Meeting Agenda – July 30, 2019 -SHTF

1. **Introductions:**

2. **Updates:**
   a. FADAA: Mark Fontaine
   b. FARR: Steve Farnsworth
   c. FCB: Level II Background Check- Neal McGarry
   d. PBC Health Care District
      a. Receiving Facility (JFK)

3. **Hospital Emergency Rooms**
   a. Practical Issues from an ER Perspective:
      a. Dr. Aaron Wohl
      b. Dr. Jason Fields
   b. Warm Hand-Offs: Effectiveness
      a. Peer Specialists in the ER
      b. Admissions and Referrals/ Parity
      c. Voluntary vs. Involuntary: Andrew Burki
   c. Legal Liability (release/referral): Susan Ramsey
   d. National Alliance for Model State Drug Laws
      a. Model Act Providing for the Warm Hand-Off of Overdose Survivors to Treatment
   e. ER Physician Training
      a. MAT waivers

4. **Legislation:**
   a. Recovery Residence Administrators Background Check Glitch Amendment
   b. NAMSDL - Model Drug Laws

5. **Public comments.**
6. **Closing remarks.**
Coverage Map
Florida Medical Examiner Districts

District 1
Escambia
Okaloosa
Santa Rosa
Walton

District 2
Franklin
Gadsden
Jefferson
Leon
Liberty
Taylor
Wakulla

District 3
*Covered by
Columbia *4
Dixie *8
Hamilton *4
Lafayette *2
Madison *2
Suwannee *2

District 4
Clay
Duval
Nassau

District 5
Cirtus
Hernando
Lake
Marion
Sumnter

District 6
Pasco
Pinellas

District 7
Volusia

District 8
Alachua
Baker
Bradford
Gilchrist
Levy
Union

District 9
Orange

District 10
Hardee
Highlands
Polk

District 11
Miami-Dade

District 12
DeSoto
Manatee
Sarasota

District 13
Hillsborough

District 14
Bay
Calhoun
Gulf
Holmes
Jackson
Washington

District 15
Palm Beach

District 16
Monroe

District 17
Broward

District 18
Brevard

District 19
Indian River
Martin
Okeechobee
St. Lucie

District 20
Collier

District 21
Glades
Hendry
Lee

District 22
Charlotte

District 23
Flagler
Putnam
St. Johns

District 24
*Covered by
Seminole *7

District 25
*Covered by
Osceola *9

Total: 4279
Average 12 Deaths Per day

ITEM 2
Coverage Map
Florida Medical Examiner Districts

District 1  48  District 5  71  District 11  105  District 19  60
Escambia  Okaloosa  Santa Rosa  Walton
District 2  5  District 6  179  District 12  69  District 20  30
Franklin  Gadsden  Jefferson  Leon  Liberty  Taylor  Wakulla
District 7  85  District 13  102
Volusia  Hillsborough
District 8  13
Alachua  Baker  Bradford  Gilchrist  Levy  Union
District 9  144  District 14  12
Orange  Bay  Calhoun  Gulf  Holmes  Jackson  Washington
District 15  201
Palm Beach
District 16  6  District 17  189  District 18  98
Monroe  Broward  Brevard
District 10  45  District 19  21  District 20  12
Duval  Hardee  Highlands  Polk
District 21  5  District 22  17
Brevard  Flagler  Putnam  St. Johns
District 23  144  District 24  53  District 25  37
Clay  Duval  Nassau  *Covered by Flagler  *Covered by Seminole
District 24  53
Flagler  Putnam  St. Johns
District 25  37
*Covered by Osceola

Total: 1849
Average 10 Deaths Per day

2018 Interim Medical Examiners Commission Drug Report

AGENDA ITEM 2
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20% decrease 2018 to 2019
49% decrease 2017 to 2018
60% decrease 2017-2019

21% decrease 2018-2019
51% decrease 2017-2018
61% decrease 2017-2019

# of calls 2017-2019 JAN - JUNE
# of Patients 2017-2019 JAN-JUNE

- 2017:
  - JAN: 102
  - FEB: 107
  - MAR: 100
  - APR: 104
  - MAY: 138
  - JUN: 130
- 2018:
  - JAN: 156
  - FEB: 136
  - MAR: 38
  - APR: 26
  - MAY: 26
  - JUN: 182
- 2019:
  - JAN: 150
  - FEB: 107
  - MAR: 120
  - APR: 133
  - MAY: 130
  - JUN: 340
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**GRAND TOTALS**

# of Calls: 1622  # of Patients: 1706
### Palm Beach County Fire Rescue

**Primary or Secondary Impression = Opioid**

1/1/2018 to 6/30/2018

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**GRAND TOTALS**

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## Certified Recovery Residences with Certified Recovery Residence Administrators
(Data Source: FARR Posted on DCF Website)

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Warm Handoffs: The Duty of and Legal Issues Surrounding Emergency Departments in Reducing the Risk of Subsequent Drug Overdoses

MICHAEL C. BARNES* & DANIEL C. MCCLUHGEN**

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I. INTRODUCTION

Around 11 p.m. on October 30, 2015, Brandon Goldner’s parents received a devastating phone call—Brandon, their 23-year-old son, had died of a heroin overdose. Blindsided, they were completely unaware that Brandon used heroin. Nor were they aware that emergency responders had revived their son and taken him to the emergency department seven times in the previous two months for opioid-related overdoses, including three times in one six-day period. While it was clear that Brandon had a substance use disorder (“SUD”), Brandon’s parents later learned that emergency department

2. Id.
providers never performed a substance abuse or psychological evaluation, intervention, or referral to treatment during any of the seven hospital visits. Upon discharge after each overdose, hospital staff never provided more than mere informational materials to Brandon to take with him, and no one ever contacted Brandon’s parents to alert them to Brandon’s situation, even though Brandon had listed his mother as his emergency contact. As a result, Brandon never got the treatment he needed, instead experiencing a potentially avoidable overdose death.

According to a December 2017 National Center for Health Statistics report, life expectancy in the U.S. fell for the second year in a row in 2016, due in large part to unintentional, fatal opioid-related overdoses. In fact, deaths involving an opioid nearly tripled between 2002 and 2015, and an estimated 131 people die per day from an opioid-related overdose. While overdose death rates attributable to prescription opioids have remained relatively steady since 2011, the U.S. saw more than a six-fold increase in heroin overdose deaths between 2002 and 2015. During the same period, combined use disorder fall into four major groupings: impaired control, social impairment, risky use, and pharmacological criteria (i.e., tolerance and withdrawal).”

4. Miller, supra note 1.
5. Id.
7. The opioid drug class includes three subclasses of prescription medications: (1) natural opiates (e.g., morphine, codeine, thebaine); (2) semi-synthetic opioids (e.g., hydrocodone, oxycodone, hydromorphone, oxymorphone, buprenorphine); and (3) synthetic opioids (e.g., methadone, propoxyphene, fentanyl, meperidine); and one class of illicit substances, which include heroin and counterfeits or analogs of prescription opioids (e.g., carfentanil). NAT’L INST. ON DRUG ABUSE, URINE DRUG TESTING FOR CHRONIC PAIN MANAGEMENT (n.d.), https://www.drugabuse.gov/sites/default/files/files/UrineDrugTesting.pdf.
overdose deaths from heroin and non-methadone synthetic opioids increased nearly sixfold, due in large part to a rise in deaths from illicit fentanyl.\textsuperscript{11} Of the more than 64,000 drug overdose deaths estimated in 2016, experts estimated that more than 20,000 were related to fentanyl and fentanyl analogs.\textsuperscript{12}

Yet emergency department practitioners could have helped avoid many of these deaths with proper identification of SUD and referral to treatment. Nearly 3 million people in the U.S. have an opioid use disorder (“OUD”), and hospitalizations related to opioid misuse and abuse have increased significantly.\textsuperscript{13} Emergency departments provide an ideal opportunity for intervention, and yet interventions are not occurring. According to a 2014 study, individuals who visit the emergency department for nonfatal overdoses present a high likelihood of future hospitalization and fatal or near-fatal events,\textsuperscript{14} partially due to the lack of follow-up treatment. According to data on privately insured individuals aged 18 to 64, 40\% of patients who received hospital care for opioid-related conditions did not receive any follow-up services whatsoever within 30 days of the hospitalization.\textsuperscript{15} Of those who did receive treatment, 6.0\% of patients received medications only, 43.3\% received behavioral therapy only, and 10.7\% received the hospital-recommended combination of both medication and behavioral therapy services.\textsuperscript{16}

As the overdose epidemic has intensified over the past 15 years, so has the discussion around how to effectively address the epidemic.

\textsuperscript{11} Id. As used in this statistic by NIDA, “deaths involving heroin and non-methadone synthetics” means deaths from heroin and synthetic opioids other than methadone (e.g., fentanyl, propoxyphene, meperidine), and also captures deaths from illicit opioids other than heroin (e.g., illicit fentanyl, carfentanil). Id.

\textsuperscript{12} Id.

\textsuperscript{13} According to a 2016 report, nearly 2.4 million Americans have a prescription OUD, and nearly half a million people have a heroin use disorder. CTRS. FOR BEHAVIORAL HEALTH STATISTICS & QUALITY, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., PATIENTS WHO ARE PRIVATELY INSURED RECEIVE LIMITED FOLLOW-UP SERVICES AFTER OPIOID-RELATED HOSPITALIZATIONS 1 (2016), https://www.samhsa.gov/data/sites/default/files/report_2117/ShortReport-2117.pdf.

\textsuperscript{14} See Kohei Hasegawa et. al., Epidemiology of Emergency Department Visits for Opioid Overdose: A Population-Based Study, 89 MAYO CLINIC PROC. 462, 464 (2014).

\textsuperscript{15} CTRS. FOR BEHAVIORAL HEALTH STATISTICS & QUALITY, supra note 13.

\textsuperscript{16} Id.
and reduce the occurrence of fatal overdose. The federal government, states, and other public bodies are increasingly assembling committees (often referred to as “task forces”) of politicians, medical experts, and others to analyze the epidemic and make recommendations. In addition, states have passed laws and regulations aimed at preventing overdoses and saving lives. For example, all states have passed laws to increase access to naloxone, an overdose rescue medication, and nearly every state has passed “Good Samaritan” laws to encourage those who witness an overdose to call for emergency assistance without fear of prosecution.

As Brandon Goldner’s story demonstrates, however, improving the opportunity and ability to revive individuals who experience an overdose cannot make a meaningful impact on reducing overdose deaths unless overdose survivors have the opportunity to receive specialized treatment to address their SUDs. Unfortunately, stories like Brandon Goldner’s are common and represent a failure to conduct timely assessments of the severity of substance use, intervene, and offer to initiate treatment at a point when individuals are often most vulnerable and at risk of subsequent overdose. As a result, some states, counties, and health care systems have implemented emergency care “warm handoff” programs. A warm handoff is the process of transitioning a patient with SUD from an intercept point, such as an emergency department, to a treatment provider once the patient is stable. Warm handoffs provide a pathway to treatment and recovery for those with SUDs and can decrease the risk of subsequent overdose.

Still, throughout the country, hospitals discharge individuals who present with overdose shortly after intervening or turn them over

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to law enforcement rather than transfer them to treatment.\textsuperscript{21} Without an intervention \textit{and} referral to treatment, these patients suffer an increased risk of experiencing a subsequent overdose death.\textsuperscript{22} Some public health and safety officials have shied from implementing warm handoff policies, fearing liability for improper disclosure of patient information under state and federal privacy laws and regulations.\textsuperscript{23} Hospitals that fail to provide warm handoff services, however, expose themselves to negligence liability.\textsuperscript{24}

This Article shows that not only can warm handoff programs comply with federal and state privacy and prescribing laws, but also that it is in hospitals’ best interests to provide warm handoff services to avoid negligence claims. Part II provides background on psychosocial treatment, revival treatment, medication-assisted treatment (“MAT”), and Screening, Brief Intervention, and Referral to Treatment (“SBIRT”) protocols. Part III discusses examples of efforts to implement emergency care warm handoff programs, namely current state laws and regulations that require emergency care providers to attempt warm handoffs. Part IV examines legal issues pertaining to warm handoff programs, including limitations to Good Samaritan laws, the initiation of MAT, medical malpractice, and patient privacy. Finally, after concluding, the authors provide a model warm handoff policy in the Appendix for hospitals to implement in their emergency department that reflects the legal considerations that this Article discusses.

II. BACKGROUND

Numerous modalities and several medications currently exist to treat OUD. Warm handoff policies help to ensure that first responders, emergency department personnel, treatment providers, and others not

\begin{itemize}
\item \textsuperscript{21} Dhruv S. Kazi et al., \textit{Medication-Assisted Treatment and Opioid Use Before and After Overdose in Pennsylvania Medicaid}, 318 J. AM. MED. ASS’N 750, 750–51 (2017).
\item \textsuperscript{22} Hasegawa et al., \textit{supra} note 14.
\end{itemize}
only revive individuals who experience nonfatal overdoses but the appropriate party also earnestly offers the individual such treatment to prevent future overdoses. This Part provides an overview of existing treatments and evidence of their effectiveness, shedding light on why warm handoff policies are so vital.

A. Revival Medications and SUD Treatment

The National Institute on Drug Abuse defines addiction as a “chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences.”\textsuperscript{25} Due to its chronic nature, addiction must be managed using long term treatment approaches.\textsuperscript{26} Several evidence-based treatment and medication modalities currently exist to first revive an individual from an opioid overdose, and then assist the individual in achieving chronic maintenance management of an OUD.\textsuperscript{27}

1. Naloxone

Naloxone is an opioid antagonist that blocks opioid receptors and reverses the toxic effects of an opioid overdose, including extreme drowsiness, slowed breathing, or loss of consciousness.\textsuperscript{28} Naloxone has a rapid onset\textsuperscript{29} and is administered when a patient is showing signs of opioid overdose. Currently, naloxone is administered by intranasal spray or by intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection.\textsuperscript{30}

\textsuperscript{25} The Science of Drug Abuse and Addiction: The Basics, supra note 3.
\textsuperscript{26} See id.
\textsuperscript{27} Id. OUD is a lifelong condition. The goal of treatment is to achieve long-term stability and periods of abstinence. CTR. FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP’T HEALTH & HUMAN SERVS., TREATMENT FOR STIMULANT USE DISORDER: TIP 33 (2009), https://www.ncbi.nlm.nih.gov/books/NBK64334/.
\textsuperscript{28} Naloxone, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone (last updated Mar. 3, 2016) [hereinafter SAMHSA, Naloxone].
\textsuperscript{30} SAMHSA, Naloxone, supra note 28.
Naloxone carries its own risks. Side effects of naloxone include opioid withdrawal symptoms, such as nervousness, restlessness, or irritability; body aches; dizziness; diarrhea; stomach pain; nausea; and fever or chills. Other side effects include hallucinations, irregular heartbeat, loss of consciousness, and seizures. Additionally, the effects of a potent analog opioid, such as carfentanil, or heroin combined with a benzodiazepine, for example, can last longer than the effects of naloxone. Therefore, if the patient does not receive proper treatment, he or she could experience “re-toxicity,” which can result in respiratory depression and death after the naloxone revival. In addition, the dose and route of administration of naloxone can impact the adverse events and withdrawal symptoms. For instance, “intravenous administration and higher doses” of naloxone “produce more adverse events and more severe withdrawal symptoms in” individuals with OUD. Given the severity of the withdrawal, many individuals choose to ingest more opioids. As a result, once the

33. Benzodiazepines (e.g., alprazolam, diazepam, clonazepam) are a type of prescription medication commonly prescribed to treat anxiety and insomnia. Like opioids, benzodiazepines have sedative effects. Combining opioids and benzodiazepines can impair cognitive function and cause respiratory depression, which can be fatal. The U.S. Food and Drug Administration now requires both prescription opioids and benzodiazepines to include labeling with “black box” warnings describing the risks of using these drugs together. Benzodiazepines and Opioids, NAT’L INST. ON DRUG ABUSE, https://www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids (last updated Sept. 2017).
37. Id.
naloxone wears off, the individual has an exceptionally high dose of the opioid in his or her system, putting him or her at risk for another overdose. For these reasons, hospitals should carefully consider discharge timing for individuals who are administered naloxone after an opioid overdose.

Medical first responders often use naloxone, but individuals with no formal training can also administer it. Until recently, laws and regulations in place prior to the overdose epidemic largely have limited community access to naloxone. Those laws are beginning to change. States have passed legislation to address at least some of the barriers to naloxone access and the provision of timely medical care. All 50 states and the District of Columbia now have laws intended to improve the availability of naloxone. These laws vary from state to state, but common characteristics include civil, criminal, or disciplinary immunity for medical professionals who prescribe or dispense naloxone and laypeople who administer it; authorization to prescribe naloxone to individuals other than those at risk of overdose; authorization to prescribe naloxone via a standing order; and authorization for organizations that are not otherwise permitted to dispense naloxone (for example, non-profit organizations) to distribute the medication.

39. Id.
40. NETWORK FOR PUB. HEALTH L., supra note 18, at 1. See also Maya Doe-Simkins et al., Overdose Rescues by Trained and Untrained Participants and Change in Opioid Use Among Substance-Using Participants in Overdose Education and Naloxone Distribution Programs: A Retrospective Cohort Study, 14 BMC PUB. HEALTH 297 (2014).
41. For example, state laws generally prohibit health care providers from prescribing a medication to anyone other than the patient to whom they will be administered (i.e., a third-party prescription), or to a patient with whom the provider does not have a provider-patient relationship (i.e., prescription via a standing order). NETWORK FOR PUB. HEALTH L., supra note 18, at 1. In addition, some providers are hesitant to prescribe or dispense naloxone due to fear of liability, even though there is rarely a legal basis for any such liability. Id. Similarly, individuals who witness an overdose may be afraid to call for medical assistance over fear of prosecution for possession of illicit drugs or paraphernalia, or other crimes, thereby preventing access to potentially life-saving care. Id.
42. Id.
43. Id.
44. Id. at 2.
2. SBIRT

SBIRT is an evidence-based practice used to help identify, reduce, and prevent problematic substance use. The goal of SBIRT is to prevent adverse health consequences among individuals whose use may not have reached the diagnostic level of a SUD, and to help those with SUD enter and remain in treatment. As such, SBIRT principles are the heart of a warm handoff policy.

The first major component of SBIRT—screening—allows health care providers to quickly identify risky substance use through standardized screening tools. During the screening process, a health care provider typically asks the patient one to three questions. If the screen is positive, the patient undergoes a more thorough evaluation using a standardized risk assessment tool.

Brief Intervention is a strategy intended to encourage the patient to modify his or her behavior and prevent the progression of substance use. A health care provider or a behavioral health provider engages the patient in a short conversation (5–10 minutes) and provides feedback and advice while discussing topics, such as how substance use can cause or worsen health problems or result in dangerous interactions with medications. Practitioners generally perform brief interventions for patients with less severe substance use and who may not need a referral to addiction treatment. Patients with SUDs may require longer, more intensive interventions (20–30 minutes). Health care providers may conduct these more intensive sessions, but often behavioral health professionals conduct them.


46. Id.
47. Id. at 2.
48. Id.
49. Id.
50. Id. at 3.
51. Id. at 2–3.
52. Id. at 3.
53. Id. at 2.
For some patients, a referral to treatment may be appropriate. The referral process includes helping patients access and select treatment programs, and identifying barriers to treatment, such as cost or lack of transportation. Ideally, health care providers will establish and cultivate relationships with addiction treatment providers to whom they refer patients, share pertinent patient information with the addiction treatment providers, and ensure that the patients receive necessary care coordination and follow-up support services.

It is possible to implement SBIRT in a variety of medical settings, and it has proved successful in hospitals and emergency departments. Implementing SBIRT protocols in emergency departments, however, can be challenging. A recent qualitative evaluation on the implementation of a novel SBIRT protocol into normal emergency department workflow suggested that impediments to implementation “include views of SBIRT appropriateness in the [emergency department], the need for continuous reinforcement and refinement of personnel training and protocol execution, and fostering of additional administrative and financial champions.”

Nevertheless, successful implementation of SBIRT in emergency departments can lead to overwhelmingly positive results. For example, the Washington State SBIRT Program has demonstrated the effectiveness of providing SBIRT to high-risk substance abusers who frequent hospital emergency departments, with substantial declines in illicit drug use. Among high-risk users of prescription opioids, at six-month follow-up, there was a 41% reduction in days of

54. Id. at 3.
55. Id.
56. Id.
57. Id.
60. Id.
drug use (from 12.8 to 7.5 days) for individuals who received only a brief intervention, and a 54% reduction (from 14.4 days to 6.6 days) for individuals who received a brief intervention, followed by brief therapy or SUD treatment. Among high-risk heroin users, at six-month follow-up, there was a 45% reduction in days of drug use (from 15.8 to 8.7 days) for individuals who received only a brief intervention, and a 50% reduction (from 16.5 days to 8.3 days) for individuals who received a brief intervention, followed by brief therapy or SUD treatment.

3. Substance Use Treatment

One cannot overstate the importance of referring SUD patients to treatment. Patients who receive psychosocial treatment have better outcomes than patients who do not. Psychosocial treatment, also known as behavioral health treatment, may include individual or group counseling; referrals to community-based services; contingency management, which is an intervention that provides tangible rewards for abstaining from substance use; and connection to family support systems. Mutual help programs, such as twelve-step facilitation treatments, may also provide relief.

Researchers have demonstrated that MAT, also known as medical therapy, which combines psychosocial treatment and FDA-approved medication, has been more effective than either behavioral interventions or medication alone in treating OUD. Compared to

61. Id. at 6.
62. Id. at 5.
65. Id.
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nondrug approaches, MAT significantly reduces problematic opioid use and improves adherence to treatment. Moreover, increased community access to MAT can reduce overdose deaths.

FDA-approved medications to treat OUD include methadone, buprenorphine, and naltrexone. Methadone treats OUD by suppressing withdrawal, blocking the euphoric effects of opioids, and reducing cravings. As a general rule, practitioners who dispense methadone to individuals for detoxification or maintenance treatment must annually obtain a registration for that purpose. Only federally regulated opioid treatment programs ("OTPs") may dispense


69. PEW CHARITABLE TRS., supra note 64.


71. 21 U.S.C. § 823(g)(1) (2012). See also 42 C.F.R. § 8.2 (2017) ("Detoxification treatment means the dispensing of an opioid agonist treatment medication in decreasing doses to an individual to alleviate adverse physical or psychological effects incident to withdrawal from the continuous or sustained use of an opioid drug and as a method of bringing the individual to a drug-free state within such period . . . . Maintenance treatment means the dispensing of an opioid agonist treatment medication at stable dosage levels for a period in excess of 21 days in the treatment of an individual for [OUD]." (emphasis added)).
methadone for OUD. These OTPs typically observe patients’ methadone consumption and limit take-home doses.

Buprenorphine effectively fills opiate receptors in the brain, thereby reducing opioid withdrawal symptoms and cravings without increasing opioid sensitivity and the risk of overdose. Buprenorphine has a “ceiling effect,” which prevents additional biological responses, including euphoria, intoxication, and respiratory depression, and reduces the possibilities for both abuse and overdose.

Qualified


74. CTR. FOR SUBSTANCE ABUSE TREATMENT, supra note 70.

75. See CTR. FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP’T OF HEALTH & HUMAN SERVS., CLINICAL GUIDELINES FOR THE USE OF BUPRENORPHINE IN THE TREATMENT OF OPIOID ADDICTION: TIP 40 (2004), http://lib.adai.washington.edu/clearinghouse/downloads/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction-54.pdf [hereinafter CLINICAL GUIDELINES]. Some oral buprenorphine products contain naloxone as an additional ingredient. See id. “Naloxone is added to buprenorphine to decrease the likelihood of diversion and misuse of the combination drug product.” Buprenorphine, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine (last updated May 31, 2016). Combination products are available as sublingual (under the tongue) tablets, sublingual film, and buccal (inside the cheek) film. Id. Buprenorphine is better absorbed orally than naloxone. See id. Therefore, when buprenorphine-naloxone combination products are taken as prescribed, buprenorphine’s effects dominate, and naloxone does not induce opioid withdrawal. Id. If oral products are manipulated and injected, however, “the naloxone effect dominates and can bring on opioid withdrawal,” thus discouraging intravenous abuse of the product. Id. Oral buprenorphine combination products are generally recommended over oral buprenorphine monoprodut, given the combination products’ injection-deterring features. Mark L. Kraus et al., Statement of the American Society of Addiction Medicine Consensus Panel on the Use of Buprenorphine in Office-Based Treatment of Opioid Addiction, 5 J. ADDICTION MED. 254, 255 (2011). The primary exception is pregnant women, for whom
health care providers can prescribe buprenorphine, which the FDA has approved in oral, injectable, and implantable forms, in office-based settings; federal law, however, requires providers to obtain a waiver to treat patients with OUD using buprenorphine and limits the number of patients they may treat at any one time. 76

Finally, naltrexone treats opioid addiction by blocking the effects of opioids in the brain’s reward system. 77 It is not an opioid, it has a low potential for diversion and abuse, and any health care provider who is licensed to prescribe medicines may prescribe it. 78 Health care providers must administer injectable naltrexone directly to patients; it is not available to patients for self-administration. 79

monopoduct is indicated to reduce the risk of harm to the fetus. Id. at 255, 258. In addition to oral buprenorphine products, practitioner-administered buprenorphine medications, such as implants and injectables, are now available and administered directly to patients by health care providers. Preeti Barnwal et al., Probuphine® (Buprenorphine Implant): A Promising Candidate in Opioid Dependence, 7 THERAPEUTIC ADVANCES IN PSYCHOPHARMACOLOGY 119, 122–23 (2017). They are not dispensed to patients for self-administration and, therefore, are not available in homes for diversion, abuse, and accidental exposure. Id. These medications are designed to deliver buprenorphine to patients continuously over time, providing certainty that the primary dose is administered according to the treatment plan. Id. at 123–24. A six-month buprenorphine implant is currently on the market, and the FDA is evaluating several weekly and monthly buprenorphine injection products, one of which was approved in November 2017. Press Release, U.S. Food & Drug Admin., U.S. Dep’t of Health & Human Servs., FDA Approves First Once-Monthly Buprenorphine Injection, a Medication-Assisted Treatment Option for Opioid Use Disorder (Nov. 30, 2017), https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm587312.htm . See also Walter Ling, Buprenorphine for Opioid Dependence, 9(5) EXPERT REV. NEUROTHERAPEUTICS 609 (2009).

76. 21 U.S.C. § 823(g)(2) (2017); CLINICAL GUIDELINES, supra note 75.
Naltrexone-assisted treatment cannot begin until an individual has stopped using opioids for seven to ten days.\(^8\)

Given the proven effectiveness of SBIRT and substance use treatment, every emergency department should implement a policy to ensure that all patients who experience a nonfatal overdose receive, at a minimum, an assessment for substance use, a brief intervention, and, if appropriate, referral to treatment.

### III. Warm Handoff Laws and Legislation

Recognizing that revival from an overdose alone is insufficient to prevent future overdose deaths, some states have committed to ensuring that their emergency departments implement protocols for screening overdose survivors for SUD, seeking patient consent to contact the patient’s emergency contact or other caregiver, and referring patients for SUD treatment if appropriate.

#### A. Florida

In June 2017, Florida Governor Rick Scott signed H.B. 249 into law, which requires each hospital with an emergency department to develop a best-practices policy to prevent unintentional drug overdoses.\(^8\) The policy may include, but is not limited to, the use of SBIRT protocols in the emergency department; the use of licensed or certified behavioral health professionals or peer specialists in the emergency department to encourage the patient to seek substance use treatment; guidelines for emergency department practitioners authorized to prescribe controlled substances to reduce the risk of opioid abuse; a process for providing an overdose patient or the patient’s next of kin with information about licensed substance use treatment services; and a process to obtain the patient’s consent to notify the patient’s next of kin and each practitioner who prescribed a controlled substance to the patient regarding the patient’s overdose, the

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80. SAMHSA, EXTENDED-RELEASE INJECTABLE NALTREXONE, supra note 78, at 3.

patient’s location, and the nature of the substance involved in the overdose.  

B. Rhode Island

In an attempt to decrease high hospital readmission rates in general, Rhode Island law requires each hospital and freestanding, emergency care facility to submit to the Director of the Department of Health a comprehensive discharge plan. The plan may include evidence that the hospital or emergency-care facility is participating in a “high-quality comprehensive discharge-planning and transitions-improvement project” that a Rhode Island nonprofit operates. Alternatively, the hospital may submit a plan for how it will provide comprehensive discharge planning and information to the patients transitioning from the hospital’s or freestanding, emergency-care facility’s care. Such a plan must employ evidence-based practices, including providing education prior to discharge; attempting to identify the patient’s primary care providers; prior to discharge, assisting with scheduling post-discharge follow-up appointments; and coordinating and improving communication with outside providers.

The law also contains several provisions that are specific to individuals who experience an opioid overdose. For example, with patient consent, a patient who presents with indication of SUD or opioid overdose must receive a substance abuse evaluation before discharge. If, after the evaluation, clinically appropriate inpatient or outpatient services are not immediately available, the facility must provide medically necessary services with patient consent until the facility can complete a transfer of care.

82. Id. at 6–7.
84. § 23-17.26-3(a)(1).
85. § 23-17.26-3(a)(2).
86. Id.
88. § 23-17.26-3(a)(3)(ii). In addition, with the patient’s consent, a physician may administer to the patient buprenorphine or other narcotic for the purpose of
Finally, the law requires that each patient presenting to a hospital or freestanding, emergency-care facility with an indication of SUD or opioid overdose receive information about the availability of clinically appropriate inpatient and outpatient services for the treatment of SUDs or opioid overdose, including detoxification; stabilization; medication-assisted treatment services; inpatient and residential treatment; licensed clinicians with expertise in the treatment of SUDs and opioid overdoses; and certified recovery coaches. Moreover, the law mandated that, by January 1, 2018, the Department of Health develop a strategy to assess, create, implement, and maintain a database of real-time availability of clinically appropriate inpatient and outpatient services. Once the database becomes available, the hospital or freestanding, emergency-care facility must provide real-time information to patients about the availability of clinically appropriate inpatient and outpatient services.

C. Massachusetts

In 2016, Massachusetts Governor Charles D. Baker signed an act relative to substance use treatment, education and prevention (“STEP Act”). The STEP Act, among other things, requires that a person presenting in an acute-care hospital or a satellite emergency facility, whom the attending physician reasonably believes to be experiencing an overdose involving an opioid, or who has received a naloxone administration prior to arriving at the hospital or facility, receive a substance abuse evaluation within 24 hours of receiving emergency room services. A “substance abuse evaluation” is an assessment that a licensed mental health professional or emergency relieving acute opioid withdrawal symptoms while arrangements are being made for treatment referral. However, only one day’s worth of medication may be administered to the person or for the person’s use at one time. Such treatment may be carried out for not more than three days and may not be renewed or extended. Id.

90. § 23-17.26-3(a)(4)(vi).
services program conducts, and it must include collecting the patient’s history of substance use; substance use by family members; types of and responses to previous treatment for SUD or other psychological disorders; an assessment of the patient’s psychological status including co-occurring disorders, trauma history, and history of compulsive behaviors; and an assessment of the patient’s human immunodeficiency virus, hepatitis C, and tuberculosis risk status.

The law requires that a substance abuse evaluation conclude with a diagnosis of the status and nature of the patient’s SUD using standardized definitions as set forth in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, or a mental or behavioral disorder due to the use of psychoactive substances, as the World Health Organization defines and codes it. Furthermore, each patient must receive the findings of the evaluation in person and in writing, and such findings must include recommendations for further treatment, if necessary, with an assessment of the appropriate level of care needed. Providers must also enter the findings from the evaluation into the patient’s medical record.

The STEP Act also prohibits an acute-care hospital or satellite emergency facility from permitting early discharge—less than 24 hours after admission or before the conclusion of a substance abuse evaluation, whichever comes sooner. If a patient does not receive an evaluation within 24 hours, the attending physician must note in the medical record the reason the evaluation did not occur and authorize the discharge of the patient.

93. “Licensed mental health professional” is defined as “a licensed physician who specializes in the practice of psychiatry or addiction medicine, a licensed psychologist, a licensed independent social worker, a licensed mental health counselor, a licensed psychiatric clinical nurse specialist or a licensed alcohol and drug counselor I as defined in section 1 of chapter 111J” of the General Laws of Massachusetts. Id.
94. Id.
95. § 51 1/2(b).
96. Id.
97. Id.
98. Id.
99. Id.
Finally, a patient may consent to further treatment after the provider performs a substance abuse evaluation. Should a patient refuse further treatment after the evaluation is complete, and otherwise be medically stable, the hospital or facility may initiate discharge proceedings. The patient, however, must receive information on local and statewide treatment options upon discharge, and any other information the attending physician deems appropriate.

On November 14, 2017, Governor Baker proposed legislation that intended in part to improve the effectiveness of substance abuse evaluations required under the STEP Act. The governor’s proposal expanded the range of medical professionals authorized to perform the evaluation and required that the emergency department affirmatively connect the patient with the appropriate level of care.

D. Pennsylvania

In 2016, the Pennsylvania Department of Drug and Alcohol Programs began implementing a warm-handoff process intended to help overdose survivors who appear in emergency departments receive

100. § 51 1/2(c).
101. Id.
102. Id.
104. The bill would add to the definition of “licensed mental health professional” as “a healthcare provider defined in section 1 of chapter 111 [of the General Laws of Massachusetts] whose scope of practice allows such evaluations pursuant to medical staff policies and practice or other professional authorized by the department through regulation.” Id. Section 1 of chapter 111 defines “healthcare provider” as

any doctor of medicine, osteopathy, or dental science, or a registered nurse, social worker, doctor of chiropractic, or psychologist licensed under the provisions of chapter one hundred and twelve, or an intern, or a resident, fellow, or medical officer licensed under section nine of said chapter one hundred and twelve, or a hospital, clinic or nursing home licensed under the provisions of chapter one hundred and eleven and its agents and employees, or a public hospital and its agents and employees.

counseling and a referral to treatment. As part of the implementation, the Department incorporated contractual changes in its grant agreement with the Single County Authorities (“SCA”), which are publicly funded organizations responsible for planning and evaluating community drug and alcohol prevention, intervention, and treatment services. The contractual changes establish overdose survivors as a priority population and require each SCA to create a process whereby such patients receive a direct treatment referral from the emergency department. In February 2017, the Department and the Pennsylvania Department of Health developed a list of local treatment providers and a flowchart designed to help health care providers in emergency departments implement warm handoffs.

According to the Department’s flowchart, if a patient presents to the emergency department with an opioid overdose or other signs and symptoms of opioid abuse, then the patient should receive a screening for OUD, a physical exam, and laboratory testing, and the patient’s history should be documented. If the provider considers the patient to be safe for discharge but believes the patient has OUD, then a physician, registered nurse, or advance care practitioner orders and documents a warm handoff in the electronic medical record. Then, per SCA protocol, a designated emergency department staff member contacts a “drug and alcohol assessor,” and the patient meets confidentially with the assessor. If the patient agrees to further treatment, the initial provider facilitates a warm handoff to an addiction treatment provider, and the patient’s primary care physician

107. Id.
109. Addressing Overdose, supra note 106.
111. PA., EMERGENCY DEP’T WARM HAND-OFF, supra note 110.
112. Id.
113. Id.
receives notification through discharge notes.\textsuperscript{114} If the patient refuses the warm handoff, then the provider discharges the patient with a naloxone prescription and information on local treatment and resources.\textsuperscript{115}

According to an August 2017 news report, the warm handoff program has shown promise.\textsuperscript{116} In Dauphin County, in particular, 50 of 116 overdose survivors who received an offer for treatment actually entered treatment.\textsuperscript{117} Even those patients who chose not to enter treatment received a caseworker who explained the benefits and availability of treatment and, in most cases, a patient’s family member also received the information.\textsuperscript{118} As part of the implementation of the warm handoff program, Dauphine County hired two caseworkers “who are available at all hours and who will arrive at the hospital within 30 minutes to meet with an overdose survivor.”\textsuperscript{119}

\textit{E. Louisiana}

In January 2016, the Louisiana Department of Health and Hospitals promulgated regulations setting forth training and monitoring requirements “for a licensed medical practitioner who prescribes, dispenses, or administers naloxone or another opioid antagonist to a person reasonably believed to be undergoing an opioid-related drug overdose.”\textsuperscript{120} The regulations require that, upon stabilization of the patient, the treating practitioner refer the patient to substance use treatment and offer information regarding substance use treatment.\textsuperscript{121}

\begin{itemize}
\item \textsuperscript{114} See \textit{id}.
\item \textsuperscript{115} \textit{Id}.
\item \textsuperscript{116} David Wenner, “Warm Handoffs” Working in Pa. to Connect Overdose Survivors with Treatment, PA. REAL-TIME NEWS (Aug. 16, 2017), http://www.pennlive.com/news/2017/08/pa_makes_progress_toward_offer.html. However, the report also noted that some counties face certain shortages, such as a lack of treatment providers, that must be addressed before warm handoffs can be implemented statewide. \textit{Id}.
\item \textsuperscript{117} \textit{Id}.
\item \textsuperscript{118} \textit{Id}.
\item \textsuperscript{119} \textit{Id}.
\item \textsuperscript{120} 42 La. Reg. 64 (Jan. 20, 2016), http://www.doa.la.gov/osr/REG/1601/1601.pdf.
\item \textsuperscript{121} \textit{Id} at 65.
\end{itemize}
F. New Jersey

In January 2018, a New Jersey lawmaker introduced legislation that would require caregivers to provide information concerning substance abuse treatment programs and resources to individuals who experience an overdose and receive an opioid antidote122 from a health care professional or first responder.123 Specifically, if a health care facility or the emergency department of a facility admits the individual, a staff member designated by the facility must provide the information to the person any time after treatment for the overdose is complete, but before discharge.124 The designated staff member may, in collaboration with an appropriate health care professional, additionally develop for the individual a substance abuse treatment plan.125

IV. LEGAL ISSUES SURROUNDING WARM HANDOFF PROGRAMS

A. Getting Patients in the Door: Good Samaritan Laws

Fear of prosecution is a significant barrier to treatment for those who experience an overdose; the individual and his or her peers may be reluctant to call emergency responders for fear of being arrested in light of illicit substance use.126 Acknowledging this barrier, at least forty states and the District of Columbia have passed overdose “Good

Samaritan” laws as of July 15, 2017.\textsuperscript{127} However, the laws vary in their protections from state to state.\textsuperscript{128} In fifteen states, the Good Samaritan laws provide protection from arrest or prosecution for certain crimes if an individual experiences a medical emergency after ingesting or using a controlled substance and makes a good-faith request for medical assistance.\textsuperscript{129} In these states, laws protect both the individual who experienced the overdose as well as individuals in his or her presence who sought medical care on the overdosing individual’s behalf.\textsuperscript{130}

Depending on the state, these laws may provide protection from arrest, charge, and prosecution for controlled substance and paraphernalia possession; protective or restraining orders; probation or parole violations; and various other crimes.\textsuperscript{131} Good Samaritan laws can also prohibit the prosecution from using any evidence obtained solely as a result of seeking medical assistance for the overdose.\textsuperscript{132} Moreover, Good Samaritan laws in several states provide that reporting an overdose can be a mitigating factor in sentencing for


\textsuperscript{128} \textit{Id.} While “good faith” may not be defined, if the individual does not call for assistance until after he or she has hidden evidence of illegal conduct, such activity may be considered not acting in good faith. \textit{See, e.g.}, People v. Taylor, 60 N.Y.S.3d 779, 780 (Cnty. Ct. Aug. 14, 2017).

\textsuperscript{129} \textit{See} NETWORK FOR PUB. HEALTH L., NALOXONE AND SAMARITAN LAWS, \textit{supra} note 127.

\textsuperscript{130} \textit{See, e.g.}, D.C. CODE § 7-403 (2018).

\textsuperscript{131} \textit{E.g.}, Shuey, 2016 Md. App. LEXIS 728 at *1 (holding that Maryland’s Good Samaritan law protected an individual who overdosed on heroin from prosecution for possessing controlled paraphernalia because he was experiencing a medical emergency). \textit{See also} NETWORK FOR PUB. HEALTH L., NALOXONE AND SAMARITAN LAWS, \textit{supra} note 127.

\textsuperscript{132} CONN. GEN. STAT. § 1-210(b) (2017).
crimes for which immunity does not exist. Less commonly, these laws can protect individuals from civil forfeiture.

In some counties, police departments have adopted policies requiring their officers to take intoxicated individuals to the hospital to avoid potential overdose—a potential first step in the warm handoff policy. In such cases, however, when a police officer transports an individual to a hospital, Good Samaritan laws do not necessarily protect the individual under the influence. Courts have noted that Good Samaritan laws do not provide immunity simply to an individual under the influence, but rather to “those individuals who are actually...”

133. See Network for Pub. Health L., Naloxone and Samaritan Laws, supra note 127. But see People v. Teper, 74 N.E.3d 1011 (Ill. App. 2016) (holding that a woman could not invoke the Good Samaritan law as a defense to a conviction for unlawful possession of a controlled substance because the possession was not “acquired as a result of” defendant “seeking or obtaining emergency medical assistance,” and the police “had probable cause to arrest defendant based on evidence that was ‘not obtained as a direct result of’ defendant ‘seeking or obtaining emergency medical assistance.’”).


135. A recent working paper by the National Bureau of Economic Research (“NBER”) examined the effect of naloxone access laws and Good Samaritan laws on opioid-related deaths. See Daniel I. Rees et al., With a Little Help from My Friends: The Effects of Naloxone Access and Good Samaritan Laws on Opioid-Related Deaths (National Bureau of Economic Research, Working Paper No. 23171, 2017), https://www.nber.org/papers/w23171.pdf. Using data from the National Vital Statistics System multiple cause-of-death mortality files for the period 1999–2014, the authors found that the adoption of naloxone access laws was associated with a 9–11% reduction in opioid-related deaths to be of comparable magnitude, but not statistically significant at conventional levels. Id. The NBER study was the first of its kind in the U.S. Its findings are consistent with a much narrower study that examined the impact of a naloxone training and distribution program implemented by several communities in Massachusetts. The observational study found that the program reduced opioid-related mortality in the communities in which reduction in opioid-related deaths. Id. In addition, the NBER study was consistent with a 2011 study examining the initial impact of Washington State’s Good Samaritan overdose law several months after the law was passed. The study found that 88% of opiate users surveyed would be more likely to call 911 when witnessing an overdose after becoming aware of the law. Id.
experiencing the deadly throes of overdose.” In other words, the condition must be “severe and life threatening.”

For instance, in *State v. Wolf*, police received an anonymous call about a possibly drunk trespasser—the defendant. Upon arresting the defendant, a police officer found heroin and drug paraphernalia on the defendant’s person. Officers noted that the defendant appeared to be under the influence because “[h]is pupils appeared constricted, his eyelids were droopy, his speech was slow and slurred,” and he would nod off easily. Fearing that a county jail would not accept an individual who was under the influence, the officer took the defendant to the local hospital, which administered naloxone. Once the hospital cleared the defendant medically, police took him to the county jail. Prosecutors indicted the defendant with possession of a controlled substance, and he received a four-year prison sentence. The defendant filed a motion to dismiss pursuant to New Jersey’s Good Samaritan law. In his motion, the defendant argued that “mere intoxication will not suffice to invoke the broad protection granted under the act.”

Moreover, in order for immunity to apply, evidence of the drug possession must be “acquired as a result of” the person seeking or obtaining emergency medical assistance. For example, in *People v.*

137. *Id.* at *3.
138. *Id.* at *1–2.
139. *Id.* at *2.
140. *Id.*
141. *Id.*
142. *Id.*
143. *Id.* at *1.
144. *Id.* at *1–2.
145. *Id.*
146. *Id.*

[a] person who is experiencing an overdose shall not be charged or prosecuted for Class 4 felony possession of a controlled, counterfeit, or look-alike substance or a controlled substance analog if evidence for the Class 4 felony possession charge was
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Teper, police officers “found [the] defendant slumped over in the driver’s seat” of her car, unresponsive, and having trouble breathing. She suffered a heroin overdose, and officers injected her with naloxone. After reviving her, officers found heroin and hypodermic needles in her car. A jury convicted her of unlawful possession of a controlled substance. In her motion to dismiss, she argued that the Good Samaritan law applied because she was experiencing an overdose, and the evidence obtained was acquired as a result of “a person seeking or obtaining emergency medical assistance.” The

acquired as a result of the person seeking or obtaining emergency medical assistance . . . .

720 ILL. COMP. STAT. § 570/414(c) (West 2014). However, such limited immunity shall not be extended if law enforcement has reasonable suspicion or probable cause to detain, arrest, or search the person . . . for criminal activity and the reasonable suspicion or probable cause is based on information obtained prior to or independent of the individual . . . taking action to seek or obtain emergency medical assistance and not obtained as a direct result of the action of seeking or obtaining emergency medical assistance.

§ 570/414(c).

148. Teper, 74 N.E.3d at 1013.

149. Id. at 1013–14. Narcan is a brand name of naloxone. Id. at 1014 n.1.

150. Id. at 1014.

151. The court convicted the defendant of unlawful possession of a controlled substance because she unlawfully possessed less than 15 grams of heroin. Id. at 1013. She was also charged with unlawful possession of hypodermic syringes because she possessed two hypodermic syringes to inject the heroin. Id. at 1016.

152. Id. at 1014. The defendant cited 720 ILL. COMP. STAT. § 570/414, which is entitled “Overdose, limited immunity from prosecution” and provides, in relevant part:

(b) A person who, in good faith, seeks or obtains emergency medical assistance for someone experiencing an overdose shall not be charged or prosecuted for Class 4 felony possession of a controlled, counterfeit, or look-alike substance or a controlled substance analog if evidence for the Class 4 felony possession charge was acquired as a result of the person seeking or obtaining emergency medical assistance and providing the amount of substance recovered is within the amount identified in subsection (d) of this Section.

(c) A person who is experiencing an overdose shall not be charged or prosecuted for Class 4 felony possession of a
The court, however, held that the Good Samaritan law did not apply because evidence of the defendant’s drug possession was not “acquired as a result of” the defendant seeking or obtaining emergency medical assistance.\textsuperscript{153} Police officers had probable cause before they administered naloxone because the defendant had parked incorrectly during rush hour, was unconscious and turning blue, and the needles and a substance in the cup holder were in plain sight.\textsuperscript{154} While the court acknowledged that the police officer provided emergency medical assistance by administering naloxone, it found that the “‘triggering fact’ for the defendant obtaining emergency medical

controlled, counterfeit, or look-alike substance or a controlled substance analog if evidence for the Class 4 felony possession charge was acquired as a result of the person seeking or obtaining emergency medical assistance and providing the amount of substance recovered is within the amount identified in subsection (d) of this Section.

(d) For the purposes of subsections (b) and (c), the limited immunity shall only apply to a person possessing the following amount:

(1) less than 3 grams of a substance containing heroin;

(e) The limited immunity described in subsections (b) and (c) of this Section shall not be extended if law enforcement has reasonable suspicion or probable cause to detain, arrest, or search the person described in subsection (b) or (c) of this Section for criminal activity and the reasonable suspicion or probable cause is based on information obtained prior to or independent of the individual described in subsection (b) or (c) taking action to seek or obtain emergency medical assistance and not obtained as a direct result of the action of seeking or obtaining emergency medical assistance. Nothing in this Section is intended to interfere with or prevent the investigation, arrest, or prosecution of any person for the delivery or distribution of cannabis, methamphetamine or other controlled substances, drug-induced homicide, or any other crime.

\textsuperscript{720 ILL. COMP. STAT. § 570/414 (West 2014).}


154. \textit{Id.} at 1015.
assistance did not occur until [after] the officers noticed the drugs and paraphernalia, which gave them probable cause.” 155 Therefore, the evidence was not “acquired as a result of” providing the emergency medical assistance. 156

Moreover, while improved naloxone access and Good Samaritan laws may help save lives, such measures alone do not prevent subsequent opioid-related overdose. Similar to a nonfatal heart attack patient who, once stable in the emergency department, would receive a referral to a cardiologist, physicians should likewise refer a patient with an SUD who survives an overdose to appropriate treatment. 157 Given that a single overdose episode can predict a subsequent overdose, 158 and given the proven effectiveness of substance use treatment, it is paramount that patients have the opportunity to receive SUD treatment. Additionally, if states want people experiencing an overdose to seek help without fear of prosecution, more states need to strengthen their Good Samaritan laws to protect the individual experiencing an overdose from criminal charges, such as possession of a non-prescribed controlled substance. 159

B. Initiation of MAT in the Emergency Department

Practitioners who dispense methadone to individuals for detoxification or maintenance treatment for OUD must annually obtain a registration for that purpose. 160 In addition, practitioners who prescribe buprenorphine for detoxification or maintenance treatment must apply for and obtain a waiver from the OTP registration

155.  Id. at 1015–16.
156.  Id. at 1013, 1015–16.
159.  NETWORK FOR PUB. HEALTH L., NALOXONE AND SAMARITAN LAWS, supra note 127.
requirement under the Drug Addiction Treatment Act of 2000 ("DATA 2000"). Under DATA 2000, prescribers may obtain a waiver to treat up to 30 patients with buprenorphine during the first year of certification, up to 100 patients the following year, and up to 275 patients the year after (the “30/100/275 patient limit”).

An exception to the 30/100/275 patient limit, known as the “three-day rule,” allows hospital practitioners who are not registered as OTPs or waived under DATA 2000 to administer (but not prescribe) narcotic drugs, including methadone or buprenorphine, to a person for relieving acute opioid withdrawal symptoms if necessary while arrangements are being made to refer the patient to treatment. Under

161. § 823(g)(2). Recent studies have demonstrated that initiating treatment with buprenorphine in the emergency department can have a positive impact on treatment engagement and illicit opioid use. First, a randomized clinical trial published in 2015 compared the efficacy of three interventions for opioid dependence: (1) screening and referral to treatment (“intervention one”); (2) screening, brief intervention and facilitated referral (“intervention two”); and (3) screening, brief intervention, emergency department-initiated treatment with buprenorphine/naloxone, and referral to primary care (“intervention three”). The authors hypothesized that, given the “profound neurobiological and behavioral changes that characterize opioid dependence, it is likely that a more potent intervention, such as emergency department-initiated treatment including buprenorphine, will be needed to produce optimal outcomes.” Gail D’Onofrio et al., Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Independence: A Randomized Clinical Trial, 313(16) J. AM. MED. ASS’N 1636 (2015). The authors found that, among opioid-dependent patients, intervention three compared to interventions one and two “significantly increased engagement in addiction treatment, reduced self-reported illicit opioid use, and decreased use of inpatient addiction treatment services.” Id. In another study published in 2017, emergency department-initiated buprenorphine with 10-week continuation in primary care was compared to both referral and brief intervention. Long-term outcomes at 2, 6, and 12 months were evaluated for these interventions. The authors found that emergency department-initiated buprenorphine was associated with increased engagement in addiction treatment and reduced illicit opioid use during the two-month interval when buprenorphine was continued in primary care. Outcomes at 6 and 12 months were comparable across all groups. See generally Gail D’Onofrio et al., Emergency Department-Initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes During and After Intervention, 32 J. GEN. INTERNAL MED. 600 (2017), https://link.springer.com/article/10.1007/s11606-017-3993-2.

162. 21 C.F.R. § 1301.28(b) (2017).

163. Id.
the three-day rule, a practitioner cannot administer or give more than one day’s medication to a patient at one time and cannot carry out treatment for more than 72 hours.\textsuperscript{164} The rule does not allow renewal or extension of such emergency treatment.\textsuperscript{165}

The intent of “three-day rule” is to provide practitioners with flexibility in emergency situations where they may face an individual undergoing withdrawal, and it would be impractical to require and improbable to obtain a waiver, given the time constraint.\textsuperscript{166} While the practitioner can, therefore, provide detoxification treatment over a three-day period, Congress did not intend the rule to circumvent the separate registration requirement.\textsuperscript{167} Moreover, detoxification alone is insufficient to properly treat an OUD; it must be part of an integrated continuum of services that promote ongoing SUD treatment.\textsuperscript{168} Yet studies have shown that up to three quarters of individuals with SUDs who receive detoxification do not receive any continued treatment afterward.\textsuperscript{169} As a result, many individuals experience subsequent overdoses, requiring further emergency treatment.\textsuperscript{170} Therefore, hospitals must adopt warm handoff programs to ensure that patients receive a referral to the appropriate care once they leave the hospital, even if they receive detoxification services during their hospital admission.

\begin{itemize}
  \item \textsuperscript{164} Id.
  \item \textsuperscript{165} Id.
  \item \textsuperscript{166} Special Circumstances for Providing Buprenorphine, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/legislation-regulations-guidelines/special (last updated Jan. 18, 2018).
  \item \textsuperscript{167} Id.
  \item \textsuperscript{170} Id.
\end{itemize}
C. Civil Liability: Wrongful Death Claims for Medical Malpractice

In reviewing analogous attempted suicide cases, one can argue that hospitals that fail to implement a warm handoff policy face increased risk of civil liability, namely wrongful death claims for medical malpractice, if it releases a patient who subsequently experiences a fatal overdose.\footnote{171}

Originally, common law denied recovery in tort once a tort victim died, and it also refused to recognize a new and independent cause of action for the victim’s family members for their own loss.\footnote{172} As a result, it was cheaper for a defendant to kill, rather than injure, a plaintiff, and the plaintiff’s family had no civil remedy.\footnote{173} Over time, however, states have addressed this illogical result by passing wrongful death statutes.\footnote{174}

State wrongful death statutes vest a right of recovery in certain enumerated heirs or representatives of a decedent, allowing such parties to sue for economic and non-economic damages resulting from the death of the decedent that another’s wrongful act caused.\footnote{175} The statutes focus on the harm the plaintiff family members suffer as a result of the decedent’s death.\footnote{176} Wrongful death statutes require plaintiffs to satisfy the same burden of proof that the decedent would have had to meet had the decedent lived.\footnote{177} Therefore, in order for a plaintiff who brings a statutory wrongful death claim for malpractice to succeed, the plaintiff must prove the elements of medical

\footnote{171. It should be noted, however, that case law in this area is still developing. In addition, given that a high percentage of medical malpractice lawsuits settle, there is not an abundance of case law analyzing this specific fact pattern. Therefore, this Section is intended to provide an overview and brief analysis of possible civil claims that hospitals and practitioners could be subject to and forced to commit valuable resources to defend.}

\footnote{172. See, e.g., Brandon J. Harrison, Comment, Wrongful Death Damages Under the Arkansas Medical Malpractice Act: Would a Change Make Cents, 54 Ark. L. Rev. 577, 583–84 (2001).}

\footnote{173. Id. at 583.}

\footnote{174. Id.}

\footnote{175. Casey Tourtillott & Matthew E. Birch, The Right to Bring a Wrongful Death Claim in Kansas: Does the Statute of Limitations Begin to Run at Death?, 70 UMKC L. Rev. 103, 103–05 (2001).}

\footnote{176. Harrison, supra note 172, at 584–85.}

\footnote{177. See, e.g., 740 ILL. COMP. STAT. ANN. § 180/1 (West 1993).}
malpractice and show that the defendant’s negligent conduct caused the decedent’s death. The essential elements of a medical malpractice claim are the same as those in an ordinary negligence action: duty, breach, causation, and damage.

1. Duty: Establishing a Standard of Care

Ordinary negligence law imposes a duty on most persons in most situations to act with reasonable care, which a court tests by asking how a reasonably prudent person would act under particular circumstances to avoid harming others. The law compares a defendant’s conduct to this objective, external standard to determine whether he or she breached the duty to act reasonably under the circumstances. Yet, while the law measures most adults against the reasonable prudent person standard, it requires that health care practitioners, given their greater-than-normal skills and learning, exercise the level of skill they actually or should reasonably possess in their profession. In other words, a health care practitioner has a duty to exercise a degree of care and skill that is expected of a reasonably competent practitioner in the same class to which the practitioner belongs, acting under similar circumstances.

Unlike ordinary negligence claims, a plaintiff in a medical malpractice case must establish this reasonably prudent practitioner standard through expert testimony. The rationale for this requirement is that a layman does not possess the requisite knowledge to determine whether the defendant gave proper treatment and followed proper procedures. As to the existence of the duty itself, a health care practitioner’s duty arises once he or she establishes a

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181. *Id.*

182. *Id.* at 1677–78.


184. *Id.* at 384.

185. *Id.* at 385.
practitioner-patient relationship with the plaintiff. Generally, an agreement or undertaking to render medical care is adequate to establish the duty of care, which continues until either the patient terminates the relationship or the provider terminates the relationship upon reasonable notice or by arranging substitute care.

Based on an expert witness’s opinion in *Bevan v. Valencia*, warm handoff policies are the standard of care when treating a patient who experienced an overdose. In that case, the plaintiffs alleged that an emergency room physician prematurely discharged a patient from the hospital after treating her for a heroin overdose with naloxone and lorazepam. The doctor kept the patient for observation for two hours after administering naloxone. He noted that the patient was alert and oriented, and he recommended “no further cares.” Along with discharging the patient, the doctor medically cleared her for incarceration. The police took the patient from the hospital to a youth development program for incarceration. Several hours later, the patient stopped breathing; she later died of “toxic effects of heroin.” The plaintiffs brought a wrongful death claim for negligence against the hospital, alleging that the hospital (1) negligently failed to adopt a policy related to the treatment of patients who overdose on heroin, (2) failed to have adequate discharge instructions, and (3) failed to obtain informed consent from the patient.

186. *Id.* at 386–87.
187. *Id.*
189. *Id.* Lorazepam primarily is prescribed to treat anxiety and belongs to a class of drugs called benzodiazepines. U.S. Nat’l Library of Med., *Lorazepam*, MEDLINEPLUS, https://medlineplus.gov/druginfo/meds/a682053.html (last updated Oct. 22, 2018). Lorazepam may also be prescribed to treat irritable bowel syndrome, epilepsy, insomnia, and nausea and vomiting from cancer treatment and to control agitation caused by alcohol withdrawal. *Id.* Combining a benzodiazepine with an opioid can increase the risk of life threatening breathing problems, sedation, coma, or death. *Id.*
191. *Id.* at *6.
192. *Id.* at *2.
193. *Id.* at *1.
194. *Id.*
to administer lorazepam, a drug that “can potentiate any narcotic that is still in the body.”

As to the failure to have a hospital policy on treating heroin overdose patients, the plaintiff’s expert opined that the hospital breached “the standard of care of a reasonably well-qualified hospital” by not implementing such a policy. He also explained, however, that a doctor may exercise independent judgment as to whether to discharge a patient, and, as such, it would be speculation to suggest that such a policy would have resulted in a different outcome in the case. The case suggests that some medical experts may consider

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195. Bevan v. Valencia, No. CV 15-73 KG/SCY, 2017 WL 4797788, at *1 (D.N.M. Oct. 24, 2017). The plaintiffs also brought a wrongful death claim alleging negligence against the doctor for prematurely discharging the patient, failing to appropriately monitor her condition, failing to provide appropriate monitoring instructions to the youth program staff and police, and failing to obtain informed consent for the patient’s discharge. Bevan, 2017 WL 5054703, at *1. The plaintiff also argued that if the patient had remained in the hospital when her condition worsened, she would have survived. Id.

As of the writing of this Article, the court had not ruled on the issue of the physician’s negligence in this particular case. However, in response to the physician’s motion for summary judgement on the issue of punitive damages, the court’s opinion included statements from the plaintiff’s expert regarding the defendant’s negligence. Id. at *4. For example, the expert noted that, if naloxone is administered alone, patients should be kept in the emergency department for two to three hours. Id. Further, he noted that, when naloxone is administered along with lorazepam, physicians must use their clinical judgment to determine the length of observation, but that the observation period should be longer than two to three hours, and that the physician should have monitored the patient for a longer period than he did. Id. Additionally, the expert opined that “[a] single recording of a heart rate one beat shy of being abnormal is not sufficient to safely discharge a patient” who had suffered respiratory arrest, overdosed on heroin, and was given lorazepam, and also that a physician should not discharge a patient like the decedent to a juvenile detention center where non-medical staff would only observe her every 15 minutes. Id. at *4.


197. While the plaintiff also presented additional expert testimony stating that the decedent likely would have survived her overdose had she been kept in the hospital, the court found that such testimony did not relate to whether an overdose policy would have prevented the decedent’s harm. Id. at *4. With regard to whether the hospital was negligent in failing to provide adequate discharge instructions and failing to obtain informed consent, the court found that the plaintiff did not present expert testimony to support such a finding. Id. at *4–5. As such, the court granted the hospital’s motion for summary judgment on these claims. Id. at *5.
implementation of a warm handoff policy to be the standard of care for emergency departments.

More experts are likely to find that warm handoff policies are the standard of care, especially as associations and thought-leaders publish guidelines encouraging the adoption of warm handoff policies and states implement warm handoff legislation. For example, Pennsylvania’s Department of Drug and Alcohol Programs has implemented a warm handoff process throughout the state. Likewise, the Joint Commission, an established health care program accreditation organization, has encouraged the adoption of adequate handoff policies. Emergency departments often serve as a gateway into the health care system and are well positioned to start the substance use treatment process. Moreover, given the extent of the overdose epidemic and growing pressure on all stakeholders, including emergency departments, to prevent fatal overdoses, the view that warm handoff programs are the standard of care for emergency departments in treating patients presenting with nonfatal overdose is gaining widespread recognition.

2. Breach

Once the plaintiff establishes the standard of care in a medical malpractice case, she must then prove that the defendant failed to satisfy, or deviated from, that standard, thereby breaching his or her duty to the patient. The plaintiff also establishes this deviation through expert testimony.

Similar to limiting the risk of subsequent overdose in a patient who experiences a nonfatal overdose, warm handoffs and other interventions in emergency departments to prevent re-attempts by those who survive a suicide attempt have become the standard of care.

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198. Addressing Overdose, supra note 106.
200. See Lynn, supra note 179, at 383–406 (outlining the elements of medical malpractice claims in the state of Connecticut).
201. Id. at 384.
Among other interventions, clinical recommendations include performing and documenting an appropriate evaluation and risk assessment, carefully formulating a discharge plan, and ensuring to obtain follow-up services when caring for both suicidal and overdose patients. Therefore, breach of such a standard can illustrate a breach of the standard of care in overdose cases.

For example, in *Tkacheff v. Roberts*, an inpatient treatment facility admitted the decedent after she complained of anxiety and depression. Two weeks after her discharge, a hospital admitted her for major depression and suicidal ideation. An attending physician discharged her nearly one week later with an instruction “to return to the hospital if her depression worsened and, if it did not, to take certain prescription medications and follow up with an outpatient provider.” Four days later, the decedent met with an outpatient psychiatric nurse practitioner. After the decedent took her own life several days later, her parents sued the hospital, the hospital’s attending physician, and the outpatient psychiatric nurse practitioner, asserting claims for wrongful death and medical malpractice. The lower court granted the defendants’ motion for summary judgement.

On appeal, the court reversed the finding that the plaintiffs failed to present material questions of fact as to whether the physician’s and nurse practitioner’s actions departed from that accepted standard of care. Specifically, while the attending physician claimed to have conducted and documented the results of a suicide risk assessment, her discharge summary did not state that such an assessment occurred or document its findings; rather, it set forth a care plan that “amounted to little beyond directing that [the] decedent take her medication and present herself to an outpatient care provider over a week later.”

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203. *Id.*
205. *Id.*
206. *Id.*
207. *Id.*
208. *Id.* at 783–84.
209. *Id.*
210. *Id.* at 785.
plaintiffs’ expert opined that, by failing to document a proper risk assessment and then discharging the decedent without ensuring that she obtain psychotherapy and medication management within 2 days, the physician did not satisfy the minimum standard of care.\textsuperscript{211}

In regard to the nurse practitioner, the plaintiffs showed that the nurse practitioner’s psychiatric assessment stated that the decedent was sad and anxious, presented with suicidal ideation, was cutting herself, and had planned to overdose in the past.\textsuperscript{212} The practitioner diagnosed the decedent with severe major depressive disorder and “noted that [the] decedent’s suicidal thoughts increased in tandem with her diagnosed panic disorder.”\textsuperscript{213} Yet the practitioner’s plan withheld further “psychotherapy and medication review until the decedent decided whether to check herself into an inpatient treatment facility and also provided to the practitioner more information about the facility.”\textsuperscript{214} In the opinion of the plaintiffs’ expert, the nurse practitioner failed to satisfy the minimum standard of care by not properly conducting and documenting a suicide-risk assessment of the decedent, “who was experiencing triggering anxiety and untreated depression.”\textsuperscript{215} In addition, the expert opined that the nurse practitioner had not met the minimum standard of care because the practitioner set forth a contingent treatment plan by “placing medication adjustment and psychotherapy on hold in the expectation that a ‘severely compromised’ person would provide more information on an inpatient treatment facility that she was curious about.”\textsuperscript{216}

Cases like \textit{Tkacheff} are instructive in the context of the care and discharge of a patient who presents in an emergency setting with nonfatal overdose. A plaintiff may be able to show that a health care provider breached the warm handoff protocol by, for example, failing to hold and monitor the patient for a sufficient amount of time to ensure that any illicit substances still in the patient’s system will not cause additional harm, conducting and documenting an appropriate assessment and risk evaluation prior to discharge, arranging for

\begin{itemize}
\item \textsuperscript{211} \textit{Id.}
\item \textsuperscript{212} \textit{Id.}
\item \textsuperscript{213} \textit{Id.}
\item \textsuperscript{214} \textit{Id.}
\item \textsuperscript{215} \textit{Id.} at 785–86.
\item \textsuperscript{216} \textit{Id.} at 786.
\end{itemize}
appropriate follow-up care, or contacting the plaintiff’s other health providers and emergency contact or other caregiver.

3. Causation

Once the plaintiff establishes that the defendant owed a duty of care and breached that duty, the plaintiff must show an actual connection between the defendant’s negligence and the plaintiff’s harm before the court will assign to the defendant responsibility for such harm. In assessing causation, most courts apply a “but-for” test, whereby the plaintiff must show that the plaintiff’s harm would not have occurred but for the defendant’s negligence. In situations where several causes could have resulted in the plaintiff’s harm, some courts will consider a defendant’s negligence a cause-in-fact of the harm if it was a substantial factor in producing it.

Moreover, the connection between the defendant’s negligence and the harm suffered must be reasonably close. Proximate cause considers whether in “logic, fairness, policy, and practicality” the law should hold a defendant accountable for harm that is remote from the defendant’s conduct. Today, foreseeability is the cornerstone of proximate cause analysis. To avoid holding defendants liable for harm that falls beyond the scope of their wrongdoing and moral accountability, courts will consider whether a consequence resulting from a chosen action was foreseeable. If the harm resulting from the defendant’s negligence was not foreseeable, then the law will insulate the defendant from liability. Again, given the complexity

218. Id.
219. Id. at 1681.
220. Id.
221. Id. at 1683.
222. Id.
223. Id. Stated differently, if an independent cause intervenes between the defendant’s negligence and the harm, the defendant may be relieved of liability. The question in an intervening cause case is whether the intervening conduct “so dominates the consequences of the defendant’s negligence as to trivialize the defendant’s role in causing the plaintiff’s harm . . . .” Id. at 1684. If the finder of fact concludes that such an intervening cause was significant enough to break the chain of proximate causation, the intervening cause is considered to supersede the defendant’s
of medical malpractice cases, plaintiffs must generally provide expert testimony to support causation.\textsuperscript{224}

For example, in \textit{Procaccini v. Lawrence & Mem’l Hospital}, a patient died of a methadone overdose after the hospital emergency room discharged her.\textsuperscript{225} In that case, paramedics brought the unresponsive decedent to the hospital emergency department.\textsuperscript{226} “M,” the attending emergency department physician, treated the decedent for a suspected methadone overdose.\textsuperscript{227} The physician discharged her after her vital signs improved and she stabilized.\textsuperscript{228} The next morning, however, a friend of the decedent found her unresponsive.\textsuperscript{229} The plaintiff brought a wrongful death claim for vicarious liability for medical malpractice against the hospital because the doctor discharged the patient after only four-and-a-half hours of medical monitoring instead of monitoring her for a full 24 hours, which is the period of time that the fatal side effects of methadone toxicity may occur.\textsuperscript{230} The plaintiff claimed that, if the hospital had held the decedent for 24 hours, then treatment could have averted her death.\textsuperscript{231} At trial, the jury returned a plaintiff’s verdict and awarded $500,000 in non-economic damages and $12,095 in economic damages.\textsuperscript{232}

On appeal, the court held that there was sufficient evidence to support a finding that the hospital’s negligence caused the decedent’s death.\textsuperscript{233} Although the jury heard conflicting expert testimony on how

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\textsuperscript{224} For example, in \textit{Foister v. Purdue Pharma L.P.}, several plaintiffs sued a manufacturer of a certain opioid analgesic, arguing that the manufacturer failed to warn them about the product’s risks of addiction. The court concluded that the plaintiffs’ conduct, including intentional alteration and misuse of the product, was a superseding cause severing the causal connection between the opioid product and the plaintiff’s injuries. \textit{See} 295 F. Supp.2d 693, 703–04 (E.D. Ky. 2003).

\textsuperscript{225} \textit{Procaccini}, 168 A.3d at 545.

\textsuperscript{226} \textit{Id.} at 543–44.

\textsuperscript{227} \textit{Id.} at 544.

\textsuperscript{228} \textit{Id.} at 545.

\textsuperscript{229} \textit{Id.}

\textsuperscript{230} \textit{Id.} at 546.

\textsuperscript{231} \textit{Id.} at 546.

\textsuperscript{232} \textit{Id.}

\textsuperscript{233} \textit{Id.} at 561.
\end{quote}
soon a methadone overdose patient would experience recurring overdose symptoms after receiving naloxone, the jury was free to believe the opinion of the plaintiff’s expert witness that respiratory depression can occur in methadone overdoses, even if such a phenomenon defied undisputed and settled toxicology principles. The plaintiff’s expert testified that the standard of care applicable to possible methadone overdoses required the doctor to monitor the decedent for 24 hours for signs of recurrent opiate overdose, and it found that the lack of such monitoring in the case caused the decedent’s death.

*Procaccini* demonstrates the importance of implementing emergency department warm handoff policies. There, had a policy existed, the hospital could have saved a life and averted a lawsuit. For example, a proper warm handoff policy, such as the one that this Article proposes in the Appendix, should ensure that emergency practitioners identify the substance or substances responsible for the overdose, obtain the patient’s history, screen for problematic substance use, and determine the patient’s drug or drugs of choice. This information can be helpful in overdose risk-reduction planning and informing treatment decisions.

Importantly, for patients with a SUD, a warm handoff policy should require that a practitioner attempt to transition a patient with a SUD directly to a treatment provider through an in-person introduction. If a provider at the recommended level of care is not available, the emergency facility can provide medically necessary care in an acute stabilization unit or the current clinical setting until the facility can complete or arrange the transfer. In addition, the emergency department must keep practitioners trained in addiction medicine, as well as a DATA 2000-waived physician, on-call 24 hours per day to allow a patient with OUD, under medically appropriate circumstances, to initiate treatment before leaving the hospital. Such

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234. *Id.* at 555–56.
235. *Id.* at 546.
providers have specialized training and can consult on treatment planning and discharge timing, among other things.

Even if the patient does not consent to a warm handoff, and does not wish to initiate treatment prior to discharge, the practitioner should attempt to contact the patient’s emergency contact or other caregiver who may convince the patient to obtain further care. Furthermore, the practitioner must provide discharge instructions to the patient and the patient’s emergency contact or other caregiver, if possible, which would detail signs and symptoms that could indicate that a return to the hospital is necessary. Emergency contacts and other caregivers are often in a position to monitor the patient after discharge and also ensure that the patient receives treatment and follow-up services. Finally, a facility must dispense or prescribe naloxone to at-risk patients prior to discharge, which can be administered to a patient who experiences a subsequent opioid overdose after discharge. Such efforts would further reduce patient risk, including patients who do not consent to treatment prior to discharge.

Therefore, in cases like *Procaccini*, warm handoff policies provide patients an opportunity prior to discharge to seek specialized treatment, initiate MAT if appropriate, and consequently extend the period of monitoring by a health care practitioner or other treatment provider. By implementing a thoughtfully structured warm handoff policy, diligently following its requirements, and documenting in the medical record the steps it took pursuant to the policy, emergency departments and their practitioners can, therefore, reduce the risk of discharging the patient without care and experience a subsequent and potentially fatal overdose, thereby breaking the causal link in a medical malpractice claim.

4. Damages

Finally, a plaintiff must show damages to establish a claim for medical malpractice. In a wrongful death claim for medical malpractice, the decedent’s death easily satisfies this element. The type of damages plaintiffs may seek in a wrongful death action, however, vary from jurisdiction to jurisdiction. In Connecticut, for example, a plaintiff is “entitled to ‘just damages’ together with the cost

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of reasonably necessary, medical, hospital and nursing services, and including funeral expenses."

Yet, even if a plaintiff prevails in showing that medical malpractice caused the death of the decedent, a court may bar or reduce the plaintiff’s damages if a jury finds that the decedent’s negligence contributed to his or her death. A small minority of states follow a “pure” contributory negligence scheme whereby the plaintiff cannot recover if the decedent’s negligence contributed at all to his or her death, even if the jury finds him or her to be only 1% at fault. Most states, however, have adopted either a “pure” or “modified” comparative negligence approach. In pure comparative negligence states, a court will reduce damages to reflect the exact percentage of fault the jury attributes to the decedent. Alternatively, under one form of modified comparative negligence, some states will permit a plaintiff to recover in the same manner he or she would under a pure comparative negligence scheme, provided that the decedent’s negligence was not as great as the defendant’s (that is, the decedent must be no more than 49% at fault). Under the other form of modified comparative negligence, the decedent’s negligence can be no greater than the defendant’s in order for the plaintiff to recover (that is, the decedent must be no more than 50% at fault).

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238. *Procaccini*, 168 A.3d 538 at 563 (explaining that “just damages” includes “(1) the value of the decedent’s lost earning capacity less deductions for her necessary living expenses and taking into consideration that a present cash payment will be made, (2) compensation for the destruction of her capacity to carry on and enjoy life’s activities in a way she would have done had she lived, and (3) compensation for conscious pain and suffering”).


241. See, e.g., Nelson v. Concrete Supply Co., 399 S.E.2d 783, 784 (S.C. 1991) (stating South Carolina is “join[ing] the vast majority of our sister jurisdictions and adopt[ing]” the comparative negligence approach).

242. Amy L. Bernstein, *Into the Red Zone: How the National Football League’s Quest to Curb Concussions and Concussion-Related Injuries Could Affect Players’ Legal Recovery*, 22 SETON HALL J. SPORTS & ENT. L. 271, 298 (2012). For example, if a jury awards a plaintiff $100,000 and the jury finds that the decedent was 60% at fault, then the award would be reduced by $60,000.

243. *Id.* at 298–99.

244. *Id.*
In defending wrongful death medical malpractice suits, practitioners, hospitals, and emergency departments will most certainly argue that the decedent was negligent in causing his or her own fatal drug overdose or that the decedent’s conduct leading to the overdose was wrongful. Some courts will bar recovery for harm that a decedent’s illegal conduct caused. Yet, while such arguments have prevailed in the past, views regarding SUD are changing. There is increased awareness that SUD is a chronic, relapsing disease and not a moral failing. It is not appropriate to use a decedent’s disease alone as a basis for determining whether the decedent’s own negligence causing his or her death. Such changing attitudes, along with the fact that we are in the midst of a drug overdose epidemic, 

245. Richard C. Ausness, The Role of Litigation in the Fight Against Prescription Drug Abuse, 116 W. VA. L. REV. 1117 (2014). For example, in Price v. Purdue Pharma Co., the plaintiff sued the manufacturer of a certain opioid analgesic and several doctors who had prescribed him the medication, among others, arguing that the medication was addictive and its addictive nature caused him injury. Id. at 1132. His claims included negligence, products liability, malicious conduct, malpractice, and fraud. Price v. Purdue Pharma Co., 920 So. 2d 479, 482 (Miss. 2006). The court granted the defendants’ motion for summary judgment, finding that the plaintiff visited several physicians at multiple clinics and used several pharmacies in multiple cities to obtain enough of the opioid medication to support his addiction. Ausness, supra, at 1133. The court declared that such “doctor shopping” by the plaintiff violated federal law, and such violation was “not merely a condition, but instead an integral and essential part of his case and the contributing cause of his alleged injury.” Price, 920 So. 2d at 485 (Miss. 2006).

246. Price, 920 So. 2d at 485.


could have an impact on courts’ rulings regarding whether a decedent with SUD was negligent in cause his or her own death.

D. Patient Privacy

Implementing an effective warm handoff policy and decreasing the risk of subsequent overdose requires strong communication between the emergency department and other parties involved in patients’ care. Such parties may include the patient’s primary care providers; the physician or medical director of a treatment program, if the patient is currently in substance use treatment; and the patient’s emergency contact or other caregiver. When sharing patients’ information with these parties, health care providers must bear in mind whether patient privacy laws permit the provider to share information without the patient’s consent. Federal patient privacy laws permit emergency care providers to share information with other health care providers without a patient’s consent, and likely permit emergency care providers to notify a patient’s emergency contact or other caregiver regarding an overdose in order to facilitate a warm handoff.

1. Health Insurance Portability and Accountability Act

Congress enacted the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) in part to protect patients’ private health information from disclosure.\(^{249}\) HIPAA generally prohibits covered health care providers from disclosing protected patient health information (“PHI”) without the patient’s consent.\(^{250}\) However, HIPAA provides exceptions to the general nondisclosure rule. Three of those exceptions likely apply when an emergency department provider notifies other parties involved a patient’s care of the patient’s overdose without the patient’s consent: health-care-provider, good-faith-belief, and best-interest exceptions.


\(^{250}\) 45 C.F.R. § 164.502(a) (2017).
i. Health-Care-Provider Exception

HIPAA’s health-care-provider exception allows an emergency care provider to disclose PHI to other health care providers.\textsuperscript{251} Therefore, emergency care providers may notify an individual’s primary care physician and, if applicable, addiction treatment physician or medical director under HIPAA.

Pursuant to the health-care-provider exception, a “covered entity” may disclose PHI for “treatment activities of a health care provider.”\textsuperscript{252} A covered entity is a health care provider that transmits any health information in electronic form.\textsuperscript{253} Health care providers include “providers of medical or health services” and include non-institutional providers, such as physicians and other practitioners.\textsuperscript{254} Treatment activities include “the provision, coordination, or management of health care and related services,” including consultation or referral between providers.\textsuperscript{255}

Emergency-care practitioners who transmit PHI in electronic form qualify as covered entities. Primary care physicians, addiction treatment physicians, and medical directors meet HIPAA’s definition of “health care provider.” Warm handoff policies may require the emergency care practitioner to inform the patient’s primary care physician, or addiction treatment medical director if the patient is currently in treatment for SUD, that the patient has suffered a nonfatal overdose. In this role, the emergency-care practitioner “coordinates health care related services” by contacting the patient’s physician or medical director. Therefore, disclosure of PHI between the emergency care practitioner and other providers falls under the health-care-provider exception and does not violate HIPAA.

ii. Good-Faith-Belief Exception

HIPAA’s good-faith-belief exception may permit an emergency care provider to notify an individual’s emergency contact or other caregiver without his or her consent because a person suffering

\begin{itemize}
\item \textsuperscript{251} 45 C.F.R. § 164.506(a) (2017).
\item \textsuperscript{252} § 164.506(c)(2).
\item \textsuperscript{253} 45 C.F.R. § 160.103 (2017).
\item \textsuperscript{254} \textit{Id}.
\item \textsuperscript{255} \textit{Id}.
\end{itemize}
a nonfatal overdose is a threat to himself or herself. Pursuant to the

good-faith-belief exception, a provider may disclose PHI if the

provider has a good faith belief that disclosing the PHI is “necessary
to prevent or lessen a serious and imminent threat to the health or safety
of a person” and the person to whom the provider is disclosing the

information is a person “reasonably able to prevent or lessen the

threat.” 256 HIPAA presumes that the provider had a good faith belief

when his or her belief is based upon the provider’s actual knowledge

(that is, based on the provider’s own interaction with the patient) or in

reliance on a credible representation by a person with apparent

knowledge or authority. 257

For example, the U.S. Department of Health and Human

Services (“HHS”) has stated that, if a doctor knows that, when a

patient’s medication is not at a therapeutic level, the patient is at high

risk of committing suicide, then the doctor may believe in good faith

that disclosure is necessary to prevent or lessen the threat of harm to

the health or safety of the patient who has stopped taking the prescribed

medication, and may share information with the patient’s family or

other caregivers who can lessen or avert the threat. 258

Overdoses likely qualify as a serious and imminent threat to

health and safety. Overdoses are serious because they can lead to

severe complications, such as seizures, organ failure, neurologic

deficits, and death. 259 An overdose is also a predictor of a subsequent

overdose. One study found that individuals with a history of a prior

overdose are nearly three times more likely to overdose than those


257. Letter from Leon Rodriguez, Dir., Office for Civil Rights, U.S. Dep’t of

Health & Human Servs., to Nation’s Health Care Providers (Jan. 15, 2013),


258. U.S. DEP’T HEALTH & HUMAN SERVS., OFFICE FOR CIVIL RIGHTS,
GUIDANCE ON HIPAA PRIVACY RULE AND SHARING INFORMATION RELATED TO
MENTAL HEALTH (2014),

259. H. Westley Clark, Even Non-Fatal Overdoses Can Lead to Severe

Consequences, SAMHSA BLOG (Sept. 2, 2014),
https://blog.samhsa.gov/2014/09/02/even-non-fatal-overdoses-can-lead-to-severe-consequences/#.
without a history of overdose.\textsuperscript{260} Another study revealed that, among the individuals who died of an opioid-related overdose, 62\% had previously experienced at least one overdose, 22\% had previously experienced at least two overdoses, and 17\% had experienced three to six nonfatal overdoses.\textsuperscript{261}

A person who has received naloxone for a non-fatal overdose is also likely to be of imminent threat to himself or herself. Administration of naloxone to opioid-dependent patients induces severe withdrawal symptoms.\textsuperscript{262} During withdrawal, individuals experience severe cravings for opioids, which can precipitate relapse and overdose.\textsuperscript{263} Additionally, the overdose reversal effects of naloxone last at most 90 minutes; the effects of some opioids, however, may last beyond 90 minutes.\textsuperscript{264} Therefore, a person may experience a rebound overdose after the naloxone wears off. Such a person would be in imminent danger and in need of medical attention.

Given that a person who has overdosed is at serious risk of complications and is an imminent threat to himself or herself, an emergency contact or other caregiver is likely in the best position to lessen or avert the threat once the emergency department releases the patient. Many times, “family members . . . are . . . the actual first responders and are best positioned to intervene within an hour of the onset of overdose symptoms.”\textsuperscript{265} Therefore, if a person starts showing signs of overdose-related symptoms or complications, for example, the emergency contact or other caregiver is in the best position to call 911. The HHS example above lists family and caregivers as examples of people who are likely to lessen or avert a serious or imminent threat.

\textsuperscript{260} Shane Darke et al., Patterns of Nonfatal Heroin Overdose Over a 3-Year Period: Findings from the Australian Treatment Outcome Study, 84 J. URB. HEALTH 283, 289 (2007).

\textsuperscript{261} Stoové et al., supra note 158, at 349.

\textsuperscript{262} Eveline L.A. van Dorp et al., Naloxone Treatment in Opioid Addiction: The Risks and Benefits, 6 EXPERT OPINION ON DRUG SAFETY 125, 130 (2007).

\textsuperscript{263} NIDA, MEDIA GUIDE, supra note 248, at 3.


Moreover, when the patient’s health care providers and emergency contact or other caregiver coordinate their efforts, they can improve treatment of painful symptoms and minimize the increased risk of subsequent overdose, overdose mortality, and other life-threatening complications, such as seizures, organ failure, and neurological deficits. These individuals are in the best position to intervene, support treatment, and foster recovery.

Therefore, given that nonfatal overdoses likely qualify as a serious and imminent threat pursuant to HIPAA, and familial support decreases life-threatening risks associated with overdose, an emergency care provider may be permitted to notify a patient’s emergency contact or other caregiver under HIPAA’s good-faith-belief exception.

iii. Best-Interest Exception

HIPAA’s best-interest exception may also permit emergency care providers to notify an individual’s emergency contact or other caregiver without his or her consent. Under HIPAA’s best-interest exception, when a patient is unable to practically object to the disclosure because the patient is either incapacitated or is in an emergency treatment situation, HIPAA permits the covered health care provider to disclose a patient’s PHI to the patient’s family, friend, or other designated person (“Interested Person”) if it is in the patient’s best interest. While the health care provider must give the patient an opportunity to consent or decline when it becomes practicable to do so, the point of when it is practicable to do so is in the health care provider’s discretion. The health care provider must limit the PHI that it discloses to the Interested Person’s involvement with the patient’s care or payment.

While HIPAA does not explicitly define “incapacity or an emergency treatment situation,” HHS guidance on this topic states that a patient is incapacitated if he or she is unconscious. In that case, a

267. Id.
268. Id.
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The physician may disclose PHI if it is in the patient’s best interest. Furthermore, HHS has stated that incapacitation or emergency treatment situations may also include circumstances in which a patient is suffering from temporary psychosis or is under the influence of drugs or alcohol.\textsuperscript{270} An opioid overdose is consistent with HHS’s examples of incapacitation or emergency treatment situations. With an opioid overdose, the patient may lose consciousness and also remains at risk of the continued dangerous effects of respiratory depression and psychosis, which can extend for more than 24 hours due to the potency of the opioids on which the patient overdosed.\textsuperscript{271} The patient may also experience severe withdrawal symptoms after opioid reversal, which include cravings strong enough to impair the patient’s judgment.\textsuperscript{272} Therefore, a person who has experienced an opioid overdose will likely fall under the incapacitation or emergency treatment situation exception.

In cases of incapacitation or an emergency care situation, a provider may disclose PHI related to the patient’s care to an Interested Person if it is in the patient’s best interest. It is often in the patient’s best interest for the emergency care practitioner to notify the patient’s emergency contact or other caregiver if the patient has experienced an overdose because, when a person has overdosed, he or she is likely still at risk of serious overdose-related symptoms and complications. An emergency contact or other caregiver can adequately support the individual only if that person knows of the overdose and related symptoms and complications. Therefore, it is likely in the patient’s best interest that the health care provider notify the emergency contact or other caregiver.

2. 42 C.F.R. Part 2

42 C.F.R. Part 2 (“Part 2”) also protects patients who receive substance abuse treatment. Part 2’s privacy protections are even more stringent than HIPAA, and HHS premised them on the understanding that stigma and fear of prosecution could discourage individuals with

\textsuperscript{270} Id.

\textsuperscript{271} Mark Zuckerman et al., Pitfalls of Intranasal Naloxone 3 (2014) (unpublished manuscript) (on file with \textit{The University of Memphis Law Review}).

\textsuperscript{272} van Dorp et al., \textit{supra} note 262, at 89.
SUDs from obtaining treatment. Part 2 prohibits the disclosure of medical information, which includes records of identity, diagnosis, prognosis, or treatment, if the provider maintains the medical records in connection with any federally assisted drug abuse prevention program, except under limited circumstances. A provider may disclose medical information to other medical personnel in a medical emergency without the patient’s permission.

Part 2 applies to federally assisted drug abuse programs. Federal regulations define “program” as any individual or entity that receives federal assistance and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment. Part 2 specifically provides that the regulations do not apply “to emergency room personnel who refer a patient to the intensive care unit for an apparent overdose unless the primary function of such personnel is the provision of substance abuse diagnosis, treatment, or referral, and they provide such services or the emergency room has promoted itself to the community as a provider of such services.

If a hospital has a co-located, federally assisted addiction treatment program, however, one could argue that Part 2 covers the hospital’s emergency department. In that case, pursuant to Part 2, emergency care practitioners may disclose information without patient permission to other medical personnel in a medical emergency. Specifically, the emergency care practitioner may disclose PHI to medical personnel “to the extent necessary to meet a bona fide medical emergency in which the patient’s prior informed consent cannot be obtained.” The regulation does not define “immediate threat”; as Part II of this Article describes, however, a nonfatal overdose poses an

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276. Id.


278. § 2.12(e)(1).

279. § 2.51.

280. § 2.51(a).
immediate threat to an individual’s health given that the person is at an increased risk for a subsequent relapse, overdose, overdose mortality, and other life-threatening complications, such as seizures, organ failure, and neurologic deficits.

A warm handoff policy may require the emergency care practitioner to notify the patient’s primary care physician and, if applicable, the patient’s addiction treatment physician or medical director if the patient overdoses. By notifying these individuals, the emergency care practitioner makes a disclosure to medical personnel. The medical personnel receive the information in order to treat the patient’s nonfatal overdose and related substance use, which is an immediate threat to the patient. Therefore, an emergency care practitioner’s release of protected information regarding nonfatal overdoses satisfies Part 2’s medical emergency exception.

Part 2 does not allow disclosure of PHI to non-medical personnel. Therefore, in the event an emergency department also qualifies as a federally assisted drug treatment program, and Part 2 governs, the emergency department cannot disclose PHI to non-medical personnel.

3. Prescription Monitoring Programs

Individuals who obtain MAT at the hospital should be aware that, if a provider prescribes a controlled substance, as opposed to dispensing or administering it, such information will appear in the state prescription monitoring program. A prescription monitoring program (“PMP”) is “an electronic database that tracks controlled substance prescriptions in a state.” PMPs can provide practitioners, state medical and pharmacy boards, and others with “timely information about prescribing and patient behaviors[;]” alert such parties to signs of prescription drug diversion, misuse, and abuse; and help practitioners form an appropriate treatment program for the patient.

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281. § 2.11.
282. § 2.51(a).
284. Id.
In some states, hospital staff must check and report to the PMP when they prescribe, administer, or dispense a controlled substance, including those used for detoxification purposes. Even in states where the law permits but does not require checking the PMP, hospital staff should do so to determine if the patient has received a prescription for any controlled substances or received MAT. The hospital practitioner can then notify the patient’s other practitioners that the patient has overdosed so they can modify their treatment plans accordingly, and the hospital staff together with the patient’s current medical team can facilitate the warm handoff.

V. CONCLUSION

Given the risk of subsequent overdose and death for patients who experience a nonfatal overdose, as well the risk of litigation by decedent’s estates and family members for medical malpractice, all emergency departments should implement a warm handoff policy to ensure patients receive proper screening for problematic substance use and, if appropriate, the opportunity to receive substance use treatment and follow-up services. In doing so, emergency departments should be mindful of surrounding legal issues, including ensuring that they adequately protect the patient’s privacy.

285. In Alabama, medications dispensed in a hospital outpatient setting must be reported to the PMP, unless the medication is administered and used by the patient on the premises of the facility. Ala. Admin. Code r. 420-7-2-.12(2)(a) (2017). In Arkansas, a licensed hospital pharmacy does not need to report to the PMP when it distributes controlled substances as part of outpatient services, inpatient hospital care, or at the time of discharge from the hospital. Ark. Code Ann. § 20-7-603(5)(B)(i) (2017).

286. Implementation of warm handoff programs has shown promising results. For example, in just over a year after the implementation of a warm handoff program in Westmoreland County, Pennsylvania, 267 patients had been identified through the program, 190 assessments had been completed, and 61 patients had successfully completed the recommended level of care. See generally Miller et al., supra note 20.
APPENDIX. SAMPLE WARM HANDOFF POLICY

Emergency Department Response to Nonfatal Drug Overdose

Model Policy\textsuperscript{287}

Section 1. Purpose

The purpose of this policy is to establish procedures for responding therapeutically to nonfatal drug overdoses in the emergency department (“ED”).\textsuperscript{288} [Insert statement on requirement under state law to develop this policy, if applicable].

This policy aims to reduce the risk of subsequent drug overdoses by providing Screening, Brief Intervention, and Referral to Treatment (“SBIRT”); notifying parties involved in patients’ care, including primary care providers and emergency contacts; educating patients and their emergency contacts or other caregivers on available treatment options; and initiating treatment in the ED.

Drug overdose deaths have reached an all-time high in the U.S. and are increasing at unprecedented rates. Preliminary estimates show that approximately 64,000 people died from drug overdose in 2016, which would be the largest annual increase in fatal overdoses in U.S. history.\textsuperscript{289} The steady increase in overdose-related deaths can be


\textsuperscript{288} This policy is intended for the treatment of adults in the ED. It may be further customized to address the treatment of special populations, including minors and pregnant patients.

\textsuperscript{289} Josh Katz, \textit{Drug Deaths in America are Rising Faster Than Ever}, N.Y. TIMES, (June 5, 2017),
largely attributed to the opioid overdose epidemic, and, in particular, a significant rise in fatal overdose from heroin and non-methadone synthetic opioids, including illicit fentanyl. At the same time, overdose deaths involving benzodiazepines more than quadrupled between 2002 and 2015, and cocaine-related deaths have nearly doubled since 2010.

In addition, [insert overdose statistics specific to the state or county in which the ED sits].

An overdose can predict subsequent overdose. Therefore, when patients present with a nonfatal overdose in the ED, it is imperative that protocols exist to help practitioners prevent, identify, and reduce problematic substance use.

For individuals with substance use disorders (“SUDs”), including opioid use disorder (“OUD”), specialized treatment has improved patient outcomes. Institutionalized discrimination against people with SUDs, however, often prevents individuals from acknowledging their disease, asking for help from their loved ones, or seeking addiction treatment.

EDs can play a critical role in addressing the overdose epidemic. Similar to a nonfatal heart attack patient who, once stable in the ED, would receive a referral to a cardiologist, a patient with a SUD who survives an overdose should likewise receive referral and treatment.


291. Id.
292. Stoové et al., supra note 158, at 350. The study lasted for a period of 5 years and 3 months. Id.
293. ESTEE ET AL., supra note 59.
Section 2. Definitions

Overdose. [A] condition, including, but not limited to, extreme physical illness, decreased level of consciousness, respiratory depression, coma, death, [or cardiac arrest] resulting from the consumption or use of any controlled substance [or other substance of abuse] that requires medical attention, assistance or treatment, [and laboratory testing for substance use] without other conditions to explain the clinical condition.295

Nonfatal overdose. An overdose that does not result in death.

Warm handoff. An approach to care-transition in which a health care provider in the ED does a face-to-face introduction of a patient with substance abuse problems to an addiction treatment provider or to an individual who can facilitate a referral to an addiction treatment provider.

Section 3. Policy

When a patient presents to the ED with a nonfatal drug overdose, the ED’s response shall include, but not be limited to, the following:

A. Conduct a Physical Assessment and Toxicology Testing

The [designated ED practitioner] shall conduct and document a detailed physical assessment that includes toxicology testing. Concurrent use of multiple prescription medications or illicit substances can lead to an overdose. Furthermore, patients who overdose may have ingested a substance different from what they expected or a substance that may have been contaminated. Identifying the substance that caused an overdose may help the patient and ED practitioner in overdose risk-reduction planning and in making informed decisions about treatment. The information will also be useful for the patient’s primary care provider, as well as any existing substance use treatment provider, or such provider to whom the patient

will be referred. Therefore, the [designated ED practitioner] shall order a blood or urine drug test that includes substances that are known to be in the community (for example, fentanyl).

The [designated ED practitioner] shall review the results prior to discharge. If results are not available prior to discharge, the [designated ED practitioner] shall review the results as soon as practicable once they become available and shall provide the results to the patient’s primary care physician and substance use treatment provider in accordance with Section 3-D of this policy.

Notwithstanding the requirements of this section, ED practitioners must remember that, in an emergency setting, stabilizing the patient is of primary importance. Once the patient is stable, however, it is appropriate to conduct a comprehensive physical exam.

B. Obtain the Patient’s History

The [designated ED practitioner] shall attempt to obtain and document historical facts in the patient’s record. Historical facts shall include at least the following:

- the type of substance(s) involved, time of exposure, amount taken, and route of administration (for example, ingestion, intravenous, or inhalation);
- why exposure to the substance occurred (for example, accidental, medical misuse, intentional abuse, or suicide attempt);
- whether and at what time naloxone was administered;
- whether and to what extent the patient has a history of substance use, psychiatric illness, or past suicide attempts; and
- all substances of abuse, prescription medications, over-the-counter medications, vitamins, and herbal supplements the patient uses.

Reliable toxicology results are typically not immediately available. Patients presenting with a nonfatal overdose may provide unreliable information, especially if presenting under the influence of
illicit drugs, with suicidal ideation, or other altered mental status. In addition, patients may unintentionally incorrectly name drugs being used. Therefore, the [designated ED practitioner] shall consider other sources of information, in addition to the patient, including:

- paramedics and emergency medical technicians;
- the patient’s other health care providers;
- the patient’s family members or friends; and
- the state prescription monitoring program (“PMP”) database.

C. Review the Prescription Monitoring Program Database

An ED practitioner authorized to review the state PMP database shall check the patient’s PMP record. The PMP is a statewide database that collects, maintains, and reports information on controlled prescription medications (“CPMs”) dispensed to individuals. The PMP is intended to give practitioners a tool to aid in making diagnoses and treatment decisions, prescribing CPMs, avoiding drug interactions (for example, concurrent use of opioids and benzodiazepines or other sedatives), and identifying potential diversion, medical misuse, or intentional abuse of CPMs. For example, the PMP can help reveal which substances have been legally dispensed to the patient and whether the patient has been prescribed the same CPM from more than one health care provider, which may be a sign that the patient has a SUD and needs treatment.

The [designated ED practitioner] shall document the search and findings in the patient’s medical record.

D. Notify Controlled Substance Prescribers and Emergency Contacts

Prior to discharge, the [designated ED practitioner] shall contact each health care provider who prescribed a CPM to the patient to inform the health care provider of the patient’s overdose and the class of substance involved in the overdose. The [designated ED practitioner] shall recommend that the prescriber conduct a full evaluation of the prescribing regimen to address whether the patient’s
dose is too high or whether it is too low, which may have contributed to non-prescribed substance use and overdose. CPM prescribers shall be identified via a patient interview and review of the PMP. In addition, the [designated ED practitioner] shall contact the patient’s primary care provider, if known or disclosed by the patient or the patient’s emergency contact, to help arrange follow-up care, preferably making an appointment before the patient’s discharge from the ED.

The [designated ED practitioner] shall record all attempts to contact such providers in the medical record. If the patient does not have a primary care provider, or the [designated ED practitioner] cannot ascertain the primary care provider, the [designated ED practitioner] shall provide the patient with a list of local primary care providers.

Optional language: Prior to discharge, the [designated ED practitioner] shall seek the patient’s consent to contact the patient’s emergency contact or other caregiver. If the patient consents, and the [designated ED practitioner] obtains contact information, then the [designated ED practitioner] shall contact the patient’s emergency contact or other caregiver regarding the patient’s overdose and class of substance involved in the overdose. If the patient does not consent, the practitioner shall document the patient’s refusal in the medical record.

E. Screen for Problematic Substance Use

A [designated ED practitioner] shall conduct a brief 1–3 question screen using a standardized tool (for example, the National Institute on Alcohol Abuse and Alcoholism’s single-question screen or the National Institute on Drug Abuse’s quick screen). If the patient screens positive using one of these instruments, then an ED practitioner shall use a standardized screening tool (for example, ASSIST, CRAFFT, AUDIT, or DAST) to assess a patient for risky substance use.

296. This model language is for a policy that requires patient consent. Consent is not legally required in every instance.  See supra Section IV.D.
The [designated ED practitioner] shall document the results of the screen in the patient’s medical record.

F. Conduct Brief Intervention

A [designated ED practitioner] shall engage in a short conversation with a patient showing risky substance use behaviors, providing feedback and advice.

If the [designated ED practitioner] determines that a more intensive intervention is appropriate, then a behavioral health professional or ED practitioner with specialized training in addiction treatment shall conduct a more intensive intervention.

G. Provide Information on Peer Recovery Support

Prior to discharge, the [designated ED practitioner] shall introduce the patient to a [state-licensed peer recovery support specialist] as soon as clinically appropriate, if one is available and the patient consents, to ensure that each overdose patient has the chance to benefit from this service. Alternatively, the [designated ED practitioner] shall provide the patient and, if possible, the patient’s emergency contact or other caregiver, with information on peer recovery support services. The practitioner shall record such efforts and consents in the patient’s medical record.

Patients who survive an overdose may be influenced to enter treatment if they talk with a peer who shares his or her experiences of addiction and recovery. Peer recovery support services may offer several types of support, including peer mentoring and coaching, recovery resource connecting, and facilitating and leading support groups.

H. Administer Medication to Relieve Acute Opioid Withdrawal Symptoms, if Clinically Appropriate

Some opioid-dependent patients who survive an opioid-related overdose may experience acute withdrawal symptoms. If clinically appropriate, the [designated ED practitioner] shall administer, with the
patient’s consent, buprenorphine or other medication approved by the FDA for relieving acute opioid withdrawal symptoms while the patient is in the ED and arrangements are being made for treatment referral. Administration of medication under such circumstances does not require the [designated ED practitioner] to have a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver, which is generally required to administer such medication. However, the practitioner may administer no more than one day’s worth of such medication to the patient per day. The [designated ED practitioner] may carry out such treatment for not more than three days and may not renew or extend it.

I. Discuss and Initiate Medication Assisted Treatment, if Clinically Appropriate

Prior to discharge, the [designated ED practitioner] shall educate a patient with OUD and, if possible, the patient’s emergency contact or other caregiver, about medication-assisted treatment (MAT). MAT, also known as medication-assisted therapy, is an evidence-based method that combines psychosocial treatment and medications approved by the U.S. Food and Drug Administration (“FDA”) for the treatment of OUD. The [designated ED practitioner] shall discuss the risks and benefits of MAT and all FDA-approved medications for the treatment of OUD, including long-acting, practitioner-administered medications, which could assure treatment adherence and eliminate the possibility of post-dispensing diversion of the treatment medication.

MAT may be initiated in the ED if clinically appropriate. The ED shall establish clear criteria for assessing clinical appropriateness for MAT. Patients who have experienced an opioid overdose need careful assessment concerning whether they might be candidates for MAT induction. Therefore, the ED shall keep on-call trained physicians in addiction medicine or addiction psychiatry who respond for real-time consultation as needed within [x hours] of being called. Medical staff trained in addiction medicine shall also be available as

297. An ED that adopts this model language should insert a response time that is consistent with the ED’s on-call policies and procedures.
needed for subject matter expertise in local policy development as well as ongoing clinical consultation.

J. Refer the Patient to Treatment

Prior to discharge, the [designated ED practitioner] shall attempt to facilitate a warm handoff for someone with an SUD who has survived an overdose. If it is clinically appropriate, and the patient consents, then the [designated ED practitioner] shall refer and transition the patient to an appropriate American Society of Addiction Medicine level of care for the patient’s SUD. If that level of care is not available, medically necessary care may be provided in an acute stabilization unit or other appropriate clinical setting until transfer is completed or arranged.

If a patient declines a warm handoff, the [designated ED practitioner] shall ensure that the patient and, if possible, the patient’s emergency contact or other caregiver, receives information about state-licensed addiction treatment services and admission procedures.

The [designated ED practitioner] shall document attempts to facilitate a warm handoff in the patient’s medical record.

K. Keep a DATA 2000-Waived Physician On Call 24 Hours per Day

The ED shall keep a health care provider qualified under the DATA 2000 to prescribe or administer buprenorphine for the treatment of OUD on-call twenty-four hours per day. To prescribe buprenorphine, health care providers must qualify for a waiver under DATA 2000.

Research has consistently demonstrated that buprenorphine is an effective treatment for OUD. Long-lasting changes in brain chemistry can make it difficult for people with OUD to abstain from

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opioids because physical withdrawal symptoms and cravings can be overwhelming. Treatment with buprenorphine reduces the symptoms of opioid withdrawal and curbs opioid cravings by blocking the effects of other opioids and heroin. When an appropriate dose of buprenorphine is reached, the medication has a “ceiling effect,” which increases its safety profile by lowering the risk of respiratory depression and overdose.

Patients and physicians surveyed by the Substance Abuse and Mental Health Services Administration about the effectiveness of buprenorphine reported an average of 80% reduction in illicit opioid use, along with significant increases in employment and other indices of recovery. Moreover, recent research comparing treatment approaches for patients with OUDs in EDs suggests that combining buprenorphine with ongoing care is more effective than simply providing referrals to addiction treatment, with or without a brief intervention. Specifically, the study showed that patients who received buprenorphine, along with a brief intervention to discuss opioid use, and up to 12 weeks of buprenorphine maintenance, were more likely to get follow-up addiction treatment and had reduced self-reported illicit opioid use. In addition, they were also less likely to need inpatient addiction treatment services, reducing health care costs.


300. CLINICAL GUIDELINES, supra note 75, at 71.

301. Id. at 18.


L. Dispense Naloxone to Patients at Risk

The [designated ED practitioner] shall determine whether it is medically appropriate to prescribe or dispense naloxone to a patient treated for a nonfatal opioid overdose. In making his or her determination, the practitioner may consider, among other things, whether the patient:

- has a history of problematic substance use, is identified as being at risk for OUD, or is diagnosed with OUD, or;
- is prescribed both a benzodiazepine and an opioid;
- is currently taking an opioid and has a documented diagnosis of a co-morbid condition; or
- requests naloxone.

If it is not possible to dispense naloxone directly to the patient in the ED, the practitioner shall provide a prescription.

The [designated ED practitioner] shall educate the patient and, if appropriate, in accordance with Section 3-D of this policy, the patient’s emergency contact or other caregiver, about how to administer naloxone. The practitioner may use a web-based educational tool to supplement in-person training.

M. Educate Patients Prescribed Opioids on Safe Use, Storage, and Disposal

If the patient is prescribed an opioid and not a candidate for OUD treatment, the [designated ED practitioner] shall educate the patient regarding safe use, storage, and disposal of the medication. Patient education shall include, but not be limited to:

- the risks, benefits, and alternatives of opioid medications;
- the need to reevaluate the prescription regimen with the patient’s CPM prescriber;
- the risks of medical misuse, intentional abuse, and diversion of opioids;
• an acknowledgment that it is the patient’s responsibility to safeguard all medications and keep them in a secure location; and
• safe disposal options for unused medication.

Safe storage and disposal of opioid medications reduces opportunities for diversion and the potential for accidental exposure. Most drugs should not be flushed given the potential harm to the environment. The FDA, however, recommends flushing certain prescription pain medications.\footnote{For the list of medicines recommended for flushing, practitioners may consult \textit{Disposal of Unused Medicines: What You Should Know}, U.S. FOOD \& DRUG ADMIN., https://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm#MEDICINES (last updated Oct. 16, 2018).} To prevent diversion and accidental exposure, patients should immediately flush these drugs when they no longer need them. In addition, some national pharmacies may have available opioid disposal packets whereby patients can chemically treat unused opioid medications and dispose of them in the trash. Patients can ask their pharmacies for more information.

N. Comply with Reporting Requirements

The [designated ED practitioner] shall follow all state law requirements for reporting overdoses.

[Describe state law requirements and procedures here.]

O. Provide Discharge Instructions and Ensure Understanding

At discharge, the [designated ED practitioner] shall provide written discharge instructions for drug overdose to the patient. The [designated ED practitioner] shall also discuss discharge instructions with the patient and, if possible, in accordance with Section 3-D of this policy, the patient’s emergency contact or other caregiver. The patient and the patient’s emergency contact or caregiver should demonstrate
an understanding of relevant aspects of patient education and the practitioner shall establish a clear follow-up. The practitioner shall record evidence of patient and caregiver understanding in the medical record.
395.1041 - Access to emergency services and care.

(6) RIGHTS OF PERSONS BEING TREATED.—

(a) A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

(b) Each hospital with an emergency department shall develop a best practices policy to promote the prevention of unintentional drug overdoses. The policy may include, but is not limited to:

1. A process to obtain the patient’s consent to notify the patient’s next of kin, and each physician or health care practitioner who prescribed a controlled substance to the patient, regarding the patient’s overdose, her or his location, and the nature of the substance or controlled substance involved in the overdose.

2. A process for providing the patient or the patient’s next of kin with information about licensed substance abuse treatment services, voluntary admission procedures under part IV of chapter 397, involuntary admission procedures under part V of chapter 397, and involuntary commitment procedures under chapter 394.

3. Guidelines for emergency department health care practitioners authorized to prescribe controlled substances to reduce the risk of opioid use, misuse, and addiction.

4. The use of licensed or certified behavioral health professionals or peer specialists in the emergency department to encourage the patient to seek substance abuse treatment.

5. The use of Screening, Brief Intervention, and Referral to Treatment protocols in the emergency department.

6. This paragraph may not be construed as creating a cause of action by any party.

(7) EMERGENCY ROOM DIVERSION PROGRAMS.—Hospitals may develop emergency room diversion programs, including, but not limited to, an “Emergency Hotline” which allows patients to help determine if emergency department services are appropriate or if other health care settings may be more appropriate for care, and a “Fast Track” program allowing nonemergency patients to be treated at an alternative site. Alternative sites may include health care programs funded with local tax revenue and federally funded community health centers, county health departments, or other nonhospital providers of health care services. The program may include provisions for follow-up care and case management.
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Civil commitment for substance use disorder patients under the Florida Marchman Act: demographics and outcomes in the private clinical setting.

Client/Matter: Estate of Keefe
Civil commitment for substance use disorder patients under the Florida Marchman Act: demographics and outcomes in the private clinical setting.

January,

Author: Sweeney TJ; Strolla MP; Myers DP


Abstract: The Florida Marchman Act, a statutory process for civil commitment of persons with substance use disorders. The paper describes the various methods by which the Act may be employed, and examines the demographics and outcomes of 100 patients admitted to a private treatment setting pursuant to Marchman Act authority.

Major Terms: Commitment of Mentally Ill, legislation & jurisprudence; Law Enforcement, methods; Substance Abuse Treatment Centers, legislation & jurisprudence; Substance-Related Disorders, rehabilitation.


Tree Major: Adolescent: M01.060.057; Adult: M01.060.116; Aged: M01.060.116.100; Commitment of Mentally Ill: N03.706.535.351.200; Demography: N06.850.505.400; Female: Female; Florida: Z01.107.567.875.750.350; Humans: B01.050.150.900.649.801.400.112.400.400; Law Enforcement: I01.880.604.594; : : Male: Male; Mandatory Programs: N04.452.521; Middle Aged: M01.060.116.630; Outcome Assessment (Health Care): N05.715.360.575.575; Patient Acceptance of Health Care: N05.300.150.600; Referral and Consultation: N04.452.758.849; Substance Abuse Treatment Centers: N02.278.808.930; Substance-Related Disorders: F03.900; Symptom Assessment: E01.370.872; Treatment Refusal: N05.300.150.600.800; Young Adult: M01.060.116.815


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Labs Ink $56M Deal To End UnitedHealthcare Kickback Claims

By Adam Lidgett

Law360 (July 24, 2019, 4:13 PM EDT) -- A group of labs have agreed to pony up about $56.2 million to resolve a case in which UnitedHealthcare Insurance Co. claimed that the labs paid kickbacks to medical providers if they ordered expensive urine tests.

U.S. District Judge Fred Biery on Tuesday signed off on a consent judgment agreed to by the labs, which initially filed suit claiming the insurer owed them for tests they performed, and UnitedHealthcare, which lobbed counterclaims against the labs. The labs included Sky Toxicology, Frontier Toxicology, Hill Country Toxicology, Eclipse Toxicology and Axis Diagnostics.

Four of the five drug-testing labs — excluding Axis Diagnostics — will have to contribute to the more than $56 million judgment amount, according to the consent judgment in favor of UnitedHealthcare, and the judge dismissed all the claims against the insurer with prejudice.

"We are fighting fraud in all its forms," UnitedHealthcare said in a statement. "This case is just one example of the aggressive measures we take to protect members and customers, and to prosecute companies for these deceptive practices."

The labs filed a second amended complaint in January making various claims, including under the Employee Retirement Income Security Act and the Texas Insurance Code.

The forensic toxicology labs had claimed that health care providers, such as pain management doctors and addiction-treatment facilities, asked for certain urinalysis testing for patients insured by UnitedHealthcare-administered plans. The labs have said that they were owed millions of dollars for the testing.

The labs said that they all made sure that any medical provider that referred specimens to the labs understood to only submit medically required referrals. Additionally, the labs said that they never "financially induced" medical providers for referrals.

UnitedHealthcare, however, hit back with counterclaims. UnitedHealthcare said the labs offered kickbacks to medical providers and treatment centers in exchange for them ordering high-cost toxicology tests that purportedly weren't necessary for UnitedHealthcare members from labs not in network.

Those purported kickbacks were masked as "legitimate investment distributions," but only entities that sent a high amount of test requests to the labs were offered those investments, UnitedHealthcare has claimed.

As the purported scheme came to light, UnitedHealthcare said, the operators of the labs started to shut them down. But those operators, and their co-conspirators, were still able to net tens of millions of dollars, UnitedHealthcare claimed.

Counsel for the labs was not immediately available for comment on Wednesday.

The labs are represented by Brian W. Bishop of the Law Office of Brian W. Bishop.
UnitedHealthcare is represented by Stephen W. Mooney and Adam Sinton of Weinberg Wheeler Hudgins Gunn & Dial LLC and Andrew G. Jubinsky of Figari & Davenport LLP.

The case is Sky Toxicology Ltd. et al. v. UnitedHealthcare Insurance Co. et al., case number 5:16-cv-01094, in the U.S District Court for the Western District of Texas.

--Editing by Nicole Bleier.
Document (1)

1. *Research Paper; Post opioid overdose outreach by public health and public safety agencies: Exploration of emerging programs in Massachusetts; (2018) 54 EINJDP 43-50*

Client/Matter: Estate of Keefe
ABSTRACT

Background

Opioid overdose is a significant public health problem. Collaborative programs between local public health and public safety agencies have emerged to connect overdose survivors and their personal networks...
with harm reduction and addiction treatment services following a non-fatal overdose event. This study explored the prevalence of these programs in Massachusetts and the different ways they have been structured and function.

**Methods**

We sent an online screening questionnaire to police and fire departments in all 351 communities in Massachusetts to find instances in which they collaborated with a community-based public health agency to implement a post-overdose outreach and support program. We conducted telephone interviews with communities that implemented this type of program and categorized programs based on their structure, outreach approach, and other key characteristics.

**Results**

Police and fire personnel from 110 of the 351 communities in Massachusetts (31% response rate) completed the screening survey. Among respondents, 21% (23/110) had implemented a collaborative, community-based, post-overdose program with a well-defined process to connect overdose survivors and their personal networks with support services or addiction treatment services. Using data from the interviews, we identified four types of programs: (1) **Multi-Disciplinary Team Visit**, (2) **Police Visit with Referrals**, (3) **Clinician Outreach**, and (4) **Location-Based Outreach**.

**Conclusions**

This study represents the first attempt to systematically document an emerging approach intended to connect opioid overdose survivors and their personal networks with harm reduction and addiction treatment services soon after a non-fatal overdose event. These programs have the potential to increase engagement with the social service and addiction treatment systems by those who are at elevated risk for experiencing a fatal opioid overdose.

**FULL TEXT**

**Introduction**

The United States is in the midst of an opioid overdose epidemic, involving both heroin and synthetic opioids (O'Donnell et al., 2017). Opioid-related overdose deaths increased three-fold in the U.S. between 2000 and 2015-with 33,091 cases in 2015 alone (Rudd et al., 2016). Individuals who experience a non-fatal overdose event are at elevated risk for overdose in the future (Darke et al., 2011; Stoove et al., 2009). From a public

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Stoove et al., 2009 M.A. Stoove, P.M. Dietze, D. Jolley; Overdose deaths following previous non-fatal heroin overdose: Record linkage of ambulance attendance and death registry data; Drug and Alcohol Review; Vol. 28, 4; (2009), pp. 347-352.
health perspective, non-fatal overdose survivors constitute a high priority group and a logical point of intervention to reduce overdose mortality rates.

Emergency departments (EDs) are a common setting for programs designed to reach and engage people who have an opioid use disorder and those who have experienced a non-fatal overdose (e.g., D’Onofrio and Degutis, 2010; D’Onofrio et al., 2017; Dwyer et al., 2015; Trowbridge et al., 2017). Examples in this area have included interventions to provide overdose education and naloxone rescue kits to patients (Dwyer et al.; Samuels, 2014), connect patients to peer-recovery coaches (Samuels), link individuals with office-based addiction clinics and methadone maintenance programs (Trowbridge et al.), and initiate buprenorphine treatment directly in the ED (D’Onofrio et al.). Despite advances in this area and wider diffusion of ED-based interventions, many overdose survivors do not receive this type of support prior to discharge from a medical facility (Naeger et al., 2016; Rosenthal et al., 2016).

Recently, a new group of programs has emerged that attempts to reach and engage non-fatal opioid overdose survivors in community-based settings using collaborations between local public health and public safety agencies. These programs are not intended to replace ED-based interventions; rather, they are intended to reach individuals who leave ED settings without being connected to addiction treatment services, those who are not ready to accept services that have been offered in the ED (Pollini et al., 2006), those who refuse transport to a medical facility after an overdose (Vilke et al., 2003; Wampler et al., 2011), and those who don’t come to the attention of the medical system. These programs also offer the opportunity to engage the personal networks of overdose survivors; a group that may not always be present during an

D’Onofrio and Degutis, 2010 G. D’Onofrio, L.C. Degutis; Integrating project ASSERT: A screening, intervention, and referral to treatment program for unhealthy alcohol and drug use into an urban emergency department; Academic Emergency Medicine; Vol. 17, 8; (2010), pp. 903-911.


Samuels, 2014 E. Samuels; Emergency department naloxone distribution: A Rhode Island department of health, recovery community, and emergency department partnership to reduce opioid overdose deaths; Rhode Island Medical Journal; Vol. 97, 10; (2014), pp. 38-39.


Vilke et al., 2003 G.M. Vilke, C. Sloane, A.M. Smith, T.C. Chan; Assessment for deaths in out-of-hospital heroin overdose patients treated with naloxone who refuse transport; Academic Emergency Medicine; Vol. 10, 8; (2003), pp. 893-896.
ED-based interaction, yet one that is known to play an important role in the lives of many individuals with a substance use disorder (Kerensky and Walley, 2017; Ventura and Bagley, 2017).

To date, there are few descriptions of public health and public safety post-overdose programs in the peer reviewed literature. Wagner et al., 2016 described a variation of this approach in which sheriff’s deputies at overdose scenes provided overdose prevention information, lists of local support services, and contact information for an addiction treatment agency. When deputies obtained contact information for an overdose survivor, a case manager contacted them within 24-h to assess their interest in treatment and to schedule an intake visit (Wagner et al.). In another example, police officers provided voluntary screening and referral to addiction treatment to people with opioid use disorder who presented at the police station (Schiff et al., 2016; Schiff et al., 2017). Outside of the peer reviewed literature, multiple press reports from across the U.S. have documented the deployment of post-overdose outreach teams in which public health and public safety personnel conducted home-based outreach visits in the days following a non-fatal overdose event (e.g., Barnes, 2017; Mayhew, 2017; Zezima, 2017). The prevalence of these programs and their characteristics are largely unknown.

To address this gap, we conducted a study in Massachusetts to: (1) assess the prevalence of collaborative, community-based, post-overdose programs that connect overdose survivors and their personal networks with support or addiction treatment services and (2) describe the structure and function of these programs. First, we present findings from a screening survey sent to all police and fire chiefs in Massachusetts. Second, we report findings from telephone interviews conducted with selected programs on key program characteristics.

Data and methods

Setting and participants
The study occurred in Massachusetts between December 2015 and December 2016. For the purposes of the study, the term “public safety agency” was used to refer to emergency first responder agencies in the community (e.g., police, firefighters, emergency medical technicians). The term “public health agency” was used to refer to agencies in the community that provide a broad range of social and addiction treatment services (e.g., drug counselors, social workers, addiction treatment counselors, outreach workers). In the first phase of the study, we sent a screening questionnaire to police and fire departments in all 351 communities in Massachusetts. In the second phase of the study, we conducted interviews with spokespersons from 20 communities that had implemented a collaborative, community-based, post-overdose program that employed a protocol to connect overdose survivors and their personal networks with support services or addiction treatment services. The Massachusetts Department of Public Health IRB reviewed and approved all study procedures.

Measures

The online screening questionnaire consisted of six questions designed to identify programs of interest. Respondents were first asked whether they provided outreach or referral services to people who use opioids or their personal networks. Those who responded affirmatively were asked whether any of these services were delivered in collaboration with other agencies. If so, they were asked to identify all agencies collaborating on the program. Those who were implementing a collaborative program were asked whether the program specifically targeted individuals who had recently experienced an overdose and their personal networks. Those who responded affirmatively were asked to describe the program and indicate whether we could contact them for a follow-up interview.

The telephone interview protocol consisted of 18 questions organized into six sections: (1) program description (what led to the development of the program; what were the program’s goals; how was the program organized; what did program staff do); (2) how individuals were identified (how did they find and select people to contact; how did they locate and make contact with people); (3) interaction with contacts (what did they do after they made contact); (4) follow-up (did they try to follow up with people after the initial contact); (5) evaluation (did they do anything to document or evaluate the program); and (6) what did they learn (what were the best ways to contact people; what were the most helpful services for the people they contacted; how did contacts respond to the program; what characteristics made for an effective staff member; what collaboration among organizations worked best; what would they tell others interested in developing programs like this). Interviewers used probes to elicit more detail and pursued interesting lines of inquiry that emerged during the interviews.

Procedure and analysis

Screening survey data were collected using SurveyGizmo (secure online software suite). We worked with the Massachusetts Chiefs of Police Association and the Massachusetts Department of Fire Services to distribute the survey link to their contact lists. Data collection occurred between December 2015 and January 2016. All data were exported into IBM SPSS Statistics Version 24 to generate descriptive statistics. We used the results from the screening survey to identify communities with a collaborative, community-based, post-overdose program. We examined the narrative description of each program and selected those that: (1) were operational at the time of the assessment, (2) included an active outreach component, and (3) had a well-defined protocol to connect overdose survivors and their personal networks with support or addiction treatment services. We excluded programs that: (1) only provided passive
services (e.g., left behind a pamphlet without further follow-up); (2) were not specifically targeting individuals who had recently experienced an overdose and/or their personal networks; (3) were not operational; and (4) did not provide sufficient detail to determine the services they provided.

Interview data were collected between February and March 2016 with representatives from programs that met the screening criteria. We conducted 20 telephone interviews lasting 60 to 90 min with key spokespersons from each program. Spokespersons included the police or fire chief who responded to the survey and/or a designee they identified as the most knowledgeable person about the program. Interviewers took extensive notes and recorded the interviews.

Interview data were analyzed using a sequential qualitative content analysis approach (Cho and Lee, 2014; Miles et al., 2014). Three members of the study team (SF, LW, BR) independently created first-order codes for each question in the interview protocol for all 20 interviews. We used Microsoft Excel to store and manage the dataset. The coders met multiple times to discuss the coding and to resolve inconsistencies. This process continued until we arrived at the most meaningful and parsimonious set of codes that represented all comments. Following the first round of coding, we created a set of second-order codes by collapsing conceptually similar themes. All members of the study team participated in the review of second-order codes and final interpretation.

Results

We received valid survey responses from 31% (110/351) of the communities in Massachusetts. Overall, 58% (64/110) of respondents were police chiefs and 42% (46/110) were fire chiefs. Respondents tended to be from larger communities (median population = 19,250) compared to communities that did not respond to the survey (median population = 6916). Responses were received from 10 of the 11 most populous communities, including Boston, and were geographically distributed across 13 of the 14 counties in the state.

Among survey respondents, 58% (64/110) reported that their public safety agency delivered outreach or referral services to people who use opioids or their personal networks. Fifty-five percent (55%) of respondents (60/110) reported that their agency collaborated with a public health agency to implement these services. Thirty percent (30%) of respondents (33/110) reported that their program specifically targeted individuals who recently experienced an overdose and/or their personal networks. After applying the exclusion criteria, 21% (23/110) were determined to be actively implementing a collaborative, community-based, post-overdose program with an active outreach component and a well-defined process to connect overdose survivors and/or their personal networks with support services or addiction treatment services.

Interviews were conducted with 87% (20/23) of the communities that met the selection criteria. Twenty-six individuals participated in the 20 telephone interviews. Sixteen of the interviews were conducted with a single respondent and four were conducted with multiple respondents. The professional role of respondents was: police chief (n = 10), social service agency staff (n = 6), police officer (n = 5), fire chief

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(n = 3), firefighter (n = 1), and emergency medical services (EMS) chief (n = 1). The communities represented by interview respondents were geographically distributed across 9 of the 14 counties in Massachusetts and had a median population of 28,576 (range: 10,303 to 95,072).

We organized the results from the interviews into three main sub-sections: (1) program impetus and goals, (2) program organization and structure (team composition, outreach approach, staffing), and (3) program operation and implementation (funding, interactions with contacts, facilitators, barriers, evaluation).

Program impetus and goals

Eighteen of the programs (18/20) emerged in response to observed increases in fatal and non-fatal opioid overdose cases, substance-related crime, and/or opioid-related emergency service calls. As one respondent described, “We had four fatal overdoses in the first three months of 2015 and were on pace to double our rate from 2014” (Police Chief 8). Most of the programs (17/20) were less than a year old at the time of the study - a period of time that coincided with a sharp increase in opioid overdose fatalities in Massachusetts (Massachusetts Department of Public Health, 2017). The mechanism through which programs were developed varied by site. Roughly half of the programs (9/20) were developed by an influential police or fire chief. As one respondent reported, “When I became chief, I wrote a drug strategy that framed what everyone’s job was to drive down drug use. Part of this was assisting drug-addicted people getting into treatment” (Police Chief 1). The other programs arose out of local planning groups or coalitions that included public health and public safety representatives (5/20), calls to action from the local community (4/20), and mandates from local elected officials (2/20).

All of the programs (20/20) reported that their goal was to engage opioid overdose survivors and provide them with information, support, and connections to social or substance abuse treatment services. Half of the sites (10/20) specifically mentioned that they tried to reach the personal networks of overdose survivors in addition to the survivor. Respondents also mentioned that their program attempted to contribute to a coordinated system of care within the community (5/20) and tried to reduce stigmatization of people who use drugs (5/20). These latter themes are represented in the following quote:

*Our goal is to get each person that’s identified to agree to work with our clinician and our staff to develop an intervention plan that suits them. Two-thirds of them have told us to go pound sand, but of those two-thirds, many have called back and said, ‘you know what… I’m ready.’… and we go into action at that point. Our goal is to create a culture in the community where when a person decides they’re ready, they can call the police. We’re also working to address the issue of stigma. Just having the police chief out there in the forefront talking about this. Particularly in a white picket-fence community* (Police Chief 10)

Program organization and structure

The most common team configuration consisted of police and clinicians working together (13/20). Other configurations included police, fire/EMS, and clinicians working together (3/20), fire/EMS working with clinicians (2/20), fire/EMS and clinicians working with a member of the faith community (1/20), and police and clinicians working with a member of the faith community (1/20) (see Table 1).

Massachusetts Department of Public Health; Number of confirmed unintentional and undetermined opioid-related overdose deaths by city/town, MA residents January 2012-December 2015; (2017).

Gary W. Roberts
### Table 1

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Police</th>
<th>Fire/EMS</th>
<th>Clinician</th>
<th>Faith</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multi-Disciplinary Team Visit (n = 8)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community A</td>
<td>-</td>
<td>Visit</td>
<td>Visit</td>
<td>Visit</td>
</tr>
<tr>
<td>Community B</td>
<td>Visit</td>
<td>-</td>
<td>Visit</td>
<td>-</td>
</tr>
<tr>
<td>Community C</td>
<td>Visit</td>
<td>-</td>
<td>Visit</td>
<td>-</td>
</tr>
<tr>
<td>Community D</td>
<td>Visit</td>
<td>-</td>
<td>Visit</td>
<td>Visit</td>
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<tr>
<td>Community E</td>
<td>Visit</td>
<td>Visit</td>
<td>Visit</td>
<td>-</td>
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<tr>
<td>Community F</td>
<td>-</td>
<td>Visit</td>
<td>Visit</td>
<td>-</td>
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<tr>
<td>Community G</td>
<td>Visit</td>
<td>Visit</td>
<td>Visit</td>
<td>-</td>
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<tr>
<td>Community H</td>
<td>Visit</td>
<td>-</td>
<td>Visit</td>
<td>-</td>
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<td><strong>Police Visit with Referrals (n = 4)</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Community I</td>
<td>Visit</td>
<td>-</td>
<td>Referred</td>
<td>-</td>
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<tr>
<td>Community J</td>
<td>Visit</td>
<td>-</td>
<td>Referred</td>
<td>-</td>
</tr>
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<td>Visit</td>
<td>-</td>
<td>Referred</td>
<td>-</td>
</tr>
<tr>
<td>Community L</td>
<td>Visit</td>
<td>-</td>
<td>Referred</td>
<td>-</td>
</tr>
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<td><strong>Clinician Outreach (n = 6)</strong></td>
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<td>Embedded</td>
<td>-</td>
</tr>
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<td>Community N</td>
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<td>-</td>
<td>Embedded</td>
<td>-</td>
</tr>
<tr>
<td>Community O</td>
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<td>-</td>
<td>Embedded</td>
<td>-</td>
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<td>Community P</td>
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<td>Referrer</td>
<td>Embedded</td>
<td>-</td>
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<td>Referrer</td>
<td>Referred</td>
<td>-</td>
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<tr>
<td>Community R</td>
<td>Referrer</td>
<td>-</td>
<td>Referred</td>
<td>-</td>
</tr>
<tr>
<td><strong>Location-Based Outreach (n = 2)</strong></td>
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<td></td>
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<tr>
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<td>-</td>
<td>Referred</td>
<td>-</td>
</tr>
<tr>
<td>Community T</td>
<td>Center</td>
<td>-</td>
<td>Center</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total (n = 20)</strong></td>
<td>17</td>
<td>6</td>
<td>20</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 1 - Sector Representation and Contact Method by Program Type (n = 20).

*aIncludes licensed clinical social workers, drug use counselors, therapists, psychologists.*
Despite commonalities in the impetus and goals of these programs, sites varied in the ways they operated and the roles of participating agencies. Four distinct types of programs emerged from the data (see Table 2).

Table 2

<table>
<thead>
<tr>
<th>Type of Outreach</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multi-Disciplinary Team Visit</strong></td>
<td>Post-OD visit to residence of OD survivor or site of the OD event</td>
</tr>
<tr>
<td><strong>Police Visit with Referrals</strong></td>
<td>Post-OD visit to residence of OD survivor or site of the OD event</td>
</tr>
<tr>
<td><strong>Clinician Outreach</strong></td>
<td>Post-OD telephone-based outreach to OD survivor</td>
</tr>
<tr>
<td><strong>Location-Based Outreach</strong></td>
<td>Media and word-of-mouth outreach to whole community (including OD survivors)</td>
</tr>
</tbody>
</table>

| Role of Public Safety Person        | Attend visit. Assist public health representative, as needed.               |
| Role of Public Health Person        | Attend visit. Provide information and resources. Make referral to public health representative. |
| Role of Public Health Person        | Contact individuals referred by police to help link them with appropriate services. |
| Role of Public Health Person        | Contact individuals referred by public safety to help link them with appropriate services. |
| Role of Public Health Person        | Assist in staffing community center and/or connecting with individuals referred by police to help link them with appropriate services. |

Table 2 - Post-OD Outreach Program Types and Characteristics (n = 20).

**Multi-disciplinary team visit (n = 8)**

In these programs, a public safety representative (police, fire, EMS) and one or more public health representatives (substance use counselors, social workers, outreach workers) travel together to the residence of the overdose survivor or site of an overdose shortly following the event. They assist survivors and members of their personal network with support services and connections to addiction treatment services. The public health representative generally takes the lead in these interactions. The public safety representative secures the site and provides support, as needed:

*We formed three-person teams of outreach workers, drug counselors, police officers, and chaplains or faith community people who volunteer to serve. They visit homes of people who recently overdosed. When they visit, they offer services to families and the person who overdosed with the goal of getting them into treatment.* (Outreach Worker 16)

**Police visit with referral (n = 4)**

These programs involve police traveling to the residence of the overdose survivor or the site of an overdose shortly following the event. The officer provides overdose survivors and members of their
personal network with information on support group schedules and addiction treatment options. If the survivor is ready to accept services, the police officer makes a referral to a partnering social service or addiction treatment program. Staff members at the social service or addiction treatment facility then conduct an assessment and determine the appropriate services for the individual (e.g., detoxification, inpatient treatment, medication for opioid use disorder). As one respondent described:

There are a couple of officers who are point people for this program called Intervention Specialists. We’ve paired with [a community-based addiction treatment provider] to have them help us when we need assistance. We had an overdose last night. Non-fatal. Now what we’ll do is reach out to that guy or his immediate family and see if he’s on his way to drug treatment or if there is a plan. We might then use [our public health partner] to see if there is a suitable treatment facility for that person (Police Chief 1)

**Clinic outreach (n = 6)**

In this program type, a clinician (e.g., licensed clinical social worker, drug use counselor, therapist, psychologist) receives contact information for an overdose survivor or a member of their personal network. The clinician is embedded within a police department or employed at a partnering social service or addiction treatment program. Referrals to the clinician are based on information gathered at the overdose scene or reviews of emergency call logs. The clinician conducts phone-based outreach to connect contacts with appropriate services. One respondent described the process as follows:

*We partnered with [a social services organization]. A case manager and clinician from this organization are embedded in our station. If we have someone overdose, they follow-up and try and get a hold of the person and steer them towards treatment. I go through the police log every morning and look for overdose cases. Then, I ship it right to them. Officers will walk in and give them a police report... That’s the whole thing with them being embedded here. They would never get that stuff if they were working out of a building somewhere else* (Deputy Police Chief 2)

**Location-Based outreach (n = 2)**

These programs encourage non-fatal overdose survivors, people with an opioid use disorder, and family or associates to visit a community-based site to obtain information, resources, and/or access to services. Information about the program is disseminated through traditional and social media, word-of-mouth, and promotion by first responders at overdose scenes. For example, one community offered connections to an addictions treatment provider for anyone with an opioid use disorder who voluntarily came to the police station. Another community set-up a drop-in center staffed by a variety of providers:

*We have a drop-in center that is a safe place for individuals and families suffering the effects of a substance use disorder to come get information, knowledge, and assistance navigating the continuum of care and peer support. There are officers there and licensed clinicians and [Peer Support Workers] - people who’ve been clean for two years who help shepherd visitors and partner people with guidance and advice* (Police Chief 5)

Respondents emphasized the importance of finding the right people to staff these different programs, especially staff members from public safety agencies. As one respondent described:

*You need a person that’s caring, that’s focused, and that can express themselves. That’s who we put in these positions. It’s important to have the right person. I can think of a dozen people I would never send to...*
a door. It’s not that they’re not good policemen; it’s just that this isn’t their thing. It’s not for everybody. You can’t just have the area cop go to the house. You absolutely cannot do that. The personality has to be right (Police Chief 17)

Another commented on the need for officers to use a humanistic approach, “Crank it up and be a cop when they have to, but take it back a few notches and take a humanistic approach when it’s necessary… and being able to determine when each approach is needed” (Police Chief 14). Additional themes included being knowledgeable about working with overdose survivors (10/20); personable, friendly, and approachable (10/20); caring and empathetic (9/20); non-judgmental (7/20); committed to the work (7/20); and patient (6/20). Respondents noted that public safety personnel were either selectively chosen for these assignments or volunteered.

Fifteen the programs (15/20) reported that they provided training to staff members on topics such as opioid use disorder, overdose response, communication skills, compassion, and stigma. As described by one respondent, “We’ve had multiple trainings on stigma and substance use disorder for my officers on this program and for the whole department. Our clinician has done it during roll calls” (Police Chief 10). In most instances, the public health partner delivered the training to public safety personnel.

Program operation and implementation

The public safety component of these programs was almost always funded as part of normal shift hours from Department budgets (19/20). Some respondents (7/20) reported that they also allocated over-time hours for public safety personnel. Respondents reported that the public health component was funded as part of normal business hours (11/20) or through external grant support (8/20). Programs with a clinician embedded within a police department (4/20) all reported that the clinician was grant-funded.

The program sites varied in how they approached overdose survivors and members of their personal networks. Thirteen programs (13/20) reported that they adhered to a harm reduction approach grounded in the principle of offering services that reduce the harms associated with substance use (e.g., overdose prevention with naloxone kits, connections to syringe services programs, and connections to addiction treatment services without coercion). The services offered by these programs were not contingent on commitment or readiness to engage in addiction treatment or abstinence. As one respondent described:

*We try to send the message that we’re there to help. We’re not there to put you in jail or give you a hard time or tell you to stop shooting dope. None of that stuff. We talk to each person, whether it’s a drug user, parent, or partner, and we try to tailor it to that person or individual* (Outreach Worker 18)

Another respondent said, “I think [our approach is] really about consistency and making our program valued to them. Telling them that this is not a one-time shot… we’re there to continue to support them regardless of where they are in their use” (Outreach Worker 16).

Five programs (5/20) followed a harm reduction approach, but assisted family members who wanted to file paperwork to initiate involuntary commitment of the overdose survivor to a court-ordered addiction treatment facility. As one respondent described, this was only done as an option of last resort:

*If there’s an overdose, [a clinician] follows up and tries to get a hold of the person. Tries to help them to access treatment. If she talks to family she’ll refer them to get Narcan, tell them about [family support groups], so it’s not just the addict they are reaching out to, it is the family too. She will explain how to*
look into [involuntary commitment to addiction treatment] if few alternatives remain for their loved one
(Deputy Police Chief 2)

Two programs (2/20) actively promoted involuntary commitments to a court-ordered addiction treatment facility when the overdose survivor was not willing to voluntarily engage in treatment services. As described by one respondent, the police in these programs acted as the court petitioner to have the individual committed:

There’s a value in bringing people to court and having a consequence… People want to help their loved ones, but it’s just hard to go to court and actually commit your son or daughter. What we’ve done is we go to court as police and petition the court for [involuntary commitment to substance abuse treatment] (Police Chief 17)

Respondents indicated that the creation of broad partnerships with multiple individuals and agencies in the community facilitated implementation of the program (7/20). As one respondent said, “Don’t recreate the wheel. The biggest lesson I learned is go talk to people who are already doing this. Don’t sit and try to Google your way out of it to come up with solutions” (EMS Chief 4). Other respondents reiterated the importance of finding the right staff members (6/20), maintaining open communication with the community and adopting a transparent process (5/20), and securing high level support and buy-in from community leaders (5/20). Several respondents (5/20) vocalized the need to put contacts at ease during outreach encounters:

The first couple of times we went out, I don’t think we got to the point right away… So people seemed a little nervous. [They thought] we were there to do some kind of inspection, tell them they were going to lose their house, or inform them that they just lost a loved one. Now, we try to let them know exactly what we’re there for. Just get right to the point right away (Outreach Worker 18)

Respondents indicated that stigma was the most common barrier to implementation (11/20). This was an issue within public safety agencies and the community at large. As described by one respondent:

Attitude change is difficult. Culture change is difficult. We still have some attitudes that need to change even inside the department. I think [the assigned officer] is probably the most picked on employee at the police department. You know. Guys will say, ‘Put handcuffs on those people. You’re not a social worker. What the hell are you doing?’ There are a lot of dinosaurs around the Department that still think like that. (Police Chief 6)

Other respondents (8/20) reported that lack of funding and long-term sustainability were barriers to implementation. One respondent said, “The hardest part is going to be money. It costs money to do the program right. We’re fortunate that we received a grant, but it is going away eventually” (Fire Chief 5). Additional barriers to implementation included navigating the addiction treatment system (4/20), gaining support from the community (3/20), union rules and town politics (3/20), and rushing to implementation without careful planning (2/20).

Almost all respondents reported they engaged in program evaluation. Evaluation activities included documenting the number of outreach contacts (12/20), describing actions taken during encounters (6/20), tracking the number of referrals (6/20), and documenting the number of referrals resulting in connections with providers (5/20). Two respondents (2/20) collected anecdotal accounts from overdose survivors and their personal networks about the short-term outcomes of the program.
Discussion

We identified four distinct types of post-overdose outreach programs in communities in Massachusetts. These programs emerged in response to observed increases in opioid overdoses at the community level and perceived gaps in the existing support system. Interview respondents reported similar goals for these programs, identified similar desirable characteristics of staff members, mentioned similar facilitators and barriers to implementation, and engaged in similar evaluation activities. The programs varied in the composition of the team members, outreach approach, the way the public health component was funded, and the extent to which the program used coercion to force overdose survivors into addiction treatment.

Research has found that overdose survivors who talk to someone following the event are more likely to seek and enroll in addiction treatment services (Pollini et al.), particularly when a direct connection is made rather than just providing information and relying on the individual to seek services on their own (D’Onofrio & Degutis). A key objective of the programs in this study was reaching overdose survivors and their personal networks and providing them with community-based, direct connections to social and addiction treatment services. In most instances, these programs acted as a secondary safety net for overdose survivors and their personal networks who came to the attention of the emergency services system but did not receive these connections in an emergency department setting.

This set of programs is one example of a broad pattern of change in the role law enforcement agencies are beginning to play in response to the opioid overdose epidemic. States are increasingly equipping law enforcement personnel with naloxone rescue kits (Davis et al., 2014; Davis et al., 2015; Wagner et al.) and passing Good Samaritan laws that offer limited immunity from drug possession charges for people who call for help during an overdose (Banta-Green et al., 2013; Davis et al., 2013). While studies have found generally positive attitudes among law enforcement officers concerning these changes (Ray et al., 2015; Saucier et al., 2016, Wagner et al.), not all officers embrace these changes to their traditional roles of investigation and arrest (Banta-Green et al.; Green et al., 2013). In our study, respondents cited departmental culture change as a barrier to implementation. One approach to addressing this issue was to choose appropriate public safety program personnel to work on the program or relying on volunteers. Departments interested in adopting

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Davis et al., 2015  C.S. Davis, A.Y. Walley, C.M. Bridger; Lessons learned from the expansion of naloxone access in Massachusetts and North Carolina; Journal of Law, Medicine & Ethics; Vol. 43, Suppl. 1; (2015), pp. 19-22.


Davis et al., 2013  C.S. Davis, D. Webb, S. Burris; Changing law from barrier to facilitator of opioid overdose prevention; The Journal of Law, Medicine & Ethics; Vol. 41, Suppl. 1; (2013), pp. 33-36.


Saucier et al., 2016  C.D. Saucier, N. Zaller, A. Macmadu, T.C. Green; An initial evaluation of law enforcement overdose training in Rhode Island; Drug and Alcohol Dependence; Vol. 162; (2016), pp. 211-218.

Green et al., 2013  T.C. Green, N. Zaller, W.R. Palacios, S.E. Bowman, M. Ray, R. Heimer, P. Case; Law enforcement attitudes toward overdose prevention and response; Drug and Alcohol Dependence; Vol. 133, 2; (2013), pp. 677-684.

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one of these programs may benefit from assessing the attitudes of officers beforehand and proactively addressing any concerns.

Loss of privacy is a potential source of harm associated with these programs. Personal information collected by law enforcement agencies and fire departments does not receive the same protection as personal information collected via health-related encounters. Data sharing between public safety and public health agencies has the potential to focus attention on individuals and communities in undesirable ways. It could, for example, lead to eviction, stigma, social control, or other adverse consequences. Such a development could result in reduced rates of calling emergency services by overdose witnesses (Davidson et al., 2002; Koester et al., 2017; Tracy et al., 2005) and less cooperation with public health agencies by people at highest risk for overdose. Communities implementing these types of programs may want to develop data sharing agreements and protocols that clearly describe data use guidelines.

The use of coercive practices to force people into court-ordered addiction treatment is another potential source of harm associated with these programs. The efficacy of this approach with overdose survivors is not well documented and there are unresolved ethical and civil rights questions surrounding this practice (Kerensky & Walley; Walton and Hall, 2017; Werb et al., 2016). One-third of the programs in our study reported the use of involuntary commitment as a potential outcome of their interaction with an overdose survivor or their personal network. Similar to the potential negative effects of loss of privacy, the misuse of this practice could result in reduced calls to emergency services during an overdose and strained relations with public health and public safety personnel. Communities interested in one of these programs may want to discuss the extent to which they plan to use involuntary commitments and communicate their decision to all staff members and the community beforehand.

Public safety personnel do not typically receive training on the most appropriate social or addiction treatment services for overdose survivors and their personal networks. Schiff et al. (2017) found, for example, that officers in their study were more likely to refer people to detoxification services rather than evidence-based medication treatment. While three of the program types we found in this study involve direct contact between a clinician and overdose survivors and their personal networks, the police visit with referral program type does not. Officers in this type of program might need additional training on making referrals to a clinician who can conduct a formal assessment and determine the best option for each individual.


Tracy et al., 2005 M. Tracy, T.M. Piper, D. Ompad, A. Bucciarelli, P.O. Coffin, D. Vlahov, S. Galea; Circumstances of witnessed drug overdose in New York City: Implications for intervention; Drug and Alcohol Dependence; Vol. 79, 2; (2005), pp. 181-190.


Finally, the effectiveness of the types of programs described in this paper remains largely untested. Wagner et al. (2016) found that one-third of overdose survivors who were contacted by a clinician within 24-h of the event made at least one visit to an addiction treatment provider. Schiff et al. (2017) found that a voluntary police-led treatment referral program was able to successfully place three-quarters of those seeking addiction treatment services. Further research is needed to determine whether the types of programs described in this study could produce similar placement outcomes.

Limitations

Several factors limit the conclusions that can be drawn from our study. First, the modest survey response rate does not allow us to make statements about the prevalence of these models statewide. We found that one-fifth of respondents were implementing one of these models. Whether a similar proportion exists among the two-thirds of communities that did not respond remains unknown. This also limits our knowledge of whether the four types of programs we identified are exhaustive of all possible configurations of post-overdose outreach programs. Second, it is unclear whether these findings are generalizable beyond Massachusetts. These programs grew out of a state-specific surge in overdose cases in a short period of time. Their frequency in other states and regions may vary considerably based on local epidemiological patterns in overdose rates. Third, we did not interview representatives from all 23 communities that we identified. This was an exploratory study. Available resources constrained the number of interviews we conducted and the depth of these interviews. The three programs we didn’t interview were each police visit with referral programs. Results from the survey showed that their descriptions were identical to the programs we did interview. We selected the four programs in this category with the best descriptions. It is possible that our findings would have varied if we had included these sites and if we had interviewed more individuals within each site. Finally, we did not interview any program recipients as part of this study. This could have contributed valuable information to our understanding of the acceptability of these services among overdose survivors and members of their personal networks.

Conclusions

We believe this to be the first systematic investigation of an emerging set of programs that have not yet received attention in the peer reviewed literature. Although this study has several important limitations, the findings help identify four different approaches to conducting post-overdose outreach at the community level by leveraging the existing public health and public safety infrastructure. These programs warrant further study as a strategy for increasing engagement with the social service and addiction treatment systems by those who are at elevated risk for experiencing a fatal opioid overdose.

Conflicts of interest

The authors declare no conflicts of interest.

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References


Stoove et al., 2009 M.A. Stoove, P.M. Dietze, D. Jolley; Overdose deaths following previous non-fatal heroin overdose: Record linkage of ambulance attendance and death registry data; Drug and Alcohol Review; Vol. 28, 4; (2009), pp. 347-352.

D’Onofrio and Degutis, 2010 G. D’Onofrio, L.C. Degutis; Integrating project ASSERT: A screening, intervention, and referral to treatment program for unhealthy alcohol and drug use into an urban emergency department; Academic Emergency Medicine; Vol. 17, 8; (2010), pp. 903-911.


Samuels, 2014 E. Samuels; Emergency department naloxone distribution: A Rhode Island department of health, recovery community, and emergency department partnership to reduce opioid overdose deaths; Rhode Island Medical Journal; Vol. 97, 10; (2014), pp. 38-39.


Vilke et al., 2003 G.M. Vilke, C. Sloane, A.M. Smith, T.C. Chan; Assessment for deaths in out-of-hospital heroin overdose patients treated with naloxone who refuse transport; Academic Emergency Medicine; Vol. 10, 8; (2003), pp. 893-896.


Ventura and Bagley, 2017 A.S. Ventura, S.M. Bagley; To improve substance use disorder prevention, treatment and recovery: Engage the family; Journal of Addiction Medicine; Vol. 11, 5; (2017), pp. 339-341.

Wagner et al., 2016 K.D. Wagner, L.J. Bovet, B. Haynes, A. Joshua, P.J. Davidson; Training law
enforcement to respond to opioid overdose with naloxone: Impact on knowledge, attitudes, and interactions with community members; Drug and Alcohol Dependence; Vol. 165; (2016), pp. 22-28.


Schiff et al., 2017  D.M. Schiff, M.L. Drainoni, Z.M. Weinstein, L. Chan, M. Bair-Merritt, D. Rosenbloom; A police-led addiction treatment referral program in Gloucester, MA: Implementation and participants' experiences; Journal of Substance Abuse Treatment; Vol. 82, Supplement C; (2017), pp. 41-47.

Barnes, 2017  J. Barnes; New bedford police, chaplains, counselors reach out to OD victims; (2017).

Mayhew, 2017  C. Mayhew; Boone county starts overdose response team; (2017).

Zezima, 2017  K. Zezima; As opioid overdoses rise, police officers become counselors, doctors and social workers; (2017).


Massachusetts Department of Public Health, 2017  Massachusetts Department of Public Health; Number of confirmed unintentional and undetermined opioid-related overdose deaths by city/town, MA residents January 2012-December 2015; (2017).


Davis et al., 2015  C.S. Davis, A.Y. Walley, C.M. Bridger; Lessons learned from the expansion of naloxone access in Massachusetts and North Carolina; Journal of Law, Medicine and Ethics; Vol. 43, Suppl. 1; (2015), pp. 19-22.

Davis et al., 2013  C.S. Davis, D. Webb, S. Burris; Changing law from barrier to facilitator of opioid overdose prevention; The Journal of Law, Medicine & Ethics; Vol. 41, Suppl. 1; (2013), pp. 33-36.


Saucier et al., 2016  C.D. Saucier, N. Zaller, A. Macmadu, T.C. Green; An initial evaluation of law enforcement overdose training in Rhode Island; Drug and Alcohol Dependence; Vol. 162; (2016), pp. 211-218.

Green et al., 2013  T.C. Green, N. Zaller, W.R. Palacios, S.E. Bowman, M. Ray, R. Heimer, P. Case; Law enforcement attitudes toward overdose prevention and response; Drug and Alcohol Dependence; Vol. 133, 2; (2013), pp. 677-684.


Tracy et al., 2005  M. Tracy, T.M. Piper, D. Ompad, A. Bucciarelli, P.O. Coffin, D. Vlahov, S. Galea; Circumstances of witnessed drug overdose in New York City: Implications for intervention; Drug and Alcohol Dependence; Vol. 79, 2; (2005), pp. 181-190.


Werb et al., 2016  D. Werb, A. Kamarulzaman, M.C. Meacham, C. Rafful, B. Fischer, S.A. Strathdee, E.

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Client/Matter: Estate of Keefe
ABSTRACT

Of central importance is that our clinical experience and treatment outcome studies to date strongly suggest that coercion is fundamental to addiction treatment and favorable outcomes from therapeutic interventions. Often the alcoholic/drug abuser must be given an opportunity to feel, face, or experience the “consequences” of their alcohol and drug addiction before the denial of their illness can be penetrated and motivation for treatment to recover from addictive illness can be developed. Continued use of alcohol and drugs is an unhealthy and dangerous state for those who are addicted and for others who are affected by their addictive illnesses. Effective therapeutic interventions and long-term recovery are more likely to succeed if avoiding “alternative consequences” are contingent on continued compliance with addiction treatment by those who suffer from addictive illnesses.

FULL TEXT

1 Introduction

1.1 Effectiveness of coerced addiction treatment with “alternative consequences”: purpose and key questions

The purpose of this review is to provide a comprehensive evaluation of coerced addiction treatment with “alternative consequences.” The review centers on key questions that are relevant to various populations of patients/clients with addictive illness. The crux of coerced treatment is to enforce alternative
consequences to motivate the client/patient to comply with addiction treatment when alcohol and drug disorders are identified as consequential to the individual and others. The alternative consequences can include loss of benefits, such as entitlement payments, or incarceration because of a drug/alcohol-related activity, if compliance with addiction treatment is not met.

The review is based on an analysis of literature from research studies of coerced or mandated addiction treatment in various populations. An analysis of treatment effectiveness and cost benefits was provided to underscore the utility and advantages of offering addiction treatment as an option or consequence. The source of the research studies was a Medline computer search, bibliographies from journal articles, textbooks, and monographs.

2 Policy targets

The findings of the review are divided into sections according to client/patient populations.

1. How do “alternative consequences” work in patient populations?
2. What are the legal and court practices for addiction treatment?
3. How do “alternative consequences” work in employed populations?
4. How do “alternative consequences” work in criminal populations?
5. How do “alternative consequences” work in driving-while-intoxicated (DWI) populations?
6. How do “alternative consequences” work in child welfare populations?
7. How do “alternative consequences” work in public aid populations?
8. Is addiction treatment effective and cost beneficial, and for whom?

2.1 How do “alternative consequences” or coerced addiction treatment work in patient/client populations?

A misconception of having alternative consequences or coerced (mandated) addiction treatment is that the individual is “forced” to comply with addiction treatment. As practiced, coerced (or mandated) addiction treatment is rarely forced on the individual. On the other hand, coercion can be considered as a form of mitigation where addiction treatment is offered to an alcoholic or drug abuser in lieu of the alternative consequences of their addiction (e.g., sentencing for theft, or driving under the influence, loss of child for neglect, loss of employment for negligence, or loss of public aid benefits or other consequences for purchasing illicit drugs or engaging in other illegal activities from alcohol or drug use). In actuality, coercion occurs when an alcoholic or drug abuser is given the choice to choose between an opportunity to comply with addiction treatment or receive the “alternative consequences” prescribed by the enforcement of the law, policy, or agency (e.g., jail time or probation, loss of child or custody, loss or receipt of employment or benefits). Moreover, the patient/client must continue to comply long-term beyond the initial treatment period or face other consequences defined as part of the agreement for the recovery from addictive illness. Rarely, the patient/client is forced to accept addiction treatment as a part of sentencing,
and has the right to refuse to acknowledge a problem with alcohol and/or drugs and consequent addiction treatment (Grossman et al. 1997).

Intervention that involves alternative consequences to addiction treatment has been a common therapeutic practice in many patient/client populations. The Johnson Intervention is a therapeutic technique in which members of the patient's social structure confront him or her about the consequences of drinking and drug use (e.g., a loss that will beset the patient if addiction treatment is refused). The Johnson technique is a form of coercion because it links confrontation and consequences to the drinking and drug use as alternatives to additions treatment. A comparison of the technique to other forms of referral including coercion and noncoercion was made in a recent study. Of those who entered treatment, the Johnson Intervention and the coerced referral groups were equally likely to complete treatment, and both groups were more likely to complete treatment than those in the other three types of noncoercive referral (Loneck, Garrett, & Banks 1996).

Addiction treatment is aimed at a reduction in the consequences through treatment of the addictive illness. Compliance with addiction treatment is closely monitored as part of the contract between the abuser and the agency responsible for administering consequences of the addictive illness (e.g., courts, child welfare, employer, or public aid).

Generally, compliance includes the requirement of abstinence from both alcohol and other addicting drugs, particularly, illicit drugs (e.g., cocaine, marijuana, and heroin). The prohibition against the use of illicit drugs is clear, as the law stipulates legal consequences for their production, use, and sale. While alcohol is legal, the addictive use often leads to illegal and harmful consequences to the individual and others who are affected by the abuser (e.g., family members, citizens, and others).

2.2 What are the legal and court practices for addiction treatment?

The Rehabilitation Act (RA) and the Americans with Disabilities Act (ADA) cover the alcoholic/drug abuser to ensure protection from discrimination that can lead to a loss of employment on the basis of alcoholism or drug addiction. However, if the abuser rejects the choice of treatment as an alternative, the ADA does not necessarily protect the abuser from loss of employment. When the Social Security Act covered the diagnoses of alcoholism and drug dependence, a potential consequence of not complying with addiction treatment was loss of social security benefits (Kermani & Castaneda 1996).

A study examined the relationships among demographics, personality variables, drug use, and early attrition from addictions treatment. Attrition was considered at two time intervals: after one visit and at 2 months. One hundred consecutive admissions to a community drug abuse treatment center were evaluated with assessment instruments following a standard intake interview. Subjects were classified according to their primary drug of abuse: 16 opiate, 16 amphetamine, 34 cocaine, and 29 marijuana abusers. Immediate


dropouts were less likely to be court-mandated than those who remained in addictions treatment. The subjects did not differ on any other demographic or drug-use variables. Analysis also indicated that those who remained in treatment were less likely to be employed than dropouts. All other comparisons between these groups failed to produce significant differences. The results indicated that severity of psychopathology is not key in predicting attrition Stark & Campbell 1988.

Inpatient alcoholics who reported being coerced into treatment by commitment or pressure from others were compared in a following study to those alcoholics who described themselves as voluntary admissions. Assessments of outcome were made between 2 weeks and 18 months. There were no significant differences between the two groups. The conclusion was that the prognosis of alcoholics who present for treatment under court order or interpersonal pressure was not substantially different from men who entered treatment without coercion. However, there was a trend for the coerced group to show less alcohol consumption, which suggests that they did better than those who voluntarily entered treatment Watson, Brown, Tilleskjor, Jacobs, & Pucel 1988.

Studies show that favorable treatment outcomes can be obtained despite less than optimal compliance with coerced treatment. A nationally representative sample of 330 outpatient addiction treatment organizations was surveyed in 1990. Sixty-four of the organizations had 75% or more court-mandated clients, and 122 had 25% or less court-mandated clients. While the former organization (75% court-ordered) had less compliance with the treatment plan than the 25% group, there were no differences in clients meeting their goals of treatment Howard & McCaughrin 1996.

### 2.3 How do “alternative consequences” work in employed populations?

Employment Assistance Programs (EAP) have traditionally worked on behalf of employers and employees to identify and refer for addiction treatment to the benefit of both. Employers and employees have long recognized the benefits of addiction treatment in terms of reduced psychiatric, medical, and legal consequences and increased productivity in the workplace. Many studies have shown the improved benefits in psychosocial functioning of the individual Hoffmann & Miller 1993.

A recent study showed that coerced employees complied with addiction treatment at rates superior to employees who sought treatment voluntarily or on their own. The coerced group had significant alcohol/drug addiction and other life problems at the start of treatment that were generally less severe or chronic than those from the self-referred group. Moreover, coerced participants were significantly more likely to remain in treatment (either inpatient or outpatient) than the self-referred participants. Posttreatment follow-up of coerced patients indicated marked improvements in alcohol and drug use,

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employment, medical, family, and psychiatric problems. These levels of improvement were comparable to those shown by the self-referred patients. The researchers concluded that the workplace urine surveillance was successful in detecting employees with significant alcohol and drug-related problems. Referral to standard treatment was associated with substantial improvements in those problems. Of interest is that the coerced employees were not as severely affected, which supports the importance of earlier intervention before more severe consequences develop from addictive illness.

Lawental, McLellan, Grissom, Brill, & O'Brien 1996.

Coercion often takes place through the use of the EAP by an employer who seeks to assist an employee for a work-related consequence of drug and alcohol addiction. Studies showed that EAP clients who received treatment for psychiatric and alcohol and other drug use had lower absenteeism (34% and 44% fewer days lost for employees with psychiatric problems and alcohol and other drug use, respectively) during the 4-year study period than did the clients who sought out treatment without using the EAP. Also, there was a 60% reduction in turnover rate of employment for psychiatric clients and 81% for alcohol and other drug use clients. Medical claims were also lower, both for the impaired employees and for their dependents. The study estimated over $4 million in reduced medical claims (in 1988 dollars) over the 3-year follow-up period and over 6,000 fewer days of absenteeism.


2.4 How do “alternative consequences” work in criminal populations?

The convicted abuser can be given an opportunity to mitigate their sentence if they comply with addiction treatment. The studies to date uniformly supported that coerced addiction treatment resulted in favorable outcomes in these patient/criminal populations. The coerced convicts complied equally as well as those who are not mandated to treatment. The studies also showed a reduction in criminal activity and improved psychosocial status from compliance with addiction treatment.

Schmidt & Weisner 1993.

The results of an analysis of the research literature supported the basic belief that criminal justice clients do as well or better than other clients in drug addiction treatment. Treatment Alternatives to Street Crime (TASC) programs and other formal or informal criminal justice system mechanisms referred individuals who had not been treated previously and many who were not yet heavily involved in drug use. The early interruption of the criminal and drug use may have important long-term benefits in reducing both crime and drug use among treated offenders, particularly, younger offenders. Criminal justice system involvement also helps to retain clients in treatment through its leverage in compliance with monitoring during treatment. There also seemed to be more substantial changes in behavior during treatment for criminal justice clients in treatment. These findings support efforts to continue and expand criminal justice programs such as TASC. TASC programs have a broad mandate to identify and refer drug abusers in the criminal justice system to treatment.

From 1969 to 1973, approximately 44,000 drug abusers were admitted to 52 federally funded and community-based treatment agencies in the Drug Abuse Reporting Program (DARP). Over the course of several years, a series of studies was conducted on this treatment population and samples of these drug abusers were followed up at about 6 years and again at 12 years after admission to treatment Simpson & Friend 1988. Overall 40% of the DARP treatment population were admitted with some form of legal status, such as probation, awaiting trial, or parole. Some of the legally involved clients reported being referred to DARP treatment from courts, parole/probation officers, and police.

The DARP treatment evaluation studies consistently indicated that drug addiction treatment was effective in improving posttreatment outcomes. Data from the 12-year follow-up interviews gave further support to this conclusion (e.g., 58% of the sample had quit opioid use by year 12). Source of referral was examined to define “legal pressure.” Those substance abusers referred by court or legal sources, which presumably carried greater legal consequences, were compared to those referred by family, friends, self, and others. The results, however, were no different from those using the original measure of legal status, in particular, DARP treatment retention for court-referrals was not significantly different from other referrals Simpson & Friend 1988.

In another study, analyses were conducted to determine whether substance abusers coerced into treatment by actions of the criminal justice system differed from voluntary entrants in terms of background characteristics, early risk factors, or drug use and criminal behavior during pretreatment, treatment, and posttreatment periods. Subjects were categorized into high, moderate, and low legal coercion groups based on their official legal status, related narcotics testing requirements, and their self-reported perceptions of criminal justice system coercion. Dependent or outcome variables included criminal justice system contact, criminal activities, drug and alcohol involvement, and measures of social functioning. Few differences within any measured domain were found among the three groups. All groups showed substantial improvement in level of narcotics use, criminal involvement, and most other behaviors during treatment. Results supported legal coercion as a valid motivation for treatment entry and compliance. Those coerced into treatment responded in ways similar to voluntary admissions regardless of gender or ethnicity Brecht et al. 1993.

2.5 How do “alternative consequences” work in DWI populations?

Multiple offenders are at high risk for continued drunken driving. In Massachusetts, individuals who were convicted of a second drunken driving offense were mandated to incarceration for 7 days or more, or to enter a 14-day residential alcoholism treatment program. A 2-year follow-up study of arrest rates assessed the impact of the two sentencing options on subsequent arrests for driving under the influence of liquor (DUIL). Offenders admitted to the 14-day program were significantly less likely to be rearrested for drunken driving (10 vs. 20%). The odds were 1.9 times greater for rearrest among the incarcerated offenders. The twofold reduction in rearrest for drunk driving suggested that mandated short-term

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Salmon & Salmon 1983

Simpson & Friend 1988

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residential treatment provided an effective intervention among repeat offenders for drunken drivers McCarty & Argeriou 1988.

Driving under the influence of intoxicating drugs other than alcohol may be an important cause of traffic injuries. A study was conducted on a consecutive sample study in Memphis, Tennessee in 1993. Subjects arrested for reckless driving who were not apparently impaired by alcohol (did not have an odor of alcohol, tested negative on breath analysis, or both) were tested for cocaine and marijuana at the scene of arrest. The results of the drug tests were compared with clinical evaluations of intoxication made at the scene by a police officer. A total of 175 subjects were stopped for reckless driving, and 150 (86%) submitted urine samples for drug testing. Eighty-eight of the 150 (59%) tested positive: 20 (13%) for cocaine, 50 (33%) for marijuana, and 18 (12%) for both drugs. Ninety-four of the 150 tested drivers were clinically intoxicated, and 80 (85%) tested positive for cocaine or marijuana. Of interest, was that nearly half of the drivers intoxicated with cocaine performed normally on standard sobriety tests. The study concluded that over half of the reckless drivers who were not intoxicated with alcohol were found to be intoxicated with other drugs Brookoff, Cook, Williams, & Mann 1994.

In another study of drug use, whole blood samples were collected from arrested DUI subjects in two locations by police in the Washington, DC area. All blood samples were screened and confirmed by gas chromatography/mass spectrometry. The results showed 39% of sampled offenders showed measurable levels of cannabinoids, and 9.5% showed measurable levels of phencyclidine Sutton & Paegle 1992.

A study examined mandated sentencing to either jail or a certified driver intervention program (DIP) in Franklin County, Ohio in 1987 after their first drunken driving (DEI) conviction. Potentially important covariates were controlled for, such as gender, age, race, blood alcohol concentration, additional charges filed at the time of arrest, and driving history. DIP attendees had significantly lower rates of subsequent impaired driving. Drivers were significantly more likely to display additional impaired driving when jailed as opposed to those enrolled in a DIP. DIPs appeared most effective when used for persons who have not had previous alcohol-related crashes or driving offenses Orsay, Doan-Wiggins, Lewis, Lucke, & RamaKrishnan 1994.

2.6 How do “alternative consequences” work in child welfare populations?

The state may move to terminate parental rights if the drug or alcohol addiction has created an atmosphere where the parents have become unable to perform their parental duties and the child, as a result, has become grossly neglected. In such cases, the state can petition the court to show evidence that the child has been continually neglected or its well-being put in danger, and the option for parental rehabilitation and recovery has not been exercised (In re Michael C., 1992).

The court does not hastily terminate parental rights as soon as neglect or endangerment charges related to drugs or alcohol have been filed. The court is interested to know, and often inquires, how long it will take a parent to recover from addiction, and the potential for recovery, if any. To this end, a waiting period of “reasonable time” is necessary in the eyes of the law (In re M.K., 1991).

The courts carefully look into the following general rules: (a) as to whether the parent is unwilling or unable to protect the child from jeopardy. If those circumstances are unlikely to change, (b) whether the parent has been unwilling or unable to provide for the child's special needs, (c) whether the child has been abandoned or neglected or harmed, and (d) whether the parent has failed to cooperate and participate in a drug and alcohol rehabilitation program. After the above threshold is established, the courts will decide what would be in the best interest of the child and may proceed with the termination of parental rights (Elijah, R., 1993; T.C 1992). The law clearly stipulates consequences to refusing addiction treatment and subsequent recovery from alcohol/drugs, namely, loss of child custody. And, finally, the courts are not interested in whether there was “intent” to harm the child through parental alcoholism and addiction. As a state Supreme Court put it, “parental intent is irrelevant when the well-being of an infant is in danger” (K.G. v. Oklahoma, 1991).

In California, the Options for Recovery (OFR) treatment program provided an alternative to incarceration or relinquishing of custody of children for chemically dependent pregnant and parenting women. The 3-year pilot project offered alcohol and other drug abuse treatment and case management to these women, and included special training and recruitment of foster parents for their children. Findings from the study showed that women who were mandated to OFR treatment programs were more likely to successfully complete treatment than women who had enrolled in OFR voluntarily. An economic analysis of the costs associated with women in OFR compared with the combined costs of incarceration and alcohol and other drug abuse treatment produced a ratio in favor of OFR. Additionally, some innovative service alternatives for women mandated to treatment were developed during the project. The impact of such changes have important implications for improving women's and family health Berkowitz, Brindis, Clayton, & Peterson 1996 Kermani & Castaneda 1996.

2.7 How do “alternative consequences” work in public aid populations?

In order to ascertain the relative impact of coercion by a welfare program on retention in an ambulatory alcoholism program, records of 178 consecutive admissions to an inner-city alcoholism clinic were reviewed. Patients who came to the clinic via coerced referral from a public assistance agency were as likely to remain in treatment for at least nine sessions as self-referred patients Brizer, Maslansky, & Galanter 1990.

Characteristics of the first 20 women consecutively admitted for treatment for alcohol and polysubstance dependence following civil commitment by Massachusetts courts were studied. Women were diagnosed as either alcohol dependent (n = 12) or polysubstance dependent (n = 8). Alcohol-dependent women were older at initial alcohol use, onset of regular alcoholic use, first treatment admission, and at this admission.

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**References**


Brizer, Maslansky, & Galanter 1990. D.A. Brizer, R. Maslansky, M. Galanter; Treatment retention of patients referred by public assistance to an alcoholism clinic; American Journal of Drug and Alcohol Abuse; Vol. 16, 3/4; (1990), pp. 259-264.

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For the group as a whole, 75% had completed high school, 50% were divorced, and 35% were supported by public assistance. Seventy-five percent had a family history of alcoholism. This sample of women who received court-ordered alcohol and polysubstance dependence treatment had multiple social, psychological, legal, and health problems (Lex, Teoh, Lagomasino, Mello, & Mendelson, 1990).

We studied temporal patterns among service utilization, disability benefits (public aid and Social Security), and substance use. Specifically, we investigated whether the first day of the first week of each month (when disability payments were disbursed) was associated with increased emergency room (ER) use and more frequent cocaine use among psychiatric patients. All presentations to the psychiatric ER in 1993 to a hospital were reviewed \( n = 1,448 \), according to the week or each month in which they occurred. A random subsample of only those admitted to an inpatient psychiatric service \( n = 143 \) was further assessed for amount of disability payments received and recent cocaine use.

The results showed that of the total population of patients utilizing the ER, most ER visits occurred during the first week, followed by weeks 2, 3, and 4 respectively. The highest percentage (49%) of patients admitted during the first week of the month were cocaine users, followed by week 2 (39%), week 4 (28%), and week 3 (25%). For the subsamples of patients admitted to inpatient services, patients hospitalized during the fourth week of the month were those receiving the highest disability payments. The conclusion was that cocaine users have the most ER visits during the first week of the month following receipt of benefits. Current data, if confirmed, would suggest public policy changes, such as payment of entitlement money to known cocaine users through a third-party payee and stipulated treatment for psychiatric patients with substance use disorders as a condition of disability payment. Ethical and political issues including confidentiality and patient autonomy would need to be considered in any such policy changes (Grossman et al., 1997).

### 2.8 Is addiction treatment effective and cost beneficial, and for whom?

Studies have clearly demonstrated that addiction treatment is effective and cost beneficial in alcoholic and drug-addicted populations. Additional cost offsets were produced by decreases in motor vehicle accidents, work-site accidents, family violence, and work and school absenteeism and improved productivity.

Historically, addiction treatment has been marginalized and not integrated with the rest of the health care system. During the Clinton administration health care reform discussions, some “experts” erroneously considered that providing access to addiction treatment for all of those in need as too expensive. The available data actually show quite the contrary—that addiction treatment is effective and reduces health care costs, as well as other costs. Accurate data on treatment outcomes and costs must become widely available, so that informed and rational decisions about treatment can be made. The following section presents the results of several recent health care services research studies that unequivocally demonstrate the cost-effectiveness of addiction treatment.

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One of the most ambitious of these was a study of addiction treatment undertaken by the State of California Department of Drug and Alcohol Programs called the “CALDATA Study” \cite{Gerstein1994}. Researchers measured outcomes in 16 counties in California on 1,850 randomly selected participants in four types of treatment programs: residential, residential “social model,” outpatient, and outpatient methadone. Follow-up interviews were conducted after treatment. The findings showed that treatment was effective, in that alcohol and drug use was reduced by about two fifths. Only slight or no differences were found in treatment effectiveness for men and women, young and old, or among African Americans, Hispanics, and Whites. On the average, $1.00 of treatment costs saved at least $7.00 in other medical and social costs. The cost-to-benefit ratio was favorable for all treatment modalities: highest for methadone and lowest for “social model” residential treatment. Finally, criminal activity declined by about two thirds after treatment. The amount of decline was related to the amount of treatment.

Several other recent studies support the cost-effectiveness of substance abuse treatment. A Fortune 100 company that analyzed the savings of its EAP found the annual medical costs for workers with addictive illness fell from $2,068 per year to $165 per year after the employees received treatment. Even when treatment costs were added, the total health care cost savings was approximately $500 per employee. Moreover, indirect costs benefits are even greater—employee absenteeism was reduced and productivity increased.

While the preceding studies focused on the benefits of addiction treatment, in general, several studies have examined the cost-effectiveness of alcoholism treatment. \cite{Holder1992} conducted a longitudinal study of the effect of alcoholism treatment on health care costs in a population of workers. The researchers reviewed approximately 20 million health insurance claims filed by alcoholics identified over a 14-year period, and compared 3,068 alcoholic employees who received alcoholism treatment with 661 alcoholic employees who did not receive treatment. The results showed a significant 24% decline in posttreatment health care costs for the treated alcoholics, including the costs of treatment, as compared to the nontreated group.

The State of Minnesota offered managed, comprehensive addiction treatment to severe alcoholics who had exhausted their medical coverage. The cost of the treatment was $50 million. The program returned 80% of treatment utilization costs during the first year, and returned 100% of costs in 3 years \cite{Turnure1993}. \cite{Hoffmann1993} conducted a study of health care costs of 3,572 patients receiving alcoholism treatment between 1983 and 1986. The results showed that after treatment, there was significant decrease in health care costs, as compared to before treatment. The reduced costs were seen in both those who remained abstinent during the 2-year follow-up period and those who relapsed, although there was less of a decrease in costs for relapers.

\begin{thebibliography}{9}


\bibitem{Holder1992} Holder and Blose 1992. H.D. Holder, J.O. Blose; The reduction of health care costs associated with alcoholism treatment; A 14 year longitudinal study; Journal of Studies on Alcohol; Vol. 53, No. 4; (1992), pp. 293-302.

\bibitem{Turnure1993} Turnure 1993. C. Turnure; Minnesota Consolidated Fund, Annual Cost Offsets; Minnesota Department of Human Services, Minneapolis (1993). .


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3 Recommending options

3.1 What are possible future directions for coerced or alternative consequences to addiction treatment? Conclusions

The preponderance of the research literature confirmed efficacy and cost benefits from coerced addiction treatment or providing addiction treatment in lieu of alternative consequences. Providing alternative consequences appeared to motivate patients/clients to comply with addiction treatment. The lack of research that showed coerced addiction treatment to be ineffective or adversive was striking. No studies reported negative findings regarding having “consequences” for refusal of addiction treatment. In reality, consequences such as loss of benefits or incarceration appeared to motivate clients/patients to accept addictions treatment. Furthermore, the efficacy and benefits were clear and substantial (decreased medical costs and crime and improved psychosocial and employment status). The combination of the “carrot and the stick” appeared to work in diverse populations including employed, public aid, criminal, and other special groups.

Our clinical experience and research studies yield the following conclusions for the relevance of “alternative consequences.”

1. Coercion can be a therapeutic step in initiating treatment interventions and long-term recovery from alcohol and drug addiction.

2. Coercion if applied therapeutically can result in improved psychosocial status for patients and reduce costs from criminal, health, and employment consequences.

3. Coercion can work in most populations that contain patients with alcohol and drug disorders, (e.g., public aid, employed, criminal, child welfare).

4. Coercion can reduce illegal drug use, and consequent criminal activity in patients and those affected by them.

Some of the questions that remain are the following:

1. How do we implement coercion in various patient/client populations?

2. What are the most effective and realistic “alternative consequences” for patients?

3. How do we define favorable outcomes?

4. How can the state ensure fair applications of coercion in patient populations?

4 Improving alcoholism and drug treatment

Improving alcoholism treatment is an important priority. In this vein, the Institute of Medicine of the National Academy of Sciences conducted a comprehensive study of the alcohol treatment process and system, entitled Broadening the Basis of Treatment for Alcohol Problems Institute of Medicine 1990. The Institute of Medicine 1990. ; Broadening the Base of Treatment for Alcohol Problems; Report of a Study by a Committee of the Institute of Medicine, Division of Mental Health and Behavioral Medicine; National Academy Press, National Academy of Sciences, Washington, DC (1990), .

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conclusions emphasized that alcohol treatment was effective, but there was a need to improve the current alcohol treatment system in a cost-effective manner. The Institute of Medicine (IOM) report identified several areas of treatment that needed improvement. These included: (a) the need for improvements and standardization in the diagnosis and assessment of alcoholism; (b) the need for more community-based assessment and interventions; (c) the need to base treatment referrals and level of treatment on the assessments; (d) the need for improved linkages between primary care, community-based treatment, and specialized treatment services; (e) a treatment system that provides better continuity of care; (f) the need for adequate financing for a spectrum of treatment modalities and sites to match the diversity of the population; and (g) the elimination of organizational, personal, and regulatory barriers to the diagnosis and treatment of alcohol problems.

In response to the IOM report, several groups have developed guidelines for the development of model treatment systems to meet the diverse needs of patients with substance use disorders. In 1993, the American Society of Addiction Medicine (ASAM) developed Core Benefit requirements for addiction treatment. These include: (a) the need for and level of treatment must be a clinical judgment based on established criteria (such as the ASAM Patient Placement Criteria; American Society of Addiction Medicine 1992), with quality of care assured by appropriate review; (b) the concept that treatment for substance-related disorders should be included in any basic health benefit; (c) coverage should include a continuum of primary care and specialty services; (d) ongoing treatment evaluation, case management, and outcome studies should be an integral part of the ongoing evaluation of services; (e) eligibility should be based on competent diagnosis using objective criteria (e.g., Diagnostic and Statistical Manual of Mental Disorders, 4th ed.; American Psychiatric Association 1994 and ICD-9/10); (f) coverage should be nondiscriminatory on the same basis as other medical care; and (g) caps or limits on treatment should be applied on the same basis as other medical care. The need for a comprehensive treatment benefit package was also affirmed at a researchers' recent consensus conference.

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References


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Brizer, Maslansky, & Galanter 1990 Brizer, Maslansky, & Galanter 1990. D.A. Brizer, R. Maslansky, M. Galanter; Treatment retention of patients referred by public assistance to an alcoholism clinic; American Journal of Drug and Alcohol Abuse; Vol. 16, 3/4; (1990), pp. 259-264.


Turnure 1993 Turnure 1993. C. Turnure; Minnesota Consolidated Fund, Annual Cost Offsets; Minnesota Department of Human Services, Minneapolis (1993).


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Level 2 background checks of service provider personnel
Section 1. Chapter 397.4073 is amended as follows:

397.4073. Background Checks of service provider personnel.
(1) PERSONNEL BACKGROUND CHECKS; REQUIREMENTS AND EXCEPTION. –
(a) Background checks shall apply as follows:
1. All owners, directors, chief financial officers, and clinical supervisors of service providers are subject to level 2 background screening as provided under s. 408.809 and chapter 435. Inmate substance abuse programs operated directly or under contract with the Department of Corrections are exempt from this requirement.
2. All service provider personnel who have direct contact with children receiving services or with adults who are developmentally disabled receiving services are subject to level 2 background screening as provided under s. 408.809 and chapter 435.
3. All certified recovery residence owners, directors, chief financial officers, and certified recovery residence administrators are subject to level 2 background screening as provided under s. 408.809 and chapter 435.

Section 2. Chapter 397.487 is amended as follows:

397.487. Voluntary certification of recovery residences.
(6) All owners, directors, and chief financial officers of an applicant recovery residence are subject to level 2 background screening as provided under s. 408.809 and chapter 435. A recovery residence is ineligible for certification, and a credentialing entity shall deny a recovery residence’s application, if any owner, director, or chief financial officer has been found guilty of, or has entered a plea of guilty or nolo contendere to, regardless of

CODING: Words stricken are deletions; words underlined are additions.

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adjudication, any offense listed in s. 435.04(2) unless the
department has issued an exemption under s. 397.4872. In
accordance with s. 435.04, the department shall notify the
credentialing agency of an owner’s, director’s, or chief financial
officer’s eligibility based on the results of his or her background
screening.

Section 3. Chapter 397.4872 is amended as follows:

397.4872- Exemption from disqualification; publication.
(1) Individual exemptions to staff disqualification or
administrator ineligibility may be requested if a recovery
residence deems the decision will benefit the program. Requests
for exemptions must be submitted in writing to the department
within 20 days after the denial by the credentialing entity and
must include a justification for the exemption.
(2) The department may exempt a person from s. 397.487(6) and
397.4871(5) if it has been at least 3 years since the person has
completed or been lawfully released from confinement, supervision,
or sanction for the disqualifying offense. An exemption from the
disqualifying offenses may not be given under any circumstances
for any person who is a:
(a) Sexual predator pursuant to s. 775.21
(b) Career offender pursuant to s. 775.261; or
(c) Sexual offender pursuant to s. 943.0435, unless the requirement
to register as a sexual offender has been removed pursuant to s.
943.04354.
Model Deflection to Treatment Act

July 1, 2019.

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Model Deflection to Treatment Act

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SECTION I. SHORT TITLE.

This Act may be cited as the Model Deflection to Treatment Act (“Deflection Act” or “Act”).

SECTION II. LEGISLATIVE FINDINGS.

(a) Recent statistics show that many millions of Americans suffer from substance use disorder, mental health disorder, or both. According to the 2017 National Survey on Drug Use and Health, within the 12 months prior to survey response, 18.7 million Americans aged 18 or older had a substance use disorder, while 44.6 million had a mental health disorder.\(^1\) Out of these two groups, an estimated 8.5 million Americans aged 18 or older suffered from both.

(b) Meanwhile, as of September 2018, the United States’ estimated incarceration rate, 655 per 100,000 people, and total incarcerated population, more than 2.1 million, are both the highest in the world.\(^2\) If the number of adults under probation or parole is added to this number,\(^3\) the total number of people under some type of justice supervision in the United States is over 6.5 million.

(c) These problems are interrelated. The prevalence of substance use and mental health disorders are many times higher in incarcerated populations than the general population.\(^4\)


\(^4\) In data collected through National Inmate Surveys (NIS) in 2007 and 2008-09, researchers found that 58% of state prisoners and 63% of sentenced jail inmates met the criteria for drug dependence or abuse, compared to approximately 5% of the general population age 18 or older. Bronson, J. and Stroop, J. Drug use, dependence, and abuse among state prisoners and jail inmates, 2007-2009. Bureau of Justice Statistics, U.S. Department of Justice, Office of Justice Programs: NCJ 250546 (June 2017). The 2011-12 NIS shows 14% of prisoners and 26% of jail
(d) Law enforcement officers, traditionally given only two choices when encountering someone they believe may have a substance use or mental health disorder—arrest, or not arrest and do nothing more—now are encouraged to use alternative approaches, such as deflection to community-based treatment programs. Indeed, the International Association of Chiefs of Police recommends that for minor offenses and noncriminal behavior “[l]aw enforcement agencies should empower police officers . . . to use alternative remedies such as drug and alcohol treatment, hospitalization, and other diversionary programs, when appropriate, as these outlets can simultaneously help citizens, save money, and reduce recidivism.”

(e) Deflection programs provide a relatively new option to law enforcement that allows them to connect people with community-based substance use, mental health, and case management services that address their underlying problems rather than involving the justice system. In 2015, it was estimated that U.S. law enforcement had over 42 million personal encounters with people annually that do not result in incarceration; countless millions of these are opportunities to make a difference.

(f) Deflection programs are still in their infancy and are considered to have formally begun in 2011. Since then, over 750 known deflection programs exist in the United States, with almost all the growth (600+ sites) having occurred only since 2015. The scale and scope then of deflection as it continues to grow as a new field of practice offers exciting opportunities for communities to use to address other human service needs beyond

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6 Davis, E. et al., *Contacts Between Police and the Public, 2015*. Bureau of Justice Statistics, U.S. Department of Justice, Office of Justice Programs: NCJ 251145 (October 2018) (estimating 53.5 million total encounters, out of which 12 million result in jail incarceration).

7 Police Treatment and Community Collaborative, Field-Wide Deflection National Overview, April 2019.
substance use disorders and mental illness.

SECTION III. PURPOSE.

The [state legislature] acknowledges that substance use and mental health disorders, overdoses, and the deaths that result are persistent and growing concerns for [state] communities. Due to their constant presence in the community interacting with the public, law enforcement officers have a unique opportunity to facilitate connections to community-based behavioral health interventions that provide substance use disorder and mental health treatment and can help save and restore lives; help reduce substance use, overdose incidence, criminal offending, and recidivism; and help prevent arrests and convictions that destabilize health, families and communities, as well as increase self-sufficiency. These efforts are bolstered when pursued in partnership with licensed behavioral health treatment providers and community members or organizations. Consistent with the specific inclusion of deflection as part of the National Drug Control Strategy\(^8\), it is the intent of the [state legislature] to authorize law enforcement to develop and implement collaborative deflection programs in [state] that offer immediate pathways to substance use disorder treatment, mental health treatment and other services for individuals in need of treatment including, where appropriate, as an alternative to traditional case processing and involvement in the criminal justice system.

SECTION IV. DEFINITIONS.

(a) For the purposes of this Act, unless the context clearly indicates otherwise, the words and phrases listed below have the meanings given them in this Section.

(b) Case management.— “Case management” means those services that assist persons suffering from substance use or mental health disorder in gaining access to needed treatment, as well as social, educational, medical, housing, vocational and other

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services. This includes but is not limited to conducting screenings and assessments, determining the diagnoses and appropriate level of care, maintaining client engagement, navigating and gaining access to various treatment modalities and community services, monitoring progress, advocating for the client, and communicating within and between systems of service providers and program partners.

(c) Community member or organization.— “Community member or organization” means an individual volunteer, resident, public office, or a not-for-profit organization, religious institution, charitable organization, or other public body committed to the improvement of individual and family mental and physical well-being and the overall social welfare of the community, and may include persons with lived experience in recovery from substance use or mental health disorder, either themselves or as family members.

(d) Community service.— “Community service” means any service accessible in a local community setting, excluding treatment, that strives to assist a person in resolving an issue, problem or challenge they are facing, such as housing, employment, vocational, food, and other social determinants needed for long term recovery and social integration. The issue, problem or challenge may be acute or chronic, and need not be clinical in nature.

(e) Deflection program.— “Deflection program” means a program in which a peace officer or member of a law enforcement agency facilitates contact between an individual and a licensed substance use disorder or mental health treatment provider in the form of a “warm handoff” for assessment and coordination of treatment planning. This facilitation includes defined criteria for eligibility and communication protocols agreed to by the law enforcement agency and the licensed treatment provider for the purpose of providing substance use disorder or mental health treatment to those persons. In some instances, this referral to treatment occurs in lieu of arrest or to prevent justice system involvement. Deflection can also include connections to housing and social services. Deflection programs should incorporate, but are not limited to, one or more of the following types of responses:

(1) a post-overdose deflection response (also called “naloxone plus,” for
administration of naloxone plus treatment) initiated by a peace officer, law enforcement agency subsequent to emergency administration of medication to reverse an overdose, or in cases of severe substance use disorder with acute risk for overdose followed up promptly by rapid and closely-coordinated integration with treatment, peers, or recovery to facilitate the most rapid engagement possible;

(2) a self-referral deflection response initiated by an individual who contacts a peace officer or law enforcement agency in the acknowledgment of their substance use or mental health disorder without fear of arrest;

(3) an active outreach deflection response initiated by a peace officer or law enforcement agency as a result of proactive identification of persons thought likely to have a substance use or mental health disorder without fear of arrest or coercion for investigative purposes as a result of being contacted;

(4) an officer prevention deflection response initiated by a peace officer or law enforcement agency in response to a community call or “on view” when no criminal charges are present; and

(5) an officer intervention deflection response, initiated by a peace officer or law enforcement agency in response to a community call or “on view” when criminal charges would be founded but are held in abeyance pending engagement with treatment.

(f) Evidence-based.— “Evidence-based” means established by research as effective in achieving long-term recovery for those with substance use disorder.

(g) Law enforcement agency.— “Law enforcement agency” means a municipal police department or county sheriff’s office of [state], the [state department of police], or other law enforcement agency whose officers, by statute, are granted and authorized to exercise powers similar to those conferred upon any peace officer employed by a law enforcement agency of [state].
(h) Mental health disorder.— “Mental health disorder” means any mental illness that is
diagnosable currently or within the past year and of sufficient duration to meet diagnostic
criteria specified within the 5th edition of the Diagnostic and Statistical Manual of Mental
Disorders (DSM-5) but excludes developmental and substance use disorders.

(i) Peace officer.— “Peace officer” means any peace officer or member of any duly organized
state, county, or municipal peace officer unit, any police force of [state], or any police force
or sheriff’s department whose members, by statute, are granted and authorized to exercise
powers similar to those conferred upon any peace officer employed by a law enforcement
agency of [state].

(j) Recovery community.— “Recovery community” means the community of people in
recovery from substance use disorder and their family, friends, and allies, including
volunteers who might assist with deflection efforts, as well as peer recovery specialists who
are trained and often certified to perform professional recovery services and support for
those in recovery.

(k) Single state authority on drugs and alcohol.— “Single state authority on drugs and alcohol”
means the state agency designated by the [state] governor to plan, manage, monitor,
coordinate and evaluate substance use disorder treatment and recovery support services in
the state, and to administer the federal Substance Abuse Prevention and Treatment Block
Grant.

(l) State administering agency on criminal justice.— “State administering agency on criminal
justice” means the state agency designated to set priorities and allocate Bureau of Justice
Assistance Office of Justice Program funding within that state.

(m) State mental health agency.— “State mental health agency” means the state agency
responsible for assuring that children, adolescents and adults, throughout the state have the
availability of and access to public-funded mental health services for those who are
diagnosed with a mental health disorder or emotional disturbance and an impaired level of
functioning based on a mental health assessment.
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(n) Substance use disorder.— “Substance use disorder” means a pattern of use of alcohol or other drugs leading to clinical or functional impairment, in accordance with the definition in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–5), or in any subsequent editions.

(o) Treatment.— “Treatment” means the treatment for substance use disorder or mental health disorder with a treatment provider in accordance with an individualized assessment and clinical placement criteria, with care that includes assessment, diagnosis, case management, medical, psychiatric, psychological and social services, medication-assisted treatment, counseling, and recovery support services that is extended to persons with substance use disorder, mental health disorder, or to their families, including children.

(p) Treatment provider.— “Treatment provider” means any substance use disorder or mental health disorder treatment facility or program that is [licensed], [certified], or [approved] by [the state] to provide comprehensive substance use disorder or mental health disorder treatment and recovery support services, with or without the support of medications, in a hospital, non-hospital residential, or outpatient basis. The term also includes any physician with expertise in providing or coordinating access to comprehensive withdrawal management, medication, counseling, and long-term recovery support services.
SECTION V. AUTHORIZATION.

(a) In general.— Any law enforcement agency may establish a deflection program subject to the provisions of this Act in partnership with one or more from each of the categories: treatment providers, case management providers, community members, and organizations or other key stakeholders as advisable to carry out its program.  

(b) Program components.— The deflection program should include at least one of the following: a post-overdose deflection response, a self-referral deflection response, an active outreach deflection response, an officer prevention deflection response, or an officer intervention deflection response.

(c) Additional responses.— Nothing in this Act precludes a law enforcement agency from developing a deflection program response based on a model unique and responsive to local issues, substance use or mental health disorder needs and partnerships, using sound and promising, or evidence-based, practices.

(d) Case management.— Whenever appropriate and available, case management should be provided by a licensed provider or other appropriate provider and may include recovery support services.

(e) Requirements for funding.— In order to receive funding for activities as described in Section IX of this Act (“Funding”), planning for the deflection program shall include:

1. the involvement of one or more from each of the categories: treatment providers, case management providers, community members or organization, and other key stakeholders as required to carry out its program; and
2. an agreement with the single state authority on drugs and alcohol, state mental health agency, and state administering agency on criminal justice to share, collect

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9 The key stakeholders will differ somewhat depending on both the type(s) of deflection program being established, as well as the structure of and interrelationship between local agencies. For example, for the “naloxone plus” deflection pathway described in Section IV(e)(1), first responders are certainly key stakeholders. For the pathway described in Section IV(e)(5), key stakeholders include state and local prosecutors. In addition, once a program is defined, the key stakeholders and funded activities become clearer.
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and use relevant statistical data related to the program for performance measurement, as established by the single administering agency on criminal justice in paragraph (2) of subsection (a) of Section VII of this Act (“Reporting and Performance Measurement”).

SECTION VI. PROCEDURE.

(a) In general.— The law enforcement agency, treatment providers, case management providers, and community members or organizations shall establish a local deflection program plan that includes protocols and procedures for participant identification, screening, and if needed based on the screening, assessment, treatment facilitation, reporting, and ongoing monitoring of the program participants, including which partners will perform these functions.

(b) Confidentiality.— In order to promote successful treatment and recovery outcomes, treatment providers and case management providers shall share information with other entities participating in the deflection program, in adherence to applicable privacy and confidentiality laws and regulations for information exchange or release. Such laws include:

(1) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191 (Aug. 21, 1996);

(2) 45 C.F.R. parts 160 and 164 (HIPAA Privacy and Security Rules);

(3) federal confidentiality law and regulations, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2;

(4) any relevant state law related to the privacy, confidentiality, and disclosure of protected health information, including but not limited to protected information concerning substance use and mental health disorders; and

(5) any policies or regulations of the single state authority on drugs and alcohol and state mental health agency governing the care of protection of client information.
SECTION VII. REPORTING AND PERFORMANCE MEASUREMENT.

(a) In general.— The state administering agency on criminal justice, in conjunction with the single state authority on drugs and alcohol, state mental health agency, state health department, an association representing [state] police chiefs, and the state department of human services [division/bureau/office for mental health], shall within six (6) months of the effective date of this Act: 10

(1) develop a standardized set of minimum data to be collected from each state-funded deflection program and reported annually, beginning one year after the effective date of this Act, by the single state authority on drugs and alcohol, state mental health agency, and state administering authority, including, but not limited to, demographic information on program participants, number of law enforcement encounters that result in a substance use disorder treatment referral, the number of such encounters that result in a mental health referral, and time from law enforcement encounter to treatment engagement; and

(2) develop a performance measurement system, including key performance indicators for deflection programs including, but not limited to, rate of treatment engagement at [X, Y, and Z,] days from the point of initial contact. Each program that receives funding for services under Section IX of this Act (“Funding”) shall include the performance measurement system in its local plan and report data quarterly to the state administering authority on criminal justice for the purpose of performance measurement of deflection programs in aggregate.

(b) The state administering authority on criminal justice shall make statistical data collected under subsection (a) of this Section available to the single state authority on drugs and alcohol, state mental health agency, state health department and the state department of

10 Information useful for the development required by paragraphs (a)(1) and (a)(2) can be found in PTACC’s Core Measures of Deflection, at https://www.theiACP.org/sites/default/files/all/p-r/PTACCoreMeasuresMarch2018.pdf (last accessed June 17, 2019).
human services [division/bureau/office for mental health] for inclusion in planning efforts for services to persons with criminal justice or law enforcement involvement.

SECTION VIII. EXEMPTION FROM CIVIL LIABILITY.

A law enforcement agency, peace officer, treatment provider, case management provider or community member or organization acting in good faith shall not, as the result of acts or omissions in providing services under Section V of this Act (“Authorization”), be liable for civil damages, unless the acts or omissions constitute willful and wanton misconduct.

SECTION IX. FUNDING.

(a) In general.— The [state legislature] may appropriate funds to the state administering agency on criminal justice for the purpose of funding services provided as part of deflection programs subject to subsection (d) of Section V of this Act (“Authorization”).

(b) Guidelines and requirements.— The state administering agency on criminal justice may adopt guidelines and requirements to direct the distribution of funds for expenses related to deflection programs. Funding shall be made available to support both new and existing deflection programs in a broad spectrum of geographic regions in [state], including urban, suburban, and rural communities.

(c) Eligible activities.— Activities eligible for funding under this Act may include, but are not limited to, the following:

(1) activities related to program administration, coordination, or management, including, but not limited to, the development of collaborative partnerships with treatment providers and community members or organizations; collection of program data; or monitoring of compliance with a local deflection program plan;

(2) case management including case management provided prior to assessment, diagnosis, and engagement in treatment, as well as assistance navigating and gaining access to various treatment modalities and support services;
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(3) Training of law enforcement officials in how to recognize and constructively engage those with substance use disorder needs and those with mental health needs to encourage them to seek treatment and other services;
(4) recovery support services that include the perspectives of persons with the experience of recovering from a substance use disorder, either themselves or as family members;
(5) transportation to a licensed treatment provider or other program partner location;
(6) program performance measurement activities;
(7) treatment; and
(8) harm reduction services, including providing naloxone.

(d) Program protocols.— Program service protocols should require specific memoranda of understanding, linkage agreements, and other necessary contracts with partners and third parties responsible for one or more program components.
(e) Family involvement.— All deflection programs shall encourage the involvement of key family members and significant others as a part of a family-based approach to treatment.
(f) Evidence-based.— All deflection programs are encouraged to refer to evidence-based practices and long-term outcome measures in the provision of substance use and mental health disorder treatment, which includes, where clinically appropriate, medications for persons suffering from substance use or mental health disorder.

SECTION X. RULES AND REGULATIONS.

State agencies and officials shall promulgate rules and regulations necessary to implement their responsibilities under this Act.
SECTION XI. SEVERABILITY.

If any provision of this Act or application thereof to any individual or circumstance is held
invalid, the invalidity does not affect other provisions or applications of the Act that can be
given effect without the invalid provisions or applications, and to this end, the provisions of
this Act are severable.

SECTION XII. EFFECTIVE DATE.

This Act shall be effective on [specific date or reference to normal state method of
determination of the effect.]
Model Universal Access to Naloxone Act
(Third Edition)

July 1, 2019.

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(Third Edition)\(^1\)

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SECTION I. SHORT TITLE.

This Act is known and may be cited as the “Model Universal Access to Naloxone Act” (the “Act”).

SECTION II. LEGISLATIVE FINDINGS.

(a) The United States and [name of state] is encountering the worst opioid overdose epidemic in its history.

(b) Many opioid-related overdose deaths are preventable if naloxone, a U.S. Food and Drug Administration (FDA)-approved opioid overdose reversal medication, is readily available to, and carried by, all first responders and a greater number of other residents of [state].

(c) In use for more than 40 years, naloxone is non-addictive and has no known potential for abuse. Naloxone can be administered easily by nearly anyone, with minimal instruction. Overdose education and naloxone distribution programs that train residents in identifying overdoses and responding with naloxone can effectively reduce opioid overdose death rates. Moreover, the distribution of naloxone for administration by non-medical experts

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2 As of 2018, many state laws providing increased access to naloxone refer to the drug in terms other than “naloxone” or “naloxone hydrochloride.” Such terms include “opioid antagonist”, “opiate antagonist”, “opioid antidote”, “opioid overdose drug”, “opioid overdose medication”, and “overdose intervention drug.” NAMSDL uses “naloxone” in this Model Act because naloxone itself has been the exclusively used opioid overdose reversal drug for 40 years. Presumably, states using a term other than naloxone do so to avoid a need to amend their laws if a reversal drug other than naloxone becomes widely used. NAMSDL, however, believes that the benefit of introducing a new, and potentially confusing, term is outweighed by simplicity and the wide public awareness of naloxone. Moreover, the term “opioid antagonist” appears to be overbroad, since it would also include naltrexone, which is not used to reverse opioid overdoses. The term “opiate antagonist” is, in addition to being overbroad for that reason, is also too narrow since many overdoses are due to synthetic opioids, not opiates. Finally, Section XIV of the Model Act provides that in the event that a new opioid overdose reversal drug is approved, the provisions of the Act are applicable to such drug for a period of two years.


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can be highly cost-effective.6

(d) All 50 states and the District of Columbia have enacted laws designed to improve access to naloxone.7 Studies show that implementation of these laws reduce overdose deaths.8 In 2018, the U.S. Surgeon General urged individuals who are personally at risk for an opioid overdose, the family and friends of such individuals, and any individuals who may encounter those experiencing opioid overdose, to keep doses of naloxone on hand at all times.9

(e) Despite these efforts, too few community members are aware of the important role that naloxone plays in saving the lives of people suffering an opioid overdose. In addition, the cost of naloxone is a barrier to some individuals accessing the medication in an easily usable form.10

addition, preliminary data arising out of a naloxone distribution collaborative formed in Hamilton County (Ohio) in late 2017 is positive. Over the first few months of 2018, the data shows a decrease in overall deaths, emergency medical service calls for overdoses, and emergency room visits for overdoses as compared to a similar timeframe in 2017. These decreases are coupled with an increase in patients seeking treatment for opioid addiction. Terry DeMio, Huge Narcan influx, treatment boost contributes to OD death drop in Hamilton County, The Cincinnati Inquirer (June 14, 2018), https://www.cincinnati.com/story/news/2018/06/14/naloxone-treatment-push-contributes-plummeting-od-deaths/697336002/.


10 In April 2018, several U.S. Senators called upon the Secretary of the U.S. Department of Health and Human Services to negotiate “a lower price for easy to administer naloxone combination products,” noting that “Narcan, which delivers naloxone as a nasal spray, costs $150 for a two pack and Evzio, a hand-held auto-injector, increased in price from $690 in 2014 to more than $4,000 today for a two pack.” Letter to the Honorable Alex Azar from sixteen U.S. Senators (April 18, 2018), https://www.petersenate.gov/download/41818-letter-on-secretary-azar-on-naloxone-prices.
SECTION III. PURPOSE

The purpose of the Act is to help save the lives of individuals who have experienced opioid-related overdoses so that they can live and seek recovery. The Act requires the issuance of a standing order that authorizes the distribution to and administration of naloxone by everyone in [state], any of whom could find themselves in a position to assist an individual experiencing an opioid-related overdose.11 In so doing, the Act creates the broadest possible access to the lifesaving medication.12 In addition, the Act ensures comprehensive financial support for the activities authorized by this Act under Medicaid, commercial insurance, and state funding mechanisms.

SECTION IV. DEFINITIONS.

(a) For the purposes of this Act, unless the context clearly indicates otherwise, the following words and phrases shall have the meanings given them in this Section.

(b) Co-prescribe.— “Co-prescribe” means, with respect to naloxone, the practice of prescribing the drug in conjunction with an opioid prescription.

(c) Community-focused organization.— “Community-focused organization” means any organization or health agency that seeks to distribute naloxone to community members.

(d) Dispenser.— “Dispenser” means any entity that is licensed, certified, or otherwise authorized by [state] to dispense prescription drugs, including naloxone. Dispensers include pharmacists, pharmacies, and dispensing practitioners licensed, certified, or otherwise authorized by [state]. Dispensers, for purposes of this Act, do not include individuals, recovery community, or other community-focused organizations granted authority to store and distribute naloxone solely by authority of this Act.

11 It is important to note here that naloxone alone may not be sufficient to address all overdoses since multiple drugs, including non-opioid substances (e.g., methamphetamine or cocaine) may be involved. Other lifesaving actions will be necessary at times. This is yet another reason why, as stated throughout the Act, it is always essential that emergency medical services be called.

12 In addition to this Act, NAMSDL has promulgated the Model Act Providing for the Warm Hand-off of Overdose Survivors to Treatment. This Act provides for a collaborative and robust intervention mechanism to intervene with, assess, and refer overdose survivors to appropriate addiction treatment services. Likewise, NAMSDL has developed Good Samaritan legislation to encourage all individuals who witness an overdose to summon emergency assistance.
(e) First responder.— “First responder” means a law enforcement officer, firefighter, emergency medical services provider, or other individual who, in an official capacity, responds rapidly to an emergency or critical incident. This includes such individual working in an official capacity on a volunteer basis.

(f) Naloxone.— “Naloxone” means naloxone hydrochloride, which binds to an individual’s opioid receptors and blocks the effects of the opioid acting on those receptors, and is approved by the federal Food and Drug Administration (FDA) for the emergency treatment of a known or suspected opioid overdose.

(g) Opioid.— “Opioid” means a class of drugs that: (1) are opiates or synthetic narcotics that resemble opiates; and (2) interact with opioid receptors on nerve cells in the body and brain.13

(h) Opioid-related overdose.— “Opioid-related overdose” means an acute condition evidenced by symptoms including, but not limited to, physical illness, coma, decreased level of consciousness, or respiratory depression, resulting from the consumption or use of an opioid or another substance with which an opioid is combined.

(i) Prescriber.— “Prescriber” means an individual licensed, certified, or otherwise authorized by [state] to prescribe prescription drugs, including naloxone.

(j) Public place.14— “Public place” means a physical location within [state]: (1) in which the public is invited or in which the public is permitted; and (2) whose owners or operators operate it as one or more of the following: bank, bar, restaurant, educational building, dorm, library, doctor’s office, dentist’s office, health care facility, laundromat, homeless shelter, fitness center, gym, grocery store, indoor arena, outdoor spectator venue, shopping mall, retail store, government office building, hotel, and theater.


14 Compare the definition of “public place” found in Rhode Island House Bill 5551, 2019 session (“Naloxone Public Access Program”), in which “public place” is defined as “an enclosed area capable of holding one hundred (100) people or more and to which the public is invited or in which the public is permitted.” Using an enumerated list for the definition has the advantage of making the requirement in subsection X(b) apply by category of facility. Upon implementation at the state level, states may choose different terminology for the categories, based on common regional verbiage and desired scope of the requirement.
(k) Standing order.— “Standing order” means a prewritten, non-individual specific order issued by a prescriber that authorizes the dispensing, distribution or administration of a drug by any individuals.

SECTION V. STATEWIDE STANDING ORDERS.

(a) In general.— The [insert appropriate state medical professional with prescribing authority, e.g., surgeon general, physician general] shall issue one or more standing orders for the dispensing, distribution, and administration of naloxone covering any individual seeking naloxone within [state].

(b) Purpose and authorization.— Standing orders issued under this section are for a legitimate medical purpose in the usual course of professional practice and shall authorize individuals, recovery community and other community-focused organizations to obtain, store, and distribute naloxone, as provided for by this Act.

(c) Order specification.— The standing order under subsection (a) shall specify, at a minimum:

(1) The naloxone formulations that are FDA-approved for community use15;
(2) Any recommended instruction for the individuals to whom the naloxone is dispensed or distributed; and
(3) Information about:
   (A) signs and symptoms of an opioid-related overdose;
   (B) proper administration of naloxone;
   (C) proper care of an individual to whom naloxone has been administered;

15 The phrase “FDA-approved for community use” refers to the terminology used by the FDA in recent presentations and press releases referring to the general public’s use of naloxone formulated as a nasal spray or auto-injector. As an example, page 17 of the FDA’s October 2016 presentation entitled “Clinical and Regulatory Perspectives on Naloxone Products Intended for Use in the Community,” (available at https://www.fda.gov/media/100648/download) describes nasal spray and auto-injector formulations as “naloxone products approved for community use.” This is in contrast to naloxone iterations administered in “off label” fashion, primarily via injectable syringe and atomizer. Our intent in using the “approved for community use” language in this Act is to require that standing orders specify, and insurers provide coverage for, naloxone formulations that require no special training for the public to use. Our use of this phrase does not suggest that a particular brand name naloxone formulation must be used, and in fact includes generic forms of nasal sprays and auto-injections as they become available.
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(D) procedures for summoning emergency medical assistance.  

(d) The [Pharmacy Board or other agency regulating pharmacies in the state] shall ensure that all pharmacies are notified of the legal requirements of this Act, and shall establish fines and fees for failure to recognize and fill a prescription for naloxone, either under an individual prescription or under the standing order set forth in this section, as provided for in Section X(a) of this Act (“Naloxone Supply and Location”).

(e) Effective period.— Any standing order issued pursuant to subsection (a) shall remain in effect for two (2) years from the date of issuance.

(f) Renewal.— Prior to the end of the two-year period of any standing order, the [appropriate state medical professional with prescribing authority] shall renew the order for two (2) additional years, unless there is no longer any significant public health benefit for renewal.

SECTION VI. CO-PRESCRIBING OF NALOXONE.

(a) Co-prescribing naloxone in conjunction with opioid prescription.—

(1) In general.— Prescribers within [state] shall co-prescribe naloxone when prescribing a schedule II, III, or IV opioid to a patient if any of the risk factors in subsection (b) are present.

(2) Risk factors.— Pursuant to subsection (a), naloxone must be co-prescribed to a patient if any of the following are present:

(A) a history of substance use disorder;

(B) high dose or cumulative prescriptions that result in over 50 morphine milligram equivalents (MME) per day;

(C) concurrent use of opioids and benzodiazepine or non-benzodiazepine sedative hypnotics; or

(D) other factors, such as drug using friends/family, which is consistent with the recommendations in the Centers for Disease Control and Prevention Guideline for

16 For example, Substance Abuse and Mental Health Services Administration, Opioid Overdose Prevention Toolkit: Five Essential Steps for First Responders, supra note 11.
Prescribing Opioids for Chronic Pain (CDC Guideline).17

(b) Education.—

(1) Medical, dental, nursing [and physician’s assistant] schools.— Each medical, dental, nursing [and physician’s assistant] school operating in [state] must require that all students who are training for health care positions with prescribing authority are trained on the co-prescribing of naloxone to patients with the risk factors identified in subsection (a).

(2) Continuing medical education.— All prescribers in [state] must receive at least one (1) hour of training on the co-prescribing of naloxone to patients with the risk factors identified in subsection (a).

SECTION VII. DIRECT PRESCRIBING AND DISPENSING OF NALOXONE.

(a) In general.— Notwithstanding the presence or lack of a statewide standing order as described in Section VI, prescribers may prescribe, and dispensers may dispense, naloxone formulations that are FDA-approved for community use directly to any individual, and recovery community or other community-focused organization. A prescription issued under this Section is for a legitimate medical purpose in the usual course of professional practice.

(b) Provision of information.— A prescriber who directly prescribes or dispenses naloxone pursuant to subsection (a) shall provide that recipient with information regarding:

(1) signs and symptoms of an opioid-related overdose;

(2) proper administration of naloxone;

(3) proper care of an individual to whom naloxone has been administered; and

17 CDC Guideline 8 provides that “[c]linicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.” Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1. This Act takes the next step by requiring co-prescription of naloxone in those circumstances, as opposed to only recommending consideration of it.
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(4) procedures for summoning emergency medical assistance.

SECTION VIII. DISTRIBUTION OF NALOXONE BY FIRST RESPONDERS AND CORRECTIONAL FACILITIES.

(a) In general.— State and municipal first responders may distribute naloxone in an FDA-approved indication currently available as a nasal spray, an auto-injector, or both, to an individual or to the individual’s family member, friend, or other person, along with instructions on the administration and use of the naloxone, to provide opioid overdose protection to the individual, if, in the good faith judgment of the first responder, the individual is at risk of experiencing an opioid overdose.

(b) Good faith judgment.— In distributing naloxone pursuant to subsection (a), first responders shall exercise their good faith judgment based on their experience, training, knowledge, observations, and information provided by the individual or by the individual's family, friend, or others with knowledge of the individual's opioid use.

(c) Availability of naloxone in correctional facilities.— All state and county correctional officers shall have naloxone readily available at all times while on duty, and shall be trained in the following:
(1) signs and symptoms of an opioid-related overdose;
(2) proper administration of naloxone;
(3) proper care of an individual to whom naloxone has been administered; and
(4) procedures for summoning emergency medical assistance.

(d) Release of inmates with substance use disorder.— Prior to the release of any state correctional or county jail inmate with a history of substance use disorder, the inmate and his or her immediate family member must be offered naloxone and instruction on the administration and use of the naloxone. The inmate’s or the family’s decision to accept such naloxone and instruction, and the providing of such naloxone and instruction, may not delay, in any way, the date and time the inmate otherwise would be released.
(e) Bulk purchasing programs.—Naloxone manufacturers and distributors doing business in [state] must establish a discounted bulk purchasing rate for FDA-approved naloxone currently available as a nasal spray, an auto-injector, or both, with the [state department of health, single state authority for drugs and alcohol, or other appropriate entity] in order to facilitate the distribution of naloxone by first responders, state correctional facilities and others.

SECTION IX. POSSESSION, DISTRIBUTION AND ADMINISTRATION OF NALOXONE BY INDIVIDUALS AND RECOVERY COMMUNITY OR OTHER COMMUNITY-FOCUSED ORGANIZATIONS.

(a) Possession of naloxone.— Notwithstanding any other law or regulation to the contrary, individuals and recovery community or other community-focused organizations receiving naloxone may possess and store the drug.

(b) Distribution of naloxone.— Under any standing order or prescription issued pursuant to this Act, recovery communities or other community-focused organizations that possess naloxone may distribute the drug to other individuals. When doing so, recovery communities or other community-focused organizations may not require recipients to provide personal identifying information about those who receive the naloxone.

(c) State storage laws.—The storage of naloxone pursuant to this section is not subject to [state] pharmacy practice laws or other [state] requirements that apply to the storage of drugs or medications.

(d) Administration of naloxone.— An individual to whom naloxone is dispensed or distributed pursuant to this Act may administer the drug to anyone that the recipient reasonably believes to be experiencing an opioid-related overdose. The individual administering naloxone shall be immune from civil and criminal liability, and is not subject to adverse professional action, for the good faith administration of the drug.

(e) Medical assistance.— Individuals who summon emergency medical assistance contemporaneously with administering naloxone pursuant to subsection (d) shall, in addition to the protections afforded under that subsection, receive the protections
afforded by [insert citation to appropriate state Good Samaritan provisions pertaining to overdoses].

SECTION X. NALOXONE SUPPLY AND LOCATION.

(a) Pharmacies.—

(1) In general.— All pharmacies licensed, certified, or otherwise authorized to do business in [state] shall dispense naloxone to an individual, recovery community, or community-focused organization pursuant to either a traditional or non-individual specific prescription within one (1) business day of the request. 18

(2) Prominent posting of standing order.— All pharmacies shall prominently post for public view notice that naloxone is available to all members of the public based on the standing order issued pursuant to Section V. Such postings shall be in English and in any other language commonly spoken by pharmacy customers. Such notices shall be approved by the [Pharmacy Board or other state agency regulating pharmacies]. The [Pharmacy Board or other state agency regulating pharmacies] shall establish a per-day fine for failure to post such notice in compliance with this Act.

(3) Use on others.— When dispensing naloxone pursuant to paragraph (a)(1), no pharmacy licensed, certified, or otherwise authorized to do business in [state] may collect or require to be disclosed any information about the person or persons for whom the customer may be seeking to obtain naloxone.

(4) Rules and regulations.— The [state department/agency that oversees pharmacies] shall implement appropriate rules and regulations to enforce this requirement. Notwithstanding [statutory section that describes the requirements for the administrative rule writing process], the [state department/agency that oversees pharmacies] is not required to provide evidence that promulgating a rule under this subsection as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated

18 An example of proposed state legislation requiring pharmacies to stock naloxone and penalizing them for failing to comply is New Jersey Senate Bill 3515, introduced in March 2019. The bill provides that a first offense is a warning (from the state board of pharmacy) followed by a civil penalty of $250 for a second or subsequent offense (with each day constituting a separate offense).
under this subsection.

(b) Public places — Any person or entity who owns or operates a public place, as defined in this Act, is encouraged to provide and maintain:

(1) On-site, functional naloxone boxes containing a supply of naloxone in quantities and types, deemed by [the state director of health] to be adequate, to ensure ready and appropriate public use during emergencies at or in the vicinity of the public place; and

(2) At least one person in each public place who is trained in the administration of naloxone, or where the public place is not usually staffed, prominently posted instructions in the operation and use of naloxone. Such instructions shall be in the language or languages known by the operators of the public place to be in common use at that location.

(c) Substance use disorder treatment programs and recovery homes.—

(1) In general.— Any person or entity who owns or operates a substance use disorder treatment program or recovery home shall provide and maintain:

(A) On-site, functional naloxone in quantity and type, deemed by the [state substance use disorder treatment program licensing agency] or [the agency or entity that certifies recovery homes] to be adequate, to ensure ready and appropriate public use during emergencies at or in the vicinity of the treatment program or recovery home; and

(B) At least one person who is trained in the operation and use of naloxone.

(2) Discharge of patients.— Any person or entity who owns or operates a substance use disorder treatment program shall offer naloxone, and instructions for its use, to a patient in recovery from opioid use disorder at the time of the patient’s discharge from the program.

19 Subsection (b) and the framework of subsection (c) are conceptually derived from Rhode Island House Bill 5551, 2019 session ("Naloxone Public Access Program"). At this time, the Act does not require "public places" to carry naloxone for public use. However, states could consider a mandatory supply provision for some more high-risk categories listed under the "public place" definition.

20 There are anecdotal reports of facilities refusing to allow their naloxone to be used by individuals outside the facility who are overdosing. Given that such individuals are at grave risk of death, this Act strongly encourages the use of naloxone whenever and wherever it is needed and discourages the morally reprehensible refusal to use one’s available naloxone while a fellow human in the vicinity may be dying of an overdose.
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(d) Registration.— Upon providing and maintaining naloxone supplies as required by subsections (b) and (c), the person or entity who owns or operates the public place, substance use disorder treatment program or recovery home shall register the location or locations of naloxone in, and actively participate with, the computer or phone application designated pursuant to Section XII(b)(5) (“Public Education Programs.”) including providing the hours the public place is open, the address and site coordinates of the public place, and where available, a contact person at the public place.

(e) Naloxone supply.— The [state department of health, single state authority for drugs and alcohol or other appropriate agency] is directed to provide, or prioritize funding for, the naloxone supplies utilized pursuant to subsections (b) and (c) of this section.

SECTION XI. IMMUNITY.

(a) Prescriber.— Any prescriber issuing a prescription for naloxone pursuant to this Act is immune from civil and criminal liability, and is not subject to adverse professional action, for: (1) the prescribing of naloxone; or (2) for any ultimate outcomes of such prescribing.

(b) Dispenser.— Any dispenser dispensing naloxone pursuant to this Act is immune from civil and criminal liability, and is not subject to adverse professional action, for: (1) the dispensing of naloxone; or (2) for any ultimate outcomes of such dispensing.

(c) Distributors and dispensers.— Any individual or entity that possesses or makes available naloxone, recovery community or other community-focused organization, or first responder who distributes or administers naloxone pursuant to this Act is immune from civil and criminal liability, and is not subject to adverse professional action, for: (1) the distributing of naloxone; (2) the administration of naloxone; or (3) for any ultimate outcomes of such distribution or administration.

SECTION XII. PUBLIC EDUCATION PROGRAMS.

(a) In general.—In conjunction with the issuance of a statewide standing order under this Act, the [state health department, single state authority on drugs and alcohol, and/or other appropriate party] shall develop public education programs as described in this
section.

(b) Elements of program.— The educational program or programs developed pursuant to subsection (a), using culturally and linguistically appropriate materials, shall:

(1) establish prescriber and dispenser training in the necessity of educating patients about the risks of opioids, the even greater risk involved with combining opioids and benzodiazepines, and the role of naloxone as an antidote to opioid overdose;

(2) promote the safe and effective distribution, use, and administration of naloxone by all [state] residents, particularly by families with someone with substance use disorder or on a long-term use of prescription opioids;

(3) post information on naloxone access inside pharmacies located in [state];

(4) maintain, on a state government webpage, an online directory of locations where naloxone is distributed, with such directory including physical address, contact information, services offered, special populations served, insurance providers accepted, hours of operation, any other information deemed necessary by the [state health department, single state authority on drugs and alcohol, and/or other appropriate party];

(5) maintain on a state government webpage, and educate the public about, one widely used computer or phone application for use in the state that enables persons carrying naloxone to register their location, and allows persons in immediate need of naloxone to use that computer or phone application to locate and directly communicate with a nearby naloxone carriers, and to locate public places where naloxone is available pursuant to Section X(d);

(6) identify resources for and develop a public education program that trains all [state] residents about the use, misuse and risks of opioid drugs, the need to carry naloxone, how to identify an overdose, the process for administering naloxone, and the necessity of immediately calling 911 upon encountering an overdose. Such program also will include instruction for students in grades seven and above concerning the above;

(7) identify resources for and develop an educational program that trains all [state] law enforcement, probation, parole, and correctional officers on the importance of encouraging individuals to call 911 upon encountering an overdose, including utilizing discretion in arresting and charging such individuals for minor crimes and offenses so as...
to not deter 911 calls;

(8) identify resources for and develop an educational program addressing the recommended procedures to limit first responders’ potential exposure to the drug(s) involved in an underlying overdose;\(^{21}\)

(9) establish or promote the development of recovery community or other community-focused organization naloxone access and distribution programs. At a minimum, such access programs shall offer participants an approved training and education program as part of the program of naloxone distribution; and

(10) include direct outreach to populations at higher risk of overdose.

SECTION XIII.NALOXONE ACCESS GRANT PROGRAM.

(a) In general.— There is established in the [state Department of Health/single state drug and alcohol authority] a Naloxone Access Grant Program for the purpose of incentivizing the development of successful naloxone access initiatives developed pursuant to this Act. An amount of [$] for fiscal years [20__ - 20__] shall be appropriated to the [Department of Health/single state drug and alcohol authority] to fund the Grant Program.

(b) Receipt of funds.—The [Department of Health/single state drug and alcohol authority] may receive such gifts, grants, and endowments from public or private sources as may be made from time to time, in trust or otherwise, for the use and benefit of the purposes of the Naloxone Access Grant Program and expand the same or any income derived from it according to the term of the gifts, grants, or endowments. In addition, the [Department of Health] shall aggressively pursue all federal funding, matching funds, and foundation funding for the Naloxone Access Grant Program.\(^{22}\)

(c) Prioritized funding.—The [Department of Health/single state drug and alcohol authority]

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\(^{21}\)Recommended procedures should address both first responders and service animals working for first responders who may also come into contact with the drug(s) causing the overdose.

\(^{22}\)For example, in 2015, the Pennsylvania Department of Drug & Alcohol Programs raised over $500,000 from several of the major state health insurers in the state to help provide naloxone for local police departments.
shall prioritize funding from the Naloxone Access Grant Program for naloxone provided and maintained pursuant to Sections X(b) and X(c) of this Act.

SECTION XIV. NEW OPIOID OVERDOSE REVERSAL DRUG.

In the event that the Food and Drug Administration (FDA) approves a new opioid overdose reversal drug, the provisions of this Act shall be applicable to such drug.23

SECTION XV. CONSENTS.

(a) In general.—The attending physician in an emergency department, or the physician’s designee, shall make reasonable efforts to obtain a signed patient consent to disclose information about the patient’s opioid-related overdose to family members or other medical professionals involved in the patient’s health care.

(b) Consent impractical.—If consent cannot practicably be provided because of the patient’s incapacity or a serious and imminent threat to a patient’s health or safety, the physician, or physician’s designee, may disclose information about a patient’s opioid-related overdose, so long as such disclosure is compliant with applicable privacy and confidentiality laws and regulations.24 Such laws include:

(1) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191 (Aug. 21, 1996);
(2) 45 C.F.R. parts 160 and 164 (HIPAA Privacy and Security Rules);
(3) federal confidentiality law and regulations, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2;
(4) any relevant state law related to the privacy, confidentiality, and disclosure of protected health information; and


24 See https://www.hhs.gov/sites/default/files/hipaa-opioid-crisis.pdf, describing how Health Insurance Portability and Accountability Act of 1996 regulations allow health professionals to share health information to certain individuals in emergency or dangerous situations.
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(5) any policies or regulations of the single state authority on drugs and alcohol governing
the care of protection of client information.

SECTION XVI. INSURANCE COVERAGE FOR NALOXONE.

(a) Medicaid.—All state Medicaid programs shall provide coverage for naloxone in a FDA-
approved community use indication currently available as a nasal spray, an auto-injector,
or both.

(b) Private insurance.— Every individual or group health-insurance contract, plan, or policy
that provides prescription coverage that is delivered, issued for delivery, amended or
renewed in [this state] on or after [date ], shall provide coverage for naloxone in a FDA-
approved community use indication currently available as a nasal spray, an auto-injector,
or both.

(c) Coverage included.—The coverage provided under subsections (a) and (b) shall include
the naloxone product itself and any reasonable pharmacy administration fees related to the
dispensing of naloxone and provision of overdose prevention consultation. This coverage
also must include refills for expired or utilized drugs.

(d) No prior authorization or co-payment.— The coverage provided under this section shall
not be subject to prior authorization, shall not be subject to the insurance plan’s deductible
or co-payment requirements, and shall cover the insured’s full cost of the naloxone.25

(e) Use on others covered.— The coverage mandated by this section shall include naloxone
intended for use on individuals other than the insured provided, however, that the insurer
may not collect or require to be disclosed any identifying information about such other
person or persons.

25 Subsection (d) should not be read to discourage insurers from negotiating with naloxone manufacturers for lower
prices. Rather, the intent of (d) is for insureds to pay no out-of-pocket cost for obtaining naloxone.
(f) Prohibited actions.26—

(1) In general.— No insurer, including but not limited to those providing life insurance, health insurance, disability or unemployment insurance, and no health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues an individual or group insurance policy in this state, shall take any adverse action against an individual based on an individual’s prior or current obtaining of, prescription for, or claim for, naloxone.

(2) Actions prohibited.— The prohibition contained in paragraph (1) covers the following:

(A) denying or canceling insurance coverage to the individual;

(B) limiting the amount, extent or kind of coverage available to the individual;

(C) charging the individual, or a group to which the individual belongs, a rate that is different from the rate charged to other individuals or groups, respectively, for the same coverage, without any additional actuarial justification unrelated to the need to carry naloxone;

(D) refusing to supply naloxone; or

(E) collecting or requiring to be disclosed any information about the person or persons for whom the customer may be seeking to obtain naloxone.

(3) Unfair discrimination.— Actions prohibited under this section constitute unfair discrimination pursuant to [state insurance law prohibiting unlawful discrimination] subject to penalties provided by [state insurance law providing penalty for unlawful

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26 Within the past year, there have been anecdotal reports of individuals being unable to purchase life insurance because of their prior purchase of naloxone for family members. See Martha Bebinger, *Why You May Be Denied Life Insurance For Carrying Naloxone* (Dec. 5, 2018), available at https://www.wbur.org/commonhealth/2018/12/05/narcan-insurance-prescription (last accessed June 11, 2019). In reaction to this emerging practice, legislators in several states introduced bills similar to subsection (f) during the 2019 legislative session. To date, laws have been enacted in Maine (2019 Public Laws, Chapter 203; "An Act To Prohibit Consideration of Naloxone Purchases in Life Insurance Underwriting") and Texas (Senate Bill 437; “An act relating to prohibited practices by a life insurance company relating to an individual's prescription for or obtainment of an opioid antagonist”). In Massachusetts earlier this year, the state commissioner of insurance issued an advisory to “Insurers Offering Individual Accident and Sickness Policies, Life Insurance Policies and Annuity Contracts in Massachusetts” that stated “[i]t would defeat the Commonwealth's important public health efforts if applications for individual accident and sickness insurance policies, life insurance policies and annuity contracts were unfavorably impacted solely because the applicant had obtained naloxone or some other opioid antagonist to address opioid overdoses of other persons or had a prescription written to prevent illness or disease.” Through subsection (f) of this Act, we believe that expanding these protections to health, disability and unemployment insurance is warranted and in the interest of promoting public health.
SECTION XVII. DATA COLLECTION AND EVALUATION.

(a) In general.—Notwithstanding any other law or regulation to the contrary, it is hereby directed that the [state prescription drug monitoring program] is authorized and required to collect certain information about the dispensing of naloxone as provided for in this section.

(b) Collection of naloxone dispensing data.—27 28

(1) In general.—Effective [date], all dispensers within [state] must submit naloxone dispensing information to the [state prescription drug monitoring program] as described further in this section.

(2) Rules and regulations.—The [state agency that regulates prescription drug monitoring programs] is directed to promulgate rules and regulations [by date] that will govern the methods and procedures for dispensers to submit this information.

(3) Limitation of purpose.—The information collected regarding dispensing of naloxone shall be for statistical, research, or educational purposes only. The rules and regulations developed pursuant to subdivision (b)(2) shall require the removal of patient, recipient, or prescriber information that could be used to identify individual patients or recipients of naloxone.

(c) Good Samaritan protections.—The collection and submission of information by dispensers does not in any way diminish the protections afforded by this Act and [state Good Samaritan law(s)] to individuals suffering overdoses and individuals who call 911 or assist in the

27 State health departments and agencies implementing statewide standing orders want naloxone dispensing information in order to determine the effectiveness of the standing order as well as to identify locations that lack pharmacies dispensing naloxone. For these purposes, the data does not need to be, and should not be, patient identifiable and should be aggregated by the geographic unit at the county level or below.

28 The second edition of this Act (published September 2018) contained a provision relating to the collection of naloxone administration data in the state prescription monitoring program. In preparing the third edition of this Act, we decided that a statutory provision addressing the collection of naloxone administration data would best be included as part of statutory language covering the collection of overdose information generally. Future NAMSDL model law projects, including an update to our Model Prescription Monitoring Program Act, will address this issue, balancing the needs for critical information to ensure safer prescribing with the need to avoid possible stigmatization of those suffering with substance use disorders.
administration of naloxone.

(d) Annual report.—The [insert appropriate state health department/agency] shall evaluate de-identified data collected pursuant to this section in conjunction with other applicable, available data, and annually report to [insert appropriate state policy bodies, e.g., governor’s office, state legislature] all findings and recommendations relevant to the development and implementation of state policy regarding opioid-related overdoses, naloxone access and distribution, opioid prescribing, prescription drug misuse, substance use disorders, diversion, substance use disorder treatment and other evidence-based public health interventions.

SECTION XVIII. RULES AND REGULATIONS.

State agencies and officials shall promulgate rules and regulations necessary to implement their responsibilities under this Act.

SECTION XIX. SEVERABILITY.

If any provision of this Act or application thereof to any individual or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act that can be given effect without the invalid provisions or applications, and to this end, the provisions of this Act are severable.

SECTION XX. EFFECTIVE DATE.

This Act shall be effective on [specific date or reference to normal state method of determination of the effect.]
Model Act Providing for the Warm Hand-off of Overdose Survivors to Treatment (Second Edition)

July 1, 2019.

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Model Act Providing for the Warm Hand-off of Overdose Survivors to Treatment (Second Edition)¹

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SECTION I. SHORT TITLE.

This Act will be known and may be cited as the “Model Act Providing for the Warm Hand-off of Overdose Survivors to Treatment” (the “Act”).

SECTION II. LEGISLATIVE FINDINGS.

(a) In 2017, 72,000 Americans died of drug overdoses, quadrupling the number of fatal overdoses that occurred in the year 2000, and making today’s opioid epidemic the worst epidemic in one hundred years. [Name of state] is also encountering the worst overdose epidemic in its history.

(b) First responders, including emergency medical services personnel, firefighters, law enforcement officers, social workers, members of the recovery community, and family members heroically have escalated their lifesaving overdose reversal efforts, all resulting in many more lives saved and many more overdose survivors in our emergency health care systems.

(c) First responders are reporting that many whose overdoses are reversed are overdosing repeatedly, indicating that most overdose survivors are not being successfully transitioned to treatment and recovery support services, placing themselves at grave risk of death and causing extraordinary strain and suffering to their families and communities, including first responder and health care system services.

(d) It is urgent that every effort be made to successfully transition overdose survivors to treatment and recovery support services, based on an individualized assessment and application of clinical placement criteria.
SECTION III. PURPOSE.

This Act is designed to:

(a) ensure that effective practices are used by emergency medical services personnel so that overdose victims are medically stabilized;\(^2\)

(b) ensure that effective protocols are used by emergency services personnel and emergency departments so that stabilized overdose survivors are successfully transferred to appropriate treatment and recovery support services, as determined by an individualized treatment plan based on an assessment and clinical placement criteria;

(c) have responsible state agencies work with all relevant stakeholders to develop a network of Overdose Stabilization & Warm Hand-off Centers where emergency medical service personnel can directly transport most overdose survivors for medical stabilization, detoxification, assessment, referral, and direct placement to individualized treatment and recovery support services;

(d) have responsible state agencies work with all relevant stakeholders to ensure that the full continuum of addiction treatment and recovery support services are available and coordinated in order to facilitate each overdose survivor’s long-term individual process of recovery; and

\(^2\) The phrase “medically stabilized” covers the variety of ways in which emergency medical service (EMS) personnel could be involved with the medical stabilization and transport of an overdose victim. In most cases, EMS personnel will transport an overdose victim to an emergency department for medical stabilization. However, there are programs throughout the country in which EMS personnel have the option to bypass the emergency department and take an already-stabilized overdose survivor meeting defined criteria directly to assessment and treatment at the appropriate level of care with detoxification or other accompanying withdrawal management services. Emergency medical service providers engaging in this function must be highly structured, physician supervised programs, with rigorous education and competency requirements. For example, effective August 2018, EMS personnel in Orange County (N.C.) may decide to take a survivor directly to a local recovery center after following a strict protocol, including a paramedic’s evaluation, so long as the EMS supervisor agrees with the decision and the survivor consents to the transport. Tammy Grubb, *Will free needles, ambulance rides to rehab help Orange County addicts get clean?*, The Herald Sun (June 22, 2018), https://www.heraldsun.com/news/local/counties/orange-county/article213578914.html. Moreover, effective EMS transport of an overdose survivor to an Overdose Stabilization & Warm Hand-off Center created pursuant to this Act, would likely involve reliance upon a similarly strict protocol. Accordingly, under this Act, EMS agencies are provided the legal flexibility to train, certify, and then allow their personnel to transport stabilized overdose survivors to a location other than an emergency department, but there is no requirement to do so. In those instances where states or localities wish to provide EMS agencies with this option, states will need to amend any existing laws/regulations prohibiting EMS from transporting a patient anywhere but to an emergency department.
(e) ensure that [state] has the necessary treatment and recovery support capacity to address the need for all overdose survivors and others at risk of overdose.

SECTION IV. DEFINITIONS.

(a) For the purposes of this Act, unless the context clearly indicates otherwise, the following words and phrases have the meanings given to them in this Section.

(b) Detoxification facility.— “Detoxification facility” means a facility licensed by the [single state authority on drugs and alcohol] to engage in the process whereby an alcohol-intoxicated, drug-intoxicated, alcohol-dependent or drug-dependent individual is assisted through the period of time to eliminate, by metabolic or other means, the intoxicating alcohol or other drugs, alcohol and other drug dependency factors or alcohol in combination with drugs as determined by a licensed physician, while keeping the physiological risk to the patient at a minimum. Such process includes therapeutic engagement with the individual to motivate the individual to engage in treatment.

(c) Drug.— “Drug” means: (1) an article recognized in the official United States Pharmacopoeia, official Homoeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them; (2) an article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; (3) an article (other than food) intended to affect the structure or any function of the body of man or other animals; and (4) an article intended for use as a component of any article specified in clause (1), (2), or (3). The term does not include devices or their components, parts or accessories.

(d) Emergency department.— “Emergency department” means a hospital emergency department, a free-standing emergency department, or a health clinic where the clinic carries out emergency department functions.

(e) Emergency department personnel.— “Emergency department personnel” means physicians, nurses, paramedics, medical assistants, nurses’ aides and other health care professionals working in an emergency department.
(f) Emergency medical services personnel.— “Emergency medical services personnel” means individuals who possess a current, valid, unrestricted license issued by [state] as an emergency medical technician, advanced emergency medical technician, paramedic, or another [state]-recognized and licensed level with a scope of practice and authority in between emergency medical technician and paramedic who practices under the supervision of a medical director.

(g) Harm reduction services.— “Harm reduction services” means a range of public health policies designed to lessen the negative social and physical consequences associated with dangerous substance use, while engaging an individual to seek treatment for a substance use disorder.

(h) Intervention services.— “Intervention services” means services provided by an individual with training and knowledge about the system of substance use disorder treatment options available in the local community and who has specific expertise in interventions with overdose survivors through a process where the substance user is encouraged to accept help.

(i) Overdose.— “Overdose” means injury to the body that happens when a drug is taken in excessive amounts. An overdose can be fatal or nonfatal.3

(j) Peer specialist.— “Peer specialist” means an individual certified as a peer specialist or as a recovery specialist by a statewide certification body which is a member of a national certification body, or an individual who is certified by another state’s substance use disorder counseling certification board.4

(k) Recovery support services.— “Recovery support services” means case management or other informational, emotional, and intentional support including but not limited to: (1) developing a one-on-one relationship in which a peer specialist encourages, motivates, and supports a peer in recovery; (2) connecting the peer with professional and nonprofessional services and resources available in the community; (3) facilitating or leading recovery-oriented group activities, including support groups and educational

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3 This is the CDC definition of overdose, found at https://www.cdc.gov/drugoverdose/opioids/terms.html.

4 This definition will need to be modified in those states that do not presently engage in the better practice of licensing or certifying peer specialists or recovery specialists.
activities; and (4) helping peers make new friends and build healthy social networks through emotional, instrumental, informational, and affiliation types of peer support.

(l) Single state authority on drugs and alcohol.— “Single state authority on drugs and alcohol” means the state agency designated by the [state] governor to plan, manage, monitor, coordinate and evaluate substance use disorder treatment and recovery support services in the state, and to administer the federal Substance Abuse Prevention and Treatment Block Grant.

(m) Substance use disorder treatment provider.— “Substance use disorder treatment provider” means any substance use disorder facility or treatment program that is [licensed], [certified], or [approved] by the state to provide comprehensive substance use disorder treatment and recovery support services, with or without the support of medications, on a hospital, non-hospital residential, or outpatient basis. The term also includes any physician with expertise in providing or coordinating access to comprehensive detoxification or other withdrawal management, medication, counseling and long-term recovery support services.

(n) Task force.— “Task force” means the Overdose Recovery Task Force established under Section VIII (“Development of Overdose Stabilization and Warm Hand-off Centers”).

(o) Treatment.— “Treatment” means substance use disorder treatment for alcohol or other drug addiction with a substance use disorder treatment provider in accordance with an individualized assessment and clinical placement criteria.

(p) Warm hand-off.— “Warm hand-off” means the direct referral and transfer of an overdose survivor immediately after medical stabilization to appropriate substance use disorder treatment. For purposes of this Act, in situations where the direct referral and transfer of an overdose survivor is not possible, “warm hand-off” includes face-to-face or other follow-up contact with recent overdose survivors by first responders and individuals providing intervention services to encourage entry into treatment.5

5 An example of an initiative involving face-to-face follow-up contact with overdose survivors is the Quick Response Team (“QRT”) that originated in Colerain Township, Ohio, and later expanded to over 40 Ohio counties and areas outside of the state. WCPO Staff, Colerain Township first responders receive award for overdose response, WCPO Cincinnati (June 11, 2018), https://www.wcpo.com/news/local-news/hamilton-county/colerain-
Warm Hand-off Centers.— “Warm Hand-off Centers” means the Overdose Stabilization and Warm Hand-off Centers established under Section VIII (“Development of Overdose Stabilization and Warm Hand-off Centers”).

SECTION V. COMPREHENSIVE STATE WARM HAND-OFF INITIATIVE.

(a) In general.— The single state authority on drugs and alcohol will lead and collaborate with the [state] Department of Health and other appropriate state and local agencies to develop a comprehensive state warm hand-off initiative to ensure that all reasonable measures are taken to have overdose survivors medically stabilized and then directly transferred to appropriate substance use disorder treatment, which may be provided by: (1) a licensed detoxification facility or other medical facility for detoxification and assessment services, followed by substance use disorder treatment by a licensed provider, matched to the individual’s clinical needs, based on the biopsychosocial assessment and application of clinical placement criteria, and coordinated with ongoing recovery support services; or (2) a physician or other substance use disorder treatment provider with expertise in providing or coordinating medication-assisted treatment.6

(b) Harm reduction.— Where an overdose survivor persistently refuses referral and transfer to appropriate substance use disorder services, as set forth in subsection (a), harm

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6 As explained in Section III, the medical stabilization may occur: (1) at an emergency department or Warm Hand-off Center, after transportation there by emergency medical service personnel; or (2) where proper training, certification, and physician supervision are present, by emergency medical services personnel themselves, prior to transporting the survivor directly to a detoxification facility or substance use disorder treatment provider. The Act does not require option (2), but is broad enough to allow it if a state/locality chooses to implement such an option in those overdose situations where there are no medical complications and direct transport to a detoxification facility or substance use disorder treatment provider is therefore medically appropriate.

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reduction services, as designated by the single state authority on drugs and alcohol, shall be provided.  

(c) Program elements.— The comprehensive state program will include, but not be limited to, the following, which will be implemented within twelve (12) months of the effective date of this Act:

(1) Establishing warm hand-off partnerships between the single state authority on drugs and alcohol, local/regional administrators, and emergency departments as follows.—

(A) The single state authority on drugs and alcohol will direct its [local/regional administrators] to establish partnerships with all emergency departments in their respective [localities/regions] and to assist those emergency departments to implement warm hand-off procedures for overdose survivors. Such assistance may include but not be limited to working with emergency departments to ensure that intervention services are available in a timely fashion.

(B) Owners/operators of emergency departments will take reasonable steps to train and credential any individuals providing intervention services, using the facility’s established credentialing process for staff and vendors providing care, in order to facilitate unhindered communication between the person providing intervention services and the overdose survivor.8

(C) The [local/regional administrators] shall regularly assess the network of available detoxification facilities, medical facilities providing detoxification services, substance use treatment providers, recovery support services, and harm reduction services, and communicate the findings of each assessment to all individuals providing intervention services for overdose survivors, so that a

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7 The Act purposely leaves it for each state to determine what to include within “harm reduction services.”

8 “Credentialing” is the process of evaluating the qualifications and practice history of a provider within a medical facility. Upon receiving credentials, the provider is granted the authority: (1) to perform the agreed upon service(s) in the medical facility; and (2) to exchange information about patient care within the framework of an interdepartmental system of care in a hospital without violating applicable privacy and confidentiality laws and regulations.
backlog of referrals does not occur and survivors can obtain treatment, including specialized programs, and other support services, where necessary.9, 10

(D) The [local/regional administrators] shall also regularly assess the network of services that address the needs of the families of overdose survivors, and shall work with emergency departments to ensure that appropriate mechanisms are in place to connect those families to needed services.

(2) Prioritizing overdose survivors for substance use disorder treatment.—

(A) Treatment funded by Medicaid and federal Substance Abuse Prevention and Treatment Block Grant.— The single state authority on drugs and alcohol will direct its [local/regional] administrators to include overdose survivors as one of its prioritized populations for Medicaid and federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funding, in accordance with individualized assessments and clinical placement criteria.

(B) Data collection.—The single state authority on drugs and alcohol shall work with its [local/regional] administrators and with the [state EMS agency] to gather the following data, which it will publish and annually update on its publicly accessible website:

(i) the number of individuals treated by emergency medical service personnel for overdoses;

(ii) levels of care and lengths of stay of overdose survivors in Medicaid facilities and federal SAPTBG-funded treatment provider facilities;

9 An example of this assessment and transmittal of near real-time information about treatment resources is the Delaware Treatment and Referral Network, in which “social workers, health care providers and others use the digital system to pinpoint where state treatment resources are available and reserve a space for a specific patient.” Mark Eichmann, Delaware online reservations for substance abuse treatment finds success, WHYY (April 19, 2019), https://whyy.org/articles/delaware-online-reservations-for-substance-abuse-treatment-finds-success/.

10 An example of a specialized program would be treatment programs in which parents with dependent children can have their children with them in the residential treatment facility. See NAMSDL’s “Model Family Preservation Act”.

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(iii) the number of Medicaid-funded and federal SAPTBG-funded overdose survivors in treatment who received a lower level of care or shorter length of stay than determined necessary by the physician or the treatment provider using the above-referenced placement criteria;

(iv) of those individuals identified in clause (iii), the number who received a lower level of care or shorter length of stay in treatment than determined necessary due to each of the following: lack of funding, patients leaving against medical advice, and any other reasons identified by the single state authority on drugs and alcohol; and

(v) any other trends or observations deemed significant by the single state authority on drugs and alcohol or its [local/regional administrators], emergency medical services personnel, substance use disorder treatment providers or the recovery support services community, which may include possible correlation in variations of the level of care and lengths of stay in treatment, with geographic region, behavioral health managed care organization, treatment program, or other factors.

(3) Emergency medical services personnel – training in effective warm hand-off protocols.—

(A) Training curriculum.— The [state] Department of Health [or other state department/agency/independent board that oversees EMS personnel licensure], in collaboration with the single state authority on drugs and alcohol and individuals from the recovery support services community, will develop a warm hand-off training curriculum for emergency medical services personnel addressing the most effective protocols to successfully transport overdose survivors for medical stabilization to emergency departments or, where available, to Warm Hand-off Centers as created in this Act and approved by the local EMS Medical Director.

(B) Elements of curriculum.— The training curriculum will address:

(i) The elements of addiction, stigma, treatment referral, recommended safety procedures to limit first responder exposure to the drug(s)
involved, resilience training and effective strategies for immediate and expeditious transport of the overdose survivor after administration of an opioid overdose reversal drug, in order to maximize the likelihood of successful transports of patients.11

(ii) Where emergency medical services is authorized, the necessary skills to determine when it is appropriate to directly transfer an overdose survivor to a Warm Hand-off Center or other appropriate substance use disorder treatment, and when it is appropriate instead to transfer the overdose survivor to an emergency department.

(iii) Effective protocols and skills for participating in face-to-face or other follow-up contact to engage recent overdose survivors to encourage and facilitate entry into treatment, including alliances with recovery support services for follow-up contacts.

(C) Continuing education requirement.— The curriculum must be in compliance with the standards of the Commission on Accreditation for Prehospital Continuing Education and be approved by the [state] Department of Health [or other state department/agency that oversees EMS personnel licensure], local EMS Medical Director and the single state authority on drugs and alcohol. These trainings will be mandatory for all emergency medical service personnel, and, in accordance with the standards set forth by the [state] Department of Health [or other state department/agency that oversees EMS personnel licensure] in consultation with the single state authority on drugs and alcohol, will require competency assurance of the necessary cognitive, psychomotor and affective skills upon completion of the program of instruction, as a condition of licensure renewal.

11 EMS personnel who begin transporting the overdose victim immediately after administering naloxone, rather than waiting until the victim fully regains consciousness, report much greater success in avoiding the dangerous situation of the victim fleeing the overdose scene. Without successful transport and follow-up stabilization, a post-reversal victim remains vulnerable to falling back into an overdose condition and dying.
(4) Emergency department personnel—training in substance use disorders, intervention, and referral to treatment.—

(A) Training curriculum.— The [state] Department of Health [or other state department/agency that oversees continuing medical education training and credits for emergency department personnel], in collaboration with the single state authority on drugs and alcohol and representatives of the recovery support services community, will promulgate a training curriculum in the effective warm hand-off to treatment of drug overdose survivors. The curriculum will address the basic elements of addiction, stigma, referral to treatment, recovery support services, the recovery community, resilience training and effective strategies for interacting with the recently reversed overdose survivor to maximize the likelihood that there will be a successful and immediate warm hand-off to treatment. The curriculum will address the needs of those who decline treatment, including harm reduction services and follow-up therapeutic engagement with the individual to motivate the individual to engage in treatment.

(B) Continuing education requirement.— The curriculum must be in compliance with [the national accrediting body (or bodies) for the continuing education of emergency department personnel] and be approved by the [state] Department of Health [or other state department/agency that oversees continuing medical education training and credits for emergency department personnel] and the single state authority on drugs and alcohol. These trainings will be mandatory for all emergency department personnel and, in accordance with the standards set forth by the [state] Department of Health [or other state department/agency/independent board that oversees continuing medical education training and credits for emergency department personnel] in consultation with the single state authority on drugs and alcohol, will require competency assurance of the necessary cognitive, psychomotor and affective skills upon completion of the program of instruction as a condition of licensure renewal. Such training may satisfy the emergency department personnel’s
patient safety continuing medical education requirements. The providers of the training shall include qualified individuals who also are in recovery.

(d) State grant for warm hand-off initiatives.—

(1) Program established.— There is established in the office of the [single state authority on drugs and alcohol] a Warm Hand-off Initiative Grant Program for the purpose of incentivizing the development of successful warm hand-off programs and operations established pursuant to this Act.

(2) Budget allocation.— An amount of [$] for fiscal years [20__ - 20__ ] shall be appropriated to the [single state authority on drugs and alcohol] to fund the Warm Hand-off Initiative Grant Program.

(3) Activities.12— The [single state authority on drugs and alcohol] may award grants from the Warm Hand-off Initiative Grant Program for the following:

   (A) To emergency departments, for one or more of the following:

      (i) Implementing warm hand-off procedures for overdose survivors, as described under paragraph (c)(1).

      (ii) Training and credentialing individuals providing intervention services, as described under paragraph (c)(1).

      (iii) Training emergency department personnel in substance use disorders, intervention and referral to treatment, as described under paragraph (c)(4).

   (B) To emergency medical services, for the purpose of training emergency medical service personnel in effective warm hand-off protocols, as described under paragraph (c)(3).

   (C) To [local/regional administrators], for the purposes described in subparagraph (c)(1)(C), the (i) assisting in the ongoing assessment of the network of available capacity in detoxification facilities, medical facilities providing

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12 In addition to specifying activities for which grants may be awarded, state legislators enacting this model Act may wish to include additional state-specific grant information in the bill, such as customary grant limitations, the grant application process, and identification of which applicants or activities may be given highest priority for awards.
detoxification services, treatment providers and recovery support services and
(ii) communicating the findings of the assessment to all individuals providing
intervention services for overdose survivors.

(D) Increasing the capacity of the network of substance use disorder providers, in
order to address the treatment needs of overdose survivors with substance use
disorders.

(4) Receipt of funding.— The [single state authority on drugs and alcohol] may receive
such gifts, grants, and endowments from public or private sources as may be made
from time to time, in trust or otherwise, for the use and benefit of the purposes of the
Warm Hand-off Initiative Grant Program and expand the same or any income derived
from it according to the term of the gifts, grants, or endowments. In addition, the
[single state authority on drugs and alcohol, and other state agencies] shall
aggressively pursue all federal funding, matching funds, and foundation funding for
the Warm Hand-off Initiative Grant Program.

(e) Emergency department implementation of effective warm hand-off procedures for
overdose survivors.—

(1) Reporting requirement.— Within six months of the effective date of this Act, the
[state] Department of Health [or other state department/agency that licenses hospitals
or other owners/operators of emergency departments] will require, as a condition of
licensure for the owner/operation of each emergency department, a written report
from each entity that meets established standards, which will include but not be
limited to:

(A) a description of the emergency department’s warm hand-off procedures;

(B) certification from the [local/regional administrator for the single state authority
on drugs and alcohol] of the emergency department’s partnership with the
[single state authority on drugs and alcohol’s regional/local administrator] to
attain the most effective possible warm hand-off outcomes;

(C) the number of overdose patients:
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(i) treated in the emergency department\(^{13}\);
(ii) screened to be in need of treatment;
(iii) successfully transferred to treatment;
(iv) refusing treatment and the reasons given for why; and
(v) who return to the emergency department on subsequent occasion(s);

(D) the emergency department’s action plan to continue to improve warm hand-off outcomes; and

(E) results of monitoring staff sensitivity, antistigma and antidiscrimination efforts within the emergency department, including an action plan to address staff training and sensitivity needs.

(2) Reporting intervals.— The reporting under this subsection will be required annually for five years following the effective date of this Act, as promulgated in rules by the single state authority on drugs and alcohol and the [state] Department of Health [or other state department/agency that licenses hospitals or other owners/operators of emergency departments] and biannually thereafter.

(3) Warm hand-off protocol and reporting requirements.— The [state] Department of Health [or other state department/agency that licenses hospitals or other owners/operators of emergency departments] and the single state authority on drugs and alcohol will develop and publish minimum warm hand-off protocol and reporting requirements for emergency departments.

(f) Medicaid; eligibility to be a provider and coverage for the warm hand-off initiative.—

(1) In general.— The [state Medicaid agency] will require emergency medical services with patient transport capability, emergency departments, and personnel working within each of these entities, to demonstrate compliance with the requirements of subsections (c)(3), (c)(4) and (e) of the Act in order to be eligible to [be in the Medicaid network].

\(^{13}\) The number of overdoses treated in emergency departments should be greater than the number transported to emergency departments by EMS personnel. The data reported by emergency departments would include individuals brought in directly by family, friends, and bystanders.
(2) Reimbursement rates.— The [state Medicaid agency] will establish and provide reasonable and fair reimbursement rates, approved by the single state authority on drugs and alcohol for the services provided for in this Act. These rates will include but not be limited to full and fair reimbursement for:

(A) emergency medical services successfully transporting overdose victims for medical stabilization at an emergency department or a Warm Hand-off Center;

(B) emergency medical services successfully medically stabilizing an overdose survivor and successfully transporting the individual to a detoxification facility, substance use disorder treatment provider or Warm Hand-off Center;

(C) follow-up contact with recent overdose survivors by emergency medical services personnel or others engaging in intervention services to encourage and facilitate entry into treatment;

(D) intervention services and warm hand-off services; and

(E) case management providing support, guidance, and navigation of the treatment and recovery systems.

(3) Provider costs incorporated.— The reimbursement rates will take into account the providers’ costs in meeting the training, data reporting and other requirements of this Act.14

(g) Private health insurance coverage for the warm hand-off initiative.—

(1) Reimbursement rates.— The [state department/agency that regulates private health insurance], in consultation with the single state authority on drugs and alcohol, will require all health insurers providing coverage in [the state] to establish and provide reasonable and fair reimbursement rates. These rates will include but not be limited to full and fair reimbursement for:

(A) emergency medical services successfully transporting overdose victims for medical stabilization at an emergency department or a Warm Hand-off Center;

14 Ideally, reimbursement rates should be designed to incentivize and reward positive outcomes for successful medical stabilization of overdose victims and successful assessment, referral and direct placement to individualized care for their substance use disorders.
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(B) emergency medical services successfully medically stabilizing an overdose survivor and successfully transporting the individual to a detoxification facility, substance use disorder treatment provider or a Warm Hand-off Center;

(C) follow-up contact with recent overdose survivors by emergency medical services personnel or intervention specialists to encourage and facilitate entry into treatment;

(D) intervention and warm hand-off services; and

(E) case management providing support, guidance, and navigation of the treatment and recovery systems.

(2) Provider costs incorporated.— The reimbursement rates will take into account the providers’ costs in meeting the training, data reporting and other requirements of this Act, and will be designed to incentivize and reward positive outcomes for successful medical stabilization of overdose victims and successful assessment, referral and direct placement to individualized care for their substance use disorders.

(3) No pre-authorization.— The [state department/agency that regulates private health insurance] will require all health insurers providing coverage in the state to eliminate pre-authorization requirements for treatment in instances where an overdose survivor is transported to treatment pursuant to this Act.

SECTION VI. CONSENTS.

(a) In general.— The attending physician in an emergency department, or a physician’s designee, will make reasonable efforts to obtain the patient’s signed consent to disclose information about the patient’s drug overdose to family members or others involved in the patient’s health care.

(b) Exception.— If consent cannot practicably be provided because of the patient’s incapacity or a serious and imminent threat to a patient’s health or safety, the physician, or physician’s designee, may disclose information about a patient’s opioid-related...
overdose, so long as such disclosure is compliant with applicable privacy and confidentiality laws and regulations. Such laws shall include:

(1) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191 (Aug. 21, 1996);

(2) 45 C.F.R. parts 160 and 164 (HIPAA Privacy and Security Rules);

(3) federal confidentiality law and regulations, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2;

(4) any relevant state law related to the privacy, confidentiality, and disclosure of protected health information; and

(5) any policies or regulations of the single state authority on drugs and alcohol governing the care of protection of client information.

SECTION VII. IMMUNITY.

(a) Emergency medical services.— Absent evidence of a malicious intent to cause harm, no emergency medical services agency or emergency medical service personnel may be held liable for medically stabilizing, or attempting to medically stabilize an overdose victim, or for transporting or attempting to transport an overdose victim for medical stabilization.

(b) Emergency department.— Absent evidence of a malicious intent to cause harm, no health care unit, emergency department personnel, or person providing intervention services or recovery support services may be held liable for their efforts to have overdose survivors properly assessed, referred and directly placed in individualized care for their substance use disorders.

15 See https://www.hhs.gov/sites/default/files/hipaa-opioid-crisis.pdf, describing how Health Insurance Portability and Accountability Act of 1996 regulations allow health professionals to share health information to certain individuals in emergency or dangerous situations.
SECTION VIII. DEVELOPMENT OF OVERDOSE STABILIZATION & WARM HAND-OFF CENTERS.

(a) Establishment.— There is hereby created an Overdose Recovery Task Force, consisting of ______ members as specified below:

(1) the [Director/Secretary] of the single state authority on drugs and alcohol or the [Director’s/Secretary’s] designee;

(2) the [Director/Secretary] of the [state] Department of Health or the [Secretary/Director’s] designee;

(3) the [Director/Secretary] of the [state department/agency that oversees EMS personnel] or the [Director/Secretary’s] designee [if different than (2)];

(4) the [Director/Secretary] of the [state department/agency that oversees emergency department personnel] or the [Director/Secretary’s] designee [if different than (2)];

(5) the [Director/Secretary] of the [state child welfare agency] or the [Director/Secretary’s] designee;

(6) representatives designated by each of the critical stakeholder groups, including, but not limited to, a representative from [the associations of emergency physicians, emergency medical service personnel, emergency medical service agencies, law enforcement agencies, hospitals, treatment programs, and a statewide recovery organization]; and

(7) an individual in recovery who is an overdose survivor.

(b) Purpose.—

(1) In general.— The initial purpose of the Task Force will be to develop and implement Overdose Stabilization & Warm Hand-off Centers. Such Warm Hand-off Centers will be staffed locations that can medically oversee the stabilization of overdose survivors, begin detoxification where necessary, engage survivors with intervention specialists, complete full addiction assessment and referral, and connect and refer survivors to all modalities and levels of treatment, depending on the survivors’ individual clinical needs.
(2) Families.— Warm Hand-off Centers will address the needs of the survivors’ families and children, and utilize them in the engagement and treatment of the survivor, as appropriate.

(c) Expansion of services.— The Task Force may also explore mechanisms to expand, where feasible, the function of currently existing crisis healthcare facilities so that they can serve as Warm Hand-off Centers, in addition to their current functions.

(d) Development.— The development and implementation of Warm Hand-off Centers undertaken by the Task Force will include:

(1) identifying areas that will benefit most from placement of the Warm Hand-off Centers, through an analysis of population density and number of overdose deaths;

(2) creating the design, staffing structure, operation, and operational protocols of the Warm Hand-off Centers, which may include consideration of existing detoxification facilities with expanded capacity and functions;

(3) expanding the functions of currently existing crisis healthcare facilities so they also serve as Warm Hand-off Centers;

(4) identifying funding source(s) for the Warm Hand-off Centers; and

(5) establishing a new licensing category to cover the Warm Hand-off Centers.

(e) Requirements.— The operations of each Warm Hand-off Center will include at least the following:

(1) capacity to safely medically stabilize and manage the chronic non-life threatening medical needs of overdose survivors;\(^{16}\)

(2) ability to identify overdose survivors whose medical situations are sufficiently complex to require immediate transportation to an emergency department, based upon developed protocols;

\(^{16}\) In this section, “chronic non-life threatening medical needs” includes, but is not limited to medical conditions such as diabetes, HIV/AIDS and hepatitis C and psychiatric conditions such as depression, schizophrenia and bipolar affective disorder.
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(3) state-licensure as a medical, non-hospital residential or hospital detoxification facility;

(4) intervention services conducted by staff with specific expertise in therapeutically engaging those who have just survived an overdose;

(5) treatment assessments with physicians or other clinicians with certified expertise in undertaking drug and alcohol assessments and applying appropriate clinical placement criteria;

(6) working relationships with treatment programs of all modalities, including those that provide family preservation services, in the reasonable vicinity of the Warm Hand-off Center;

(7) development of protocols and referral agreements to govern the transfer of patients to and from emergency departments and treatment programs; and

(8) access to direct transportation from the Warm Hand-off Center to treatment programs.

(f) Evaluation.— The Task Force will periodically evaluate the performance and effectiveness of the Warm Hand-off Centers, and will gather and make recommendations for continuous quality improvement.

(g) Application.— The provisions of Sections VI and VII(b) of this Act apply to Warm Hand-off Centers.

SECTION IX. RULES AND REGULATIONS.

State agencies and officials will promulgate rules and regulations on an [expedited or emergency] basis necessary to implement their responsibilities under this Act.

SECTION X. ANNUAL REPORT TO THE LEGISLATURE.

(a) In general.— The single state authority on drugs and alcohol and the [state] Department of Health [or other state department(s)/agency(ies)/independent board(s)] that oversees EMS personnel licensure and/or continuing medical education and credits for emergency department personnel] jointly will provide a brief, written, annual report to the members of the [appropriate legislative committees], documenting:
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(1) compliance with the requirements of this Act;

(2) The number of overdose survivors successfully being transferred to and engaged in treatment;

(3) The number of Warm Hand-off Centers in operation;

(4) The total number of overdose victims each Warm Hand-off Center has received; and

(5) The total amount of funds awarded from the Warm Hand-off Initiative Grant Program in the previous year and the amount each grantee received.

(b) Publication.— This annual report will also be published on the publicly accessible websites of the single state authority on drugs and the other involved department(s)/agency(ies)/independent board(s).

SECTION XI. SEVERABILITY.

If any provision of this Act or application thereof to any individual or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act which can be given effect without the invalid provisions or applications, and to this end the provisions of this Act are severable.

SECTION XII. EFFECTIVE DATE.

This Act will be effective on [specific date or reference to normal state method of determination of the effect.]
Model Patient Protection and Treatment Ethics Act

July 1, 2019.

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Model Patient Protection and Treatment Ethics Act

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SECTION I. SHORT TITLE

This Act may be referred as the Model Patient Protection and Treatment Ethics Act.

SECTION II. LEGISLATIVE FINDINGS

(a) The nation remains in the grips of an epidemic of substance use disorders.

(b) The nation is blessed with countless excellent addiction treatment programs. These programs and their staff perform tireless and lifesaving work, much of it entirely outside the limelight, and much of it thankless, on an illness that is still far too stigmatized (a stigma that often extends to the very people trying to treat it). These are not the programs and people giving rise to this Act.

(c) This Act is intended to create a level playing field that denies advantage to programs and personnel that engage in, or support, predatory, unsafe, and unethical practices. These practices create barriers to desperately needed treatment, and cause incalculable needless harm to desperate families and the communities they live in. Enacting legislation that sets forth, and provides for the enforcement of, uniform ethical standards for treatment programs benefits all residents of [name of state] by improving the availability of high-quality, ethical treatment, and by protecting families and individuals in crisis from misleading information and other unethical practices.

SECTION III. PURPOSE

This Act is designed to protect families and patients. It is the intent of the legislature that all provisions of this Act are to be construed in favor of maximizing protections for patients and families, and the communities in which they live.
SECTION IV. DEFINITIONS

(a) “Recovery residence” means a shared living environment that is, or is intended to be, free from alcohol and illicit drug use and is centered on peer support and connection to services that promote sustained recovery from substance use disorders.

(b) “Referral”. A person or entity shall be considered to have made a referral if the provider or recovery residence has informed a patient by any means of the name, address, or other identifying information for a licensed service provider or recovery residence.

(c) “Treatment facility” means a facility or program that is, or is required to be, licensed, accredited, or certified to provide substance use disorder treatment services.

(d) “Treatment provider” means an individual who is, or is required to be, licensed, accredited, or certified to provide substance use disorder treatment services and, for purposes of this Act, also includes treatment facilities.

Comment:

The definition of recovery residence includes housing where patients are using prescribed medications as part of medication-assisted treatment. Some stakeholders have observed that there is an appropriate role for shared housing that is entirely medication-free. This definition is not meant to, and does not, preclude or exclude housing where none of the users are receiving medication-assisted treatment. Housing that is free of any medication is (by definition) free of illicit drug use.

Some stakeholders have noted that housing that is entirely drug-free (that is, shared housing where none of the residents are receiving medication-assisted treatment) may violate the Americans with Disabilities Act. The point is well taken (although we take no substantive position on whether any particular shared housing arrangement violates the ADA). But we do not think it makes sense to permit violations of any federal law (the ADA being just one example) to remove any entity from the scope of this Act. To the extent that this Act reaches recovery residences that are not treatment providers—it does not do so directly, but it does establish certain standards for treatment providers in their dealings with dealing with recovery residences—it makes sense to include as broad a definition of recovery residence as possible. To put it another way, allowing recovery residences to avoid the scope of one set of laws (this Act) by violating another set of laws (the ADA) seems unwise.

The term recovery residence includes and encompasses recovery houses, sober homes, and Oxford houses.
SECTION V. GENERAL PRINCIPLE

Every treatment facility doing business in the State shall adopt, and make available to all patients and prospective patients, a written code of ethics that covers and ensures full compliance with the requirements set forth in this Act.

SECTION VI. TRUTH IN MARKETING

(a) Any marketing or advertising materials published or provided by a treatment facility shall provide accurate and complete information, in plain language that is easy to understand, and shall include the following:

(1) Information about the types and methods of services provided or used, and information about where they are provided, using the categories of treatment and levels of care identified in [the State’s licensing laws];

(2) The average lengths of stay during a preceding twelve-month period, for each of the treatment settings referred to in the preceding subparagraph;

(3) The treatment facility’s name and brand; and

(4) A brief summary of any financial relationships between the treatment facility and any publisher of marketing or advertising.

(b) It is unlawful for any treatment provider to knowingly and willfully make a materially false or misleading statement, or provide false or misleading information about, the nature, identity, or location of substance use disorder treatment services or a recovery residence, in advertising materials, on a call line, on a website, or in any other marketing materials.

(c) Any treatment facility providing outpatient services along with a housing component must clearly label its program as such, and must distinguish itself from licensed residential substance use disorder treatment.

1 Not every state licenses every level of care, and some licensure taxonomies do not provide much detail. States should adopt an approach that clearly communicates treatment settings and levels of care to consumers. We also note that every level of care may include medication-assisted treatment, and anything suggesting that medication-assisted treatment is a separate, distinct level of care should be avoided because it risks confusing families and patients.
(d) It is unlawful for any treatment provider to knowingly make a false or misleading statement about their status as an in-network or out-of-network provider.

(e) It is unlawful for any person or entity to knowingly provide, or direct any other person or entity to provide, false or misleading information about the identity of, or contact information for, any treatment provider.

(f) It is unlawful for any person or entity to knowingly include false or misleading information about the internet address of any treatment provider’s website, or to surreptitiously direct or redirect the reader to another website.

(g) It is unlawful to suggest or imply that a relationship with a treatment provider exists, unless the treatment provider has provided express, written consent to indicate such a relationship.

(h) It is unlawful for any person to knowingly make a materially false or misleading statement about substance use disorder treatment services.

(i) Violating the provisions of this section constitutes a deceptive act or practice under the [State’s] Unfair Trade Practice and Consumer Protection Law, regardless of whether any consumer was actually misled or deceived.

(j) Any person or entity that knowingly violates any provision of this section commits a felony of the third degree.

Comment:

Families in communities across [name of state], who are seeking substance use disorder treatment for a loved one suffering with a substance use disorder, are being widely victimized by the growing presence of deceptive and misleading information.

[Name of state] has enacted robust consumer protection laws [cite state consumer protection laws]. Those laws, however, have proven difficult to apply and enforce in this context, and therefore inadequate to provide meaningful protection to those who need it. There are both jurisdictional and substantive reasons for this.

A great deal of dangerous and misleading conduct happens on the internet. For a variety of reasons – resources, habit, expertise, and difficulty tracking down deceptive and predatory actors–state-level regulators have not vigorously enforced, in this context, the rules and standards that typically govern and apply to false advertising. In July 2018 the Federal Trade Commission—the federal agency with front-line responsibility for protecting consumers from false marketing—noted problems with unfair and deceptive practices surrounding substance use
disorder treatment, including patient brokering and lead generation. Letter from Commissioner Rohit Chopra to leadership of the House Energy and Commerce Committee (July 24, 2018). That letter stated that unfair and deceptive marketing by substance use disorder treatment facilities and lead generators “may violate” the FTC’s enabling statute. In the fall of 2018 Congress passed the SUPPORT for Patients and Communities Act, H.R. 6, 115th Cong. 2018 (“H.R. 6”), which expressly brought within the FTC’s enforcement jurisdiction any “unfair or deceptive act or practice with respect to any substance use disorder treatment service or substance use disorder treatment product”. H.R. 6, §§ 8021, 8023. It is too soon to tell how effective these changes will be. Moreover, the state of [name of state] has its own independent interest in protecting the residents of our state from unethical predatory conduct; state and local resources are also needed to protect our families from such conduct.

The proposed language places responsibility for advertising activities squarely on treatment providers, which brings these activities squarely within reach of state-level regulators.

Google uses an Addiction Treatment Certification program (sometimes referred to as Legit Script), which applies to substance use disorder treatment providers that use paid advertising on Google. We understand that Bing and Facebook (and almost certainly others) are also working with Legit Script. Legit Script requires advertisers to comply with licensing and other requirements, and requires advertisers to provide information that provides a certain degree of transparency. The project, however, is limited. It applies only to purchased advertisements – the material that appears at the top (and sometimes the bottom) of the page when you do a Google search. It does not apply to the results that come up in the map that appears (in the middle of the results page), or the results that appear in the bottom of the page (search results proper). Furthermore, the substantive requirements for Legit Script certification are necessarily limited. Legit Script is helpful, but is not a replacement for the other protections established in this Act.

This section requires treatment providers to include information about care provided, using terminology from the state’s existing licensure scheme. One of the reasons regulating this area has proven so difficult is because some websites deliberately obscure the services available. Instead of using a common, shared vocabulary that would effectively communicate to a patient or family in crisis what treatment, exactly, is being offered, they offer meaningless descriptors. Even the initiated can have a difficult time gleaning, from a website, what types of treatment and levels of care a facility offers. For example, references to “counseling and residential detox” mean the patient will likely have a very short detoxification stay, and then move to recovery housing. But almost nobody who is not already acquainted with the field would necessarily know that.

Nothing in this Model Act precludes providers from providing additional information about themselves (so long as it is truthful), above and beyond the categories of treatment as set forth in State licensure laws.
Some commenters have suggested that we extend the scope of this section to include marketing companies that are not treatment providers. We agree on the need for greater transparency and accountability when it comes to marketing companies. The regulation of marketing entities, however, is beyond the scope of this Act.

Subparagraph (i) refers to a change to the state’s Unfair Trade Practice and Consumer Protection Law. The provision is placed here for the purpose of clarity; in most states, this particular provision would be placed within the state’s Unfair Trade Practice and Consumer Protection law.

The criminal sanction is appended to the substantive standard in this submission for the sake of clarity. In some states, the statutory organization of the criminal code might counsel in favor of demarking criminal sanctions separately from the substantive standard.

Also, felony grading standards differ substantially from state to state; each state will need to make its own determination on this.

SECTION VII. LEAD GENERATOR AND REFERRAL MARKETING

(a) Except as provided in subparagraph (b), it shall be unlawful for a treatment provider to enter into a contract with, or to provide any consideration to, a marketing provider who agrees to generate leads or referrals for the placement of patients with a treatment provider or recovery residence through a call center or website.

(b) A contract for, or payment or other consideration for, advertising is not unlawful if:

(1) it is through a website operated or controlled by a treatment provider or an operator of a recovery residence;

(2) the entity that operates or controls the website is clearly identified in plain language on the website; and

(3) compensation paid to the entity that operates or controls the website is not based on the volume or value of referrals, clicks, or any similar metric.

(c) In addition to any other punishment authorized by law, a person or entity that knowingly violates this section commits a felony of the third degree.

(d) Nothing in this Act shall apply to websites relating to substance use disorders or substance use disorder treatment operated by federal, state, or local governmental entities.
Comment:

There has been a great deal of discussion and testimony surrounding the use of marketing entities—primarily call centers, internet aggregators, and navigators—that are not associated directly with a treatment program and are therefore not subject to the regulatory oversight mechanisms that treatment programs are. The drafters are of the view that the clearest way to address this problem is a bright-line rule that forecloses treatment programs from doing business with marketing-only entities. There are two reasons for this.

First, aggregators are supported by payments from treatment programs. It is difficult to reconcile this business model with a clear, powerful anti-kickback statute that bars treatment providers from paying for patients. Regardless of the particular mechanisms involved, the ultimate result is that aggregators get paid by treatment providers for sending them patients or calls from patients.

Second, any more nuanced standard would be, as a practical matter, unenforceable. For example, Utah’s anti-brokering statute, enacted in 2018, expressly permits payments to “information services” that provide information without charge to consumers, so long as the charges are set in advance and are not based on the potential value of patients to the treatment provider, and so long as the information service does not steer the patient based on monetary rather than clinical criteria. Utah Code Ann. § 62A-2-116(6)(e). This is a good idea, but it poses significant enforcement challenges.

While theoretically there could be a risk that our bright-line approach might starve out internet resources that would otherwise be helpful to be families in crisis, such a concern does not appear to be borne out by what is actually occurring. The most trusted and trustworthy resources are universally associated with government resources, longstanding programs with established reputations, or organizations that do not appear to rely on funding from providers. We are not aware of any evidence, or indeed any serious claim, that marketing-only call centers, aggregators, and navigators have proven to be important, credible sources of information for families in crisis. The evidence consistently has pointed to the opposite conclusion.

Some commenters who reviewed earlier drafts of this document have noted that Google adwords and other similar internet marketing approaches include payments made on a per-click basis. The current language does not proscribe such arrangements, because Google and its search-engine counterparts are not providing the clicks “through a call center or website”.

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SECTION VIII. DRUG TESTING

(a) A treatment facility, and a licensed health care professional providing care to patients at a treatment facility or a recovery residence, shall not refer drug tests to an out-of-network laboratory if an in-network laboratory is reasonably available to meet the patient’s drug testing needs.

(b) A treatment facility, and a licensed health care professional providing care to patients at a treatment facility, shall not order or perform confirmatory testing in the absence of a documented medical or legal need for such confirmatory testing.

(c) Any person or entity who violates any provision of this section, where the amount billed for the drug test totals less than $5,000, commits a felony of the fourth degree, and shall be ordered to pay a fine of $5,000 per violation, in addition to full restitution to the parties adversely impacted.

(d) Any person or entity who violates any provision of this section, where the amount billed for the drug test totals $5,000 or more, commits a felony of the third degree, and shall be ordered to pay a fine of $10,000 per violation, in addition to full restitution to the parties adversely impacted.

(e) Any person or entity who violates any provision of this section, where the aggregate amount billed for drug tests referred, ordered, or performed in violation of this section over any twelve-month period is greater than $100,000, commits a felony of the second degree, and shall be ordered to pay a fine of $100,000, in addition to the full restitution to the parties adversely impacted.

Comment:

Patients and health insurance companies continue to be charged too much money by some treatment providers for needless drug tests. Drug tests should be conducted as needed to provide optimum clinical care for the patients, not to maximize the profits of a treatment facility or other provider that is operating unethically. The proposed language gets at both the cost problem and the quantity problem.

The sticker-shock prices almost invariably come from out-of-network laboratory providers. In-network prices are invariably a small fraction of the price for out-of-network users.
Every major health insurance plan has in-network laboratory providers in every state in the country (either directly, or through contracts that allow them to rent local networks), and the in-network laboratories are easy to identify for each health plan. Absent truly extraordinary circumstances, there is no reason to use out-of-network providers for drug testing, for patients who have in-network coverage.

Individuals in treatment often have little to no say in where their laboratory samples go. For this reason, responsibility should reside with the treatment facility, which does have a significant say in where laboratory samples go.

Apart from these issues, we are aware of more general concerns surrounding the overutilization of drug testing. The America Society of Addiction Medicine, for example, observed in 2017 that relatively cheap over-the-counter urine drug screens were often entirely appropriate and sufficient. American Society of Addiction Medicine, Consensus Statement: Appropriate Use of Drug Testing in Clinical Addiction Medicine (April 5, 2017).

Sometimes additional testing is needed to prevent legal harm from false positive results. A parole violation proceeding is one example of this. The reference to “documented medical or legal need” permits additional testing in these situations.

SECTION IX. RECOVERY RESIDENCES

(a) A treatment facility shall not make a referral of a prospective, current, or discharged patient to a recovery residence unless the recovery residence holds a valid [certification/license/accreditation/registration]

(b) Every treatment facility provider shall maintain records of referrals to or from recovery residences, including, where available, information about where a patient referred by a treatment facility elected to go.

(c) A treatment facility shall not make a referral of a prospective, current, or discharged patient to a recovery residence if the recovery residence requires the patient to receive treatment from a particular treatment provider or treatment facility as a condition of staying at the recovery residence, unless:

(1) The recovery residence is subject to the oversight and control of the referring treatment facility;
(2) The arrangements among and between the patient, recovery residence, and treatment facility are not in violation of section X of this Act;

(3) The recovery residence meets the standards set forth in subsection (a); and

(4) The recovery residence is located essentially contiguous with the referring treatment facility.

(d) No government funds may be used to pay for recovery housing that does not meet the standards set forth in subsection (a).

Comment:

Most states do not regulate recovery housing (except through general health and safety regulations—building codes, local health and safety codes, etc.—that are applicable to essentially all buildings or to all buildings that are open to the public). Some states certify recovery housing, and have developed either developed standards or have endorsed or otherwise credited standards have been established by, and are available through, organizations such as the National Association of Recovery Residences (and their state affiliates) and Oxford Houses.

The landscape here is evolving rapidly. Government regulation of recovery housing and individuals who run recovery residences remains a long-term goal. In the meantime, it makes sense to credit and utilize those markers of competence and integrity that are currently in place. Where certification standards are in place, they should be used.

Anti-discrimination laws have often been mentioned as a barrier to enforcing recovery housing standards. We note that Delray Beach, Florida has enacted an ordinance that identifies certification by the Florida Association of Recovery Residences (essentially the Florida incarnation of NARR) as a reasonable accommodation. Delray Beach, Fla., Ordinance 25-17 (2017), https://delraybeach.legistar.com/LegislationDetail.aspx?ID=3100473&GUID=B9DB85ED-6FCF-4479-A806-E6083032CAC9. This seems a sensible approach that protects those who need good recovery housing, while also addressing legal concerns under federal antidiscrimination laws.

Subparagraph (d) connects directly to laws banning unlawful use of government funds. Every state has such laws already in effect. A particular state’s embodiment of this Model Act provision will make these connections explicit.

Some commenters who reviewed earlier drafts of this Model Act accurately noted that subparagraph (d) might be difficult to enforce. Establishing a violation of these substantive
provisions as a violation of laws governing misuse of government funds more generally will bring a variety of tested enforcement mechanisms to bear.

SECTION X. PATIENT BROKERING AND KICKBACKS

(a) It is unlawful for any person, including any treatment provider or laboratory, to:

(1) Offer or pay anything of value, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, to induce the referral of a patient or patronage to or from a treatment provider or laboratory;

(2) Solicit or receive anything of value, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in return for referring a patient or patronage to or from a treatment provider or laboratory;

(3) Solicit or receive anything of value, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in return for the acceptance or acknowledgment of treatment from a health care provider or health care facility; and

(4) Aid or abet any conduct that violates this section.

(b) This section shall not apply to any discount, payment, waiver of payment, or payment practice that is expressly authorized by 42 U.S.C. § 1320a-7b(b)(3) or regulations adopted thereunder.

(c) This section shall not apply to reasonable contingency management techniques or other reasonable motivational incentives that are part of treatment provided by an accredited, licensed, or certified treatment provider.

(d) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.

(e) Any person who violates any provision of this section commits a felony of the third degree, and shall be ordered to pay a fine of $50,000.

(f) Any person who violates any provision of this section, where the prohibited conduct involves 10 or more patients but fewer than 20 patients, commits a felony of the second degree, and shall be ordered to pay a fine of $100,000.
(g) Any person who violates any provision of this section, where the prohibited conduct involves 20 or more patients, commits a felony of the first degree, and shall be ordered to pay a fine of $100,000.

Comment:

Patient brokering and unlawful kickbacks lie at the heart of the problem as it emerged, first in Florida and then in other states. A kickback is paying someone to refer a patient. A recovery residence or patient broker would refer a patient to a particular treatment facility—a referral driven by financial incentives and not by valid clinical considerations and the patient’s best interest. In exchange, the recovery residence or patient broker would be paid, sometimes many hundreds of dollars a week, by the treatment facility. Patients were often required to attend a particular treatment program (the one paying the bribe) as a condition of continuing to stay in the recovery residence receiving the kickback.

Patient brokering is a particular type of kickback. The money goes to an individual—a patient broker—in exchange for sending patients to the treatment facility.

We know from the Florida grand jury report and many other sources that kickbacks and patient brokering are often directly associated with the worst abuses. Presentment of the Palm Beach County Grand Jury, Report on the Proliferation and Abuse in Florida’s Addiction Treatment Industry, (Dec. 8, 2016), http://www.sa15.state.fl.us/stateattorney/SoberHomes/content/GrandJuryReport2.pdf (last visited June 26, 2019).

A recovery residence that relies on kickbacks from a treatment program for its very survival is not likely to put a patient’s clinical needs and safety first. Obviously, any meaningful solution needs to squarely address kickbacks and patient brokering.

Preliminarily, however, it is important to look at the broader context of private insurance and privately paid treatment. Recovery residences are not covered under private insurance, and patients in early recovery are often indigent and unable to pay. Certain commercial outpatient treatment facilities are using some of the funds they receive for providing treatment to create (or fund the creation of) substandard, unregulated “recovery housing”. Dollars flow from the licensed, regulated part of the treatment ecosystem to a largely unlicensed, largely unregulated part of the ecosystem. In terms of systems design, this invites corruption and requires constant vigilance. This issue is addressed below.

Kickbacks sometimes take the form of free air travel, free lodging, or payment of insurance premiums. These are benefits and remuneration that fall within the scope of the statutory language.
The Federal Landscape

When federal money is involved, a powerful and effective array of federal anti-kickback and antifraud rules apply. Kickbacks are prohibited under the federal anti-kickback statute, 42 U.S.C. § 1320a-7b; self-referrals are prohibited under the Stark Act, 42 U.S.C. § 1395nn. Violations of these statutes are felonies; they can result in exclusion from federal healthcare plans; they can bring significant civil monetary penalties; and they can give rise to significant liability under the federal false claims act. The federal government properly brings enormous resources to bear detecting and prosecuting these violations. They are joined in this mission by a vigorous plaintiffs’ bar investigating and pursuing federal civil whistleblower cases against doctors and companies that engage in this misconduct.

While kickbacks remain a problem with federally funded healthcare, systemic violations that take place in plain sight are now rare and invariably short-lived. It is no accident that the majority of the abuses observed in Florida involved private payments and private insurance.

The federal opioid bill passed in late 2018, H.R. 6, included the Eliminating Kickbacks in Recovery Act of 2018 (“EKRA”), which made kickbacks involving substance use disorder treatment a federal crime even when no federal dollars are involved. H.R. 6, § 8122 (codified at 18 U.S.C. § 220). This is a sensible and salutary development. Importantly, however, EKRA does not provide for any civil monetary penalty or civil damages remedy; the only tool available for enforcement is a federal criminal prosecution.

Insurance Industry Efforts to Eliminate Unlawful Kickbacks

There are notable instances of private insurance companies pursuing affirmative litigation against healthcare providers involved in kickback schemes, but those cases are in fact somewhat rare, and only make economic sense when significant dollars are involved and recoverable. Experience counsels that claims by insurers and health plans are not a reliable and complete enforcement mechanism.

This Act does establish new claims and causes of action that will be available to a number of affected entities and persons, including in some instances payors (and therefore insurers and health plans). There is every reason to expect the basic structural dynamics that apply to claims by payors—namely, the need for significant and recoverable damages—will continue to apply; and there is no reason to expect the interests of payors and other actors—for example, law enforcement and patients—to align in every respect. As a result, there is a continuing need for other enforcement mechanisms.

The State Landscape

Before 2017, a majority of states had anti-kickback statutes roughly similar to the federal anti-kickback statute. Most of them only applied when public money was involved. A few,
however—including Florida—had anti-kickback statutes that applied to healthcare paid by private insurance and in some instances by patients and families. Florida had two: section 456.054 prohibited kickbacks generally, and applied to “any health care provider or provider of health care services”, Fla. Stat. § 456.054(2); section 817.505 prohibited kickbacks “to induce the referral of patients or patronage to or from a health care provider or health care facility,” Fla. Stat. § 817.505(1)(a).² A number of other states had similar anti-kickback laws that extended to private payors. See, e.g., Cal. Health and Safety Code § 445 (“No person, firm, partnership, association or corporation, or agent or employee thereof, shall for profit refer or recommend a person to a physician, hospital, health-related facility, or dispensary for any form of medical care or treatment”); La. Stat. Ann. § 37:1745 (prohibition against payments for patient referrals; applicable to licensed professional counselors); Mass Gen. Laws Ch. 175H § 3 (prohibition against kickbacks whenever “payment is or may be made in whole or in part by a health care insurer”; applicable to “any person”); Mich. Comp. Laws § 752.1004 (prohibition against “kickback or bribe” in connection with goods or services paid by private insurance; applicable to “any person”); N.C. Gen. Stat. §§ 90-401, 90-402 (prohibition against providing and receiving compensation; applicable to health care providers, a term that includes licensed substance use disorder professionals); S.C. Code Ann. § 44-113-60 (prohibition against paying or receiving a kickback; applicable to health care providers, a term that includes licensed, certified, and registered health care providers); Tex. Occ. Code Ann. § 102.001 (prohibition against paying or receiving a kickback; applicable to any person licensed, certified, or registered by a state regulatory agency).

The penalties for violating these statutes were (and are) predominantly criminal.

These statutes did not, manifestly, prevent the problems with patient brokering and other kickbacks that emerged around privately insured and private-pay patients in need of substance disorder treatment. Some industry professionals have described patient brokering as the standard practice, not the exception. Florida of course proves the point: a clear, powerful anti-kickback statute and separate anti-brokering statute did not prevent the crisis.

Following an extensive investigation into the problem and its causes, as reflected in the report of an Investigative Grand Jury that was handed down on December 8, 2016, Florida changed its anti-brokering statute in two ways. First, it changed the definition of payment to add a “benefit”; this was intended to capture gifts and amenities that were often used to lure patients. Second, it dramatically increased the criminal penalties. Those penalties now increase in severity with the number of patients affected; brokering involving 20 or more patients is now punishable as a first degree felony, and carries a fine of $500,000.

² This provision was originally enacted in 1996. See 1996 Fla. Sess. Law Serv. Ch. 96-152 (C.S.H.B. 283) (West.). It has since been modified, but the substantive core remains the same.
Equally important, Florida made a radical commitment to enforcing the law, by expanding enforcement jurisdiction to include the office of statewide prosecution (anti-brokering prosecutions were previously left to local authorities), and by devoting significant resources to investigations and enforcement.

Florida’s efforts have gone a long way to fixing the problem. The problem has not disappeared from the national landscape; indeed, some of the worst actors have moved to states that have not taken these enforcement steps. In the words of one stakeholder, “the fleas have moved on to a different dog”. Furthermore, our own fact gathering process has confirmed that patient brokering is still occurring.

We think there is an important lesson in Florida. Merely having a law on the books is not sufficient. Resources need to be devoted to enforcement. We also conclude, based on comparison of results at the federal level and the state level, that adding civil enforcement tools, including private civil enforcement tools, to the arsenal is critical. Properly incented civil plaintiffs bring monitoring and enforcement resources to bear at no cost to the government. Furthermore, civil remedies have a lower burden of proof (preponderance of the evidence—the archetypal tipping of the scales—as opposed to beyond a reasonable doubt); do not require the plaintiff to prove criminal intent; offer far broader discovery; and can have broader venue provisions that make it easier to bring all the participants in an unlawful enterprise into the same proceeding.

**Self-Dealing in Referrals to Recovery Residences**

Self-referrals in healthcare are the subject of considerable regulation. The federal ban that prevents doctors from referring patients to healthcare facilities that they own—generally, the Stark Act and its implementing regulations—is a centerpiece of federal health care law. The overwhelming majority of states have roughly similar laws. These laws are complicated and are replete with exceptions and safe harbors, because they have to strike a complicated balance between (a) the concern with self-dealing against (b) the legitimate need to let doctors and other clinicians participate (both professionally and financially) in the development of health care facilities that often require extensive capital.

We do not include a self-referral ban expressly directed to substance use disorder treatment, largely because self-referrals have not emerged as a significant problem in their own right in this area. (This stands in marked contrast to kickbacks and patient brokering, where changes in the law and enforcement strategies are clearly necessary.) We also note that state and federal Stark law restrictions remain in force.

There are, however, two ways in which referrals to facilities owned by the maker of the referral have emerged as a major concern: recovery residences that require their residents to use
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a particular treatment facility; and excessive, overpriced drug tests. We have dealt with those concerns in Sections IV and V.

SECTION XI. MANAGED CARE

No treatment program shall enter into any contract or agreement with a third-party payor that includes any inducement or incentive to reduce or limit services to a level or duration below what is in the best clinical interest of the patient.

Comment:

Skewed funding drives much of the misconduct we are seeking to address in this model law.

For example, the strange practice of intensive outpatient programs paying hundreds of dollars a week to unregulated recovery residence operators is driven by payors not paying the treatment programs to house the patients themselves. For patients in early recovery, there is no clinical reason why it is better for the patient to sleep in a hotel or a rooming house instead of a room at the place they are receiving treatment, and there are serious clinical reasons why a hotel or rooming house could be worse for the patient.

This section does not take a position on the ongoing policy conversation about the appropriate role of residential substance use disorders.

Some voices in this conversation claim support for residential treatment in the literature, and in the accumulated wisdom and lived experience of the many people in strong recovery who found sobriety through meaningful residential treatment stays followed by less intensive, community-based care. Other voices in the conversation stress concerns about institutionalization for those with a stigmatized disease; stress the comparative importance of long-term community-based care for sustained recovery; and express concern with methodological flaws in studies that appear to support meaningful residential treatment stays.

Rather than take a position, this section both guarantees and requires that all treatment providers participate in those specific parts of the conversation that will shape the care of the provider’s patients. This applies not only to residential treatment, but to all parts of the continuum of care.
Another way funding drives care is through the use of case rate contracts that reward facilities for providing less care, and penalize them for providing more care. As one national, multicenter provider of substance use disorder treatment explained in a recent 10-K, “third-party payors are beginning to carve out specific services, including substance abuse treatment and behavioral health services, and establish small, specialized networks of providers for such services at fixed reimbursement rates.” AAC Holdings, Inc., Annual Report (Form 10-K), at 15 (Feb. 23, 2018). Under these case rate contracts, the shorter the treatment, the more money the treatment facility makes. Also, facilities have incentives to turn away the sickest patients.

Case rate contracts are increasingly common, and there is anecdotal evidence that these case rates are based on an implicit length of stay that is dangerously short. Anecdotally, there is enormous pressure placed on treatment facilities to enter into these contracts if they want to be in-network.

Where public funding is involved, a contract between a hospital and a doctor intended to induce the doctor to reduce or limit medically necessary care would violate the federal anti-kickback statute. See 42 U.S.C. § 1320a-7a(b)(1) (barring payments made to a doctor “as an inducement to reduce or limit medically necessary services”). There is a regulatory exception that countenances these inducements, but that exception is carefully defined and tightly constrained. See 42 C.F.R. § 1001.952(u). The exception is designed to prevent, and indeed requires the contracting parties to actively monitor for, underutilization. 42 C.F.R. § 1001.952(u). The proposition that improperly constructed case rates can harm patient care is not a novel one, although it is perhaps an underappreciated one—particularly with diseases of denial. And if these contracts have the potential to harm patient care when public dollars are being spent, they have the potential to harm patient care when private dollars are being spent.

More generally, other authorities also recognize the potential link between reimbursement contracts and patient safety. See, e.g., Health Benefit Plan Network Access and Adequacy Model Act § 6(F)-(I) (Nat’l Ass’n of Ins. Comms., 2015) 45 C.F.R. § 156.230 (network adequacy regulations for qualified health plans under the Affordable Care Act); Cal. Health & Safety Code §§1367.03, 1367(h)(1) (requiring contracts to be “fair [and] reasonable”); Fla. Stat. § 641.234(2)(a) (state office of insurance regulation review to ensure contracts with providers are not “detrimental to the subscribers”); Ga. Code Ann. § 33-20A-6(a) (“A managed care plan may not use a financial incentive or disincentive program that directly or indirectly compensates a health care provider or hospital for ordering or providing less than medically necessary and appropriate care to his or her patients or for denying, reducing, limiting, or delaying such care.”); 40 Pa. Stat. § 1554(b)(3) (Department of Health approval of contracts between HMOs and physician groups “which are found by the [S]ecretary [of Health] to provide adequate financial incentives for the provision of quality and cost-effective care”); 40 Pa. Stat. § 991.2112 (“No managed care plan shall use any financial incentive that compensates a
health care provider for providing less than medically necessary and appropriate care to an enrollee.”); 28 Pa. Code § 9.722(f)(3) (managed care regulation; to be approved by the Department of Health, provider contract must “include no financial incentive that compensates a health care provider for providing less than medically necessary and appropriate care to an enrollee”).

While it is critical that payors be required to offer contracts that are in the best interests of patients, it is also true that a payor-provider contract that is not proper for the payor is a contract that is not proper for the provider. No ethical treatment program should enter into an improper contract.

These contracts are invariably hidden from the view of patients and families, and almost always sit beyond the view of state and federal regulators. When form contracts are reviewed in connection with state or federal insurance regulation, case rate information almost always resides in schedules or attachments that are not part of that review. (The theoretical ability of regulatory personnel to obtain and review these schedules and attachments is, experience tells us, of little practical import.) And because these contracts move decisions about what care the patient receives from the managed care company to the provider, the practical mechanisms of managed care appeals—mechanisms that are supposed to form the backbone of patient protection—cannot even take hold. If a treatment program tells the patient that she is ready to go to sober housing after a four-day detox, there is no adverse benefit determination to appeal.

For this reason, it is essential that treatment facilities also assume responsibility for the safety of their managed care contracts. The proposed language does that.

Another way to underscore the point is to take a broader view of the Florida model, and managed care’s role in both enabling the model and failing to prevent its metastasis. Why did payors continue to pay for so much treatment, even after the problems in Florida were the subject of an investigative grand jury and extensive press coverage? When patients from out of state got on the plane to Florida, they were almost always heading to a treatment ecosystem limited to intensive outpatient or partial hospitalization (which is daytime only), and where they would have to pay for housing on their own. But these patients never received a denial letter from their health plan, telling them residential treatment was off the table. The language set forth here is hopefully the beginning of a broader and more transparent discussion that extends beyond treatment providers to other actors that play a significant role in determining whether or not patients can access the treatment they need to regain their health and achieve recovery.

These concerns are present across the continuum of care. Reimbursement should be fair and appropriate, and should not adversely affect patient care, at all levels of care.
Some commenters have noted that effective enforcement of the Mental Health Parity and Addiction Equity Act (“MHPAEA”), and the many State-law incarnations of that bill, would address many of the problems and concerns with managed care discussed here. We agree. But meaningful parity enforcement has not yet arrived, and there is no guarantee it will arrive anytime soon. We’re not waiting.

Similarly, some commenters have noted the need for more general improvements in the regulation of managed care organizations. We agree, but note that those changes are beyond the scope of this model law.

Some commenters suggested that we require both treatment and ethics providers to comply with recognized placement criteria, or with a particular set of recognized criteria (more precisely, ASAM). We do not think this is a workable solution, for several reasons. First, different funders use (and require the use of) different criteria, and requiring providers to use one set of a criteria when a funder is requiring them to use another one would place the provider in an impossible position. Second, different patient populations may require different criteria. Third, ASAM criteria (and similar criteria) determine placement; they do not directly establish or determine treatment. Fourth, reliance on ASAM criteria (or any private standards) raises serious constitutional concerns, because some state constitutions do not allow governments to delegate the creation of public standards to private standard-setting organizations. As a result, designating one particular set of privately-created criteria such as ASAM may prove an uncertain foundation for a statutory standard.

SECTION XII. RESPONSIBILITY, TRANSPARENCY, AND ACCOUNTABILITY

(a) Every treatment facility subject to this Act shall, on or before the end of the first fiscal year commencing after the effective date of this Act, submit to the [licensing entity] the following:

(1) an attestation, signed by a responsible corporate officer under oath, attesting that:
(A) the treatment facility has complied with the requirements of this Act, except as expressly noted in the attestation;
(B) the treatment facility has adopted, and is enacting and enforcing, policies and procedures designed and intended to ensure compliance with this Act; and
(C) the attestation is based on a reasonable investigation carried out at the direction of, and under the supervision and control of, the responsible corporate officer.
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(2) A detailed account of those areas where the treatment facility has failed to comply with the provisions of this Act, together with a corrective action plan designed to address any such deficiencies.

(b) Civil Remedies

(1) A treatment provider shall not request, receive, or retain payment for substance use disorder treatment services provided to a patient by a treatment provider as a result of conduct declared unlawful under this Act.

(2) Any person or entity who suffers any ascertainable loss of moneys or property, real or personal, as a result of the use or employment by another person of any method, act, or practice declared unlawful under this Act or the Act hereby amended and supplemented may bring an action or assert a counterclaim therefor in any court of competent jurisdiction, against the treatment provider who committed such violation and against any other person or entity who knowingly aided, abetted, or took part in such violation. In any action under this section the court shall, in addition to any other appropriate legal or equitable relief, award three times the damages sustained by any person in interest. In all actions under this section, the court shall also award reasonable attorneys’ fees, filing fees and reasonable costs of suit.

(3) The Attorney General, any District Attorney, [the appropriate licensing authority], or any other person with an ascertainable interest, may bring an action under the [state’s declaratory judgment act] to declare that an act or practice violates this Act. Where the action is successful, in whole or in part, the court shall award attorneys’ fees, costs of investigation and prosecution, costs of investigation and prosecution, filing fees, and all other reasonable costs of bringing the action, to the plaintiff.

(4) The Attorney General, any District Attorney, [the appropriate licensing authority], or any other government entity or agency with an ascertainable interest, may bring an action to enjoin any person or entity who has violated, is violating, or is otherwise likely to violate any provisions of this Act. Where the action is
successful, in whole or in part, the court shall award attorneys’ fees, costs of investigation and prosecution, filing fees, and all other reasonable costs of bringing the action, to the plaintiff.

(5) The [appropriate licensing authority] may investigate allegations of violations of any provisions of this Act. Upon finding a violation, the [appropriate licensing authority] may do any or all of the following:

(A) Assess a penalty upon any licensed provider;

(B) Suspend or revoke the license of any licensed provider or deny an application for licensure; and

(C) Recommend disciplinary actions, including but not limited to termination of employment and suspension or revocation of a license.

(6) Any person or entity who violates any provisions of this Act shall be subject to a civil monetary penalty of not more than $10,000 for each violation.3

(7) The Attorney General, any District Attorney, [the appropriate licensing authority], or any other government entity or agency with an ascertainable interest, may bring an action to recover any civil monetary penalty provided for in this Act. Where the action is successful, in whole or in part, the court shall award attorneys’ fees, filing fees, and all other reasonable costs of bringing the action, to the plaintiff.

(c) Additional Criminal Accountability

(1) Any person or entity who engages in or participates in a scheme to circumvent any of the provisions of this Act commits a felony of the second degree.

(2) Where a person or entity has been convicted of a criminal offense under this Act, the court shall award to the prosecuting entity, as part of restitution, all of the costs of investigating and prosecuting the criminal case. Such restitution shall be in addition to any appropriate restitution ordered for payors, patients, patients’ families, and other parties adversely impacted by the defendant’s unlawful practices.

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3 Civil money penalties under federal law range up to $100,000 for each violation. 42 U.S.C. § 1320a-7a(a).
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(d) The provisions of this section are in addition to any other civil, administrative, or criminal actions provided by law and may be imposed against both corporate and individual defendants.

Comment:

States with whistleblower laws should ensure that these protections apply to individuals reporting violations of the substantive provisions of this Model Act.
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76 billion opioid pills: Newly released federal data unmask the epidemic

By Scott Higham, Sari Horwitz and Steven Rich
July 16

America's largest drug companies saturated the country with 76 billion oxycodone and hydrocodone pain pills from 2006 through 2012 as the nation's deadliest drug epidemic spun out of control, according to previously undisclosed company data released as part of the largest civil action in U.S. history.

The information comes from a database maintained by the Drug Enforcement Administration that tracks the path of every single pain pill sold in the United States — from manufacturers and distributors to pharmacies in every town and city. The data provides an unprecedented look at the surge of legal pain pills that fueled the prescription opioid epidemic, which has resulted in nearly 100,000 deaths from 2006 through 2012.

Just six companies distributed 75 percent of the pills during this period: McKesson Corp., Walgreens, Cardinal Health, AmerisourceBergen, CVS and Walmart, according to an analysis of the database by The Washington Post. Three companies manufactured 88 percent of the opioids: SpecGx, a subsidiary of Mallinckrodt; Actavis Pharma; and Par Pharmaceutical, a subsidiary of Endo Pharmaceuticals.

Purdue Pharma, which the plaintiffs allege sparked the epidemic in the 1990s with its introduction of OxyContin, its version of oxycodone, was ranked fourth among manufacturers with about 3 percent of the market.

The volume of the pills handled by the companies skyrocketed as the epidemic surged, increasing about 51 percent from 8.4 billion in 2006 to 12.6 billion in 2012. By contrast, doses of morphine, a well-known treatment for severe pain, averaged slightly more than 500 million a year during the period.

Those 10 companies along with about a dozen others are now being sued in federal court in Cleveland by nearly 2,000 cities, towns and counties alleging that they conspired to flood the nation with opioids. The companies, in turn, have blamed the epidemic on overprescribing by doctors and pharmacies and on customers who abused the drugs. The companies say they were working to supply the needs of patients with legitimate prescriptions desperate for pain relief.

The database reveals what each company knew about the number of pills it was shipping and dispensing and precisely when they were aware of those volumes, year by year, town by town. In case after case, the companies allowed the drugs to reach the streets of communities large and small, despite persistent red flags that those pills were being sold in apparent violation of federal law and diverted to the black market, according to the lawsuits.

Plaintiffs have long accused drug manufacturers and wholesalers of fueling the opioid epidemic by producing and distributing billions of pain pills while making billions of dollars. The companies have paid more than $1 billion in fines to the Justice Department and Food and Drug Administration over opioid-related issues, and hundreds of millions more to settle state lawsuits.
But the previous cases addressed only a portion of the problem, never allowing the public to see the size and scope of the behavior underlying the epidemic. Monetary settlements by the companies were accompanied by agreements that kept such information hidden.

The drug companies, along with the DEA and the Justice Department, have fought furiously against the public release of the database, the Automation of Reports and Consolidated Order System, known as ARCOS. The companies argued that the release of the “transactional data” could give competitors an unfair advantage in the marketplace. The Justice Department argued that the release of the information could compromise ongoing DEA investigations.

Until now, the litigation has proceeded in unusual secrecy. Many filings and exhibits in the case have been sealed under a judicial protective order. The secrecy finally lifted after The Post and HD Media, which publishes the Charleston Gazette-Mail in West Virginia, waged a year-long legal battle for access to documents and data from the case.

On Monday evening, U.S. District Judge Dan Polster removed the protective order for part of the ARCOS database.

Lawyers for the local governments suing the companies hailed the release of the data.

“The data provides statistical insights that help pinpoint the origins and spread of the opioid epidemic — an epidemic that thousands of communities across the country argue was both sparked and inflamed by opioid manufacturers, distributors, and pharmacies,” said Paul T. Farrell Jr. of West Virginia, co-lead counsel for the plaintiffs.

In statements emailed to The Post on Tuesday, the drug distributors stressed that the ARCOS data would not exist unless they had accurately reported shipments and questioned why the government had not done more to address the crisis.

“For decades, DEA has had exclusive access to this data, which can identify the total volumes of controlled substances being ordered, pharmacy-by-pharmacy, across the country,” McKesson spokeswoman Kristin Chasen said.

A DEA spokeswoman declined to comment Tuesday “due to ongoing litigation.”

Cardinal Health said that it has learned from its experience, increasing training and doing a better job to “spot, stop and report suspicious orders,” company spokeswoman Brandi Martin wrote.

AmerisourceBergen derided the release of the ARCOS data, saying it “offers a very misleading picture” of the problem. The company said its internal “controls played an important role in enabling us to, as best we could, walk the tight rope of creating appropriate access to FDA approved medications while combating prescription drug diversion.”

While Walgreens still dispenses opioids, the company said it has not distributed prescription-controlled substances to its stores since 2014. “Walgreens has been an industry leader in combatting this crisis in the communities where our pharmacists live and work,” said Phil Caruso, a Walgreens spokesman.

Mike DeAngelis, a spokesman for CVS, said the plaintiffs’ allegations about the company have no merit and CVS is aggressively defending against them.

Walmart, Purdue and Endo declined to comment about the ARCOS database.
A Mallinckrodt spokesman said in a statement that the company produced opioids only within a government-controlled quota and sold only to DEA-approved distributors.

Actavis Pharma was acquired by Teva Pharmaceutical Industries in 2016, and a spokeswoman there said the company “cannot speak to any systems in place beforehand.”

A virtual road map

The Post has been trying to gain access to the ARCOS database since 2016, when the news organization filed a Freedom of Information Act request with the DEA. The agency denied the request, saying some of the data was available on its website. But that data did not contain the transactional information the companies are required to report to the DEA every time they sell a controlled substance such as oxycodone and hydrocodone.

The drug companies and pharmacies themselves provided the sales data to the DEA. Company officials have testified before Congress that they bear no responsibility for the nation’s opioid epidemic.

The numbers of pills the companies sold during the seven-year time frame are staggering, far exceeding what has been previously disclosed in limited court filings and news stories.

Three companies distributed nearly half of the pills: McKesson with 14.1 billion, Walgreens with 12.6 billion and Cardinal Health with 10.7 billion. The leading manufacturer was Mallinckrodt’s SpecGx with nearly 28.9 billion pills, or nearly 38 percent of the market.

The states that received the highest concentrations of pills per person per year were: West Virginia with 66.5, Kentucky with 63.3, South Carolina with 58, Tennessee with 57.7 and Nevada with 54.7. West Virginia also had the highest opioid death rate during this period.

Rural areas were hit particularly hard: Norton, Va., with 306 pills per person; Martinsville, Va., with 242; Mingo County, W.Va., with 203; and Perry County, Ky., with 175.

In that time, the companies distributed enough pills to supply every adult and child in the country with 36 each year.

The database is a virtual road map to the nation’s opioid epidemic that began with prescription pills, spawned increased heroin use and resulted in the current fentanyl crisis, which added more than 67,000 to the death toll from 2013 to 2017.

The transactional data kept by ARCOS is highly detailed. It includes the name, DEA registration number, address and business activity of every seller and buyer of a controlled substance in the United States. The database also includes drug codes, transaction dates, and total dosage units and grams of narcotics sold.

The data tracks a dozen different opioids, including oxycodone and hydrocodone, which make up three-quarters of the total pill shipments to pharmacies.

Under federal law, drug manufacturers, distributors and pharmacies must report each transaction of a narcotic to the DEA, where it is logged into the ARCOS database. If company officials notice orders of
drugs that appear to be suspicious because of their unusual size or frequency, they must report those sales to the DEA and hold back the shipments.

As more and more towns and cities became inundated by pain pills, they fought back. They filed federal lawsuits against the drug industry, alleging that opioids from the companies were devastating their communities. They alleged the companies not only failed to report suspicious orders, but they also filled those orders to maximize profits.

As the hundreds of lawsuits began to pile up, they were consolidated into the one centralized case in U.S. District Court in Cleveland. The opioid litigation is now larger in scope than the tobacco litigation of the 1980s, which resulted in a $246 billion settlement over 25 years.

‘Where the virus grew’

Judge Polster is now overseeing the consolidated case of nearly 2,000 lawsuits. The case is among a wave of actions that includes other lawsuits filed by more than 40 state attorneys general and tribal nations. In May, Purdue settled with the Oklahoma attorney general for $270 million.

In the Cleveland case, Polster has been pressing the drug companies and the plaintiffs to reach a global settlement so communities can start receiving financial assistance to mitigate the damage that has been done by the opioid epidemic.

To facilitate a settlement, Polster had permitted the drug companies and the towns and cities to review the ARCOS database under a protective order while barring public access to the material. He also permitted some court filings to be made under seal and excluded the public and press from a global settlement conference at the outset of the case.

Last June, The Post and the Charleston Gazette-Mail asked Polster to lift the protective order covering the ARCOS database and the court filings. A month later, Polster denied the requests, even though he had said earlier that “the vast oversupply of opioid drugs in the United States has caused a plague on its citizens” and the ARCOS database reveals “how and where the virus grew.” He also said disclosure of the ARCOS data “is a reasonable step toward defeating the disease.”

Lawyers for The Post and the Gazette-Mail appealed Polster’s ruling. They argued that the ARCOS material would not harm companies or investigations because the judge had already decided to allow the local government plaintiffs to collect information from 2006 through 2014, withholding the most recent years beginning with 2015 from the lawsuit.

“Access to the ARCOS Data can only enhance the public’s confidence that the epidemic and the ensuing litigation are being handled appropriately now — even if they might not have been handled appropriately earlier,” The Post’s lawyer, Karen C. Lefton, wrote in her Jan. 17 appeal.

The lawyers also noted the DEA did not object when the West Virginia attorney general’s office provided partial ARCOS data to the Gazette-Mail in 2016. That data showed that drug distribution companies shipped 780 million doses of oxycodone and hydrocodone into the state between 2007 and 2012.

On June 20, the 6th Circuit Court of Appeals in Ohio sided with the news organizations. A three-judge panel reversed Polster, ruling that the protective order sealing the ARCOS database be lifted with reasonable redactions and directed the judge to reconsider whether any of the records in the case should be sealed.

On Monday, Polster lifted the protective order on the database, ruling that all the data from 2006 through 2012 should be released to the public, withholding the 2013 and 2014 data.

‘Prescription tourists’
The pain pill epidemic began nearly three decades ago, shortly after Purdue Pharma introduced what it marketed as a less addictive form of opioid it called OxyContin. Purdue paid doctors and nonprofit groups advocating for patients in pain to help market the drug as a safe and effective way to treat pain.

But the new drug was highly addictive. As more and more people were hooked, more and more companies entered the market, manufacturing, distributing and dispensing massive quantities of pain pills.

Purdue ending up paying a $634 million fine to the Food and Drug Administration for claiming OxyContin was less addictive than other pain medications.

Annual opioid sales nationwide rose from $6.1 billion in 2006 to $8.5 billion in 2012, according to industry data gathered by IQVIA, a health care information and consulting company.

Individual drug company revenues ranged in single years at the epidemic’s peak from $403 million for opioids sold by Endo to $3.1 billion in OxyContin sales by Purdue Pharma, according to a 2018 lawsuit against multiple defendants by San Juan County in New Mexico.

During the past two decades, Florida became ground zero for pill mills — pain management clinics that served as fronts for corrupt doctors and drug dealers. They became so brazen that some clinics set up storefronts along I-75 and I-95, advertising their products on billboards by interstate exit ramps. So many people traveled to Florida to stock up on oxycodone and hydrocodone, they were sometimes referred to as “prescription tourists.”

The route from Florida to Georgia, Kentucky, West Virginia and Ohio became known as the “Blue Highway.” It was named after the color of one of the most popular pills on the street — 30 mg oxycodone tablets made by Mallinckrodt, which shipped more than 500 million of the pills to Florida between 2008 and 2012.

When state troopers began pulling over and arresting out-of-state drivers for transporting narcotics, drug dealers took to the air. One airline offered nonstop flights to Florida from Ohio and other Appalachian states, and the route became known as the Oxy Express.

A decade ago, the DEA began cracking down on the industry. In 2005 and 2006, the agency sent letters to drug distributors, warning them that they were required to report suspicious orders of painkillers and halt sales until the red flags could be resolved. The letter also went to drug manufacturers.

Even just one distributor that fails to follow the law “can cause enormous harm,” the 2006 DEA letter said.

DEA officials said the companies paid little attention to the warnings and kept shipping millions of pills in the face of suspicious circumstances.

As part of its crackdown, the DEA brought a series of civil enforcement cases against the largest distributors.

The corporations to date have paid nearly $500 million in fines to the Justice Department for failing to report and prevent suspicious drug orders, a number that is dwarfed by the revenue of the companies.

But the settlements of those cases revealed only limited details about the volume of pills that were being shipped.

In 2007, the DEA brought a case against McKesson. The DEA accused the company of shipping millions of doses of hydrocodone to Internet pharmacies after the agency had briefed the company about its obligations under the law to report suspicious orders.

"By failing to report suspicious orders for controlled substances that it received from rogue Internet pharmacies, the McKesson Corporation fueled the explosive prescription drug abuse problem we have in this country,” the DEA’s administrator said at the time.
In 2008, McKesson agreed to pay a $13.25 million fine to settle the case and pledged to more closely monitor suspicious orders from its customers.

That same year, the DEA brought a case against Cardinal Health, accusing the nation’s second-largest drug distributor of shipping millions of doses of painkillers to online and retail pharmacies without notifying the DEA of signs that the drugs were being diverted to the black market.

Cardinal settled the case by paying a $34 million fine and promising to improve its suspicious monitoring program.

Some companies were repeat offenders.

In 2012, the DEA began investigating McKesson again, this time for shipping suspiciously large orders of narcotics to pharmacies in Colorado. One store in Brighton, Colo., population 38,000, was ordering 2,000 pain pills per day. The DEA discovered that McKesson had filled 1.6 million orders from its Aurora, Colo., warehouse between 2008 and 2013 and reported just 16 as suspicious. None involved the Colorado store.

DEA agents and investigators said they had amassed enough information to file criminal charges against McKesson and its officers but they were overruled by federal prosecutors. The company wound up paying a $150 million fine to settle, a record amount for a diversion case.

Also in 2012, Cardinal Health attracted renewed attention from the DEA when it discovered that the company was again shipping unusually large amounts of painkillers to its Florida customers. The company had sold 12 million oxycodone pills to four pharmacies over four years.

In 2011, Cardinal shipped 2 million doses to a pharmacy in Fort Myers, Fla. Comparable pharmacies in Florida typically ordered 65,000 doses per year.

The DEA also noticed that Cardinal was shipping unusually large amounts of oxycodone to a pair of CVS stores near Sanford, Fla. Between 2008 and 2011, Cardinal sold 2.2 million pills to one of the stores. In 2010, that store purchased 885,900 doses — a 748 percent increase over the previous year. Cardinal did not report any of those sales as suspicious.

Cardinal later paid a $34 million fine to settle the case. The DEA suspended the company from selling narcotics from its warehouse in Lakeland, Fla. CVS paid a $22 million fine.

As the companies paid fines and promised to do a better job of stopping suspicious orders, they continued to manufacture, ship and dispense large amounts of pills, according to the newly released data.

“The depth and penetration of the opioid epidemic becomes readily apparent from the data,” said Peter J. Mougey, a lawyer for the plaintiffs from Pensacola, Fla. “This disclosure will serve as a wake up call to every community in the country. America should brace itself for the harsh reality of the scope of the opioid epidemic. Transparency will lead to accountability.”

Aaron Williams, Andrew Ba Tran, Jenn Abelson, Aaron C. Davis and Christopher Rowland contributed to this report.

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