences and naloxone can be directed to these more active areas. A portion of the funds also will be used to educate local law enforcement and other first responders, particularly those in rural areas, on responding to a heroin or prescription opioid incident and how to administer naloxone.

Prescription Opioid Training and Increasing Access to Treatment

During an October 2015 visit to West Virginia, President Barack Obama announced two additional actions the White House would be undertaking to address prescription drug and heroin abuse.⁶¹ To curtail the over-prescription of opioid medications, which have been shown as the starting point for many new heroin users, federal executive departments and agencies will be required to provide training on, at a minimum, "best practices on the appropriate and effective prescribing of pain medication, principles of pain management, misuse potential of controlled substances, identification of potential substance use disorders, and referral for further evaluation and treatment, and proper methods for disposing of controlled substances."⁶² An initial training and refresher course every three years will be required for federal healthcare professionals who prescribe controlled substances, as well as federal contractors, clinical residents, and clinical trainees. The second priority for addressing prescription drug abuse and heroin use is to improve access to medication-assisted treatment and to modernize benefit design. To accomplish this goal, federal agencies that provide or reimburse healthcare services or facilitate access to health benefits are directed to review relevant policies, tools, and strategies to identify barriers to accessing medication-assisted treatment and develop an action plan based on those findings.

In keeping with the commitment to expanding the availability of medication-assisted treatment, the U.S. Department of Health and Human Services announced that one of its regulatory priorities for the current fis-

cal year is to improve access to buprenorphine for the treatment of opioid addiction. The Department hopes to ease restrictions to allow more physicians to prescribe the medication.⁶³

Drug Courts

Among the most important requirements for participating in a drug court program is that individuals remain drug-free. However, in many cases, no exception has been allowed for those drugs used in medication-assisted treatment. A 2010 survey of 103 drug courts found that 98 percent of the courts reported having some participants who were opioid dependent. Conversely, among the same courts, 50 percent reported that under no circumstances was medication-assisted treatment available to opioid-dependent participants, while only 56 percent offered any form of medication-assisted treatment to any of its participants.⁶⁴

Recognizing the evidence and success supporting medication-assisted treatment, the ONDCP announced in February 2015 that any drug court receiving federal money no longer would be able to ban opiate addicts from using medication-assisted treatments.⁶⁵

CONCLUSION

The legislative response by SLC policymakers to both the prescription opioid and heroin epidemics is a positive step toward an effective drug abuse strategy. While the six components examined represent building blocks, a comprehensive strategy extends beyond these and requires collaboration and vigilance. Additional policy options, all of which currently exist in some fashion in varying states across the nation, include providing over-the-counter access to naloxone, as other states have done; fully decriminalizing hypodermic needles and syringes by amending the definition of “drug paraphernalia;” implementing education and early intervention strategies; adding fentanyl to controlled substance crimes; and implementing and enforcing insurance policies that provide adequate coverage and opportunities for substance use disorder treatment.

High Intensity Drug Trafficking Areas

High Intensity Drug Trafficking Areas (HIDTA) is a federal program that provides assistance to federal, state, local, and tribal law enforcement operating in critical drug trafficking regions of the country. The 28 HIDTAs across 48 states, Puerto Rico, U.S. Virgin Islands, and the District of Columbia work to reduce drug trafficking and production by facilitating law enforcement cooperation, enhancing shared intelligence, and supporting coordinated strategies.

While these policies provide options for the at-risk individual, it also is important to consider the impacts heroin and other opioid addictions have on families and communities. The impact of substance use disorders can have consequences that persist even after a user achieves sobriety. Policies that go beyond public health and safety can help make strides in other areas that many states are seeking to confront. For example, supporting re-entry policies like “ban the box” could help recovering addicts obtain meaningful employment to provide for themselves and their families. Beyond the positive economic impact this can have, research shows that meaningful employment also reduces the idle time during which many drug offenders return to drug abuse and criminal behavior. State policies that focus on providing treatment for pregnant women and mothers, rather than zero-tolerance criminal policies that automatically place those children in state custody, can help alleviate the pressure on already strained social service resources. Policies that focus on treatment instead of punishment also may encourage women to seek help while pregnant, which can lead to a reduction in cases of Neonatal Abstinence Syndrome.

Ultimately, the fight against prescription and illicit drug abuse requires a multi-pronged approach that combines a certain degree of enforcement and compassion. While the declared “war on drugs” has raged on for more than 40 years, the variety and abuse of drugs has existed for centuries.

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Appendix 1		Naloxone Access in SLC Member States		
State	Enacting Legislation	Direct & Standing Orders	Third-party Prescriptions	Training, Education, or Instructions Required for Lay Possessor
Alabama	HB 208 (2015)	Yes	Yes*	Yes
Arkansas	SB 880 (2015)	Yes	Yes	Not specified
Florida	HB 751 (2015)	Direct only	Yes	Not specified
Georgia	HB 965 (2014)	Yes+	Yes	Yes
Kentucky	HB 366 (2013); SB 192 (2015)	Yes	Yes	Yes
Louisiana	HB 210 (2015)	Yes	Yes	Yes
Mississippi	HB 692 (2015)	Yes	Yes	Not specified
Missouri	HB 2040 (2014)	No	Qualified First Responders Only	Yes
North Carolina	SB 20 (2013); SB 154 (2015)	Yes	Yes*	Yes
Oklahoma	HB 1782 (2013); HB 2666 (2014)	Yes+	Yes	Yes
South Carolina	HB 3083 (2015)	Yes#	Yes*	Yes
Tennessee	SB 1631 (2014); SB 871 (2015)	Yes	Yes*	Yes
Texas	SB 1462 (2015)	Yes	Yes	Not specified
Virginia	HB 1672 (2013); HB 1458 (2015)	Yes	Not specified**	Yes
West Virginia	SB 335 (2015)	Yes#	Yes	Yes

Source: Naloxone Access: Status of State Law Maps, National Alliance for Model State Drug Laws, current through September 21, 2015

Notes:

+Authorization for standing orders is implied.

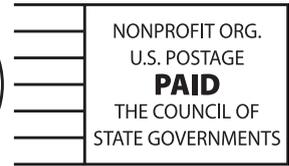
#Standing orders are authorized for first responders.

*As an indicator of good faith, the prescriber can require a written statement from a prescription recipient that provides a factual basis for an individual's risk of overdose or their connection to an at-risk individual.

**Virginia's HB 1458 (2015) states that a person may possess and administer naloxone or other opioid antagonist to a person who is believed to be experiencing or about to experience a life-threatening opiate overdose.

Liability Protections

Civil	Criminal	Professional
<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser, Administrator</i>	
<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser, Administrator</i>
<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser</i>	<i>Prescriber, Dispenser</i>
<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser, Administrator</i>
<i>Administrator</i>	<i>Administrator</i>	<i>Prescriber, Dispenser</i>
<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser</i>
<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser, Administrator</i>
<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser, Administrator</i>	
<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser, Administrator</i>
<i>Prescriber, Dispenser, Administrator</i>		<i>Prescriber, Dispenser, Administrator</i>
<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser, Administrator</i>
<i>Prescriber, Dispenser, Administrator</i>		
<i>Prescriber, Dispenser, Administrator</i>	<i>Prescriber, Dispenser, Administrator</i>	



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SOUTHERN LEGISLATIVE CONFERENCE

THE SOUTHERN OFFICE OF THE COUNCIL OF STATE GOVERNMENTS

REGIONAL VIEW NATIONAL REACH

This report was authored by Lauren Greer and edited by Colleen Cousineau and Lily Schieber for the Human Services & Public Safety Committee of the Southern Legislative Conference (SLC) of The Council of State Governments (CSG) under the chairmanship of Representative Joni Jenkins of Kentucky. This report reflects the body of policy research made available to appointed and elected officials by the Southern Office.

The Southern Office of The Council of State Governments, located in Atlanta, Georgia, fosters and encourages intergovernmental cooperation among its 15 member states. In large measure, this is achieved through the ongoing work of the standing committees of its Southern Legislative Conference. Through member outreach in state capitols, policy research, international member delegations, staff exchange programs,

meetings and fly-ins, staff support state policymakers and legislative staff in their work to build a stronger region.

Founded in 1947, the SLC is a member-driven organization and the largest of four regional legislative groups operating under CSG and comprises the states of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia.

The SLC's six standing committees provide a forum which allows policymakers to share knowledge in their area of expertise with colleagues from across the South. By working together within the SLC and participating on its committees, Southern state legislative leaders are able to speak in a distinctive, unified voice while addressing issues that affect their states and the entire region.