

911 Good Samaritan Recommendations

Analysis and Recommendations for Reducing Drug-Related Overdoses in Wisconsin



May 2013

**Wisconsin State Council on Alcohol and Other Drug Abuse
Prevention Committee
911 Good Samaritan Ad-hoc Committee**



State of Wisconsin
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Charge to the 911 Good Samaritan Ad-hoc Committee

There is growing evidence that drug overdose deaths are increasing nationally and in Wisconsin. The increasing number of deaths caused by heroin and opiates, prescription drugs like OxyContin®, Vicodin® and morphine, is a major concern. Poisoning deaths have surpassed vehicle crashes as the number one cause of accidental death in Dane County, and two-thirds of these poisoning deaths are drug overdoses. In recognition of this growing problem, the Wisconsin State Council on Alcohol and Other Drug Abuse (SCAODA) established the 911 Good Samaritan Ad-hoc Committee in January 2012. The Ad-hoc Committee was charged with researching and discussing the incidence of opiate overdoses in Wisconsin and 911 Good Samaritan Laws as a tool to reduce fatal overdoses. The Ad-hoc Committee will report out on their findings and develop recommendations to SCAODA for possible legislation as it relates to overdose prevention.

DRAFT

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Executive Summary

The misuse of opiates, both prescription (pain relievers) and non-prescription (heroin and opium) lead to a variety of health consequences such as dependence or abuse, overdose and death. Recent increases in the number of treatment admissions for opiate abuse, the number of hospital visits for opiate overdoses and the number of naloxone (Narcan®) administrations statewide are clear indicators that Wisconsin is facing a growing public health concern related to opiate use.

For 12-months, the 911 Good Samaritan Ad-hoc Committee of the Wisconsin State Council on Alcohol and Other Drug Abuse (SCAODA) examined opiate misuse and abuse in Wisconsin. The Ad-hoc Committee focused on data related to the overall scope of opiate use and abuse as well as factors that can remediate the fatal consequences associated with opiate abuse. The Ad-hoc Committee comprises stakeholders that are closely affected by opiate abuse including; law enforcement, health care, prosecutors, public health and treatment providers.

The Ad-hoc Committee reviewed national, statewide and county-level data in order to better understand the range and scope of opiate abuse. The Ad-hoc Committee also consulted with experts in states that currently have 911 Good Samaritan Legislation in order to understand the components of current legislation and the findings from evaluations conducted before and after legislative passage. Most notably, the Ad-hoc Committee worked with representatives from Washington State, who shared evaluation findings from surveys conducted of substance users, law enforcement officials and first responders related to perceptions of the 911 Good Samaritan Drug Overdose Law.

This report details the research findings and recommendations that the 911 Good Samaritan Ad-hoc Committee developed after careful discussion and review of available data and materials. The recommendations are grouped into four broad categories with recommendations under each. Listed below is a summary of the categories and recommendations.

- 911 Good Samaritan Legislation Recommendations
 - Draft a 911 Good Samaritan Law to meet Wisconsin's needs.
 - Language providing limited immunity from prosecution for possession to those who call for or receive medical assistance in an overdose situation.
 - Language providing deferred prosecution with the option of treatment for persons who call for or receive medical assistance in an overdose situation.
 - Language incorporating the provision of Screening Brief Intervention and Referral to Treatment (SBIRT) services for

persons who call for or receive medical assistance in an overdose situation (see “*Additional Recommendations*”, pg. 24 for more information on SBIRT).

- Language providing individuals, acting in good faith, the legal right to receive, possess, or administer naloxone to an individual suffering from an apparent overdose (see “*Naloxone Recommendations*” pg. 18).
 - Provide education and outreach regarding legislation to all stakeholders.
- Naloxone Recommendations
 - Pass a 911 Good Samaritan Law that allows a person acting in good faith to receive a naloxone prescription, possess naloxone, or administer naloxone to an individual suffering from an apparent overdose without penalty.
 - Adapt and deliver research-based educational materials and training curricula to paraprofessionals and others who may administer naloxone; e.g. police officers, fire fighters, non-paramedic EMTs.
 - Train substance abuse treatment providers and their clients, including medication assisted treatment programs in overdose education and response.
 - Provide education within correctional facilities in overdose prevention and reversal.
- Data Recommendations
 - Conduct surveys to gather information on public perception of current laws and practices as well as establishing factual accounts of emergency medical services and law enforcement practices related to life-saving calls for overdose assistance.
 - Develop standards for reporting incidence of fatal overdoses such that reports are consistent across jurisdictions/departments and the presence of individual drugs is specified.
 - Provide ongoing support for the monitoring of opioid overdoses and fatalities as well as other consequences that opiates have on the community at the state and county level.
- Additional Recommendations
 - Create a workgroup to address the problem of heroin addiction.
 - Increase access to substance use disorders (SUDs) and AODA treatment.
 - Establish Drug Treatment Courts throughout the State.

While, the goal of this Ad-hoc Committee was to provide recommendations in order to improve health outcomes, we recognize there is no silver bullet when it comes to reducing the misuse and abuse of opiates. The recommendations in this report are designed to assist Legislators in drafting a 911 Good Samaritan Law that addresses the needs of Wisconsin residents. A 911 Good Samaritan Law can provide a useful tool for law enforcement, health care providers and first responders when responding to an overdose situation, while also reducing the stigma that is associated with substance abuse.

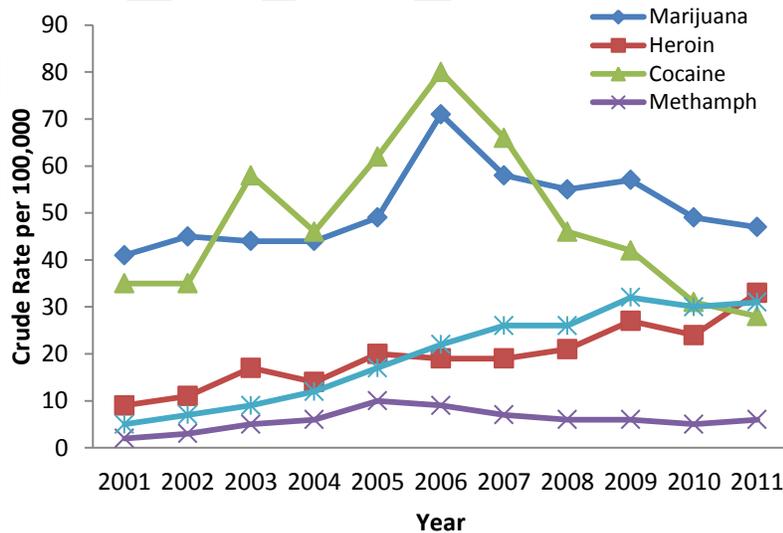
Background

Drug Overdose is a Major Public Health Problem

As stated in the *Reducing Wisconsin's Prescription Drug Abuse: A Call to Action* (2012), Wisconsin has an alarmingly increasing problem with opiate use, with both prescription medications (pain relievers) and non-prescription (heroin and opium). This category of drugs is particularly dangerous, due to their highly addictive nature and abundant supply. The misuse of opiates leads to a variety of health consequences such as dependence or abuse, overdose and death. This is indicated by recent increases in the number of treatment admissions for opiate abuse (Figure 1), the number of hospital visits for opiate overdose (Figure 2) and the number of naloxone (Narcan®) administrations (Figure 3).

As a result of opiate misuse, there have been dramatic increases in repeated substance abuse treatment episodes and an increased need for funding treatment programs. Public-funded substance abuse treatment episodes in Wisconsin have continually increased since 2001 (Figure 1). In addition, each year between 2001-2011, showed a 5-9% increase in admissions to Wisconsin opiate treatment programs, where methadone and Suboxone® are utilized to treat opiate and heroin addiction. In 2011, there were 5,203 people enrolled in 14 methadone clinics across the state.

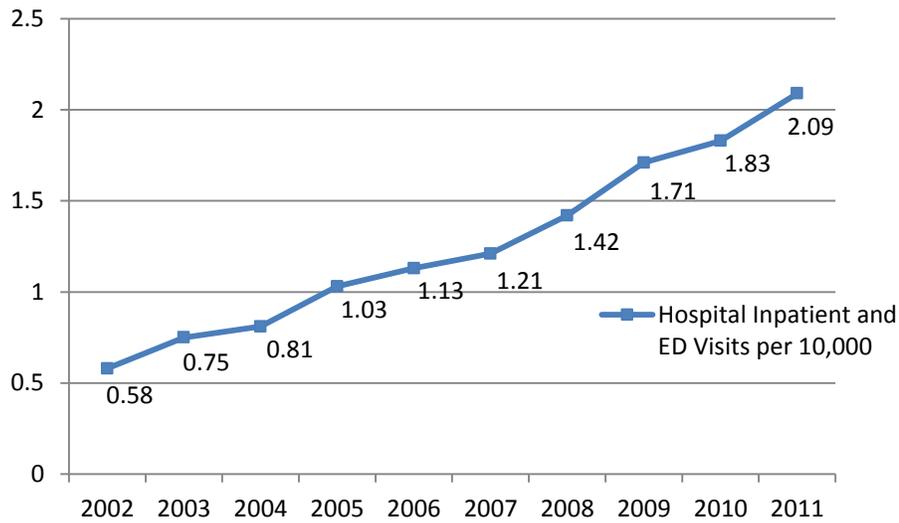
Figure 1: Wisconsin Public-Funded Substance Abuse Treatment Episodes 2001-2011



Source: Substance Abuse Mental Health Administration Treatment Episode Data Set (TEDS).

Throughout Wisconsin, opiate-related hospitalizations and response calls have increased in the last decade. In 2011, there were 246,833 drug-related hospital visits (inpatient and emergency department visits) in Wisconsin; 1,193 (2.1 hospital visits per 10,000) were for unintentional opiate-related poisoning (overdose) (Figure 2), and 11,298 (20 visits per 10,000) were for opiate dependence and non-dependent abuse.

Figure 2: Unintentional Opiate Poisoning Hospitalizations & Emergency Department Visits per 10,000 people; Wisconsin, 2002-2011

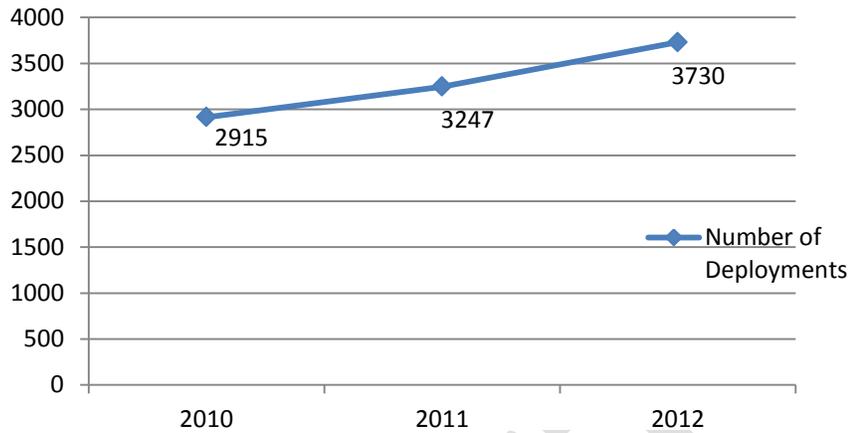


Source: Wisconsin Department of Health Services, Hospital Patient Data System

Note: Figure does not include three VA Hospitals. Emergency department visit counts exclude those admitted as inpatients.

Since 2010, emergency medical services (EMS) across the state have seen an increased need to deploy naloxone for potential overdoses. There was a total increase of 815 deployments from 2010-2012 (Figure 3). It should be noted that this data is under reported and there may be some inaccuracies (e.g. some ambulance companies do not report into this system and county data from an ambulance company may include deployments from other counties).

Figure 3: Pre-Hospital Narcan® Deployments by Wisconsin EMS, 2010-2012

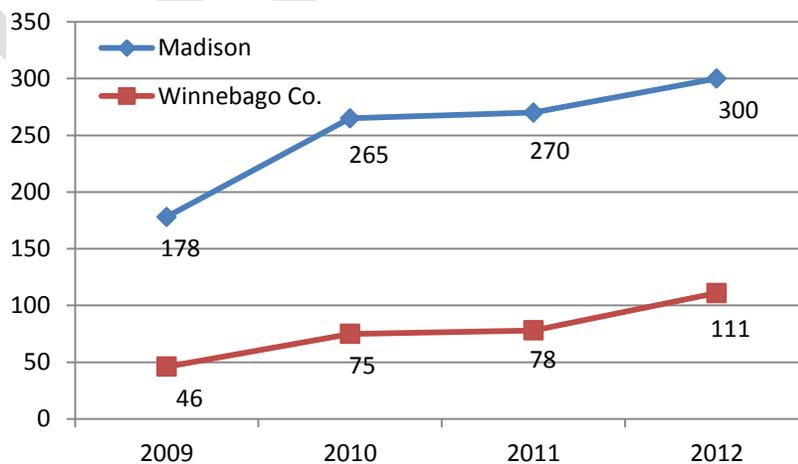


Source: Wisconsin Ambulance Run Data System

Information provided by two local communities – Winnebago County and the City of Madison (located in Dane County), both indicate that EMS calls where naloxone was deployed for potential overdose increased at an alarming rate between 2009 and 2012 (Figure 4):

- EMS calls, where naloxone was deployed, in Winnebago County more than doubled from 46 in 2009 to 111 in 2012.
- Naloxone EMS calls in Madison, nearly doubled from 2009 (178) to 2012 (300).

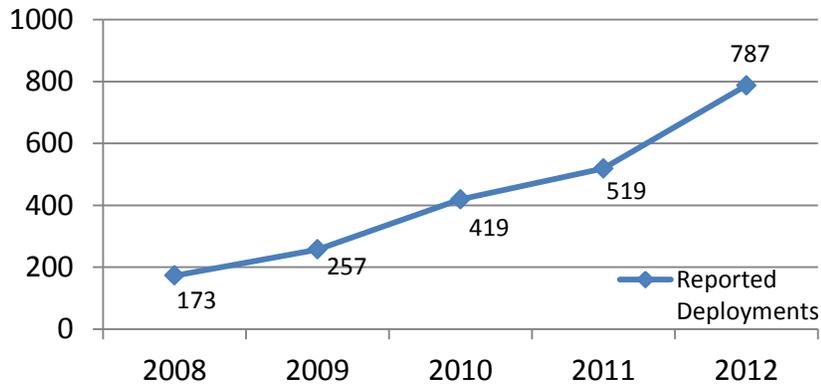
Figure 4: Naloxone Deployments by Madison and Winnebago County EMS, 2009-2012



Source: Madison Fire and EMS; Oshkosh Fire and Rescue & Gold Cross Ambulance (Winnebago Co. Only).

There has also been an increase in the number of times naloxone has been administered by non-medical personnel in the community. The Lifepoint Fatal Overdose Prevention program began in 2005 through the AIDS Resource Center of Wisconsin (ARCW). This program has reported 2,158 lives saved across Wisconsin from 2005 through 2012 with the use of naloxone (Figure 5).

Figure 5: ARCW Lifepoint Program Reported Naloxone Deployments, 2008-2012



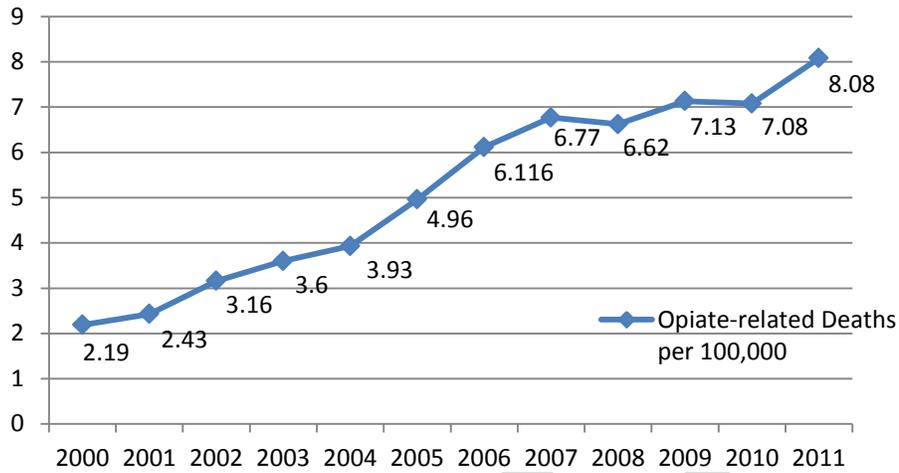
Source: AIDS Resource Center of Wisconsin Lifepoint Program

A Dane County overdose survey (Public Health – Madison & Dane County, 2013) indicated how common opiate overdoses are in the community:

- One hundred sixty-five, or 33%, of over 500 current & past drug users surveyed reported that they had a personal overdose experience.
- Seven hundred and eighty-three, or 75%, of over 1,000 survey respondents (Dane County law enforcement, EMS and current/past drug users) reported that they had witnessed an overdose.

Drug overdose fatalities, in particular those due to opioid medications, have continued to increase nationally. In Wisconsin, drug-related deaths in which heroin or other opioids were mentioned on the death certificate increased between 2000 and 2011 (Figure 6).

Figure 6: Wisconsin Opiate-related Deaths per 100,000 Population, 2000-2011



Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics: Hospital Patient Data System

Note: Includes all deaths to Wisconsin residents or occurring in Wisconsin

In 2011, there were 711 drug-related deaths in Wisconsin (1.4% of all deaths); 65% of these deaths were opiate-related.

Increases in drug overdose deaths, particularly due to opiates, were also seen at the local county level. In Dane County, there were 14 opiate-related deaths (3.3 per 100,000) in 2000 and 45 opiate-related deaths (9.2 per 100,000) in 2010. In Winnebago County, drug overdose deaths ranged from 13-17 (9.1 per 100,000) between 2008 and 2010. However, in 2011 and 2012, the number of drug overdose deaths increased to 25-27 (14.9 per 100,000) – the majority of which were opiate-related¹.

Drug Overdose Deaths are Preventable

The majority of overdose deaths occur within one to three hours after the individual has taken an opiate, and most of these deaths occur in the presence of others. This situation gives a significant amount of time for witnesses to the overdose to intervene and call for medical assistance. Unfortunately, fear of arrest and prosecution, as well as the stigma attached to drug use, prevent many witnesses from calling 911 and summoning emergency medical assistance. If these barriers were removed, countless lives could be saved, offering survivors the opportunity for recovery.

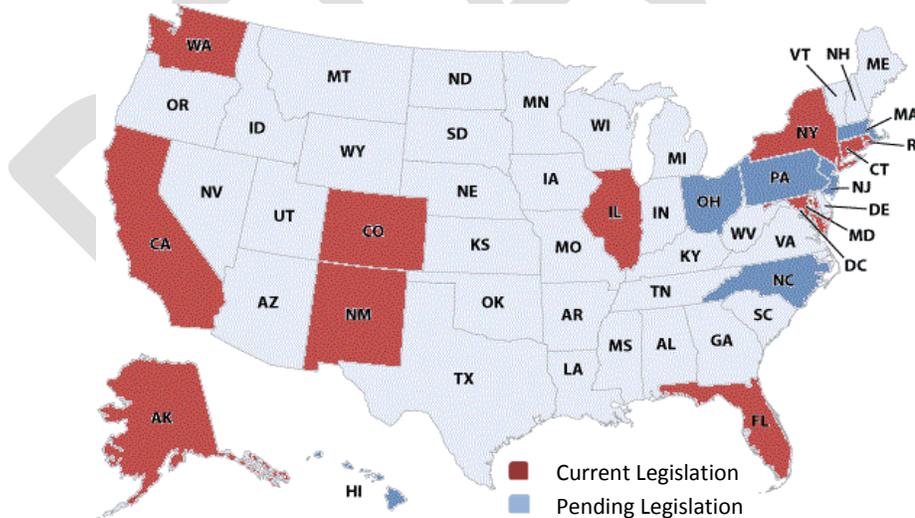
States Have Responded by Passing 911 Good Samaritan Laws

¹ Note: Dane County and Winnebago County data is reported due to its availability to the Ad-hoc Committee. Given the overall statewide increases in opiate-related overdose deaths, other counties are likely to have experienced increases as well.

Currently, according to Wisconsin law, in an emergency situation an individual who, in good faith, provides emergency care to an individual facing a possible fatal overdose is not protected from prosecution in criminal court. A 911 Good Samaritan Law could change this. A 911 Good Samaritan Law could assure in the event of an overdose, that an individual(s) providing emergency care and the individual(s) receiving emergency care are granted limited immunity from criminal prosecution. The care is defined as the action of administering naloxone (or another opiate antagonist), and/or calling 911, and/or transporting the overdosing individual to a medical facility. Limited immunity from criminal prosecution covers only possession of drugs at the scene of the overdose or administration of a drug that reduces the effects of the overdosing opiate (naloxone).

Nationally, many states have either enacted or are currently developing 911 Good Samaritan legislation. At this time, thirteen states have some form of legislation with limited immunity from arrest or prosecution for people who call 911 in an overdose situation (Figure 7). These states are; Alaska, California, Colorado, Connecticut, Florida, Illinois, Maryland, Massachusetts, New Mexico, New York, North Carolina, Rhode Island, and Washington. Similar measures are also pending in other states including; Hawaii, New Jersey, Ohio, Pennsylvania and the District of Columbia.

Figure 7: Good Samaritan Legislation and Pending Legislation, United States - 2013



Washington State passed a 911 Good Samaritan Drug Overdose Law in 2010. An initial evaluation by Banta-Green, Kuszler, Coffin & Schoeppe (2011) indicated the following:

- Opiate overdoses were common:

- 42% of opiate users and 62% of Seattle police reported being present at the scene of a serious opiate overdose in the prior year.
- 911 Good Samaritan Drug Overdose Law had impact on planned behavior:
 - 88% of opiate users indicated that they were aware of the law and would be more likely to call 911 during future overdoses.
- The 911 Good Samaritan Drug Overdose Law made the existing informal law enforcement policy, (most police were not arresting people that called 911 for possession) into formalized state law.
- Despite lingering concerns about possible negative consequences of the new law, no evidence of negative consequences has been found to date.

In addition to state-level legislation, a growing number of national and state-based organizations support 911 Good Samaritan laws to prevent overdose deaths and increase access to emergency medical assistance. In 2008, the U.S. Conference of Mayors passed a resolution calling for a comprehensive approach to overdose prevention, including the passage of 911 Good Samaritan laws.

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911 Good Samaritan Legislation Recommendations

Background

Death from opiate overdose usually takes place within three hours from the time the drug is administered (Davidson et al., 2003; Zador et al. 1992). This offers emergency services a valuable window to intervene and save lives, however, they must be contacted to intervene. Rates of survival when paramedics are present at opiate overdoses reach almost 100 percent (Sporer, 1996). Therefore, interest is growing nationwide in 911 Good Samaritan laws aimed at saving lives by encouraging people who witness drug overdoses to call 911. The laws typically provide legal immunity from drug possession prosecution for the person who overdoses and the individual who calls emergency services.

The legislation is designed to save lives by eliminating legal concerns that may prevent people from seeking proper medical treatment. Proponents maintain that Good Samaritan policies reduce barriers to help-seeking behavior (Rowe, 2005). Opponents maintain that by removing these repercussions, such policies may enable or encourage drug abuse or decrease opportunities for treatment.

Research

The first study on 911 Good Samaritan policy was conducted by Lewis & Marchell (2006) on the campuses of Cornell University. Cornell University recognized the need for a change in their policy regarding underage alcohol consumption after an undergraduate student survey revealed of the 19 percent of students who had considered calling emergency services for an alcohol overdose; only four percent had made the call. The top two reasons reported for not calling emergency services were: not knowing if the situation was serious enough to call, and fear of consequences for the individual overdosing. In response to their findings, Cornell University implemented an educational program which provides all students the ability to better recognize an overdose and steps that can be taken in order to provide medical intervention when needed.

They also implemented a medical amnesty policy that provided immunity for an individual who calls emergency services in an alcohol overdose situation along with the hosting organization (i.e. fraternity and sorority houses). The individual who experienced the alcohol overdose would be granted immunity if they completed two sessions of Brief Alcohol and Screening Intervention for College Students. This intervention, similar to Screening, Brief Intervention, and Referral to Treatment (SBIRT), utilizes cognitive-behavioral and motivational interviewing techniques to decrease alcohol consumption and related risk behaviors.

The student surveys found that by the second year of implementation, 80 percent of students were aware of the policy, and that the percentage of students not calling for fear of getting the individual that experienced the overdose in trouble dropped 2.3 percent. Cornell's Emergency Medical Services records showed a 22 percent increase in calls for alcohol-related emergencies for the first two years following implementation of the

The story of Chase Newman: Life that could have been.

My name is Jeff Newman and I am the father of Chase Newman, an opiate addict who also suffered from Bi-Polar Disease and Depression.

On March 23rd of 2010 my wife and I received a call from a Madison Police Officer who asked if we were Chases' parents. He then told me that they had received a call from a friend of Chase about a non-responsive adult male and an ambulance was dispatched to the house. When we met with police, one of the things they told us was that the paramedics had to give Chase a drug called Narcan® to bring him back to life. My wife and I were almost knocked off our feet when we heard this; being quite naïve about drugs we thought that when police mentioned "unresponsive" they meant passed out like someone who had drank too much, not someone who is dead!

The police told us that Chase was really lucky because when his friend had gotten concerned about Chase's condition he had left the house for a short while and when he had returned he called for help. The police told us that his friend probably left to take his drugs and drug paraphernalia to some other location so that he wouldn't be caught with them. I don't condone the use of drugs at all but if his friend wouldn't have had to worry about his drugs, he may not have been as harrowing an experience for Chase, his friend or Chase's mother and me.

Chase received help to fight his addiction from many agencies and programs and stayed clean for over a year before he had a relapse. On May 2, 2012 he lost the battle to an accidental overdose.

The autopsy report tells about one of his roommates returning home and finding him sleeping on the couch and snoring. In the morning she went to work and reported that he was still on the couch snoring heavily. At 7:15 her boyfriend/roommate got up to leave for work and also tried to wake Chase. He went to ask a neighbor for help, but the neighbor concluded that Chase was simply sleeping heavily. The roommate was concerned enough to contact his girlfriend later and at 10:45 she returned from work to find Chase unresponsive and not breathing. We don't blame Chase's roommates for his death, but we wonder if an earlier call to the proper authorities may have saved his life.

Your mother and I miss you Chase.

policy. The researchers compared this data to the rate of alcohol use on Cornell's campus to verify that the increase in calls was not due to a general increase in alcohol consumption and found no significant change in total consumption rates. The emergency room and health center records showed increases in utilization of Brief Alcohol and Screening Intervention for College Students from 22% prior to implementation to 52% following implementation.

Out of the eleven states that have passed Good Samaritan laws, Washington State is the first state to comprehensively study the effects of the law, which not only provides legal immunity, but also allows the prescribing of an opioid antidote medicine, (naloxone) to drug users and their partners. The study examined the legal intent, implementation and outcomes of the law. Preliminary results of the study have been released and are summarized below. Ultimately, this study will provide a report on how the law is impacting overdoses and 911 calls.

Law enforcement and prosecutors' associations initially opposed the Washington Good Samaritan law, thinking it was unnecessary because people are rarely arrested or prosecuted for drug possession during overdoses. However, as they heard from their constituents, such as campus police supportive of Good Samaritan laws, and learned about the dramatic increase in the use and abuse of pharmaceuticals by people across the age spectrum, they became supportive. Banta-Green et al. (2011) found, "The law gives legal cover to what's been standard practice for a long time". Legislators and organizational stakeholders agreed that framing the law as a public health issue, not as a legal issue, was also key to its passage.

A survey conducted by Public Health-Seattle and King County in 2012 found that 42 percent of heroin users had witnessed an opiate overdose in the prior year and 911 was called in half of the cases. Police responded along with paramedics 62 percent of the time, but just one person was reported to have been arrested at the scene of an overdose. Only one-third of heroin users had heard of the Good Samaritan law. According to the survey, 88 percent indicated that now that they were aware of the law, they would be more likely to call 911 during future overdoses.

In Wisconsin, a recent survey conducted in Dane County (10/12 – 1/13), with current and past drug users, indicated that 911 was not called at an overdose more than 50% of the time. The majority of the reasons for not calling were related to being worried about charges, or police, or a friend being mad at them because they might be arrested.

Seattle paramedics reported that police are usually at the scene of overdoses, but arrests of those that overdose or bystanders rarely occur. Sixty-two percent of police surveyed said the law would not change their behavior during a future overdose because they would not have made an arrest for possession anyway, 20 percent were unsure what they would do, and 14 percent said they would be less likely to make such an arrest.

The survey results show that with limited changes to law enforcements' behaviors at the scene of an overdose, a 911 Good Samaritan Law can increase the likelihood that emergency services will be contacted. The results also highlight the importance of community education regarding the law. Banta-Green et al. (2011) stated "These findings indicate we need to make sure we're getting information into the hands of police and the community at large".

This data is the basis for the Ad-hoc Committee to recommend that any drafted Wisconsin legislation should include an education component.

911 Good Samaritan Draft Legislation

Through a thorough review of all States' 911 Good Samaritan Laws, the Ad-hoc Committee found the law written for Washington State to be the most comprehensive and well researched. The following are some key points from the law as it is written in Washington (for the full Washington Law see Appendix A).

- (1)(a) A person acting in good faith who seeks medical assistance for someone experiencing a drug-related overdose shall not be charged or prosecuted for possession of a controlled substance pursuant to RCW 69.50.4013, or penalized under RCW 69.50.4014, if the evidence for the charge of possession of a controlled substance was obtained as a result of the person seeking medical assistance.
- (b) A person acting in good faith may receive a naloxone prescription, possess naloxone, and administer naloxone to an individual suffering from an apparent opiate-related overdose.
- (2) A person who experiences a drug-related overdose and is in need of medical assistance shall not be charged or prosecuted for possession of a controlled substance pursuant to RCW 69.50.4013, or penalized under RCW 69.50.4014, if the evidence for the charge of possession of a controlled substance was obtained as a result of the overdose and the need for medical assistance.
- (3) The protection in this section from prosecution for possession crimes under RCW 69.50.4013 shall not be grounds for suppression of evidence in other criminal charges. [2010 c 9 § 2.]

Table 1: Myths and Facts about 911 Good Samaritan Laws

Myth	Fact
This law would allow drug dealers to escape prosecution.	The law does not allow immunity for charges of drug distribution, only drug possession.
Criminals could use this law to get immunity if their home is about to be raided by police.	The law only protects those who have police contact as a result of a good faith effort to seek medical attention.
This law would prevent prosecutions for reckless homicide under the Len Bias Law.	The law offers no protection for those who would be charged with reckless homicide, however by reducing overdose fatalities there may be decreases in the number of these cases.
This law would decrease treatment admissions.	Research has shown an increase in treatment admissions for those who claim immunity under Good Samaritan Laws.

Education and Outreach

In order for 911 Good Samaritan law to be effective those who are impacted must be aware of the law. There are a number of targeted groups that will need to be educated and taught how to utilize this law to better the community as a whole. Education and outreach serve a secondary purpose of decreasing stigma and misconceptions relating to the law.

Based on the above considerations, the 911 Good Samaritan Ad-hoc Committee developed the following recommendations:

Recommendation 1: Draft a 911 Good Samaritan Law to meet Wisconsin’s needs.

In drafting 911 Good Samaritan Legislation in Wisconsin, the following options for inclusion should be considered:

- Language providing limited immunity from prosecution for possession to those who call for or receive medical assistance in an overdose situation.
- Language providing deferred prosecution with the option of treatment for persons who call for or receive medical assistance in an overdose situation.
- Language incorporating the provision of Screening Brief Intervention and Referral to Treatment (SBIRT) services for persons who call for or receive medical assistance in an overdose situation (see “*Additional Recommendations*” on pg. 24 for more information on SBIRT).
- Language providing individuals, acting in good faith, the legal right to receive, possess, or administer naloxone to an individual suffering from an apparent overdose (see “*Naloxone Recommendations*” pg. 18).

Note, none of the above proposed options would allow for immunity from prosecution for drug distribution.

Recommendation 2: Provide education and outreach regarding legislation to all stakeholders.

Outreach to Law Enforcement and the Justice System:

- Informational meetings on the 911 Good Samaritan law, naloxone information and overdose prevention should be offered to law enforcement and judiciary agencies. Law enforcement should identify trainers, utilizing syringe exchange staff to develop trainings for roll calls, district hearings and meetings dedicated to disseminating information about overdose. By utilizing existing resources a budget would not be needed for these outreach efforts.
- Published literature will identify resources for officers and judicial officers.
- Education will include available materials and resources. For example, Washington State has offered the use of the video they created to train officers about the law. This is available on-line at no cost.
- Informational meetings should be provided on any current or new policies adopted related to this report.

Consumer (Drug User) Education:

- Syringe exchange sites in the community should take the lead in disseminating published and oral education materials for consumers that clarifies how this law impacts them.
- Treatment centers and social service programs should be utilized as information dissemination sites.
- Substance use recovery organizations should provide educational materials regarding the law and the increased risk of overdose for their clients in recovery.

Healthcare Workers & First Responders:

- Education should be provided at staff meetings on how this law impacts their work, policies and practices, including the increased access to community-based naloxone.

General Community:

- The general community should be targeted to increase knowledge of the law for those people who are actively using but not engaged in services.
- Community education should be designed to increase support for overdose prevention and decrease stigma associated with addiction.
- The general community should be reached by press releases from stakeholder agencies, social media and news coverage.

Naloxone Recommendations

Background

Narcan® administration can be a vital part of saving a life in an event of an opiate overdose. Naloxone is the generic name for this medication. This section will provide information about naloxone, explain its uses, and provide recommendations that will allow for greater access to this life-saving antidote to opiate overdose.

Prescribed Usage

Naloxone prevents or reverses the effects of opioids including respiratory depression, sedation and hypotension. It works by blocking the central nervous system effects of several types of opiate medications such as morphine, oxycodone, methadone or heroin (U.S. National Library of Medicine, 2012). When properly administered, and in the absence of another opioid or opioid antagonist, there is no pharmacological effect on the patient.

When naloxone is administered intravenously (I.V.), the onset of action is generally apparent within two minutes. The onset of action is slightly less rapid when it is administered intranasal or intramuscularly (I.M.). The duration of action is dependent upon the dose and route of administration of naloxone. Intramuscular administration produces a more prolonged effect than intravenous administration. Since the duration of action of the antagonist may be shorter than that of some opiates, the effects of the opiate may return as the effects of naloxone dissipates. The requirement for repeat doses of the medicine will also be dependent upon the amount, type and route of administration of the opioid being antagonized.

“Having naloxone saved my girlfriend’s life, I was so glad I had it. Thank you for another saved life”

- 22 year old white male 2012

The patient who has satisfactorily responded to overdose reversal should be kept under continued surveillance and repeated doses should be administered, as necessary, since the duration of action of some opioids may exceed that of naloxone.

Naloxone has not been shown to produce tolerance or cause physical or psychological dependence. In the presence of physical dependence on opioids, naloxone will produce withdrawal symptoms. These opiate withdrawal symptoms may appear within minutes of naloxone administration and subside within about two hours. The severity and duration of the withdrawal symptoms are related to the dose and to the degree and type of opioid dependence.

Access to Naloxone

1. Some community overdose prevention programs provide emergency opiate overdose education and a take-home supply of naloxone for people who use/abuse opiate medication or heroin and their family members, friends, or caregivers to use in case of an opiate overdose. Currently, ARCW is the only agency in Wisconsin providing a program like this. It is available after a training program by prescription only.

Intramuscular naloxone is the only route of administration currently being provided through the ARCW’s needle exchange program.

2. Presently physicians can write a prescription for naloxone that can be filled at any pharmacy. However, many prescribers are hesitant to do this as, the person it is prescribed to will most likely use it on another individual, who does not have a prescription, which is currently illegal in Wisconsin.
3. Emergency room personnel/physicians and paramedics can administer naloxone. However, many first responders including police officers, fire fighters and EMT Basics are not permitted under current law to administer naloxone.

Shortage of Naloxone

There is only one manufacturer of naloxone in the United States. The Food and Drug Administration (FDA) does not allow importing this life-saving drug from outside of the United States. This has resulted in a supply shortage and rising costs. For the health and safety of the general public, the FDA or other intervention agencies should advocate for increased availability and price reduction.

Table 2: Pros and Cons of Naloxone Administration

Pros	Cons
Naloxone administration can be a vital part of saving a life in an event of an opiate overdose.	A person who is administered naloxone in large amounts may experience severe withdrawal symptoms. This may lead to additional use, bringing back the overdose.
Naloxone prevents or reverses the effects of opiates including respiratory depression, sedation and hypotension. In the absence of opiates, it exhibits no pharmacologic activity when deployed.	Some view wider availability of naloxone as a means to continue drug use and delay initiation of AODA treatment.
Naloxone has not been shown to produce tolerance or cause any physical or psychological dependence.	Shortage of naloxone and higher costs may limit access.
Naloxone provides immediate care until EMS arrives.	Reduces 911 calls with further medical care.

Based on the above considerations, the 911 Good Samaritan Ad-hoc Committee developed the following recommendations related to naloxone:

Recommendation 3: Pass a 911 Good Samaritan law that allows a person acting in good faith to receive a naloxone prescription, possess naloxone, or administer naloxone to an individual suffering from an apparent overdose without penalty.

See Appendix A for draft legislative language.

- The administration, dispensing, prescribing, purchase, acquisition, possession, or use of naloxone to anyone shall not constitute unprofessional conduct or violation of law if said conduct results from a good faith effort to assist a person experiencing, or likely to experience to an opiate-related overdose.

- Persons administering naloxone in good faith shall not be subject to civil or criminal liabilities.

Recommendation 4: Adapt and deliver research-based educational materials and training curricula to paraprofessionals and others who may administer naloxone; e.g. police officers, fire fighters, non-paramedic EMTs.

Recommendation 5: Train substance abuse treatment providers and their clients, including medication assisted treatment programs in overdose education and response.

- Education should include information on access to naloxone for clients and the increased risk of overdose after prolonged absence of a drug from one's system.

Recommendation 6: Provide education within correctional facilities in overdose prevention and reversal.

- Education should include information on access to naloxone after release from a correctional facility and the increased risks of overdose after prolonged absence of drug use.

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Data Recommendations

When the Ad-hoc Committee began reviewing the merits of a 911 Good Samaritan Law for Wisconsin, a number of data-related questions arose. In order to fully understand the incidence and scope of opioid-related overdose fatalities in Wisconsin, available data sources needed to be reviewed and additional data sources needed to be identified. After reviewing available data, it became clear that one of the barriers to fully understanding this issue, and consequently proposing strategies to reduce the incidence of overdose deaths, is the availability of reliable data that consistently shows the depth and breadth of the problem. Three main focus areas related to data collection and availability were evident.

Perception Versus Practice

Anecdotal testimony indicates that there is a gap between what opioid users perceive will happen in the event they call 911 for assistance in an overdose situation and what police report regarding their practices and policies when responding to an emergency overdose situation. Treatment providers report that opioid users are fearful of calling 911 for assistance because they do not want to be arrested and prosecuted for drug possession. Conversely, some law enforcement agencies report that it is not their practice to make a drug possession arrest in a situation where someone is in need of medical assistance for an overdose. However, these practices and policies are not consistent across law enforcement agencies.

Surveying opioid users regarding their overdose experiences and perceptions and law enforcement personnel regarding their practices will help to understand this dynamic. In order to increase opportunities for and decrease barriers to receiving timely life-saving assistance, a knowledge-base for making informed decisions related to the creation of consistent practices and laws aimed at reducing the incidence of opioid-related fatalities must be established. Surveying groups affected by opioid abuse will lay the foundation for making educated, solution-focused decisions.

Uniform Reporting Across Disciplines

Many community sectors are affected by persons using and abusing opioids for non-medical purposes. These groups have the ability to track outcomes related to their involvement with an opioid users' care. In researching the scope of opioid fatalities in Wisconsin, the Ad-hoc Committee found that there is inconsistent reporting of data across organizations and departments. Some Emergency Medical Service (EMS) departments may collect data on dispensing naloxone, while others may not. There are no standard practices for reporting the presence of drugs on death certificates by coroners and medical examiners. Police departments within the same county may have different policies for arresting users, and court systems have varying conviction or treatment options available to offenders.

Consistency in data monitoring and tracking within community sectors is integral to identifying drug use patterns and trends. Standardization of data within disciplines provides all sectors the opportunity to have up to date, reliable information with which to

make informed policy decisions. Standardizing not only data collection and tracking but organizational practices will provide a more consistent standard of care statewide.

Monitoring and Evaluation

The need for continued monitoring of non-medical opioid use patterns is clear. Tracking the use, misuse and abuse of prescription opioids (OxyContin®, methadone, etc.) and the abuse of non-prescription opioids (heroin, opium) provides much needed insight into who, what, where and how people are abusing a substance and the negative outcomes that result from abuse. There are many strategies that could be implemented to reduce mortality related to the abuse of opioid analgesics. Although the scope of this report is to investigate the merits of a 911 Good Samaritan Law for persons seeking limited immunity from prosecution in drug-related life-threatening situations, there are other policies or strategies that would help to reduce the incidence of opioid-related overdose fatalities that could be pursued based on an assessment of need and appropriateness to the community. For this reason, regardless of whether a 911 Good Samaritan Law is proposed or passed in Wisconsin, there is a need for ongoing monitoring of use and abuse patterns and the consequences to individuals and the community, and also evaluation as it relates to public perception, institutional practices, and societal burden. Evaluation should be supported across all centers of care to ensure that policies are meeting need, should inform policy decisions, and inform community education and services in order to close the gap between public perception and institutional policies/practices.

Based on the above considerations, the 911 Good Samaritan Ad-hoc Committee developed the following recommendations related to data:

Recommendation 7: Conduct surveys to gather information on public perception of current laws and practices as well as establishing factual accounts of emergency medical services and law enforcement practices related to life-saving calls for overdose assistance.

- Current and past opioid users should be surveyed through needle exchange programs, methadone clinics and recovery organizations in an effort to understand why calls for medical assistance may or may not be made.
- Law enforcement and emergency medical services in both urban and rural settings should be surveyed to determine current practice, current perceptions of practices and levels of support for additional institutionalized policies.
- Collaboration should be established with local police chief and EMS chief associations.

Recommendation 8: Develop standards for reporting incidence of fatal overdoses such that reports are consistent across jurisdictions/departments and the presence of individual drugs is specified.

- The Wisconsin Medical Examining Board should establish standard reporting requirements and provide training in these requirements to members.
- Resources should be made available so that timely drug testing can be done in cases of overdose death.

- The data gathered should be centralized and made available and usable on a statewide level.
- Link coroner and medical examiner data statewide and provide guidance and training regarding recommended drug testing protocols at time of death to ensure that fee-for-service laboratories chosen are able to provide the desired scope of testing.

Recommendation 9: Provide ongoing support for the monitoring of opioid overdoses and fatalities as well as other consequences that opiates have on the community at the state and county level.

The Division of Mental Health and Substance Abuse Services (DMHSAS) and the Division of Public Health (DPH) already produce a biannual *Wisconsin Epidemiological Profile on Alcohol and Other Drugs*, which contains consumption and consequence indicators for substance abuse. For ongoing monitoring of opiates, it is recommended that additional data be included in the Profile:

- Drug-related deaths by county,
- Further detailed data of drug-related deaths to include opiate-related deaths,
- Further detailed data of drug-related hospital visits (emergency department and hospital admissions), to include poisoning by substance type (state and by county), opiate poisoning (state and by county) and opiate-related abuse and dependence (state),
- EMS calls for naloxone dosing,
- Naloxone deployments from community naloxone overdose prevention programs (state-wide),
- Publicly funded substance abuse treatment admissions (by drug type, including heroin and other opiates), and
- Data on local methadone clinic admissions.

See Appendix B for further details of data indicators and data sources.

Additional Recommendations

Background

During the course of Ad-hoc Committee meetings there were a number of topics that continually came up for discussion but were not directly related to the Ad-hoc Committee's charge. The following recommendations identify those areas that Ad-hoc Committee members feel should be addressed moving forward.

Creation of a Heroin Workgroup

In order to examine the extent of heroin use in the state of Wisconsin, it is recommended that a workgroup be developed that will be dedicated to identifying and examining the many facets that lead to heroin use.

Historically, the use of heroin in the state of Wisconsin until the mid-1990's was limited to a small number of users. Due to the low purity of the heroin available, the predominant method of use was through intravenous injection. Beginning in the late 1990's, Wisconsin began to experience an increase in the availability and use of heroin. This mirrored a national trend that severely impacted the eastern United States, and then spread to the Midwest and subsequently to Wisconsin. Between 2006 and 2011, Wisconsin experienced a 350% increase in heroin samples submitted to the Wisconsin State Crime Laboratory (WSCL) by law enforcement. In addition, during a recent 2012 drug survey of law enforcement agencies across the state, many agencies reported that heroin is an increasing problem within their jurisdiction, or in many instances, the number one drug problem in their jurisdiction.

Heroin use is not only a law enforcement problem, but affects many other factions of society as well. From emergency medical services that have to intervene when a heroin-related overdose incident occurs, to hospital staff that treat the patient, to insurance companies that may have to cover the cost of treatment, to addiction counselors and opiate treatment facilities that work with the patient upon release. All of these different entities that deal with someone who uses heroin have been negatively impacted by the increase in the use of heroin. Even more troubling is many innocent citizens across the state have also been negatively impacted by the increase in the use of heroin. Either by being a victim of a crime perpetrated by someone in order to support their heroin use, or involved in an accident by someone who was impaired by heroin while operating a motor vehicle.

Therefore, a multidisciplinary workgroup should be formed in order to comprehensively examine the causes of the increase in heroin use in the state of Wisconsin.

Increase Access to Treatment

A meta-analysis of the research literature on opiate addiction undertaken by the National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction (1998) found that treatment involvement reduces the risk of overdose for those dependent on opiates. According to the NSSATS profile (2011) out of the 17, 385 Wisconsin residents that received substance abuse treatment only 18 percent, or 3,165, were in

Opioid Treatment Facilities. While the 2010 Treatment Episodes Data Set (TEDS) report shows out of the 29,354 Wisconsin residents in substance abuse treatment less than 11 percent, or 3,103 clients, entered treatment for heroin or other opiate abuse.

Therefore, we reiterate the recommendation of the Wisconsin State Council on Alcohol and Other Drug Abuse Prevention Committee Controlled Substances Workgroup to:

Integrate high quality medication management and psychosocial interventions for substance abuse disorders that both are available to consumers as their conditions indicate.

Medication Assisted Treatment

Medication assisted treatment (MAT) has three primary goals. The first is to reduce the severity of the addiction of heroin and prescription opiates and to allow the addict to function on a day-to-day basis. Second, MAT seeks to reduce the negative impact heroin/opiate addiction has on communities by reducing criminal behavior and thereby enhancing public safety. A final goal of MAT is to improve public health by decreasing the transmission of AIDS and other diseases associated with heroin use. There are currently 15 Opioid Treatment Programs (OTPs) that utilize medication to treat heroin/opiate addiction in Wisconsin. These programs utilize methadone and Suboxone® in conjunction with individual and group counseling to stop cravings and withdrawal symptoms which allow the patient to focus on sobriety and finally recovery.

Screening Brief Intervention and Referral to Treatment

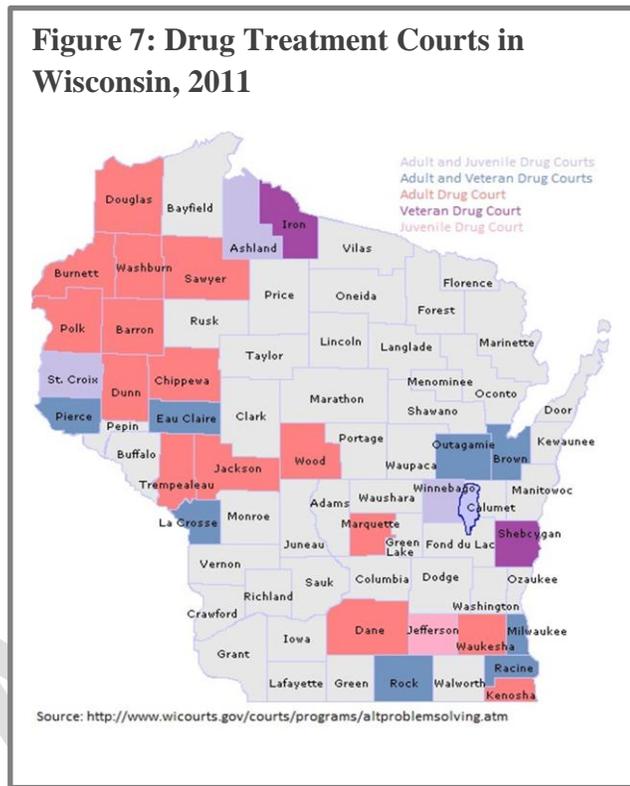
Screening Brief Intervention and Referral to Treatment (SBIRT) is a model that provides Physicians, treatment providers, pharmacists and other individuals who provide services in a one-on-one setting, with the tools to screen for risky or hazardous substance misuse and to provide a brief intervention tailored to the level of risk identified in the screening process. This affords an opportunity to reinforce protective factors and assist the individual to change risky behaviors or reduce substance use. SBIRT has been implemented predominantly in medical settings and research has shown the model to be effective in assisting individuals in reducing their risky or hazardous substance use (Solberg et al., 2008). The interventions take into account not only the individuals' screening results, but also their overall risk of overdose. Thus, those at varying levels of risk for overdose receive specific information during a brief intervention designed to target his/her most risky behavior.

Establish and Support Drug Treatment Courts Throughout the State

One of the promising approaches that law enforcement has undertaken over the past 20 years is the use of Drug Treatment Courts (DTC). DTC have been effective in increasing treatment retention and decreasing recidivism, (Carey, Finigan, & Pukstas, 2008). For a summary of the effectiveness of Drug Treatment Courts, on a national level, see <http://www.nadcp.org/learn/facts-and-figures>. The National Institute of Justice's Multi-site Adult Drug Court Evaluation compiled by the Urban Institute (2011), found that DTC programs significantly reduce drug use, both during and after program participation. Another research project found that those who are engaged in treatment are far less likely to overdose, (Best, Gossop, Man, Stillwell, Coomber, & Strang, 2002). From these

findings it can be inferred that those who are actively in a DTC program are less likely to overdose.

There are a number of counties across the state that have already established DTCs and are seeing the benefits of these programs. In Dane County, two studies have shown the effectiveness of their DTC. Brown's (2011) study found a reduction of recidivism for DTC clients, especially among women, older individuals, minorities, and those with more serious criminal histories. Another DTC study, focused on the effectiveness of opiate agonist therapy among the prison population and found that if methadone was initiated prior to or immediately after release from prison, it increases treatment entry and reduces heroin use at 6 months compared to counseling only, (Gordon, Kinlock, Schwartz, & O'Grady, 2008).



See Figure 7 for a map on Drug Courts in Wisconsin and for a directory of Wisconsin DTC programs, see <http://wicourts.gov/courts/programs/altproblemsolving.htm>.

Another recommendation is to restructure or increase current state funds for treatment programs and other supportive services. Wisconsin advocacy group, Wisdom, and Human Impact Partners, an Oakland, California-based nonprofit, studied the effects of public policies on communities. The report projected with increase financial support of the criminal justice system that the benefits would include 3,100 fewer prisoners a year, 21,000 fewer jail admissions, a reduction in repeat crimes and between 1,150 and 1,619 parents who remain in the community and not separated from their children. The group suggested that \$95 million a year would cut the cost of keeping such non-violent offenders in prison.

http://lacrossetribune.com/news/local/crime-and-courts/report-m-for-diversion-programs/article_cc66fc22-3913-11e2-9e9b-001a4bcf887a.h

Based on the above considerations, the Good Samaritan committee developed the following recommendations:

Recommendation 10: Create a workgroup to address the problem of heroin addiction.

Overview of Development of Waukesha Drug Treatment Court

By 2010, law enforcement and public health officials in Waukesha County were alarmed by a consistent trend of approximately three dozen annual deaths per year resulting from opiate overdoses. The nature of the problem was presented to our Criminal Justice Collaboration Council, and the Council directed the formation of an ad hoc Drug Abuse Trends Committee.

A broad coalition of law enforcement, county government, public health officials, educators, treatment providers and others came together to examine the problem. The committee brought in experts on drug trafficking enforcement, drug abuse treatment, evidence-based drug treatment court models and criminal justice programs aimed at addressing drug addiction currently operating in southern Wisconsin.

Waukesha County implemented Wisconsin's first Alcohol Treatment Court six years ago, and has experienced great success in addressing addiction and reducing criminal recidivism.

Based upon that experience and the results of our year-long examination of the nature of the opiate problem and the potential solutions available, the Drug Abuse Trends Committee ultimately recommended that Waukesha County establish a Drug Treatment Court (DTC).

Fortuitously, about the time the committee made its recommendation, a federal grant became available to assist local jurisdictions in establishing drug treatment courts. We sought and received a grant that is currently funding a three year pilot program. We are currently in our first year of operating a DTC.

Suggested members of the group should include, but not be limited to:

- A Research Specialist – This representative shall be charged with conducting research of the data needed for the group as a whole.
- Addiction Treatment Professional – This representative will be able to provide insight as to the physical and mental aspects of heroin addiction.
- Criminal Intelligence Analyst – This representative will be able to provide historical data in regard to heroin use in Wisconsin and provide a strategic analysis of future heroin trends.
- State Opiate Treatment Authority – This representative will be able to provide insight in regard to the state opiate addiction treatment protocols.
- AIDS Resource Center of Wisconsin – This representative will be able to provide insight in regard to current needle exchange programs, naloxone deployment and trends amongst user populations.
- Emergency Medical Service – This representative will be able to provide insight and data in regard to emergency medical services response to opiate-related incidents.
- Medical Examiner – This representative will be able to provide input and data in regard to heroin-related deaths throughout the state.
- Bureau of Vital Statistics – This representative will be able to provide data in regard to heroin-related incidents occurring throughout the state.
- Wisconsin State Hygiene Lab – This representative will be able to provide insight and data in regard to opiate-related Operating While Intoxicated incidents.
- Law Enforcement – This representative will be able to provide insight and information in regard to the impact heroin use has on the law enforcement community.
- Wisconsin Legislator – This representative will be able to assist in developing legislation that may aid in the reduction in heroin use.
- Wisconsin State Crime Lab – This representative will be able to provide data and trends analysis in regard to heroin submissions in the state of Wisconsin.
- District Attorney – This representative will be able to provide insight and data in regard to the number of heroin-related prosecutions and other criminal activity related to heroin use.

Recommendation 11: Increase access to substance use disorders (SUDs) and AODA treatment.

- Integrate high quality medication management and psychosocial interventions for substance abuse disorders such that both are available to consumers as their conditions indicate.
- Based on conversations with treatment providers, increased access to treatment should include medication management, residential treatment, when appropriate, and easier access to the treatment system through a one point entry system.
- Increase the affordability and access to opiate agonist therapy (MAT) throughout the state rather than a general increase in traditional AODA treatment.
- Increase access to SBIRT services.

Recommendation 12: Establish Drug Treatment Courts throughout the State.

- Those counties that currently do not have drug treatment courts should convene workgroups to determine the feasibility of establishing a DTC.
- All drug treatment courts should follow the Ten Key Components recommended by the National Association of Drug Treatment Court Professionals (see Appendix C).

Overview of Development of Waukesha Drug Treatment Court cont...

The program, which utilizes the Ten Key Components recommended by the National Association of Drug Treatment Court Professionals, is free to participants. The grant includes funding for intensive case management, training for the drug treatment court team (judges, DA’s Office, Public Defender, Human Services, law enforcement and case managers), participant incentives and rewards, drug testing and treatment. After the implementation of the program, a secondary grant was obtained to fund administration of prescription medications to assist in sobriety maintenance.

Waukesha County residents who are high-risk drug-addicted and have been charged with felonies and habitual criminality misdemeanors are potentially eligible to participate in DTC. Offenders with a current or past violent offense are not eligible. A participant enters a plea or pleas under an agreement reached between the prosecutor and defense counsel. The judge takes the plea(s), but withholds entry of judgment pending the defendant’s completion of the DTC.

The program can only accommodate approximately 25 participants at once. There is a waiting list.

Since the DTC began serving participants in March of 2012, several individuals have been discharged unsuccessfully from the program. At least one has suffered an overdose from which he was brought back to life by a Sheriff’s Deputy utilizing naloxone, and one suffered a fatal overdose. It is clear to us that this population of offenders will be very difficult to manage. While no participant has completed the program yet, we are encouraged by the short-term success of the majority of our participants.

Our hope is to establish a record of measurable success that would make a compelling case for the county to continue funding the program. Our DTC team recommends that the State of Wisconsin encourage the development of DTC programs statewide.

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Appendix A: Washington State Legislative Language

Washington State adopted SB5516 in 02/05/2010. The language used for the bill to pass the 911 Good Samaritan legislation as follows:

In NEW SECTION 1: The legislature intends to save lives by increasing timely medical attention to drug overdose victims through the establishment of limited immunity from prosecution for people who seek medical assistance in a drug overdose situation. Drug overdose is the leading cause of unintentional injury death in Washington State, ahead of motor vehicle related deaths. Washington State is one of sixteen states in which drug overdoses cause more deaths than traffic accidents. Drug overdose mortality rates have increased significantly since the 1990s, according to the centers for disease control and prevention, and illegal and prescription drug overdoses killed more than thirty-eight thousand people nationwide in 2006, the last year for which firm data is available. The Washington state department of health reports that in 1999, unintentional drug poisoning was responsible for four hundred three deaths in this state; in 2007, the number had increased to seven hundred sixty-one, compared with six hundred ten motor vehicle related deaths that same year. Many drug overdose fatalities occur because peers delay or forego calling 911 for fear of arrest or police involvement, which researchers continually identify as the most significant barrier to the ideal first response of calling emergency services.

In NEW SECTION 2: A new section is added to chapter 69.50 RCW to read as follows:

(1)(a) A person acting in good faith who seeks medical assistance for someone experiencing a drug-related overdose shall not be charged or prosecuted for possession of a controlled substance pursuant to RCW 69.50.4013, or penalized under RCW 69.50.4014, if the evidence for the charge of possession of a controlled substance was obtained as a result of the person seeking medical assistance. (b) A person acting in good faith may receive a naloxone prescription, possess naloxone, and administer naloxone to an individual suffering from an apparent opiate-related overdose.

(2) A person who experiences a drug-related overdose and is in need of medical assistance shall not be charged or prosecuted for possession of a controlled substance pursuant to RCW 69.50.4013, or penalized under RCW 69.50.4014, if the evidence for the charge of possession of a controlled substance was obtained as a result of the overdose and the need for medical assistance.

(3) The protection in this section from prosecution for possession crimes under RCW 69.50.4013 shall not be grounds for suppression of evidence in other criminal charges.

In NEW SECTION 3: A new section is added to chapter 18.130 RCW to read as follows: The administering, dispensing, prescribing, purchasing, acquisition, possession, or use of naloxone shall not constitute unprofessional conduct under chapter 18.130 RCW, or be in violation of any provisions under this chapter, by any practitioner or person, if the unprofessional conduct or violation results from a good faith effort to assist:

(1) A person experiencing, or likely to experience, an opiate- related overdose; or

(2) A family member, friend, or other person in a position to assist a person experiencing, or likely to experience, an opiate- related overdose.

In SECTION 4: RCW 9.94A.535 and 2008 c 276 s 303 and 2008 c 233 s are each reenacted and amended to read as follows: The court may impose a sentence outside the standard sentence range for an offense if it finds, considering the purpose of this chapter, that there are substantial and compelling reasons justifying an exceptional sentence. Facts supporting aggravated sentences, other than the fact of a prior conviction, shall be determined pursuant to the provisions of RCW 9.94A.537.

Whenever a sentence outside the standard sentence range is imposed, the court shall set forth the reasons for its decision in written findings of fact and conclusions of law. A sentence outside the standard sentence range shall be a determinate sentence. If the sentencing court finds that an exceptional sentence outside the standard sentence range should be imposed, the sentence is subject to review only as provided for in RCW 9.94A.585(4). A departure from the standards in RCW 9.94A.589 (1) and (2) governing whether sentences are to be served consecutively or concurrently is an exceptional sentence subject to the limitations in this section, and may be appealed by the offender or the state as set forth in RCW 9.94A.585 (2) through (6).

(1) Mitigating Circumstances - Court to Consider The court may impose an exceptional sentence below the standard range if it finds that mitigating circumstances are established by a preponderance of the evidence. The following are illustrative only and are not intended to be exclusive reasons for exceptional sentences.

(a) To a significant degree, the victim was an initiator, willing participant, aggressor, or provoker of the incident.

(b) Before detection, the defendant compensated, or made a good faith effort to compensate, the victim of the criminal conduct for any damage or injury sustained.

(c) The defendant committed the crime under duress, coercion, threat, or compulsion insufficient to constitute a complete defense but which significantly affected his or her conduct.

(d) The defendant, with no apparent predisposition to do so, was induced by others to participate in the crime.

(e) The defendant's capacity to appreciate the wrongfulness of his or her conduct, or to conform his or her conduct to the requirements of the law, was significantly impaired. Voluntary use of drugs or alcohol is excluded.

(f) The offense was principally accomplished by another person and the defendant manifested extreme caution or sincere concern for the safety or well-being of the victim.

(g) The operation of the multiple offense policy of RCW 9.94A.589 results in a presumptive sentence that is clearly excessive in light of the purpose of this chapter, as expressed in RCW 9.94A.010.

(h) The defendant or the defendant's children suffered a continuing pattern of physical or sexual abuse by the victim of the offense and the offense is a response to that abuse.

- (i) The defendant was making a good faith effort to obtain or provide medical assistance for someone who is experiencing a drug-related overdose.

(2) Aggravating Circumstances - Considered and Imposed by the Court The trial court may impose an aggravated exceptional sentence without a finding of fact by a jury under the following circumstances:

(a) The defendant and the state both stipulate that justice is best served by the imposition of an exceptional sentence outside the standard range, and the court finds the exceptional sentence to be consistent with and in furtherance of the interests of justice and the purposes of the sentencing reform act.

(b) The defendant's prior unscored misdemeanor or prior unscored foreign criminal history results in a presumptive sentence that is clearly too lenient in light of the purpose of this chapter, as expressed in RCW 9.94A.010.

(c) The defendant has committed multiple current offenses and the defendant's high offender score results in some of the current offenses going unpunished.

(d) The failure to consider the defendant's prior criminal history which was omitted from the offender score calculation pursuant to RCW 9.94A.525 results in a presumptive sentence that is clearly too lenient.

(3) Aggravating Circumstances - Considered by a Jury -Imposed by the Court Except for circumstances listed in subsection (2) of this section, the following circumstances are an exclusive list of factors that can support a sentence above the standard range. Such facts should be determined by procedures specified in RCW 9.94A.537.

(a) The defendant's conduct during the commission of the current offense manifested deliberate cruelty to the victim.

(b) The defendant knew or should have known that the victim of the current offense was particularly vulnerable or incapable of resistance.

(c) The current offense was a violent offense, and the defendant knew that the victim of the current offense was pregnant.

(d) The current offense was a major economic offense or series of offenses, so identified by a consideration of any of the following factors:(i) The current offense involved multiple victims or multiple incidents per victim;(ii) The current offense involved attempted or actual monetary loss substantially greater than typical for the offense;(iii) The

current offense involved a high degree of sophistication or planning or occurred over a lengthy period of time; or(iv) The defendant used his or her position of trust, confidence, or fiduciary responsibility to facilitate the commission of the current offense.

(e) The current offense was a major violation of the Uniform Controlled Substances Act, chapter 69.50 RCW (VUCSA), related to trafficking in controlled substances, which was more onerous than the typical offense of its statutory definition: The presence of ANY of the following may identify a current offense as a major VUCSA:(i) The current offense involved at least three separate transactions in which controlled substances were sold, transferred, or possessed with intent to do so;(ii) The current offense involved an attempted or actual sale or transfer of controlled substances in quantities substantially larger than for personal use;(iii) The current offense involved the manufacture of controlled substances for use by other parties;(iv) The circumstances of the current offense reveal the offender to have occupied a high position in the drug distribution hierarchy;(v) The current offense involved a high degree of sophistication or planning, occurred over a lengthy period of time, or involved a broad geographic area of disbursement; or(vi) The offender used his or her position or status to facilitate the commission of the current offense, including positions of trust, confidence or fiduciary responsibility (e.g., pharmacist, physician, or other medical professional).

(f) The current offense included a finding of sexual motivation pursuant to RCW 9.94A.835.

(g) The offense was part of an ongoing pattern of sexual abuse of the same victim under the age of eighteen years manifested by multiple incidents over a prolonged period of time.

(h) The current offense involved domestic violence, as defined in RCW 10.99.020, and one or more of the following was present:(i) The offense was part of an ongoing pattern of psychological, physical, or sexual abuse of the victim manifested by multiple incidents over a prolonged period of time;(ii) The offense occurred within sight or sound of the victim's or the offender's minor children under the age of eighteen years; or(iii) The offender's conduct during the commission of the current offense manifested deliberate cruelty or intimidation of the victim.(iv)The offense resulted in the pregnancy of a child victim of rape.

(j) The defendant knew that the victim of the current offense was a youth who was not residing with a legal custodian and the defendant established or promoted the relationship for the primary purpose of victimization.

(k) The offense was committed with the intent to obstruct or impair human or animal health care or agricultural or forestry research or commercial production.

(l) The current offense is trafficking in the first degree or trafficking in the second degree and any victim was a minor at the time of the offense.

(m) The offense involved a high degree of sophistication or planning.

(n) The defendant used his or her position of trust, confidence, or fiduciary responsibility to facilitate the commission of the current offense.

(o) The defendant committed a current sex offense, has a history of sex offenses, and is not amenable to treatment.

(p) The offense involved an invasion of the victim's privacy.

(q) The defendant demonstrated or displayed an egregious lack of remorse.

(r) The offense involved a destructive and foreseeable impact on persons other than the victim.

(s) The defendant committed the offense to obtain or maintain his or her membership or to advance his or her position in the hierarchy of an organization, association, or identifiable group.

(t) The defendant committed the current offense shortly after being released from incarceration.

(u) The current offense is a burglary and the victim of the burglary was present in the building or residence when the crime was committed.

(v) The offense was committed against a law enforcement officer who was performing his or her official duties at the time of the offense, the offender knew that the victim was a law enforcement officer, and the victim's status as a law enforcement officer is not an element of the offense.

(w) The defendant committed the offense against a victim who was acting as a Good Samaritan.

(x) The defendant committed the offense against a public official or officer of the court in retaliation of the public official's performance of his or her duty to the criminal justice system.

(y) The victim's injuries substantially exceed the level of bodily harm necessary to satisfy the elements of the offense. This aggravator is not an exception to RCW 9.94A.530 (2).

(z)(i)(A) The current offense is theft in the first degree, theft in the second degree, possession of stolen property in the first degree, or possession of stolen property in the second degree; (B) The stolen property involved is metal property; and (C) The property damage to the victim caused in the course of the theft of metal property is more than three times the value of the stolen metal property, or the theft of the metal property creates a public hazard. (ii) For purposes of this subsection, "metal property" means commercial metal property, private metal property, or nonferrous metal property, as defined in RCW 19.290.010.

(aa) The defendant committed the offense with the intent to directly or indirectly cause any benefit, aggrandizement, gain, profit, or other advantage to or for a criminal street gang as defined in RCW 9.94A.030, its reputation, influence, or membership.

SECTION 5: RCW 18.130.180 and 2008 c 134 s 25 are each amended to read as follows: The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:

(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;

(3) All advertising this is false, fraudulent, or misleading;

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which create an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

- (5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;
- (6) Except when authorized by section 3 of this act, the possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;
- (7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;
- (8) Failure to cooperate with the disciplining authority by:
- (a) Not furnishing any papers, documents, records, or other items;
 - (b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;
 - (c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or
 - (d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;
- (9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;
- (10) Aiding or abetting an unlicensed person to practice when a license is required;
- (11) Violations of rules established by any health agency;
- (12) Practice beyond the scope of practice as defined by law or rule; (13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;
- (14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;
- (15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving.

(16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;

(17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(18) The procuring, or aiding or abetting in procuring, a criminal abortion;

(19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority;

(20) The willful betrayal of a practitioner-patient privilege as recognized by law;

(21) Violation of chapter 19.68 RCW;

(22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding; (23)

Current misuse of: (a) Alcohol; (b) Controlled substances; or (c) Legend drugs;(24) Abuse of a client or patient or sexual contact with a client or patient;

(25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health- related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards."

On page 1, line 1 of the title, after "prevention;" strike the remainder of the title and insert "amending RCW 18.130.180; reenacting and amending RCW 9.94A.535; adding a new section to chapter 69.50 RCW; adding a new section to chapter 18.130 RCW; and creating a new section."

EFFECT: A person will not be charged or prosecuted for possession of a controlled substance under the Uniform Controlled Substances Act if: (1) That person believes he or she is witnessing a drug-related overdose and seeks medical assistance for that person in good faith; or(2) that person experiences a drug-related overdose and is in need of medical assistance. A person will also not be charged if the evidence for the charge of

possession of a controlled substance under RCW 69.50.4013, or penalty under RCW 69.50.4014, was obtained as a result of that person seeking or receiving medical assistance. However, that person remains liable for charges of manufacturing or sale of a controlled substance. This protection does not apply to suppression of evidence in other criminal charges.

A person acting in good faith may receive, possess, and administer naloxone to an individual suffering from an apparent opiate-related overdose. Health practitioners or persons who administer, dispense, prescribe, purchase, acquire, possess, or use naloxone in a good faith effort to assist a person experiencing or likely to experience an opiate-related overdose will not be in violation of professional conduct standards or provisions.

A court may impose an exceptional sentence below the standard range if it finds that mitigating circumstances are established by a preponderance of the evidence including, but not limited to, a defendant's good faith effort to obtain or provide medical assistance for someone experiencing a drug-related overdose.

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Appendix B: Wisconsin Data Indicators and Sources

WISCONSIN STATEWIDE DRUG CONSEQUENCE AND CONSUMPTION DATA Expansion of WI Epidemiological Profile on Alcohol & Other Drugs

- Drug-Related Deaths [by county]
- Poisoning Deaths, opiate-related deaths or multi-drug deaths with opiates mentioned [statewide and county, if possible]
Data source: Division of Public Health, Office of Health Informatics
- Drug Poisoning and Opiate Poisoning Hospital Visits (ED & Hospital Admissions)- [statewide and by county]
- Drug-related Substance Related Disorder (abuse, dependence and psychosis) and Opiate Non-Dependent Abuse & Dependence [statewide]
Data source: Division of Public Health, Office of Health Informatics
- EMS Calls for Naloxone Dosing [Select agencies within Counties]
Data source: County Emergency Medical Service providers
- Naloxone Use (saves) Report in Community Programs (Overdose Prevention) [statewide and by Region]
Data source: ARCW's Lifepoint Fatal Overdose Prevention Program
- Police Report Drug Data - All Drug Overdoses & Deaths and Opiate Overdoses and Deaths by type [by County]
Data source: WI Department of Justice, Div. Of Criminal Investigation, Field Operations Bureau and local County law enforcement agencies - narcotics
- Drug Behavior (Consumption) for Youth:
 - Use of prescription drugs for non-medical purposes (regional data?)
Data source: National Survey on Drug Use, SAMSHA, Division of Public Health, Office of Health Informatics
 - Heroin use (lifetime) [by county]
Data source: Youth Risk Behavioral Surveillance System, WI of Public Instruction
- Substance Abuse Treatment - Methadone Clinic admissions [statewide & by local geographic area]
Data source: Division of Mental Health and Substance Abuse Services, Bureau of Treatment, Prevention & Recovery; local methadone clinic

Appendix C: Ten Key Components of Drug Treatment Courts

1. Drug courts integrate alcohol and other drug treatment services with justice system case processing.
2. Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
3. Eligible participants are identified early and promptly placed in the drug court program.
4. Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
5. Abstinence is monitored by frequent alcohol and other drug testing.
6. A coordinated strategy governs drug court responses to participants' compliance.
7. Ongoing judicial interaction with each drug court participant is essential.
8. Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
9. Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
10. Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

Reproduced from the National Association of Drug Court Professionals. (1997, January). *Defining drug courts: The key components*. Washington, DC: Drug Courts Program Office, Office of Justice Programs, U.S. Department of Justice.