SB

23

<TARGET><BILL>SB 23</BILL><SUBJECT>SB
23</SUBJECT><COMM>SJUD29</COMM></TARGET>

SENATE COMMITTEE REPORT

DATE: 3/25/15

FURTHER: Rules

DATE TURNED IN TO OFFICE: 4/1/15

Judiciary Committee considered SENATE BILL NO. 23

SB 23 IMMUNITY FOR PROVIDING OPIOID OD DRUG

"An Act relating to immunity for prescribing, providing, or administering opioid overdose drugs."

and recommends:

[✓] be **replaced** with **CS** SB 23 ___ (JUD) [ ] *Same Title* [✓] *New Title*

[ ] adopt **previous CS** _____ (_____) [ ] *Same Title* [ ] *New Title*

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

Dept Abbr.	
ADM	LWF
CED	LAW
COR	LEG
EED	MVA
DEC	DNR
DFG	DPS
GOV	REV
DHS	DOT
AJS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
COR			✓	3

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
CED			✓	2

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Coghill	✓			
	COSTELLO	✓			
	Wielechowski	✓			
CHAIR:	McGuire	✓			

ALASKA STATE LEGISLATURE

While in Session
State Capitol
Juneau, AK 99801
(907) 465-3704
Fax: (907) 465-2529

While in Anchorage
716 W. 4th Ave
Anchorage, AK
(907) 269-0169
Fax: (907) 269-0172

SENATOR JOHNNY ELLIS

Senate Bill 23 - Sectional Analysis

Section 1. Amends AS 09.65 by adding a new section (09.65.340) to give immunity for prescribing, providing, or administering an opioid overdose drug

Subsection (a) exempts a person from civil liability if providing or prescribing an opioid overdose drug if the prescriber or provider is a health care provider or an employee of an opioid overdose program and the person has been educated and trained in the proper emergency use and administration of the opioid overdose drug

Subsection (b) except as provided in (c) exempts a person who administers an opioid overdose drug to another person who the person reasonably believes is experiencing an opioid overdose emergency if the person

1. Was prescribed or provided the drug by a health care provider or opioid overdose program and
2. Received education and training in the proper emergency use and administration

Subsection (c) does not preclude liability for civil damages that are a result of gross negligence or reckless or intentional misconduct

Subsection (d) defines

1. "health care provider" as a licensed physician, advanced nurse practitioner, physician assistant, village health aide3, or pharmacist operating within the scope of the health care provider's authority;
2. "opioid" includes the opium and opiate substances and opium and opiate derivatives listed in AS 11.71.140
3. "opioid overdose drug" means a drug that reverses in whole or part the pharmacological effects of an opioid overdose
4. "opioid overdose program" means a program operated or otherwise funded by the federal government, the state, or a municipality that provides opioid overdose drugs to persons at risk of experiencing an opioid overdose or to a family member, friend, or other person in a position to assist a person at risk of experiencing an overdose.

ALASKA STATE LEGISLATURE

SENATOR JOHNNY ELLIS

SPONSOR STATEMENT – SENATE BILL 23

SB 23 – An act relating to immunity for prescribing, providing, or administering overdose drugs.

Heroin and opioid pain reliever (OPR) use and abuse constitute a dangerous and growing public health threat throughout Alaska, yet one of the medical tools to reverse opioid overdoses are currently unavailable when needed most. Senate Bill 23 removes civil liabilities from doctors who prescribe and trained bystanders who administer naloxone, or Narcan, an opiate antidote which reverses opiate drug overdoses thereby saving the life of the victim.

Although naloxone is a prescription drug, it is not a controlled substance and has no abuse potential. It is most commonly injected intravenously for fastest action or in a nasal spray, which usually causes the drug to act within a minute, and last up to 45 minutes. A 2002–2004 study referenced by the Centers for Disease Control (CDC) found that 50 naloxone programs nationwide had reversed more than 10,000 overdoses.

Recently, the American Medical Association endorsed the training of lay people in the use of naloxone to prevent overdoses, and the U.S. Drug Czar remarked that naloxone distribution is a key component of overdose prevention. 26 other states and the District of Columbia have passed naloxone access laws as a result of growing opioid use and overdose rates. That's up from 18 in 2013 and just eight in 2012.

OPR and heroin overdoses constitute a growing public health threat nationally, and have reached a crisis level in Alaska. According to the Alaska State Troopers' 2014 Annual Drug Report, there has been a resurgence of heroin and other opiate use and abuse in the last few years, identifying an increase in heroin abuse and the continued abuse of other opiates as significant concerns in both urban and rural Alaska. Lieutenant Rex Leath, deputy commander of the troopers' Statewide Drug Enforcement Unit commented upon reviewing the report that, "the whole state has been really adamant that they feel like heroin is taking over their neighborhoods. Heroin, it literally is killing our kids."

The Anchorage Police Department (APD) reported a 94% increase in heroin seizures in 2013, and heroin-related overdoses are now claiming more young lives than traffic fatalities.

Last year, the Legislature wisely passed HB 369 referred to as the "Make the Call" Good Samaritan bill, offering a restriction from prosecution to those who alert the authorities when someone they're with experiences an overdose. SB 23 further addresses Alaska's opioid abuse epidemic by removing some legal barriers to the timely administration of naloxone.

While rehabilitation and drug enforcement are still critical to stemming the tide of this epidemic, SB 23 gives Alaskans who need it a vital tool that could save Alaskan lives. I strongly urge you to join in support of Senate Bill 23.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: SB 23
Fiscal Note Number:
() Publish Date:

Identifier: SB023-DCCED-CBPL-03-14-15
Title: IMMUNITY FOR PROVIDING OPIOID OD DRUG
Sponsor: ELLIS
Requester: (S) Health and Social Services

Department: Department of Commerce, Community and Economic Development
Appropriation: Corporations, Business and Professional Licensing
Allocation: Corporations, Business and Professional Licensing
OMB Component Number: 2360

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Fund Source (Operating Only)

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							

Estimated SUPPLEMENTAL (FY2015) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By: Janey Hovenden, Director — Phone: (907)465-2538
Division: Corporations, Business, and Professional Licensing — Date: 03/14/2015 09:55 AM
Approved By: Catherine Reardon, Director — Date: 03/14/15
Agency: Division of Administrrative Services, DCCED

The Network for Public Health Law

Ideas. Experience. Practical answers.

LEGAL INTERVENTIONS TO REDUCE OVERDOSE MORTALITY: NALOXONE ACCESS AND OVERDOSE GOOD SAMARITAN LAWS

Background

Fatal drug overdose has increased more than six-fold in the past three decades, and now claims the lives of over 36,000 Americans every year.[1] The epidemic is largely driven by prescription opioids, which were responsible for over 16,000 deaths in 2010.[2] This increase is mostly driven by prescription opioids such as OxyContin and hydrocodone, which now account for more overdose deaths than heroin and cocaine combined.[3] Opioid overdose is typically reversible through the timely administration of the medication naloxone and the provision of emergency care.[4] However, access to naloxone and other emergency treatment is often limited by laws and regulations and that pre-date the overdose epidemic. In an attempt to reverse this unprecedented increase in preventable overdose deaths, a number of states have recently amended those laws to increase access to emergency care and treatment for opiate overdose.

Law as both problem and solution

Although naloxone (commonly known by its trade name, Narcan) is a prescription drug, it is not a controlled substance and has no abuse potential.[5] It is regularly carried by medical first responders and can be administered by ordinary citizens with little or no formal training.[6] Yet, it is often not available when and where it is needed. Because opioid overdose often occurs when the victim is with friends or family members, those people may be the best situated to act to save his or her life by administering naloxone. Unfortunately, neither the victim nor his companions typically carry the drug. Law is at least partially responsible for this lack of access. State practice laws generally discourage or prohibit the prescription of drugs to a person other than the intended recipient (a process referred to as third-party prescription) or to a person the physician has not personally examined (a process referred to as prescription via standing order). Additionally, some prescribers are wary of prescribing naloxone because of liability concerns.[7] Likewise, even where naloxone is available, bystanders to a drug overdose may be afraid to administer it for fear of legal repercussions.[8] Finally, overdose bystanders may fail to summon medical assistance for fear of legal consequences.[9]

Since most of these barriers are rooted in unintended consequences of laws passed for other purposes, they may be addressed through relatively simple changes to those laws. At the urging of organizations including the U.S. Conference of Mayors, the American Medical Association and the American Public Health Association, a number of states have addressed the overdose epidemic by removing some legal barriers to the seeking of emergency medical care and the timely administration of naloxone.[10] These changes come in two general varieties: the first encourages the wider prescription and use of naloxone by clarifying that prescribers acting in good faith may prescribe the drug to persons who may be able to use it to reverse overdose and by removing the possibility of negative legal action against prescribers and lay administrators.[11] The second type encourages bystanders to become "Good Samaritans" by summoning emergency responders without fear of arrest or other negative legal consequences.[12]

Overview of naloxone access and Good Samaritan laws

In 2001, New Mexico became the first state to amend its laws to make it easier for medical professionals to prescribe and dispense naloxone, and for lay administrators to use it without fear of legal repercussions. [13] As of December 15, 2014, twenty-six other states (NY, IL, WA, CA, RI, CT, MA, NC, OR, CO, VA, KY, MD, VT, NJ, OK, UT, TN, ME, GA, WI, MN, OH, DE, PA and MI) and the District of Columbia have made similar changes (28 total).[14] Based partly on these changes, at least 188 community-based overdose prevention programs now distribute naloxone. As of 2010, those programs had provided training and naloxone to over 50,000 people, resulting in over 10,000 overdose reversals.[15] A recent evaluation of one such program in Massachusetts, which trained over 2,900 potential overdose bystanders, reported that opioid overdose death rates were significantly reduced in communities in which the program was implemented compared to those in which it was not.[16]

In 2007, New Mexico became the first state to amend its laws to encourage Good Samaritans to summon aid in the event of an overdose. As of December 15, 2014, nineteen other states (WA, NY, CT, IL, CO, RI, FL, MA, CA, NC, NJ, VT, DE, MN, GA,WI, AK, LA, MD, and PA) and the District of Columbia have followed suit (22 total).[17] Additionally, Indiana[18] permits courts to consider the fact that a Good Samaritan summoned medical assistance in mitigation, and Utah law provides that a person who reports an overdose and takes other steps may use that fact as an affirmative defense to some offenses, and can be raised as a mitigating factor at sentencing for others.[19] Initial evidence from Washington state, which amended its law in 2010, is positive, with 88 percent of drug users surveyed indicating that they would be more likely to summon emergency personnel during an overdose as a result of the legal change.[20]

The following tables document laws that have been amended or enacted to increase access to naloxone and encourage bystanders to summon medical assistance in the event of overdose. Tables 1 and 1a cover laws aimed at increasing lay access to naloxone by reducing barriers to prescription and administration ("state naloxone access laws"). Tables 2 and 2a address criminal concerns for Good Samaritans who summon aid in overdose situations ("state overdose Good Samaritan laws"). Tables 1 and 2 are broken down into columns, with each column identifying whether a particular state law addresses a certain characteristic. Tables 1a and 2a provide more detailed descriptions of each law, with quotes from those laws where practicable. For those states that have passed laws too recently for those laws to have been codified, only the relevant bill is listed. This chart will be updated regularly to reflect changes in this rapidly evolving area of law.

Note that these tables cover only laws that were passed specifically to address drug overdose. That does not necessarily mean the activities covered by the laws in these tables are not permitted in other states, only that they are not explicitly authorized by laws created for that purpose. For example, North Carolina's Project Lazarus, which has seen marked success using an integrated model that includes partnering with local physicians, pharmacists and law enforcement officials, operated for many years without the benefit of explicit authorizing legislation.[21] The categories listed were chosen because of their prevalence in existing laws and may not necessarily reflect best practices.[22]

Conclusion

Opioid overdose kills thousands of Americans every year. Many of those deaths are preventable through the timely provision of a relatively cheap, safe and effective drug and the summoning of emergency responders. As with most public health problems, there is no magic bullet to preventing overdose deaths. A comprehensive solution that includes input and active involvement from medical providers, policymakers and public health, law enforcement and elected officials is likely necessary to create large-scale, lasting change. Evaluation is necessary to ensure that legal changes have the intended effect and to suggest additional amendments.[23]

However, it is reasonable to believe that laws that encourage the prescription and use of naloxone and the timely seeking of emergency medical assistance will have the intended effect of reducing opioid overdose deaths. Since such laws have few if any foreseeable negative effects, can be implemented at little or no cost, and will likely save both lives and resources, they may represent some of the lowest-hanging public health fruit available to policymakers today.

Alaska State Troopers

Alaska Bureau of Investigation
Statewide Drug Enforcement Unit

2014 Annual Drug Report

2014 ANNUAL DRUG REPORT

TABLE OF CONTENTS

INTRODUCTION

The Alaska State Troopers' Alaska Bureau of Investigation, Statewide Drug Enforcement Unit (SDEU) in authoring this publication, has endeavored to represent the drug and illegal alcohol situation in Alaska in a manner that provides the broadest possible picture of the true illicit drug situation.

There are numerous Municipal, Borough, and Federal agencies that conduct drug investigations in Alaska. While some agencies have less formal relationships with the Department of Public Safety, many work closely and collaboratively with the Alaska State Troopers. In order to properly represent the true drug and illegal alcohol situation in Alaska, statistics from as many agencies in Alaska as possible are included in this report. While we made an effort to provide the most accurate seizure data and made a deliberative effort to avoid duplication, there are instances where a specific seizure may have been counted in more than one report. Information provided by all sources should be considered when attempting to measure how drugs and illegal alcohol are impacting the citizens of this state.

We believe including as much information from all agencies involved in drug and illegal alcohol enforcement in Alaska is vital when analyzing the needs of the state in the arena of drug and illegal alcohol enforcement. However, it is important to note that the numbers alone should not be the sole source from which to make a complete assessment of the true drug and illegal alcohol situation in Alaska. To get the most accurate picture of the illicit drug and alcohol situation within Alaska, we have attempted to take into account the anecdotal information gathered from conversations with those investigators on the frontlines of Alaska's efforts to investigate, document, and apprehend those who have chosen to participate in Alaska's illicit drug and alcohol culture.

OUR MISSION

SDEU provides a team-building role in coordinating law enforcement's efforts to reduce the availability of illegal alcohol and controlled substances throughout Alaska. SDEU recognizes that a successful alcohol and drug interdiction program depends upon a unified effort—blending traditional law enforcement techniques with demand reduction programs that address educational, social, and community concerns.

SDEU's Mission is to:

- Interdict and seize alcohol and controlled substances that are illegally distributed throughout Alaska.
- Identify and arrest distributors of controlled substances and illegal alcohol.
- Provide training and investigative support to criminal justice agencies.
- Support and participate in public education programs.

STAFFING AND SUPPORT

SDEU recognizes that because of Alaska's geographical vastness, no single law enforcement agency is capable of addressing the illegal drug and alcohol issues alone. Using a combination of federal and state funding, the Department of Public Safety helps to fund a number of multi-jurisdictional task forces around the state. SDEU encourages cooperative efforts between federal, state, and local law enforcement agencies and has taken a leadership role in fostering and developing many cooperative arrangements through multi-jurisdictional and/or multi-agency efforts. The ABI-SDEU Headquarters office in Anchorage primarily participates in six (6) investigative task forces throughout the state. These teams are broken down by region as follows:

- Alaska Interdiction Task Force / Anchorage Enforcement Group (DEA sponsored)
- Fairbanks Area-wide Narcotics Team
- Mat-Su Narcotics Enforcement Team
- South Central Area-wide Narcotics Team
- Southeast Alaska Cities Against Drugs Task Force
- Western Alaska Alcohol and Narcotics Team

State Wide Drug Enforcement Unit Map

Additional specific information on the individual units can be found at: http://dps.alaska.gov/AST/ABI/SDEU.aspx

SDEU participates with and receives assistance from several investigative agencies involved in drug enforcement. These agencies include the Drug Enforcement Administration (DEA); Federal Bureau of Investigation (FBI); the US Postal Inspection Service; the Internal Revenue Service (IRS); Bureau of Alcohol, Tobacco, Firearms and Explosives (BATFE); Department of Homeland Security (DHS), to include US Immigration and Customs Enforcement (ICE), and the United States Coast Guard (USCG). SDEU also works closely with other local law enforcement agencies.

DRUGS OF CHOICE

Alcohol, cocaine, heroin, marijuana, methamphetamine, and prescription drugs have been identified as the primary substances of abuse and are the focus of most Alaskan law enforcement efforts.

During 2014, the Alaska State Troopers did not investigate or respond to a single report of a methamphetamine lab, down from five the previous year. Despite progress in eradicating methamphetamine labs throughout the state and enhanced methamphetamine precursor laws in 2006, methamphetamine continues to be readily available throughout Alaska and arrives mostly from sources outside of the state.

The apparent increase of the abuse of heroin and continued abuse of other opiates (including various opioid based prescription medications) is of significant concern, primarily in the urban areas. Alcohol and marijuana continue to be the overwhelming drugs of choice for rural Alaska; however, seizures of methamphetamine, heroin, and prescription drugs have been increasing in smaller rural communities in 2014.

HEROIN

Heroin is a highly addictive drug derived from morphine which is obtained from the opium poppy. It is a "downer" or depressant that affects the brain's pleasure systems and interferes with the brain's ability to perceive pain. It is a white to dark brown powder, or a tar-like substance. Heroin can be used in a variety of ways, depending on the user's preference and the purity of the drug. Heroin can be injected into a vein or muscle, smoked in a water pipe or standard pipe, mixed in a marijuana joint or regular cigarette, inhaled as smoke through a straw, or snorted as a powder via the nose.

The short term effects of heroin abuse appear soon after a single dose and disappear after a few hours. After an injection of heroin, the user reports feeling a surge of euphoria accompanied by a warm flushing of the skin, a dry mouth, and heavy extremities.

Heroin use is not isolated to the urban areas of Alaska. Undercover buys and interdictions of heroin have been reported in several smaller communities. Heroin is primarily imported into Alaska via parcels and body carries. Investigations have shown that heroin use crosses socio-economic boundaries.

SDEU Heroin Statistics

Heroin Seized (Pounds)

2012	2013	2014
4.93	55.12	22.42

Heroin Charges/Arrests

2012	2013	2014
146	151	209

Administer Naloxone

Overdose Response

Nasal Naloxone:

1. Do rescue breathing for a few quick breaths if the person is not breathing.
2. Affix the nasal atomizer (applicator) to the needleless syringe and then assemble the glass cartridge of naloxone (see diagram).
3. Tilt the head back and spray half of the naloxone up one side of the nose (1cc) and half up the other side of the nose (1cc).
4. If there is no breathing or breathing continues to be shallow, continue to perform rescue breathing for them while waiting for the naloxone to take effect.
5. If there is no change in 3-5 minutes, administer another dose of naloxone and continue to breathe for them. If the second dose of naloxone does not revive them, something else is wrong—either it has been too long and the heart has already stopped, there are no opioids in their system, or the opioids are unusually strong and require more naloxone (can happen with Fentanyl, for example).

Nasal Naloxone – *Photo: N.O.M.A.D (Not One More Anonymous Death)*

Injectable Naloxone:

Injectable naloxone comes packaged in several different forms- a multi dose 10 mL vial and single dose 1mL flip-top vials with a pop off top. With all formulations of naloxone, it is important to check the expiration date and make sure to keep it from light if it is not stored in a box. If someone has an injectable formulation of naloxone, all of the steps in recognizing and responding to an overdose are the same except how to give the naloxone. To use injectable naloxone:

1. Do rescue breathing for a few quick breaths if the person is not breathing.
2. Use a long needle: 1 – 1 ½ inch (called an IM or intramuscular needle)- needle exchange programs and pharmacies have these needles.
3. Pop off the orange top vial
4. Draw up 1cc of naloxone into the syringe 1cc=1mL=100u.
5. Inject into a muscle – thighs, upper, outer quadrant of the butt, or shoulder are best.
6. Inject straight in to make sure to hit the muscle.
7. If there isn't a big needle, a smaller needle is OK and inject under the skin, but if possible it is better to inject into a muscle.
8. After injection, continue rescue breathing 2-3 minutes.
9. If there is no change in 2-3 minutes, administer another dose of naloxone and continue to breathe for them. If the second dose of naloxone does not revive them, something else may be wrong—either it has been too long and the heart has already stopped, there are no opioids in their system, or the opioids are unusually strong and require more naloxone (can happen with Fentanyl, for example).

Once naloxone has been delivered and if the person is not breathing, continued rescue breathing is important until help arrives.

Naloxone only lasts between 30 – 90 minutes , while the effects of the opioids may last much longer. It is possible that after the naloxone wears off the overdose could recur. It is very important that someone stay with the person and wait out the risk period just in case another dose of naloxone is necessary. Also, naloxone can cause uncomfortable withdrawal feelings since it blocks the action of opioids in the brain. Sometimes people want to use again immediately to stop the withdrawal feelings. This could result in another overdose. Try to support the person during this time period and encourage him or her not to use for a couple of hours.

IMPORTANT!

If a victim is not responsive to stimulation, not breathing, and has no pulse after receiving naloxone and rescue breathing, then the victim needs cardiopulmonary resuscitation (CPR) via a trained bystander and the emergency medical system. ***Call 911!***

Next Page: Aftercare

THE PEW CHARITABLE TRUSTS

Stateline

The Changing Face of Heroin

February 04, 2015

By Teresa Wiltz

Phil Wahby, an outreach coordinator with the STLHeroinHelp organization, waves to motorists during an anti-heroin rally in Belleville, Illinois. (AP)

On Super Bowl Sunday, most football fans watched ads for Victoria's Secret, the lost Budweiser dog and a deadpan Kim Kardashian extolling the virtues of T-Mobile. But in St. Louis, those national ads were supplemented with a different kind of Super Bowl commercial.

On screen, the camera focused on the face of a white middle class teenager as he died of a heroin overdose. Off screen, a singer crooned along to perky guitar music: *First you stole prescription pills from your mom/You threw back a few and then they were gone/So you're jonesing real bad and you need some more… And that's how, how you got addicted to heroin.*

Beginning in the 1920s, when heroin became illegal, people tended to think of heroin abuse as a problem plaguing people of color in the big cities. But in the past decade, heroin abuse has exploded—and it is hitting white people in suburbs and rural areas particularly hard. As the demographics of heroin use have changed, so have states' efforts to combat the problem.

"People have recognized that (heroin addiction) is a problem facing folks they know as well as groups that are distant from them. That certainly affects the way you view the problem," said Kurt Schmoke, who as Baltimore mayor from 1987 to 1999 was harshly criticized for his efforts to decriminalize drug use.

Twenty-seven states and the District of Columbia now have laws designed to make naloxone, a heroin antidote that is 99 percent effective, more easily accessible to overdose victims, according to the Network for Public Health Law. Since 2007, 21 states and the District adopted so-called "Good Samaritan laws" that provide some type of immunity for people calling 911 to report or seek help for an overdose.

Last year, Vermont Gov. Peter Shumlin, a Democrat, devoted his entire State of the State speech to his state's heroin crisis. Last month, Republican Gov. Larry Hogan of Maryland declared a "state of emergency" and pledged to dedicate resources to combat

the heroin scourge in his state. And last week Democratic Virginia Gov. Terry McAuliffe introduced six heroin-related bills.

"In some states, now that budgets are generally looking better, states are looking at this as a different problem than in the previous decade," said Karmen Hanson, program manager for the National Conference of State Legislatures (NCSL). "It's not just an urban problem; it's a rural problem. It's not just under the viaduct in the big cities. It's also a suburban problem. It's widespread culturally and ethnographically."

Explosive—and Widespread—Growth

Between 2006 and 2013, the number of first time heroin users nearly doubled, from 90,000 to 169,000, according to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Ninety percent of the people who tried the drug for the first time in the past decade are white, compared to an equal number of white and nonwhite users who got their start before the 1980s, according to a study published last year in *JAMA Psychiatry*.

"Heroin use has changed from an inner-city, minority-centered problem to one that has a more widespread geographical distribution, involving primarily white men and women in their late 20s living outside of large urban areas," researchers concluded.

Perhaps not coincidentally, the past two years have seen a remarkable uptick in "harm reduction" laws that focus on saving lives, rather than incarcerating users.

"With the changing demographics, there is the ability to frame this as a public health issue because many policy makers and law enforcement folks seem to relate to white users who are experiencing heroin use disorders more than people of color," said Kathie Kane-Willis, director of the Illinois Consortium on Drug Policy at Roosevelt University. Kane-Willis is a former heroin user who was introduced to the drug as a college student at Sarah Lawrence College in the late 1980s.

Ted Cicero, a psychiatry professor at Washington University Medical School and a coauthor of the JAMA study, agreed that "when heroin became a white problem of middle-class kids," that got lawmakers' attention. "Now that it's hit home (for some legislators), it's become a major, major issue. No question the epidemic is growing. The demand is growing for it. And as long as there is that demand, the need will be met."

The shifting attitude fits a historical pattern, according to Marc Mauer, executive director of The Sentencing Project, a nonprofit that promotes sentencing reforms. In the 1930s, he said, the popular perception of marijuana was that it was "used in the racy part of town, in jazz clubs. The public perception was the users were Mexicans and African-Americans." As a result, Mauer said, marijuana was viewed as "the demon drug" and penalties for its use were harsh.

But by the 1960s, white middle-class youth had started smoking pot and perceptions changed. Several decades later, Washington state and Colorado have legalized recreational marijuana use and other states are poised to follow suit.

Pain-Killer Roots

The 21st century heroin epidemic has its roots in the crackdown on the abuse of OxyContin, Vicodin and other opioid pain medications. According to the U.S. Department of Health and Human Services, nearly 80 percent of heroin users say that they previously abused prescription opioids. When, for example, the formula for OxyContin was tweaked to make it more difficult to grind up to snort or inject, many abusers switched to heroin.

The shuttering of so-called "pill mills" also contributed to the scarcity of prescription opiates.

Meanwhile, drug traffickers peddling heroin slashed their prices to undercut the rising prices of prescription opiates—and a new market was created. Heroin supplies increased exponentially as well. Between 2007 and 2013, seizures of the drug increased 289 percent, according to the Office of National Drug Control Policy.

"The face of heroin changed with the rise and use of prescription drugs," said Barbara Cimaglio, the deputy commissioner of Alcohol and Drug Abuse Programs with the Vermont Department of Health. "We found more people getting into trouble because they had an injury or some medical condition that got them involved with prescription opiates. Then when a lot of those folks were no longer able to get those prescription opiates, it was heroin because it was cheaper and easier to get."

Among those who started using heroin in the 1960s, more than 80 percent reported that heroin was the first drug that they had ever used. Of those who began using heroin in the 2000s, 75 percent reported that their first drug use began with prescription opiates. Beginning in 2010, as heroin use increased across the country, prescription opioid use decreased, Cicero of Washington University said.

A New Battle Plan

To address Vermont's runaway heroin problem—the state saw a 250 percent increase in people seeking treatment for heroin addiction between 2000 and 2014—lawmakers set up a pretrial services system, Cimaglio said. The system allows people arrested on drug charges to get screened for substance abuse and gives them the option of going to treatment rather than being charged with a crime and entering the criminal justice system.

This usually works when officials are able to determine that the arrestee's criminal activity was related to addiction and that they are not a drug dealer or trafficker, Cimaglio said.

"People are much more aware that addiction is a health problem. Because of the illegality of certain substances, people are driven to commit acts they wouldn't have to commit to get alcohol," Cimaglio said.

As Baltimore mayor, Schmoke faced considerable criticism for turning the war on drugs into a public health issue. For his efforts to implement a needle exchange program to reduce the spread of HIV/AIDS, he was dubbed "the most dangerous man in America" by U.S. Rep. Charles Rangel, a Democrat.

Now, Schmoke said, he watches with bemusement today's legislative efforts to combat heroin addiction.

"I obviously wish that elected officials had embraced the idea of a public health war on drugs rather than criminal justice war on drugs," said Schmoke, now president of the University of Baltimore. "It would have allowed us to reduce our incarcerated population; it would have left people without criminal records that now complicate their ability to get employment and lead stable lives."

"(But) that's in the past now. We can only look to the future and focus more on the public health aspects of this rather than the criminal justice aspect."

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Changing Law from Barrier to Facilitator of Opioid Overdose Prevention

Corey Davis, Damika Webb, and Scott Burris

Background

Drug overdose has recently surpassed motor vehicle accidents to become the leading cause of unintentional injury death in the United States.[1] The epidemic is largely driven by opioids such as oxycodone, hydrocodone, and methadone, which kill more Americans than heroin and cocaine combined.[2] The demographics of overdose have changed over the past few decades as well: according to the latest data, the average overdose victim is now a non-Hispanic white man aged 45-54.[3]

These deaths — over 16,000 per year — are almost entirely preventable. Opioid overdose kills by slowly depressing respiration, a process that can take several hours.[4] It can be quickly and effectively reversed by the timely administration of naloxone, an opioid antagonist that works by displacing opioids from the brain receptors to which they attach, reversing their depressant effect.[5] Naloxone, also known as Narcan, has many benefits and minimal risks.[6] Although it is a prescription drug, it is not a controlled substance and has no abuse potential.[7] It is regularly carried by medical first responders, and can be administered by ordinary citizens with little or no formal training.[8] Yet, this life-saving drug is often not available when and where it is needed.

Law is a primary driver of this lack of access. Because opioid overdose often occurs when the victim is with friends or family members, those people may be the best situated to act to save his or her life by administering naloxone.[9] Unfortunately, neither the victim nor his or her companions typically carry the drug.[10] Naloxone is available only via prescription, and state practice laws generally discourage or prohibit the prescription or dispensing of drugs to a person other than the intended recipient (a process referred to as third-party prescription).[11] But prescribers are in short supply, and people at risk of overdose may be uncomfortable with requesting a naloxone prescription or may not have the knowledge and foresight to do so. Even where the request is made, some prescribers are wary of prescribing naloxone because of liability concerns.[12]

Evidence shows that overdose bystanders are willing and able to safely administer naloxone in an overdose situation.[13] However, since bystanders often do not have the drug, they must call 911 to summon the first responders who do. Unfortunately, they often refrain from doing so because they fear arrest and prosecution — a fear that evidence suggests may be justified.[14] When first responders are summoned, it is often too late: a review of medical examiner data in North Carolina showed that over half of accidental overdose victims died by the time paramedics arrived.[15]

These legal barriers are unintended consequences of attempts to address other problems. The public interest is, in general, served by regulatory control of prescription medications, which may include criminal sanctions to deter unauthorized distribution and use. However, laws directed towards that end have an extraordinarily severe side effect: thousands of preventable deaths every year. These laws can be modified to remove their negative effect while sustaining their original intent, and doing so presents a critical opportunity to save many lives at little or no cost.

Corey Davis, J.D., M.S.P.H., *is a staff attorney with the Network for Public Health Law - Southeastern Region at the National Health Law Program.* **Damika Webb, J.D.,** *is a law fellow at the Center for Health Policy and Practice, Temple University Beasley School of Law.* **Scott Burris, J.D.,** *is a Professor of Law at Temple University Beasley School of Law.*

Saving Lives by Changing Laws

Despite the high and rising number of people felled by opioid overdose, this preventable epidemic initially received little notice outside of the occasional celebrity death. This has changed. Perhaps as a result of the shifting demographics of overdose victims combined with increased awareness, a number of states have recently acknowledged and attempted to address the problem by modifying state law.[16] These legislative amendments have two separate but related aims. The first is to encourage the prescription and use of naloxone by removing the possibility that medical professionals who prescribe the drug and lay administrators (such as the family members and friends of the overdose victim) who administer it will face legal or regulatory sanction for doing so. The second is to encourage bystanders to summon emergency responders by ensuring that they will not face prosecution as a result of that selfless act.

In 2001, New Mexico became the first state to amend its laws to make it easier for medical professionals to provide naloxone, and for lay administrators to use it without fear of legal repercussions.[17] As of January 1, 2013, seven other states (NY, IL, WA, CA, RI, CT, and MA) made similar changes. Most of these laws explicitly remove the possibility of civil liability for prescribers and administrators acting in good faith to prevent overdose, and some remove the possibility of criminal penalties for prescribers and those who possess or administer the drug. Four of the eight also explicitly or implicitly permit third-party prescription.[18]

In 2007, New Mexico again took the lead in amending state law to encourage Good Samaritans to summon aid during an overdose. As of January 1, 2013, nine other states (WA, NY, CT, IL, CO, RI, FL, MA, and CA) have followed suit. The protection offered by these laws varies slightly.[19] While all of the laws protect both the Good Samaritan and victim from prosecution for possession of controlled substances, three extend that protection to drug paraphernalia as well. An additional two states have passed laws explicitly requiring (AK) or permitting (MD) courts to take the fact that a Good Samaritan summoned medical assistance into account at sentencing even where the Good Samaritan is convicted of a crime. All require that the caller have a good-faith belief that a medical emergency exists when he or she summons aid, and most provide protection only for crimes that were discovered pursuant to the seeking of assistance.

Unlike some earlier attempts to modify laws to reduce health risks to drug users (in the area of syringe exchange, for example), amendments targeted at reducing overdose deaths have seen little organized opposition and have passed in states across the political spectrum. They have received support from a number of governmental and non-governmental actors, including the Office of National Drug Control Policy, the U.S. Conference of Mayors, the American Medical Association, and the American Public Health Association.[20] The Florida Sheriff's Association and the Florida Police Benevolent Association supported Florida's Good Samaritan law, which the state legislature passed nearly unanimously in 2012.[21]

Evaluation of the effects of these laws is urgently needed, but early reports are encouraging. The CDC recently reported that at least 188 community-based overdose prevention programs now distribute naloxone. To date, those programs provided naloxone, as well as training in how to recognize overdose and counteract it, to over 50,000 people, resulting in over 10,000 overdose reversals.[22] A study from Washington, which enacted a Good Samaritan act in 2010, found that 88 percent of drug users surveyed indicated that they would be more likely to summon emergency personnel during an overdose as a result of the legal change.[23]

> The public interest is, in general, served by regulatory control of prescription medications, which may include criminal sanctions to deter unauthorized distribution and use. However, laws directed towards that end have an extraordinarily severe side effect: thousands of preventable deaths every year. These laws can be modified to remove their negative effect while sustaining their original intent, and doing so presents a critical opportunity to save many lives at little or no cost.

Next Steps

Other legal barriers should be addressed as well. A chief barrier to greater naloxone access is the drug's

prescription status; if it were available over-the-counter, many of the ancillary legal issues would disappear. The FDA held hearings on this issue in April, 2012, but the process to make a prescription drug available over the counter is lengthy and often expensive.[24] However, alternative policy and regulatory measures can increase access in the meantime. Legislatures and licensing bodies could encourage physicians to prescribe naloxone with every opioid prescription and grant pharmacists the authority to prescribe and dispense it in their stead. Those insurance policies that do not currently cover the drug should be required to do so. Some states do not permit low-level first responders to administer the drug, a shortcoming that can be easily rectified.

In addition, states considering naloxone access and Good Samaritan bills can take steps to enhance the incentives for providing naloxone and seeking emergency help. Naloxone access bills should explicitly permit third party prescription and distribution via standing order, so that the friends and family members of a person at heightened risk of overdose can more easily access the drug. Likewise, Good Samaritan laws should extend their grant of immunity to all minor crimes discovered as a result of the caller seeking help during an overdose emergency, not just those that are drug-related. Furthermore, Good Samaritan laws should provide protection from arrest, as well as charge and prosecution. Bills should also include an education component that targets medical and law enforcement professionals as well as patients and the public. Finally, these laws should be rigorously evaluated to determine if they are having the intended effect, and to suggest changes in their scope or means of implementation.

As with most public health problems, there is no magic bullet for preventing opioid overdose deaths. Initial efforts to combat the epidemic, including monitoring of prescription opioid medications, diversion prevention efforts, improved access to pain care, and drug treatment services have proven insufficient.[25] While those interventions are a part of the solution, they must be combined with common-sense legal change of the type outlined above.

Conclusion

Opioid overdose kills thousands of Americans every year. Many of these deaths are preventable through the timely provision of a cheap, safe, and effective drug and the summoning of emergency responders. Preliminary evidence and common sense suggest that laws that encourage the prescription and use of naloxone and the transformation of bystanders into Good Samaritans will reduce opioid overdose deaths. Since such laws have few negative effects, can be implemented at little or no cost, and have the potential to save both lives and resources, they represent some of the lowest-hanging public health fruit available to policymakers today.

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THE WALL STREET JOURNAL.

http://www.wsj.com/articles/states-expand-access-to-overdose-reversal-drug-1409247874

U.S. NEWS

States Expand Access to Overdose-Reversal Drug

New Laws Put Naloxone in Hands of Abusers, Their Families and Peers

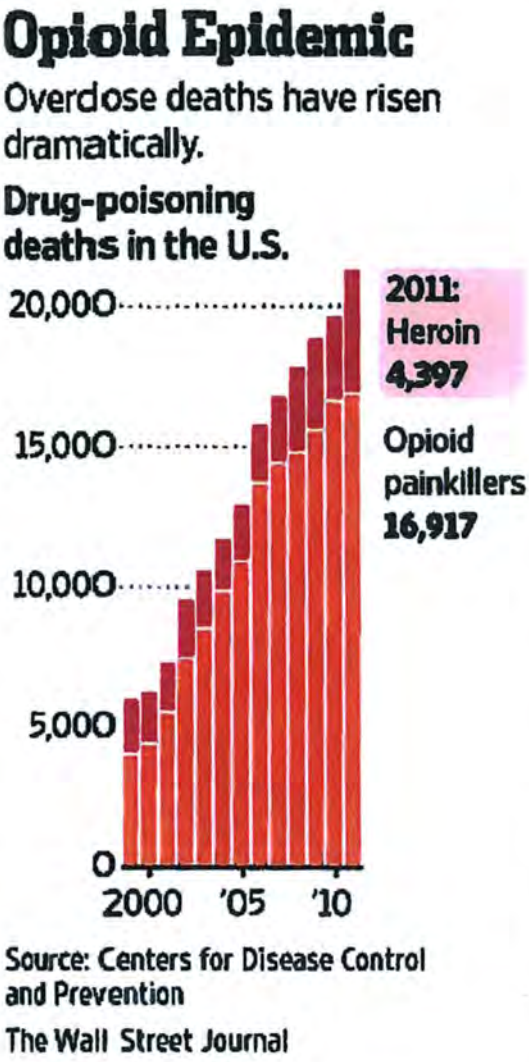
A patient is given a supply of naloxone at a clinic in Asheville, N.C. *ANDY MCMILLAN FOR THE WALL STREET JOURNAL*

By **ARIAN CAMPO-FLORES** and **ZUSHA ELINSON**
Aug. 28, 2014 1:44 p.m. ET

Faced with an unrelenting epidemic of heroin and pain-pill deaths, many states are pushing to make more widely available a drug called naloxone that can reverse overdoses from such opioid drugs within minutes.

In North Carolina, Louise Vincent, an outreach worker in Greensboro, has rescued scores of opioid addicts from the brink of death by giving them naloxone.

Now, she is delivering the drug to those she says are in the best position to help overdose victims—their friends and family members—under a North Carolina law passed last year that expanded access to naloxone.



"It could be the difference between life and death," said Ms. Vincent, a contract worker for the North Carolina Harm Reduction Coalition, a not-for-profit organization that has dispensed about 3,000 naloxone kits statewide since the law took effect.

The program so far has resulted in 125 overdose reversals, said Executive Director Robert Childs. Deaths from heroin and pain medications totaled 712 in North Carolina in 2012, according to the state's Department of Health and Human Services.

Nationwide, overdose deaths from painkillers such as oxycodone rose 23% to 16,917 between 2006 and 2011, according to the Centers for Disease Control and Prevention. Those due to heroin, which is related to the opioid drugs, jumped 110% to 4,397 over the same period.

There are now 24 states, along with the District of Columbia, that have passed laws expanding access to naloxone, 17 of them in the last two years, said Corey Davis, deputy director of the Network for Public Health Law's Southeastern region, who tracks such policies. The measures vary, but common provisions include allowing doctors to prescribe naloxone to a drug user's friends and family members, and removing legal liability for prescribers and those who administer the medication.

Meanwhile, 17 states and the District of Columbia have passed "good Samaritan" laws that provide limited legal immunity—from drug charges, for instance—to people who call for emergency help for an overdose, Mr. Davis said.

The moves are prompted in part by concerns that those present during an overdose often are reluctant to call 911 because they fear legal repercussions or may themselves be using drugs, said Traci Green, a professor of emergency medicine at Brown University who is an expert on overdose prevention.

The naloxone legislation has drawn support from a broad political spectrum. While liberal-leaning states like Massachusetts and Washington have led the way, a naloxone bill sailed through the conservative Utah legislature this year. A measure in Alabama is being promoted by a Republican lawmaker who is a police captain.

WSJ Radio

Arian Campo-Flores tells WSJ This Morning's Bruce Johnson about these efforts

00:00 | 08:32

Still, the proposals have met some opposition, including from those who argue that making naloxone more accessible effectively condones opioid abuse, like providing clean needles to heroin users to protect them from HIV and hepatitis C.

Republican Gov. Paul LePage of Maine vetoed a naloxone bill last year, saying it would provide "a false sense of security that abusers are somehow safe from overdose." But this year, after working with lawmakers on a new naloxone bill, he allowed it to become law without his signature.

Naloxone was developed in the 1960s to counter overdoses of heroin and other opioids. It works by displacing the drugs from their receptors in the brain.

Considered safe and effective by medical experts, it has been stocked by emergency rooms and doctors' offices for decades. It is now sold as a generic by pharmaceutical companies including Hospira Inc. and Mylan Inc. and can be administered by injection or nasal spray.

Naloxone, which requires a prescription, costs about $4 a dose for an injectable version and roughly $45 for a nasal-spray form, said Dan Bigg, director of the Chicago Recovery Alliance.

Although legislation has paved the way for greater access to naloxone, distributing it remains a challenge.

Twenty-six states have at least one police department equipping personnel with naloxone, according to Mr. Davis. Another way to make it available is through overdose-prevention organizations like the Harm Reduction Coalition, which has offices in New York and California and has dispensed thousands of naloxone kits at needle-exchange sites and other locations.

et another option gaining traction is to make it easier for people to get naloxone from pharmacies.

In

Robert Childs of the North Carolina Harm Reduction Coalition. *ANDY MCMILLAN FOR THE WALL STREET JOURNAL*

Rhode Island, a so-called collaborative practice agreement among various parties, including the state Board of Pharmacy and Walgreen Co. made it possible for anyone to request the drug at any of the pharmacy chain's locations in the state. As part of the arrangement, a prescription written by a doctor at a local hospital applies essentially to everyone.

Under a pact announced last week, CVS Caremark Corp. said it would offer naloxone without a prescription at all 63 of its Rhode Island pharmacies.

Health officials in Kitsap County, Wash., just west of Seattle, have reached a similar agreement with Albertsons supermarket pharmacies that is slated to take effect soon. And in New Mexico, the state Board of Pharmacy this year added naloxone to a list of drugs that pharmacists may prescribe.

So far, only 10 pharmacies in the state regularly stock naloxone, said Michael Landen, state epidemiologist at the New Mexico Department of Health. But, he said, the program "has great potential."

Write to Arian Campo-Flores at arian.campo-flores@wsj.com and Zusha Elinson at zusha.elinson@wsj.com

Heroin reaches into rural Alaska communities

By - *Associated Press - Monday, April 28, 2014*

ANCHORAGE, Alaska (AP) - Heroin has crossed beyond Alaska's urban centers, increasingly winding up in the state's more isolated, rural communities.

State investigators say the highly addictive drug has become more common in all parts of the state, including villages, the Anchorage Daily News reported Saturday (http://is.gd/q0zy1K).

The state's annual drug report showed the drug's availability increased throughout Alaska in 2012 and 2013. The report concludes that heroin is no longer confined to urban areas.

Authorities made 64 heroin-related arrests and charges in 2009. That number has since more than doubled, with 151 arrests and charges last year.

In Kodiak, police seized more than 25 ounces of methamphetamine and almost 2 ounces of high-grade heroin on April 19. It was the largest seizure in the police department's history.

In Nome, authorities began recognizing a growing heroin trend a couple of years ago when an officer found paraphernalia at a local hotel that appeared to be from intravenous drug use.

"We're finding it in a lot of the villages out in western Alaska now," said Lt. Katherine Peterson of the Alaska Bureau of Investigations. "I can't tell you in every village. But it is certainly unlike years ago."

In the recent Kodiak drug seizure, police estimated a street value of about $35,000 for the heroin and $2.1 million for the methamphetamine. Kodiak Police Chief Ronda Wallace said that between the two types of drugs, the local upturn in heroin is more recent.

"It's definitely a trend," Wallace said. "We've been seeing a lot more meth, but we've been noticing in the last few years that heroin is increasing."

In Nome, Mayor Denise Michels said the town has seen wider use of heroin the last few years among residents in their 20s. That demographic includes her nephew, who is completing a drug rehabilitation program in Arizona for heroin addiction, she said. He entered the program in 2012 after telling his family he needed help.

"Who would have ever thought that this would be here?" Michels said. "It happened so fast and so under the radar for the public."

Information from: Anchorage (Alaska) Daily News, http://www.adn.com

Valley heroin use 'epidemic'

By Christina Seine For the Frontiersman | Posted: Tuesday, July 1, 2014 1:35 pm

MAT-SU — Janet, a pretty, brown-eyed 20-something-year-old, sits at a conference table at a medical clinic in Wasilla and fidgets while the doctor goes over her chart. She's pregnant, although not yet far enough along to show much. Her hand goes to her belly; awkwardly she moves it away.

"How are you doing?" the doctor asked. Her eyes met his for a millisecond. "I feel, um … I feel better," she said.

It's been about three weeks since Janet last used heroin, and two weeks since she started seeing Dr. John Zipperer, who runs an addiction center in Wasilla.

Dr. John Zipperer

Dr. John Zipperer, who runs an addiction center in Wasilla, says heroin use is widespread in the Valley, calling it 'epidemic.'

Janet — not her real name, of course — doesn't fit the stereotype of what heroin addiction looks like. Her skin is a deep-summer tan, not pale. There are no dark circles under her eyes. She's slim and healthy-looking, not emaciated.

Except for a certain jittery wariness, she could be anyone — the barista who remembers to put extra whipped cream on your caramel mocha, the shy girl in your macroeconomics class, the receptionist at your kids' dentist office. Any of them could be on heroin and you might not even know it, Zipperer said.

"Very often, you can't tell by looking at people," he said. "Often, addicts manage to work a job, have a family. You'd be surprised."

The drug is so widespread in the Mat-Su now that Zipperer called it an "epidemic."

"It's rampant in the Valley. It's unbelievable," he said.

Law enforcement officials wholeheartedly agree. According to the Alaska State Troopers annual drug report, troopers seized 55 pounds of heroin and made 151 heroin-related arrests in 2013. That's up from about 6 pounds seized and 118 heroin-related arrests in 2011.

"The resurgence of the abuse of heroin and continued abuse of other opiates, including various

opioid-based prescription medications, is of significant concern," the report states.

Wasilla Police Chief Gene Belden underscored troopers' findings.

"We've seen quite an increase in heroin use in the last year or so," he said. "It's an easy drug to get a hold of — it's easily transported, it's easily hidden."

Belden said his department is working toward increasing training that will help local law enforcement stop the drug dealers.

"We've been catching the users," he said. "We need to go after the sellers."

However, sellers can be hard to find. And they're persistent, working hard to keep their customers hooked, Janet said. A close friend of hers died recently of a suspected overdose, and she has other friends who use it as well — whether they can afford it or not.

"One of my best friends started, um … putting herself out there, to two or three different dealers … to pay for it," she said.

Heroin is an opiate that occurs naturally in the resin of poppy plants and is synthesized from morphine. It's used recreationally for the extreme relaxation and euphoria it induces when injected, sniffed or smoked. It's known on the street as H, smack, horse, brown, black and tar, and troopers say it's becoming more prevalent outside urban areas, crossing socio-economic boundaries.

Lately, Mat-Su residents have encountered evidence of the Valley's growing drug problem on lawns, playgrounds and parks. A recent Facebook post warned residents to use a bag to catch lawnmower clippings after a businessperson discovered used needles in the weeds and grass. A walk through a Valley park turned up several tiny pieces of burnt tinfoil.

"Yeah, that's a 'nifty,'" Janet explained. "Those little squares of foil … about a tenth of a gram (of heroin). They usually go for $50. A lot of people won't want to do less than $50."

A person with a serious addiction might go through four or five a day, she added.

That means an addict can require several hundreds of dollars a day to fund their habit.

"Some people trade their food stamps," Janet said. "Some people steal a lot. Some people have a job, and all of that money goes toward their drug habit."

The number of illicit drug users ages 12 and older in Alaska has remained about 30 percent above the national average, according to Alaska Department of Heath & Social Services documents. In 2008, Alaska ranked sixth in the country for illicit drug use.

Janet was introduced to the drug at the age of 18 by a boyfriend, the father of her first child (now a toddler and seemingly healthy, although Janet used heroin during that pregnancy as well). She's been to treatment centers — one for six months, once for a little more than 30 days. She's been

incarcerated. She's been homeless. It didn't stop her.

Her story is not unusual, Zipperer said.

"Some people — not everyone, of course — but some people are predisposed to addiction. Most people, maybe 89 percent or 90 percent of the population, can have that one glass of wine or a Percocet after a dental surgery, and they don't have a problem," he said. "But for people who are genetically predisposed to it, heroin is an incredibly powerful addiction. It's evil. It's like you belong to Satan now. It just possesses you."

The drug has about a 95 percent relapse rate for patients who try to quit "cold turkey," he added.

"So, out of every 100 people who go off the drug completely, who try their best, who really believe they're never going to use it again, maybe five will be successful."

Zipperer didn't originally intend to work in drug rehabilitation, he said. However, when working at a local hospital, he began noticing a number of patients suffering side-effects of heroin use.

"At one point, there were five different women with heart valve infections," he said. "That's one of the complications you see when people are injecting heroin."

He was already doing research on addiction when his own father, who had been on prescription pain medication for years, died of an overdose.

"I have to be honest … I was ashamed at first … I didn't want to tell anybody," he said.

But that pain also was a catalyst, he said. He wanted to help people.

He recalled an earlier patient who struggled with addition.

"She was 21 years old, and the Hell's Angels just owned her," he said. "I tried to help her …" he broke off mid-sentence and reflected for a moment. "You know, those who want to criticize (people addicted to heroin) … what if it was your granddaughter? What if that was someone you loved? Why wouldn't we do everything we could to help them?"

In addition to the clinic, Zipperer runs Buprenorphine Anonymous, a free 12-step program similar to Alcoholics Anonymous or NarcAnon. Buprenorphine is a medication used to treat heroin addiction. It's also used to control pain.

Zipperer said patients using Buprenorphine (also known as Suboxone) do not get "high." Instead, he said, it allows them to function normally and cope without heroin in their system.

"When they're stable on it, you can't even tell they're on it," he said.

"With an addict, when they don't have heroin, it's like their brain is screaming at them — all the time. With buprenorphine, with suboxone (and sometimes methadone), it quiets that. We see people

on this treatment doing really well, people that have tried many times before to quit on their own and failed."

In Janet's case, it seems to be working.

"It's the one thing that's helped me so far," she said.

For more information on Buprenorphine Anonymous, call 376-5228.

Addicted to Heroin, Part 2: APD Calls Overdose Deaths An 'Epidemic'

February 26, 2013 | By Abby Hancock | Channel 2 News

ANCHORAGE, Alaska — Heroin overdoses have reached an "epidemic" level, according to the Anchorage Police Department. APD Sgt. Kathy Lacey says heroin use is back in force and heroin-related overdoses are claiming more young lives than traffic fatalities.

"Heroin has come on stronger and stronger and stronger every year, we're seeing more of it," Sgt. Lacey said. "It is now the drug of choice on the street and we're seeing young people dying from it at an alarming rate."

In 2011, there were 27 opioid-related deaths in Anchorage. Opioid is the term used to describe pain-killing drugs like morphine, oxycodone, and heroin. APD statistics show that in 2012, there were 22 heroin overdose deaths in the city. Heroin investigations are five times more common than cases stemming from other drugs, according to police. Police say the average age of a heroin user who overdoses is 29-years-old.

"It's a young person's drug and I think that's what shocks people," Lacey said. "They don't realize how plentiful it is. It is everywhere. It's not like it's difficult to get. I could walk out of this room and in ten minutes have bought some heroin on the street."

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Addicted to Heroin Part 2

A woman named Lisa, who would not disclose her last name, says she has used heroin for years. In a February interview, she shared her on-going struggles with addiction, just hours before heading to the Anchorage Jail where she would have to spend at least the next two months behind bars for breaking probation.

She is also on the wait list for the methadone treatment program at the Center For Drug Problems in Anchorage.

"I like the way it makes me feel, you know," Lisa said. "When you're addicted, it's hard to stop because you go through withdrawals and you're sick and it hurts and it's just easy to get a quick fix rather than have to suffer and be in pain."

According to Sgt. Lacey, heroin is cheaper than other opioids like prescription pain pills, however it can be equally addictive. A tenth of a gram of heroin, known as a "nifty", has a street value of about $50. An ounce runs on average about $5,000, which drug dealers parcel into fractional units, often mixing it with unknown ingredients to increase their profits.

"You have no idea what they're cutting it with and that's the problem," Sgt. Lacey said. "People have no idea what they're putting into their system, nd when you're trusting your drug dealers (with) what you're putting in your system.... that's a dangerous place to be."

Note: This is the second story in a three-part series "Addicted to Heroin." Part 3 will air Wednesday on the Channel 2 Newshour.

Contact Abby Hancock:

Heroin in Alaska: From Bush villages to Fairbanks, it's showing up more and more

By Sam Friedman / sfriedman@newsminer.com Fairbanks Daily News-Miner | Posted: Sunday, March 18, 2012 12:01 am

Part 1 of 2

Heroin in Alaska: From Bush villages to Fairbanks, it's showing up more and more

FAIRBANKS — There's a new drug in town that's not really a new drug.

Heroin, a drug that was almost non-existent in Fairbanks 10 years ago, has made its way back to Alaska, and more recently into the Interior, following the spike in the street value for prescription opiate pills such as OxyContin.

While it is still far from common in Fairbanks, law enforcement and drug treatment program managers warn the powerful drug has the potential to do a disproportionate amount of harm in the form of overdose deaths and the spread of diseases that can accompany a drug that is generally injected.

Re-emergence

Sgt. Scott Johnson has been on the multi-agency Fairbanks Areawide Narcotics Team for five years and seen a major transformation in drug use habits in the Interior. He's now the head of the team.

"When I first got into the drug unit, we were buying prescription meds like crazy," he said. "Lots of meth and lots of marijuana. But no heroin, I mean zero. It just wasn't around up here."

Anecdotal reports suggest the drug was somewhat more available in Fairbanks during the 1970s pipeline construction boom and then all but disappeared in the last few decades, occasionally accompanying new resident-users to the area but seldom available on the black market.

That began to change about four years ago when Johnson was called to Palmer to help execute a search warrant on a series of seven houses. He expected the usual mix of drugs he had been seeing in Fairbanks. Each of the seven was a heroin house.

Like many other things in Alaska, heroin eventually spread from the most-populated region to the second-largest city.

"About three years ago we started hearing about heroin (in the Interior)," Johnson said. "We would

talk with folks who would get themselves into trouble and they'd say 'Well so-and-so is selling heroin.' And we'd say 'What? Are you sure it was heroin?' ... Now it's every day."

This year's annual reports of the multi-agency Alaska Statewide Drug Enforcement Unit give a dramatic picture of an increasing focus on heroin by law enforcement over the past five years.

Ten years ago the unit was seizing a few dozen 10 mg dosage units a year.

During the last few years it has seized more than 10,000 units per year. 2008 was the biggest year for heroin seizure in 20 years, but last year was one of the largest with 6.41 pounds (or almost 30,000 dosage units) seized and 118 people arrested for heroin offenses. There are about a dozen Interior heroin cases in the court system, Johnson said.

Opiate pills and heroin are most common in Alaska's cities but have spread to Bush Alaska, with recent heroin busts in Bethel and Dillingham, said Lt. Chris Thompson, a deputy commander of the Alaska Bureau of Investigation, part of the Alaska State Troopers.

While annual report numbers are useful, arrest statistics are not necessarily a sign of drug prevalence because law enforcement is likely to find what it is looking for based on the way it moves through networks of traffickers using confidential informants.

"We have to be kind of careful with trends and that sort of thing because they are sort of self-fulfilling," Thompson said. "Sometimes if we focus on something we tend to find it."

In Fairbanks, an increase in heroin availability in the last year also is reported at Project Special Delivery and Turning Point Counseling Services, which have programs to treat opiate addicts.

Supply and demand

A change in the manufacture of one popular painkiller to make it harder to abuse may have helped spawn the new market for heroin.

Before the re-emergence of heroin, some Alaskans, including in the Interior, had a sizable appetite for pain pills in which the active ingredient — like that in heroin — is related to the opium poppy.

Most popular is OxyContin (generic name oxycodone), but there's also hydrocodone, morphine and drugs that combine opiates with other drugs — Vicodin and Percocet are examples of these. Drug dependencies sometimes begin when someone is prescribed the pills as medicine. The pills can be taken orally, but heavier users tend to smoke or inject them because it gives a stronger effect.

In 2010, Alaska's Statewide Drug Enforcement Unit seized the equivalent of 5,958 dosage units of OxyContin/oxycodone, the most commonly abused opiate drug on the black market, according to the organization's 2011 annual report.

That same year, in the spring, the U.S. Food and Drug Administration approved a new formulation

by OxyContin, designed specifically to make it harder for recreational drug users to crush the pill and get around the timed release of the medication. The new pills are marked with the letters OP instead of OC.

In no time, drug users began to look elsewhere. Prices spiked for other oxycodone pills, said Johnson at the Fairbanks Areawide Narcotics Team. An 80 mg oxycodone dose in Fairbanks can now cost upward of $280, he said. 2011 actually saw a drop in the number of OxyContin/oxycodone doses seized by the drug enforcement unit.

Opiate users build up tolerance and require larger and more expensive doses over time. The spiraling expense of an addiction leads people to a cheaper opiate such as heroin.

A typical dose of heroin is now a comparative bargain at about $80, Johnson said.

In Fairbanks, most heroin is low-grade black tar heroin, although a purer variation known as China White has recently entered the market, he said.

A younger crowd

At Project Special Delivery, an opiate treatment program operated by the Interior AIDS Association, staff has recently observed another trend — the composition of its clients.

The average age of a client has decreased from the 40s to its current average of 34, according to clinical director Brenda Henze-Nelson

"Our clients basically over the years have an opiate addiction after either they've come through an alcohol addiction or maybe cocaine or maybe something else," she said.

That's changed recently.

"Kids, instead of starting on alcohol or marijuana, started smoking Oxy right off the bat."

Gunnar Ebbesson, clinical director at Turning Point Counseling Services, which also runs an opiate treatment program, has also noticed his opiate clients. They tend to be young, Caucasian and from middle or upper-middle class families, he said. The fact that they tend to be wealthier is likely a result of Turning Point being a private clinic that predominantly treats clients with insurance, he said.

"It's a good thing for treatment because when parents who have a voice in the community have kids who are addicted and get treatment and are successful, then they advocate for treatment within the community versus saying "Oh, that's South Cushman's problem,'" he said, in reference to the area of Fairbanks viewed as having greater drug use and crime.

By one national drug-use survey, non-medical use of prescription drugs is the most popular category of abuse among Alaska high school students, trailing alcohol, tobacco and marijuana.

According to 2011 data from the Centers for Disease Control and Prevention's Youth Risk Behavior

Survey, 15.8 percent of Alaska students reported having used prescription pills without a prescription. The category includes opiates as well as other prescription medications that are sometimes abused, including Xanax and Ritalin.

The anonymous, written survey was given at traditional high schools.

Reported heroin use among high school students was barely on the map. It was 2.5 percent in 2011 and like in other recent survey years it was reported less commonly than inhalant drug use (like glue and aerosols), cocaine, ecstasy and methamphetamine.

Authorities don't want to see the general increase in heroin use reach into the schools.

Johnson, the sergeant with the drugs team, said there is a risk of heroin use expanding among Interior high school students. Already, he said, the drug enforcement program has changed the way it does education programs at high school.

"Just the other day I did five presentations at schools," he said. "We used to skip over heroin when I first got in there because it just wasn't an issue. Now we try to get in schools and educate the kids that this is a drug that more likely than not you will be exposed to."

Contact staff writer Sam Friedman at 459-7545.

Alaska Dispatch News

Published on *Alaska Dispatch News* (http://www.adn.com)

Tegan Hanlon [1]
February 27, 2015
Main Image:
2014 Alaska State Troopers drug report [2]
Main Image Credit:
Alaska Dispatch News

The quantity of heroin seized by Alaska State Troopers dropped by more than half in 2014 compared to the year before, but the number of drug-related arrests jumped, according to the troopers' annual drug report released Friday [3].

Lt. Rex Leath, deputy commander of the troopers' Statewide Drug Enforcement Unit, said when reviewing the report he took particular note of last year's 209 heroin-related arrests and charges. The statistic bolstered what the public had repeatedly reported, he said.

"The whole state has been really adamant that they feel like heroin is taking over their neighborhoods," Leath said. "All of these communities have been saying 'heroin, heroin, heroin.'"

The report identified an increase in heroin abuse and the continued abuse of other opiates as significant concerns, primarily in urban Alaska.

But heroin has also penetrated rural communities [4]. Seizures of heroin, methamphetamine and prescription drugs increased in rural communities in 2014, though alcohol and marijuana remained the most popular drugs, the report said.

Across Alaska, trooper seizures of alcohol, heroin and processed marijuana declined. Seizures of prescription drugs also dropped while seizures of cocaine and methamphetamine more than doubled, according to the report.

The number of marijuana grows busted remained unchanged at 38. The number of meth labs closed dropped from five in 2013 [5] to zero last year. But, the report said, "although the number of labs has remained low, it appears that use and abuse of the drug lingers."

Marijuana accounted for the most drug-related arrests and charges by far at 716 last year. This year, troopers must alter enforcement efforts since the state legalized marijuana, Leath said. The law went into effect Tuesday.

The number of arrests and charges for alcohol, cocaine and prescription drugs decreased in 2014 from 2013 [6], while they increased for marijuana, methamphetamine and heroin.

Leath cautioned that the annual changes in numbers of arrests and quantities of confiscated drugs don't always accurately reflect the prevalence of drugs in Alaska. The statistics waver with the number of community reports and the size of the Statewide Drug Enforcement Unit, which Leath said has shrunk.

He flagged the pounds of heroin seized as one deceptive statistic in the recent report. In 2014, troopers seized about 22 pounds of heroin, compared to about 55 pounds in 2013.

"People are breaking heroin down into smaller dosages," he said. "So the number doesn't really reflect accurately whether or not it's on the street."

In some areas, he said, troopers have tightened their focus on low-level heroin dealers instead of on big shipments. According to the report, heroin is typically imported into Alaska by both parcel and human carriers.

By focusing on the low-level dealers, busts yield smaller quantities of heroin. Leath said troopers have taken this approach to learn what drives dealers to sell. Many, they have found, are addicted to heroin themselves.

"Heroin, it literally is killing our kids," he said.

An earlier version of this story misstated the trend in cocaine seizures between 2013 and 2014.

Source URL: http://www.adn.com/article/20150227/drug-seizures-down-arrests-2014-alaska-state-troopers-report

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Overdosed and Overrun: Alaska's heroin epidemic

OCTOBER 11, 2012 - 12:38 POSTED IN: NEWS BY: SCOTT CHRISTIANSEN

A rising tide of heroin addiction has been killing people in Anchorage and around Alaska. Police have been making more arrests and more drug seizures. Ambulance crews are being called more often to homes where an addict lies unconscious on the floor after overdosing on the drug. And the state has few places for an addict to turn for help.

Ron Greene, clinical director at the Center for Drug Problems, believed his clinic was

clearing a hurdle in spring of 2009, and could help stem a problem that had building for years. The clinic had been running on flat funding, but state lawmakers committed about $210,000 to increase drug rehabilitation services around Alaska. The Center for Drug Problems would get its share and would be able to increase the number of patients in its budget from 75 to 100.

"We thought that would fix the problem, that we wouldn't have a waiting list," said Greene, the Center's clinical director.

That didn't happen. The number of patients grew as fast as the clinic could accommodate them. The clinic was serving about 78 people on its previous budget. Today it serves 108 on a budget meant for 100 (The clinic never turns away pregnant women, which is why the patient-count is always slightly higher than projected in its budget).

Most of the new patients want help to kick heroin, some were turned on to the drug after abusing prescription painkillers, which had become harder to come by on the street.

"Heroin is cheap and it's in abundance. The drug of choice for the people who come to this clinic for the last few years has been heroin. It has been epidemic in Alaska, especially in Anchorage," Greene said.

Drug counselors aren't the only people who have watched heroin become Alaska's hard drug of choice. Paramedics are being called to rescue more people who have overdosed. Police have been arresting more heroin addicts, who are often dealing drugs, or engaged in prostitution, robbery or burglaries to afford their habit.

Last month an addict named Jason Barnum was accused of attempted murder after he allegedly ambushed two policemen inside a motel room near Merrill Field. There was a stand-off, complete with news media cameras and an evacuation of the motel. The cops who arrived first were looking for Barnum, who police later described as a serial burglar, a heroin addict and a suspect in a string of thefts. Police say Barnum shot first, firing from the motel room's bathroom, and in the close quarters patrol officer Dan Thyen was grazed in the back by a bullet. Barnum took a bullet to his right arm, and would later be charged with attempted murder.

The charging documents in Barnum's case say he admitted to burglarizing homes to support his addiction. Things could have gone down much worse, and in many news reports about the ambush, the shooting and the standoff, the drug that seems to have been central to Barnum's crimes was barely mentioned. Heroin might be at the center of more crimes than the police or the public will ever know about. The quick, straight-forward

confession Barnum allegedly made to cops is likely the exception, rather than the rule. Cops say direct links between heroin abuse and crime (with the exception of possession or dealing) are not always easily established.

"Sometimes, they will say it, but when you are arresting people they don't necessarily want to talk," said Sergeant Kathy Lacey, supervisor of the Anchorage Police Department vice squad. "It's not something we can prove with statistics, but whenever people don't have a full-time job and they're also addicted, they may be paying for that through property crime."

Heroin's popularity crosses a lot of social boundaries, and thuggish characters such as Barnum are not the only people using it.

"Lately, we have been pulling people out of cars," said Michael Crotty, a paramedic and the chief medical officer at Anchorage Fire Department. "They are looking for a private place to use heroin, and if they have a car, that gives them privacy."

Paramedics generally only meet addicts in the event of an overdose. Some overdose victims have hollow cheeks and needle scars on their arms. But some, Crotty said, "look like they just came from a community college campus—like they just tried it because somebody told them it was cool."

When a paramedic meets a heroin addict, Crotty said, it's usually because of an overdose that someone witnessed. "They will typically be blue and on the floor" and the ambulance crew has to make quick decisions to save their life. Crotty has a bird's-eye view of the city's ambulance crews. As a supervisor and chief medical officer, he can roam from station to station, sometimes riding along with crews to fill in for an absent paramedic or to ride with a new paramedic being mentored.

Crotty says if the purity of heroin changes on the street paramedics will notice a rise in overdoses. "It's hard to quantify how much is out there, but when something changes within that community—It could be a change in purity or if there's a lot of money on the street, like after the permanent fund dividend—we will notice that," he said. "I have saved an awful lot of overdose patients, some of them more than once."

Last month Crotty was on a shift during which two heroin users overdosed and were hospitalized the same day. "Both of them would have been fatal, one of them may have a poor outcome," he said. By "poor outcome" Crotty means permanent brain damage.

Heroin is a depressant, or downer. During an overdose the patient's heartbeat and breathing slow down and eventually can stop completely. The breathing will stop first. The

heart muscle will continue pumping blood until the heart itself has no oxygen. But before that happens the brain is slowly deprived and dying, in a fashion similar to drowning. A person cannot sleep-off a heroin overdose. To make matters worse, a junkie slipping into a coma looks a lot like a junkie experiencing their normal high. The witness who calls 911, whether a friend, relative or other drug user, will often make the decision too late.

There are also street myths to contend with, among them that a person can be shot up with another drug, or with salt water, tap water or even milk as a form of first aid for an overdose. None of those things work. Calling 911 promptly is the single most important thing anyone can do.

Crotty once arrived at a home where some people had used a needle to administer milk to an overdose patient. "I don't know where [the myth] comes from, but it's out there," he said. "They had the milk out and needle drawn up. They were crying and apologizing and saying they did everything they could do. The outcome for that patient was not good."

The more a paramedic knows about the patient the better, of course, but often the people who called for help split as soon as an ambulance arrives. They don't want to deal with police, but when they disappear it can leave paramedics with scant information about the patient. There's no one to explain what mix of drugs the victim used, or anything about the victim's drug abuse history or how much heroin might be in their blood.

Paramedics use a drug called Naloxone to counter the effects of an overdose of heroin. Naloxone can be injected with a needle but paramedics often use a mask and mist device to administer the drug nasally. The drug is called an opioid antagonist—it almost instantly counters the effects of opiates. "They can go from unconscious and not breathing to wide awake and wanting to fight you in a matter of minutes. They can go from at-death's-door, to walking to the ambulance," Crotty said.

The seemingly miraculous recovery is only temporary, however. It wears off in 30 or 40 minutes and the patient must be taken to a hospital. They must be carefully monitored for several hours afterward. In some users, the Naloxone triggers withdrawal symptoms, so the patient will vomit and risk choking. Other patients slip back toward respiratory failure and could die.

Detective Sergeant Lacey has been in charge of the Anchorage Police vice squad for seven years, and worked a street crime unit before that. As a department policy, patrol officers contact Lacey whenever they see an overdose of hard rugs such as heroin. But police don't have automatic access to medical files—medical privacy laws prevent that—so Lacey is often left with only sketchy details about what mix of drugs the person used.

"We do know that overdosing has really sky-rocketed in the last year or two," Lacey said. "That could be from [the heroin] being stepped on, and you don't really know what chemicals they used."

The Anchorage Police and the state medical examiner are working on new protocols for collecting information about drug overdoses. The use of street drugs called "spice" and "bath salts," which purport to be synthetic marijuana and synthetic cocaine, is on the rise. Lacey says those chemicals are leading to overdoses, too.

Lacey said 71 people died from overdose in Anchorage between 2008 and 2009, the last period for which she had statistics. In that same two-year period, there were 33 traffic fatalities.

Lacey said police intend to work more closely with the medical examiner to gather information about what drugs people are using. "We are trying to get a handle on this information, so that we can know what we can do to combat this," Lacey said. "A lot of

what we have is anecdotal. The only thing we can know for certain is, if they die, what was in their body."

Heroin has supplanted prescription painkillers such as oxycodone, because heroin sells for about $40 for one-tenth of a gram dose. Compare that to an 80-milligram oxycodone pill that costs $160 in Anchorage—double the 1990s price for the same drug. "Oxies are expensive and the expense and the difficulty in getting them has been pushing people to heroin," Lacey said. "We are also seeing a lot of prostitutes on heroin now, who used to be on crack—they bypassed the oxy route."

Part of Ron Green's voicemail greeting at Center for Drug problems is dedicated to informing callers about a meeting just for addicts who are on the clinic's waiting list. Like the rule about never turning away a pregnant woman, the meeting for wait-listed clients is a requirement of the programs that fund the clinic. It's not very well attended. The waiting list includes about 17 people, Greene said, but only two or three will make it to his Wednesday meeting. "We just added a guy to the program. We just got him in here and he had been on our waiting list since December 12, 2010—That's how long it took to get him into this program, almost two years," Greene said. (The Center for Drug Problems is run by a non-profit called Narcotic Drug Treatment Center, Inc. and uses federal and state money.)

As clinical director at Anchorage's only methadone clinic, Greene manages counselors and oversees the counseling of individual addicts. His work is purposefully separated from the medical doctor who can write a prescription for methadone. The counseling staff and the medical staff are divided by a Great Wall-type policy that has become standard at clinics that dispense methadone. "We don't even go in the same room where they dispense it," Greene said.

Decisions to use methadone are between the doctor and the patient, and Greene's counseling staff won't interfere. They don't advise addicts when to get off methadone, but they will be there to help when an addict decides to take that step. "If they do it too fast, they will fail," Greene said.

Greene's small office has a bookshelf stocked with titles that illustrate two distinct, but interrelated themes: addiction recovery and criminal rehabilitation. His office is adjacent a meeting room where a white board has the words "Relapse prevention lesson 1" on it. It could be a boardroom, except that it lacks the long table the culture of decision-makers requires. Chairs are stacked in one corner, waiting to be arranged in a talking circle or in rows. One poster on the wall is all text, titled "Criminal Thinking Errors" and lists examples—anger, pride, sexuality, perfectionism and "fear of fear" among them.

Kicking heroin—or the prescription drugs that mimic opiates such as heroin—leads to severe withdrawal. It begins with anxiety and progresses to include fevers, sweating, nausea, vomiting and pain in the stomach, back and legs. Some symptoms don't peak until a day after the last dose of heroin, and for some addicts it can take days for the pain and nausea to subside.

"They won't die [from withdrawal]," Greene said. "But they get sick enough that they wish they were dead. It's why addicts continue to use heroin, because they don't want to go through withdrawal. They get dope-sick and that dope-sick is what heroin users fear the most."

Greene can describe a clear distinction between clients who are dependent on methadone and a drug abuser who is addicted. Phrases such as "doctor shopping" are part of his trade. ("If you are doctor shopping, you are an addict," he said.) The clinic's controls on methadone are called "diversion control" and the clinic must prove the methadone it dispenses is not being abused by clients or diverting onto the street. Patients are monitored—there are home visits, random tests for drugs and alcohol, and empty bottles to be accounted for—and the clinic is inspected by an independent accreditation agency.

Methadone itself is addictive and most of people with prescriptions must take it orally at the clinic. Some are allowed to take the medicine home, but only after months of counseling and meeting goals set by the program—staying clean, achieving a stable home life and length of time in the program are among them.

The patient also must prove that there is a benefit of decreasing attendance at the clinic that outweighs the risks. Currently, 27 of the 108 clients at Center for Drug Problems have take-home privileges, according to Greene. "They have earned that right," Geene said. "They have proven they are not involved in any illegal activity."

Methadone works by stopping the cravings for other opioids and in small doses gives a milder high than heroin. The effect last longer, in what clinicians call a "half-life" that prevents withdrawal. It can be taken once a day to replace a habit that may have required a dose of heroin every four or five hours.

The treatment is controversial. (That's partly why Greene draws a distinction between methadone dependence and addiction.) One thing clinics such as Center for Drug Problems have shown, is that a recovering addict can lead a productive life when the fear of withdrawal is removed from their lives. The counseling is a vital part of that, but so is removing the addict's biggest fear. They no longer panic about where and how to score the

illegal drug before withdrawal sets in. And a doctor controls their dose, so they no longer run the risk of overdose, or buying contaminated supply.

"Some of them will be dependent on this medication for the rest of their lives," Greene said, "and if you ask them if they should stop, they will say 'Why should I do that?'—They were robbing, stealing and dealing. Now that they have this medication they are able to work at a job and pay taxes. They are able to keep their family together."

The Center for Drugs Problems has, since the late-1970s, held out a standing offer of hope for heroin addicts. Their clients come with referrals, often from family members and doctors, or attorneys and even cops. But with tight funding by the state and federal governments, and a clientele that's far from recognized as a political constituency, it's not clear if the clinic will ever catch up.

Greene, in his office surrounded by files and paperwork, had been explaining the jargon-laden technicalities of his job to a reporter, when he paused. His tone softened and looked straight across his desk. This year, he said, one addict died while on his waiting list. Greene shook his head gently. "You don't need to be dying at the age of 23," he said.

Alaska Dispatch News

Published on *Alaska Dispatch News* (http://www.adn.com)

Laurel Andrews [1]
April 21, 2014
Main Image:
Kodiak Alaska Coast Guard 3 [2]

The Kodiak Police Department seized more than $2 million worth of methamphetamine and high-grade heroin on Saturday, the largest drug bust in the police department's history, according to a press release sent out by chief of police Ronda Wallace on Monday.

Eric R. McDaniel, 44, of Washington state, was arrested Saturday and charged with two felony counts of misconduct involving a controlled substance after police found 25.3 ounces of methamphetamine and 1.8 ounces of high-grade heroin in his hotel room, along with drug paraphernalia.

McDaniel had been living in Kodiak since December 2013. He was first contacted by law enforcement officers in January 2014, when he was at a residence in Kodiak associated with narcotics activity. After receiving numerous tips via Crime Stoppers and community members, officers began investigating McDaniel's activity in January. McDaniel had a long criminal history in Washington state including convictions for dealing and possessing drugs, and was a fugitive from justice in Washington when he arrived in Kodiak to begin distributing drugs, the release said.

Search warrants were obtained for McDaniel's hotel room and person following months of surveillance and investigation. In the early morning of April 19, police "were able to lure McDaniel from his room" and apprehend him, the release states. His 32-year-old girlfriend, Tina Bettrof, reportedly fled when she saw the officers.

Officers found a large amount of methamphetamine, heroin, a digital scale, packaging material and drug paraphernalia in the hotel room. Based on the current street price in Kodiak, the seized drugs were worth roughly $2.2 million.

The weekend's drug investigations follow two other drug investigations this year where the police department seized large quanities of methamphetamine and heroin. During one of the busts, in January, police seized roughly $120,000 worth [3] of heroin, methamphetamine, crack and cocaine, and at the time was the largest drug seizure which Kodiak Police Chief Ronda Wallace said she had seen in her 15 years working for the Kodiak police department.

Another seizure in late January amount to a roughly $30,000 seizure in illegal drugs, Wallace said on Monday. In January, she said that the island has long struggled with sales of methamphetamine, and that there was a rising trend of heroin use in Kodiak.

Saturday's drug bust "affirms that belief, that (illegal drug use) is just an increasingly growing problem," Wallace said.

She urged community members to send information to the police department, or send tips to Kodiak Crime Stoppers [4].

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[4] http://www.kodiakcrimestoppers.com/

JPD drug take nears Anchorage levels

Report: $5.8 million worth of illegal drugs seized in 2014

Posted: March 2, 2015 - 1:02am

JUNEAU EMPIRE

According to a report released Friday by the Alaska State Troopers, the Juneau Police Department seized $5.8 million worth of illegal drugs in 2014, just five percent less than the value of the drugs seized by the Anchorage Police Department.

The Municipality of Anchorage, with a population of 301,000 people, is almost nine times more populated than Juneau, but the surge in seizures appears to be due to good police work, not an increase in crime.

JPD released its drug-seizure statistics in early February, but information on other police departments was not available until Friday, when troopers published their annual report on the work of the Alaska Bureau of Investigation's Statewide Drug Enforcement Unit.

According to the report, the SDEU seized drugs with a street value of $15.2 million — more than the Anchorage and Juneau figures combined. Fairbanks figures were not included in the report.

In 2013, JPD seized less than $2 million in illegal drugs. The difference in 2014, JPD Lt. Kris Sell told KTOO-FM in February, was a series of large heroin busts. In 2014, JPD officers captured more than 10 pounds of heroin with a street value approaching $4.7 million. In the previous year, they seized less than a pound and a half.

Seizures of illegally traded prescription drugs declined as their price rose in 2014, Sell said, leading users to switch to heroin.

Statewide, the troopers' drug unit seized 22 pounds of heroin, a figure down from 2013. Lt. Rex Leath, deputy commander of the troopers' drug unit, told Alaska Dispatch News that troopers focused on smaller dealers in 2014. Heroin arrests were up, from 151 to 209, even as the quantity of seized drugs fell.

Methamphetamine, previously identified as a top priority by troopers, also saw a change in strategy. Troopers seized no meth labs but captured almost 20 more pounds of methamphetamine and made almost 50 more arrests in 2014 than 2013.

This year promises changes in focus for statewide drug units as marijuana regulations change. In 2014, troopers made 716 marijuana-related arrests, seized almost 170 pounds of marijuana and eradicated 38 grow efforts.

In Juneau last year, JPD seized about 33.7 pounds of marijuana worth an estimated $459,000.

Alaska Dispatch News

Published on *Alaska Dispatch News* (http://www.adn.com)

6 arrested in Kenai Peninsula meth, heroin bust

Megan Edge [1]
February 20, 2015

Six people from the Kenai Peninsula were arrested Thursday for their roles in selling methamphetamine and heroin, Alaska State Troopers say.

Four of the suspects were arrested at about 9:30 a.m. Thursday, after officers executed a search warrant at a residence off Tustumena Lake Road in Kasilof and another at a residence on Friendship Avenue in Kasilof, troopers wrote in an online dispatch Friday morning.

Joshua Tri, 30, of Kasilof was arrested for two counts of third-degree misconduct involving a controlled substance. John Fisler, 51, of Kasilof was charged with four counts of third-degree misconduct involving a controlled substance. Stacy Whiteley, 40, of Soldotna was charged with one count of fourth-degree misconduct involving a controlled substance. Ashley Armknecht, 23, of Soldotna was charged with probation violations.

Officers from the Statewide Drug Enforcement Unit, the Alaska Bureau of Investigation, Alaska Wildlife Troopers, the Kenai Police Department, the Soldotna Police Department, the federal Bureau of Alcohol, Tobacco, Firearms and Explosives and the Department of Homeland Security jointly served the warrants, according to the troopers dispatch.

At about 5 p.m. Thursday, two additional people, Levi Shannon and Isis Holcombe, both 18, were also arrested as they attempted to deliver drugs, troopers said.

Holcombe was charged with two counts of second-degree misconduct involving a controlled substance and two counts of third-degree misconduct involving a controlled substance, troopers wrote, while Shannon was charged with three counts of third-degree misconduct involving a controlled substance.

Lt. Rex Leath, an Alaska state trooper who is also deputy commander of the Statewide Drug Enforcement Unit, said the two-month investigation was sparked by community tips. Troopers purchased 18.3 grams of methamphetamine, which Leath said sells for $100 for every 0.3 gram.

According to Leath, investigators don't believe the drugs were being made in Alaska, but shipped in from the Lower 48 and other countries.

All six people arrested were taken to Wildwood Pretrial Facility and held without bail, troopers said.

Leath added that more charges may be filed.

Links:
[1] http://www.adn.com/author/megan-edge

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

March 16, 2015

The Honorable Bert Stedman
Alaska State Senate
State Capitol, Room
Juneau AK 99801

RE: Senate Bill 23 – Immunity for Providing Opioid Overdose Drugs

Dear Senator Stedman:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of Alaskans.

ASMA is supportive of Senate Bill 23 providing health care providers immunity from civil liability for providing, prescribing, or administering opioid overdose drugs to a patient at risk of experiencing an opioid overdose emergency. SB 23 will allow health care providers to prescribe opioid overdose drugs and provide the necessary training and education on the proper use and administration of those drugs which should increase the utilization of these lifesaving drugs.

Overdose deaths is a growing national crisis nearly tripling since 1999 and Alaska currently ranks 29th among states for the highest drug overdose mortality rate. Alaska's mortality rate due to drug overdoses was about 11.6 per 100,000 people in 2010, an increase of 55 percent from 1999. ASMA is committed to working on responsible strategies for reducing opioid abuse and respectfully request the Alaska Legislature pass SB 23.

Thank you for your consideration of our position and if you have any questions please let me know.

Sincerely,

Michael Haugen
Executive Director
Alaska State Medical Association

The TRUST

The Alaska Mental Health Trust Authority

March 6, 2015

Senator Johnny Ellis
State Capitol Bldg., Room 7
Juneau, AK 99801

RE: Senate Bill 23 – An act relating to immunity for prescribing, providing, or administering opioid overdose drugs

Dear Senator Ellis,

The Alaska Mental Health Trust Authority is pleased to submit this letter in support of SB23, "An act relating to immunity for prescribing, providing, or administering opioid overdose drugs."

The Trust supports programs, services and policy that positively impacts the lives of Trust beneficiaries, those Alaskans who experience a mental illness, substance abuse related disorders, traumatic brain injury, Alzheimer's and Related Dementia (ADRD) or developmental disabilities.

The Trust is an advocate of community-based services, treatment and supports for Alaskan's struggling with alcoholism, drug dependence and abuse. Alaskan communities across the state are seeing a rise in the abuse of opioid based prescription medications and access to and abuse of heroin. Alaska has more than twice the rate of prescription overdose deaths in Alaska than compared to the broader U.S. While accidental overdose is an unfortunate risk of dependence and abuse, opioid overdose is reversible when naloxone is administered in a timely manner. We view SB23 as a rational approach to provide immunity for those that are adequately trained to prescribe or administer naloxone which may subsequently reduce the incidence of overdose by increasing availability and administration of this life and death intervention.

We appreciate your effort to reduce barriers to timely and effective interventions for Alaskans struggling with addictions. Thank you for your advocacy on behalf of Trust beneficiaries and we look forward to continuing to work with you on this very important issue.

Sincerely,

Jeff Jessee, CEO
The Alaska Mental Health Trust Authority

3745 Community Park Loop, Suite 200 Anchorage, Alaska 99508 Tel: 907-269-7960 Fax: 907-269-7966 www.mhtrust.org

NARCOTIC DRUG TREATMENT CENTER, INC.

CENTER FOR DRUG PROBLEMS

CHEMICAL SCREENING PROJECT • S.T.O.P. AIDS PROJECT

January 23, 2015

Dear Senator Ellis and colleagues,

The Narcotic Drug Treatment Center, Inc., Center for Drug Problems is a non-profit grant based program that provides opioid addiction treatment for Alaskans. Funding for NDTC, Inc. is distributed by the State of Alaska, Department of Health and Social Services, Division of Behavioral Health. Narcotic Drug Treatment Center, Inc. is accredited by the Commission on Accreditation for Rehabilitation Facilities (CARF).

The Narcotic Drug Treatment Center, Inc. provides comprehensive substance abuse treatment services by a multi-disciplinary team, this includes medication assisted treatment.

Narcotic Drug Treatment Center, Inc. Center for Drug Problems supports Senator Ellis' SB 23, the Opioid Overdose Protection Act, to prevent Alaskans from dying of opioid addiction.

Sincerely,

Ron Greene, CDCS

Ron Greene

Clinical Director

A United Way Agency

520 E. 4th Ave., Suite 102 • Anchorage, Alaska 99501 • Phone: (907) 276-6430 • Fax: (907) 276-3637
e-mail: ndtc@ak.net

Advisory Board on Alcoholism
and Drug Abuse

abada
amhb

Alaska Mental Health Board

ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
431 NORTH FRANKLIN STREET, SUITE 200
JUNEAU, ALASKA 99801
(907) 465-8920

March 17, 2015

Senator Johnny Ellis
Alaska State Capitol Room
Juneau, Alaska 99801

Re: Support for SB 23 – Immunity for Opioid Overdose Drugs

Dear Senator Ellis,

The Advisory Board on Alcoholism and Drug Abuse (ABADA) appreciates your leadership in ensuring that Alaskans experiencing substance use disorders have access to treatment and services. We appreciate that Senate Bill 23 continues those efforts by protecting physicians, emergency responders, and family members who act to prevent deaths through use of Naloxone and/or other medications that counter the effects of opioid overdose.

According to the Centers for Disease Control and Prevention, deaths due to drug overdose have risen steadily over the past twenty years. "Every day, 120 people die as a result of drug overdose, and another 6,748 are treated in emergency departments for the misuse or abuse of drugs." The Alaska Bureau of Vital Statistics reports that, since 2010, 512 people died due to poisoning (the category into which drug overdoses appear). The CDC reports that "nearly 9 out of 10 poisoning deaths are caused by drugs."

ABADA has received public comment in support of increased access to Naloxone and similar medications to prevent overdose deaths. We have also received queries from medical providers about the extent to which they can prescribe these medications under Alaska law and codes professional ethics. There being no clear guidance from the State Medical Board on these issues, we believe that the express policy and protections in Senate Bill 23 are necessary and appropriate.

We appreciate your tireless efforts on behalf of Alaskans experiencing behavioral health disorders and their families – and for all our communities affected by these issues.

Sincerely,

J. Kate Burkhart
Executive Director

cc: Bob Coghill, Chairman ABADA

Anchorage Police Department employees Association

PO Box 230330
Anchorage, Alaska 99523
(907) 561-7500
www.apdea.org

March 17, 2015

Senator Johnny Ellis
State Capitol Bldg., Room 7
Juneau, AK 99801

Dear Senator Ellis,

I write to you today in support of SB23, "An act relating to immunity for prescribing, providing, or administering overdose drugs."

As the President of the Anchorage Police Department Employees Association, I proudly represent more than 475 employees of the Anchorage Police Department. Our members, sworn and non-sworn alike have experienced an increasing occasion to receive and respond to calls for service involving the illegal use and overdose of opioid based prescription medications and heroin. Our emergency 911 dispatchers answer the calls from citizens whose friends and family members have had a negative affect to an excessive use of a drug. Our officers respond to the scene and either assist with the medical intervention or investigate the untimely deaths of these citizens.

Our officers have seen first hand how effective emergency administration of an opioid overdose drug can be. Many of our officers have arrived at the scene of a reported overdose to find a victim non-responsive and clearly near death. Our public safety counter parts on the paramedic side then administer the overdose drug and the person very quickly recovers; the results are astonishing. The thought of having this life saving drug available to friends and families is very compelling.

While the members of the APDEA do not see this as a final fix for this terrible epidemic, we do support the idea of providing this as an option to be made available to help those along the road to recovery from addition to these terrible drugs. Drug enforcement and rehabilitation should still be employed as a full scale response.

Thank you for your collective efforts on this important issue. Please let me know if you have any questions.

Sincerely,

Sgt. Gerard Asselin
President
APDEA

29-LS0058\E
Wallace
3/27/15

adopt.
a1

CS FOR SENATE BILL NO. 23(JUD)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - FIRST SESSION

BY THE SENATE JUDICIARY COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR ELLIS

A BILL

FOR AN ACT ENTITLED

"An Act relating to opioid overdose drugs and to immunity for prescribing, providing, or administering opioid overdose drugs."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 09.65 is amended by adding a new section to read:

Sec. 09.65.340. Immunity for prescribing, providing, or administering an opioid overdose drug. (a) Except as provided in (c) of this section, a person is not liable for civil damages resulting from an act or omission in prescribing or providing an opioid overdose drug to a person at risk of experiencing an opioid overdose or to a family member, friend, caregiver, or other person in a position to administer an opioid overdose drug to a person at risk of experiencing an opioid overdose if

(1) the person

(A) prescribing or providing the opioid overdose drug is a health care provider; or

(B) providing the opioid overdose drug is an employee or

volunteer of an opioid overdose program; and

(2) each person to whom the opioid overdose drug is prescribed or provided has been educated and trained in the proper emergency use and administration of the opioid overdose drug by the health care provider or the opioid overdose program.

(b) Except as provided in (c) of this section, a person who administers an opioid overdose drug to another person who the person reasonably believes is experiencing an opioid overdose emergency is not liable for civil damages resulting from an act or omission in the emergency administration of the opioid overdose drug if the person

(1) was prescribed or provided the opioid overdose drug by a health care provider or an opioid overdose program; and

(2) received education and training in the proper emergency use and administration of the opioid overdose drug by the health care provider or the opioid overdose program.

(c) This section does not preclude liability for civil damages that are the result of gross negligence or reckless or intentional misconduct.

(d) In this section,

(1) "health care provider" means a licensed physician, advanced nurse practitioner, physician assistant, village health aide, or pharmacist operating within the scope of the health care provider's authority;

(2) "opioid" includes the opium and opiate substances and opium and opiate derivatives listed in AS 11.71.140;

(3) "opioid overdose drug" means a drug that reverses in whole or part the pharmacological effects of an opioid overdose;

(4) "opioid overdose program" means a program that provides opioid overdose drugs to persons at risk of experiencing an opioid overdose or to a family member, friend, or other person in a position to assist a person at risk of experiencing an opioid overdose.

*** Sec. 2.** AS 17.20 is amended by adding a new section to read:

Sec. 17.20.085. Opioid overdose drugs. (a) Notwithstanding a provision or

rule of law to the contrary, a health care provider authorized to prescribe an opioid overdose drug may prescribe an opioid overdose drug directly or by standing order or protocol to a person at risk of experiencing an opioid overdose or to a family member, friend, caregiver, or other person in a position to administer an opioid overdose drug to a person at risk of experiencing an opioid overdose.

(b) An employee or volunteer of an opioid overdose program, if acting under a standing order or protocol under (a) of this section, notwithstanding a provision or rule of law to the contrary, may receive a supply of opioid overdose drugs, possess opioid overdose drugs, and provide an opioid overdose drug to a person at risk of experiencing an opioid overdose or to a family member, friend, caregiver, or other person in a position to administer an opioid overdose drug to a person at risk of experiencing an opioid overdose.

(c) In this section,

(1) "health care provider" means a licensed physician, advanced nurse practitioner, physician assistant, village health aide, or pharmacist operating within the scope of the health care provider's authority;

(2) "opioid" includes the opium and opiate substances and opium and opiate derivatives listed in AS 11.71.140;

(3) "opioid overdose drug" means a drug that reverses in whole or part the pharmacological effects of an opioid overdose;

(4) "opioid overdose program" means a program that provides opioid overdose drugs to persons at risk of experiencing an opioid overdose or to a family member, friend, or other person in a position to assist a person at risk of experiencing an opioid overdose.

ALASKA STATE LEGISLATURE

While in Session
State Capitol
Juneau, AK 99801
(907) 465-3704
Fax: (907) 465-2529

While in Anchorage
716 W. 4th Ave
Anchorage, AK
(907) 269-0169
Fax: (907) 269-0172

SENATOR JOHNNY ELLIS

Senate Bill 23 - Sectional Analysis

Section 1. Amends AS 09.65 by adding a new section (09.65.340) to give immunity for prescribing, providing, or administering an opioid overdose drug

Subsection (a) exempts a person from civil liability if providing or prescribing an opioid overdose drug if the prescriber or provider is a health care provider or an employee of an opioid overdose program and the person has been educated and trained in the proper emergency use and administration of the opioid overdose drug

Subsection (b) except as provided in (c) exempts a person who administers an opioid overdose drug to another person who the person reasonably believes is experiencing an opioid overdose emergency if the person

1. Was prescribed or provided the drug by a health care provider or opioid overdose program and
2. Received education and training in the proper emergency use and administration

Subsection (c) does not preclude liability for civil damages that are a result of gross negligence or reckless or intentional misconduct

Subsection (d) defines

1. "health care provider" as a licensed physician, advanced nurse practitioner, physician assistant, village health aide3, or pharmacist operating within the scope of the health care provider's authority;
2. "opioid" includes the opium and opiate substances and opium and opiate derivatives listed in AS 11.71.140
3. "opioid overdose drug" means a drug that reverses in whole or part the pharmacological effects of an opioid overdose
4. "opioid overdose program" means a program operated provides opioid overdose drugs to persons at risk of experiencing an opioid overdose or to a family member, friend, or other person in a position to assist a person at risk of experiencing an overdose.

ALASKA STATE LEGISLATURE

While in Session
State Capitol
Juneau, AK 99801
(907) 465-3704
Fax: (907) 465-2529

While in Anchorage
716 W. 4th Ave
Anchorage, AK
(907) 269-0169
Fax: (907) 269-0172

SENATOR JOHNNY ELLIS

Senate Bill 23 – Explanation of Changes
Version A to Version E

Section 1, subsection d (4) and Section 2, subsection d (4) changed the definition of "opioid overdose program" so that it is not limited to federal, state or municipal funded programs
Added a new section

Subsection a authorizes health care providers to prescribe an opioid overdose drugs directly or by standing order or protocol to a person at risk of experiencing an opioid overdose or to a family member, friend, caregiver, or other person in a position to administer the drug to a person at risk of experiencing an overdose.

Subsection b authorizes an employee or volunteer of an opioid overdose program to receive a supply, possess and provide opioid overdose drugs to persons at risk of experiencing an opioid overdose or to a family member, friend, caregiver, or other person in a position to administer the opioid overdose drug to a person at risk of experiencing an overdose.

Section 2.

Subsection (a) authorizes a health care provider to prescribe an opioid overdose drug directly or by standing order to a person at risk of experiencing an opioid overdose or to a family member, friend, caregiver, or other person in a position to administer an opioid overdose drug to a person at risk of experiencing an opioid overdose.

Subsection (b) an employee or volunteer of an opioid overdose program can understanding order or protocol under (a) of this section may receive, possess, and provide opioid overdose drugs to a person at risk of experiencing an opioid overdose or to a family member, friend, caregiver, or other person in a position to administer an opioid overdose drug

Subsection (c) Definitions (see Section 1; Subsection d above)

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: SB 23
Fiscal Note Number:
() Publish Date:

Identifier: SB0023-DOC-HRS-03-20-15
Title: IMMUNITY FOR PROVIDING OPIOID OD DRUG
Sponsor: ELLIS
Requester: (S) Health & Social Services

Department: Department of Corrections
Appropriation: Health and Rehabilitation Services
Allocation: Health and Rehabilitation Director's Office
OMB Component Number: 3097

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Fund Source (Operating Only)

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							

Estimated SUPPLEMENTAL (FY2015) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency?
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

The previous fiscal note indicated that an employee would have successfully completed a training program approved by the Department of Heatlh and Social Services. It has been determined tht the bill does not task the Department of Health and Social Services with any training program oversight or approval, and this section of the Corrections fiscal note has been removed.

Prepared By: April Wilkerson — Phone: (907)465-3460
Division: Administrative Services - Department of Corrections — Date: 03/30/2015 10:00 AM
Approved By: Remond Henderson, Deputy Commissioner — Date: 03/30/2015
Agency: Department of Corrections

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. SB23

Analysis

This legislation amends AS 09.65 by adding a new section to grant immunity from civil damages, except in cases of gross negligence or intentional misconduct, to persons prescribing, providing or administering an opioid overdose drug to a person at risk of experiencing an opioid overdose.

Passage of this new section will allow employees of the Department of Corrections to obtain and administer an opioid overdose drug if the employee has successfully completed a training program.

The Department of Corrections does not anticipate a significant fiscal impact with passage of this legislation and the additional training requirements therefore is submitting a zero fiscal note.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version:	SB 23
Fiscal Note Number:	2
(S) Publish Date:	3/25/2015

Identifier: SB023-DCCED-CBPL-03-14-15
Title: IMMUNITY FOR PROVIDING OPIOID OD DRUG
Sponsor: ELLIS
Requester: (S) Health and Social Services

Department: Department of Commerce, Community and Economic Development
Appropriation: Corporations, Business and Professional Licensing
Allocation: Corporations, Business and Professional Licensing
OMB Component Number: 2360

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016 Appropriation Requested	Included in Governor's FY2016 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Fund Source (Operating Only)

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							

Estimated SUPPLEMENTAL (FY2015) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By:	Janey Hovenden, Director	Phone:	(907)465-2538
Division:	Corporations, Business, and Professional Licensing	Date:	03/14/2015 09:55 AM
Approved By:	Catherine Reardon, Director	Date:	03/14/15
Agency:	Division of Administrrative Services, DCCED		

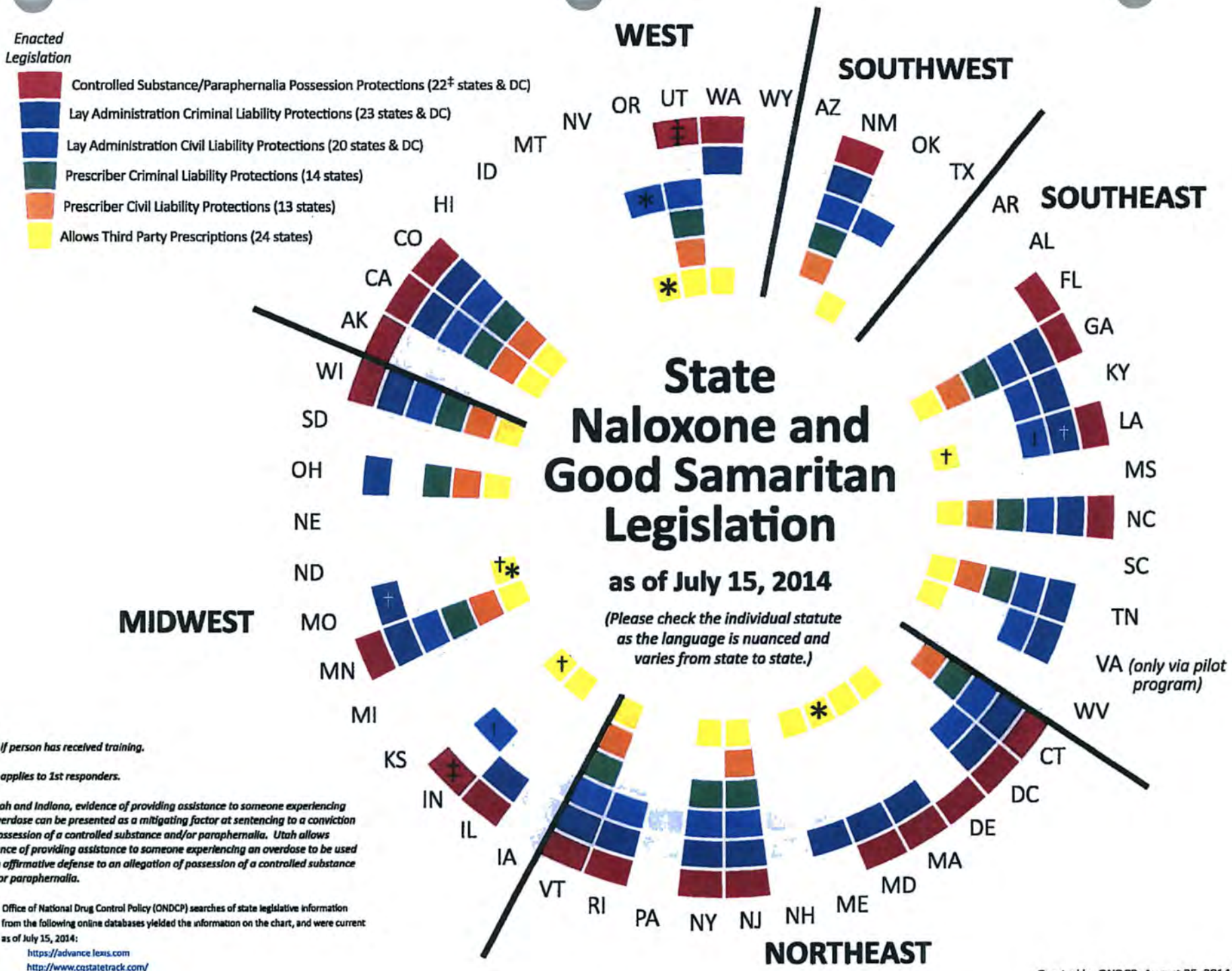
FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

Analysis

Under SB23, a person is not liable for civil damages resulting from an act or omission in prescribing or providing an opioid overdose drug to a person at risk of experiencing an opioid overdose, under certain conditions.

The Division of Corporations, Business, and Professional Licensing does not anticipate fiscal impact from this legislation.



*Only if person has received training.

†Only applies to 1st responders.

‡In Utah and Indiana, evidence of providing assistance to someone experiencing an overdose can be presented as a mitigating factor at sentencing to a conviction for possession of a controlled substance and/or paraphernalia. Utah allows evidence of providing assistance to someone experiencing an overdose to be used as an affirmative defense to an allegation of possession of a controlled substance and/or paraphernalia.

Source: Office of National Drug Control Policy (ONDCP) searches of state legislative information from the following online databases yielded the information on the chart, and were current as of July 15, 2014:

https://advance.lexis.com
http://www.cqstatetrack.com/
http://openstates.org/

Created by ONDCP: August 25, 2014

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 18, 2015

SUBJECT: Department of Corrections liability
(CSSB 23( ); Work Order No. 29-LS0058\W)

TO: Senator Johnny Ellis
Attn: Amory Lelake

FROM: Megan A. Wallace
Legislative Counsel MAW

You have asked for an opinion as to whether the Department of Corrections would benefit from the provisions of CSSB 23( ) if enacted.

As an initial matter, please note that AS 09.50.250 governs civil claims brought against the state. The state is immune under AS 09.50.250 for failure to exercise or perform a discretionary function. Accordingly, as it relates to administering an opioid overdose drug, the Department of Corrections may benefit from the discretionary immunity enjoyed by the state.

Under CSSB 23( ), an employee working for the Department of Corrections would be able to obtain and administer an opioid overdose drug if the employee successfully completes the training program approved by the Department of Health and Social Services. (*See* sec. 1, AS 17.23.010.) Furthermore, in addition to the discretionary immunity potentially available under AS 09.50.250, if an employee working for the Department of Corrections successfully completes the training program approved by the Department of Health and Social Services, a claim may not be brought against that individual for an act or omission relating to the administration of an opioid overdose drug in good faith in an emergency situation.[1] (*See* sec. 1, AS 17.23.040(a).) An employee working for the Department of Corrections would not be immune from a claim for gross negligence or reckless or intentional misconduct. (*See* sec. 1, AS 17.23.040(c).)

In summary, so long as the Department of Corrections employees are trained under the training program approved by the Department of Health and Social Services, its employees would benefit from the provisions of CSSB 23( ) if enacted.

---

[1] A claim may also not be brought against an individual for an act or omission relating to prescribing or providing the opioid overdose drug under specified circumstances. (*See* sec. 1, AS 17.23.040(b).)

If you have any additional questions, please advise.

MAW:lem
15-176.lem

March 16, 2015

Senator Johnny Ellis
State Capitol Building, Room #7
Juneau, Alaska 99801

RE: Senate Bill No.23 – "An Act relating to immunity for prescribing, providing, or administering Opioid overdose drugs."

Dear Senator Ellis,

I am a citizen of Anchorage, Alaska and have family members who have substance abuse. I am writing in support of this bill. I think this should not be any further discussion and should become law ASAP. By passing this bill it could save my loved one's life and many others who are inflicted with substance abuse in our State. Most other State's have this in place already and Alaska needs this as well.

I live everyday not knowing if my loved one will be alive due to substance overdose. I need to know that I could save him/her by administering an opioid overdose drug and have immunity for doing so.

It is crystal clear that this bill needs to become law and that we need to continue our efforts to do more for those inflicted with addictions.

I look forward to working with the legislature and continue to be and an advocate for this who suffer with substance abuse in our great State. This is a small piece of much needed work that we all need to do to assist those suffering with addiction. Let's get it done and continue with our fight to help those who need it.

Thank you,

Lisa Reynolds
butter@gci.net
907-440-1179