



Meeting Record

Governor's Task Force on Drug Enforcement, Treatment, and Prevention

October 15, 2015 | 12:30 p.m. - 4:30 p.m. | University of Southern Indiana | Evansville

Facilitators:

John Hill, Governor's Office
Dr. Jerome Adams, Indiana State Department of Health

Task Force Members Present:

Dr. Joseph Fox, Anthem
Jane Bisbee, Indiana Department of Child Services
Dr. Tim Kelly, Community Health

Senator Jim Arnold, Indiana State Senate
Dr. Charles Miramonti, Indianapolis Emergency Medical Services
Representative Wendy McNamara, Indiana House of Representatives
Sheriff John Layton, Marion County Sheriff's Office
Reverend Rabon Turner Sr., New Hope Missionary Baptist Church
Dan Miller, Indiana Prosecuting Attorneys Council
Representative Terry Goodin, Indiana House of Representatives
Bernard Carter, Lake County Prosecutor
Dr. Joan Duwve, IU Fairbanks School of Public Health and Indiana State Department of Health
Judge Roger Duvall, Scott County Circuit Court
Judge Wendy Davis, Allen County Superior Court
Supt. Doug Carter, Indiana State Police

Others Present:

Presenters:

Nicholas Hermann, Vanderburgh County Prosecuting Attorney
Dr. Donna Purviance, Goodman Campbell Brain & Spine
First Sergeant Jeff Bell, Vigo County Sheriff's Office
Dr. Miriam Komaromy, ECHO Institute
Parri Black, Youth First, Inc.

Staff Support to the Task Force Present:

Veronica Schilb, Office of the Governor
Devon McDonald, Indiana Criminal Justice Institute
Mary Kay Hudson, Indiana Judicial Center
Diane Haver, Indiana Judicial Center

Public:

Michael Mitcheff
Donna Purviance
Sean O'Daniel
Samantha Horton

Roger David
Deborah Williams
Bernard Carter
Wade Lowharn

Bill Wooten
Charlotte Conerton
Jean Hart
Nick Hermannn

Terry Cook
David Bozell
Jeff Bell
Kevin Moore
Jeremy Furgy

Helen Peck
Julie St Clair
Jerry Parkinson
Andrew Guasent

Kathleen Bates
Daniel Bugher

Task Force Members Absent:

Dr. John Wernert, Co-Chair, Indiana Family Social Services Administration
Chief Michael Diekhoff, Bloomington Police Department
Commissioner Bruce Lemmon, Indiana Department of Correction
Justice Mark Massa, Indiana Supreme Court
Senator Jim Merritt, Indiana State Senate
Tony Gillespie, Indiana Minority Health Coalition

Meeting Summary:

- Presenters from various disciplines spoke on how their professions are impacted by drug addiction and presented recommendations and solutions in their respective fields.
- Task Force members were given the opportunity to pose questions to the presenters.
- Two members of the public provided testimony and offered recommendations regarding work force development and an overdose reversal initiative.
- Task Force members discussed potential action items and recommendations for Governor Pence.

Presentations:

Nicholas Hermann

Mr. Hermann, elected prosecutor for Vanderburgh County, took office in January 2011. Since then, he has taken a close look at the drug problem in southern Indiana. At one point, Vanderburgh County led the state in methamphetamine lab seizures. The drug problem in southern Indiana impacts quality of life, families, and communities. Mr. Hermann explained that meth is easy to make and the materials were at one time easily available at local drug stores. Such accessibility led to the “one-pot” methamphetamine labs in cars and homes which were susceptible to explosion and put the unassuming in danger. Crystal meth, manufactured in super labs in Mexico, later made its presence in southern Indiana. Vanderburgh County continues to battle both forms of the drug.

Mr. Hermann explained the effects of methamphetamine. The drug induces an intense pleasure sensation that lasts for several minutes then tapers off to a euphoric high that last for several hours. Dopamine levels greatly increase and the individual eventually enters a state of depression. With continued use, the body desensitizes to dopamine and hijacks the body’s system to respond to rewards, such as eating, drinking, and social engagement. Psychotic behavior may be prompted. It becomes increasingly more difficult for the individual to experience pleasure so the individual typically seeks more of the drug.

In order to combat the manufacturing of methamphetamine, pseudoephedrine was moved behind pharmacy counters, individuals were tracked when buying, and quantities were limited. Manufacturers began to use “smurfs” to buy the drug for them. Mr. Hermann noted that in order to stop the manufacturing of methamphetamine in the dangerous and explosive one-pot laboratories, pseudoephedrine needs to become a scheduled drug. But as PowerPoint slide 12 indicates, the drug problem will continue as crystal meth imports have risen from 516 grams seized in 2011 to 27,786 in 2014. Heroin is also creeping into Vanderburgh County, but the biggest problem in the area is that of

prescription drug abuse. Mr. Hermann notes that they are in need of a reporting system that will track the prescriptions written as legal substances are being used illegally. He explained that Vanderburgh County's approach is to treat the addicts and to incarcerate the dealers. They also have a successful drug court, a forensic diversion program, probation, home detention, work release, and in-home drug testing. The community uses WeTip to help law enforcement fight crime.

Mr. Hermann explored options to fight the drug problem in southern Indiana. He noted that the county jail is now overcrowded due to the criminal code rewrite and the jail does not provide treatment for addicts like the DOC. It is important to determine who is actually in need of treatment versus those in need of punishment. Mr. Hermann presented that incarceration leads to recovery. The only way to get better is to face punishment so minimum sentencing should be written in order to incentivize people to behave. Mr. Hermann offered four criminal code amendment proposals found on slides 25-28:

- Amend IC 35-48-4-1 and IC 35-48-4-1.1 to enhance the dealing offense by two levels if the defendant has more than one enhancing circumstance.
- Amend IC 35-50-2-2.2 to restore mandatory minimum sentences if an enhancing circumstance applies or if the amount of the drug is over 10 grams.
- Add family house complex (IC-35-31.5-2-127) and youth program center (IC 35-31.4-2-357) to the locations covered by the 500 foot rule in the definition of enhancing circumstances (IC 35-48-1-16.5).
- Eliminate language in IC 35-48-4-1 and IC 35-48-4-1.1 that requires evidence in addition to the weight of the drug to prove intent to deal the drug.

Nicholas Hermann answered questions from the Task Force members.

Dr. Donna Purviance and First Sergeant Jeff Bell

Dr. Purviance from the Goodman Campbell Brain & Spine in Vigo County presented on the naloxone administration by law enforcement. As noted on slide 33, the purpose of the training was to teach and assess knowledge deficits and to decipher law enforcement attitudes associated with saving a life from an opiate overdose, be it intentional or accidental, whether legally prescribed or illicit use. SEA 227 allows for a law enforcement officer to administer an overdose intervention drug to an individual who is suffering from an overdose. SEA 406 allows for a prescriber of naloxone to write an order that authorizes an individual in a position to assist a person experiencing an opioid-related overdose to receive and distribute naloxone. Dr. Purviance began leading naloxone trainings in Vigo County and then later reached out to Vermillion County and Clark County. As of September 21, 2015, 41 entities have trained law enforcement first responders. She has also trained at Indiana State University and Notre Dame. The pretests and posttests indicated that trained officers felt more confident in naloxone administration after the training. The last question of the test indicated that 100% of responders wanted to provide help to a person who has overdosed. Slide 37 indicates that after one year of first responders administering the drug, there have been 129 uses, 3 deaths despite officers using naloxone appropriately, no legal issues, one combative victim, and more than 80% of hospital admittance after resuscitation.

First Sergeant Jeff Bell was among the first group to be trained on the administration of Narcan while on patrol. During the training, he learned about opiates, when to use the counter agent drug, who could administer it, what the ramifications were, and the legal right to administer the drug. The training attendees took turns administering the drug on a mannequin. On April 1, 2015, the policy to allow law enforcement first responders to administer the drug to overdose victims took effect and the Narcan kits were placed in patrol cars. Sergeant Bell became the first officer in Vigo County to administer the drug on a victim of overdose. The individual survived.

Dr. Purviance and Sergeant Bell answered questions from the Task Force. Dr. Purviance noted that they are in the process of putting together a regional map to see if their training areas are corresponding with areas that have the highest overdose rates. She also noted that the drug only works with opiates and therefore, a victim will not be hurt by it if the overdose did not occur as a result of opiate use. Dr. Purviance conducts the trainings at no cost and the Department of Homeland Security is in the process of posting an online training. Dr. Purviance noted that the stigma of Narcan has a negative impact on the level of funding provided.

John Hill noted that there is movement in Narcan but discrepancies still occur, such as prohibiting EMTs from administering the drug. Mr. Hill recommended the process of identifying the gaps and to focus on looking at the counties with high instances of overdose.

Dr. Miriam Komaromy

Dr. Miriam Komaromy with the ECHO Institute presented via teleconference on the ECHO program. ECHO carries a mission to democratize medical knowledge and get best practice care to underserved people all over the world. The program began in New Mexico by a gastro-neurologist who specialized in the treatment of hepatitis C. When he began ECHO, New Mexico had the highest rate of hepatitis C cases in the nation. At that time, no primary care providers knew how to treat hepatitis C and patients had to travel over 200 miles to get treatment from him. As a result, the doctor worked to teach the primary care providers how to treat the disease by way of a virtual clinic. Through ECHO, primary care teams now connect with specialists at universities two hours each week and assess cases that they are managing. Specialists gather in a teleconference and provide professional feedback to the primary care providers, while they continue to develop more knowledge. The ECHO model uses video technology to manage scarce resources and relies on the sharing of best practices and case-based learning. The participants are actively engaged, which works well for the adult brain. Rural clinicians have seen a benefit to the educational program, CMU's are offered, and there is no cost to participate. After an evaluation of the hepatitis C treatment provided by rural primary care providers, it was determined that they delivered a level-of-care like that of a specialist. As a result, they gained confidence in the model and determined it could be replicated for other diseases. It is recommended that the ECHO approach be used for common diseases that demand complex management, treatment with medicines, have a societal impact, and would render serious outcomes if left untreated.

The ECHO model has been used to facilitate educational workshops related to substance use disorders in New Mexico. It now has routine participation by primary care providers around the state of New Mexico. Opiate cases and MAT are most commonly discussed. They have recruited providers to become trained in suboxone and buprenorphine. Slide 67 shows the tremendous increase in the number of physicians trained in using buprenorphine to treat opiate addiction. There has been a recent focus on training community health workers via ECHO. Additionally, the ECHO model has been used in prisons with peer educators who work to train other inmates on the spread of disease. A great benefit of the model is its promising impact on communities with expanded access to care for a variety of common complex diseases in high need communities.

Dr. Miriam Komaromy answered questions from the Task Force and noted that her contact information could be found on her first slide. She offers a three-day training for groups interested in exploring the ECHO concept.

Parri Black

Parri Black presented on Youth First, Inc., a non-profit organization with a mission to strengthen youth and families by providing evidence-based programs that prevent substance abuse, promote healthy

behaviors, and maximize student success. The agency spent 17 years developing a model of prevention that is transforming lives. Youth First, Inc. uses a model that incorporates master's level social workers in schools, uses a menu of proven programs, forges strong partnerships with schools, churches, and other agencies, and undergoes continuous evaluation and improvement. Youth First currently employs 39 master level social workers that are accessible to more than 26,000 students in 57 schools, and 11 school systems across 6 counties. The agency provides consultations with school faculty and staff, parents, and caregivers. They will also refer students to community resources and family programs. They offer services that are accessible and free of charge, rely on the use of evidence-based practices, use strategies designed to reduce risk factors and increase protective factors, and boost social skills. Improvement of lives can be measured and the improvements are generally sustained for at least 18 months. For example, 91% of students working with Youth First advanced to the next grade level or graduated and 89% of graduates had college and/or career plans. Ms. Black reported that the return on investment yields \$18 in savings for every one dollar spent on effective prevention. Slide 108 presents the breakdown of funding sources.

Ms. Parri Black answered questions from the Task Force.

Public Testimony:

Sean O'Daniel

Mr. O'Daniel began his presentation by stating that he is supportive of the points made by the presenters and had hoped to offer the Task Force a few suggestions for their consideration. He began by providing the background related to the tragic loss of his son to suicide. While in school, his son received services by Youth First. He was later found with a self-inflicted gunshot wound that ended his life. The firearm used was a rifle that he purchased from an unknown individual. The autopsy report showed his system had in it two prescribed medications and one additional controlled substance of which he did not have a prescription.

Mr. O'Daniel recommended a gun registration and excise tax be placed on the purchase of firearms in order to pay for needed programs. Dr. Adams asked Mr. O'Daniel if he knew what drugs were in his son's system at the time of his death. Mr. O'Daniel stated that he has the autopsy and could email the answer. A pharmacist at one time confirmed that all three substances were prescription medications. Mr. O'Daniel looked up the side effects and learned that panic attacks may occur. Dr. Adams noted that the doctor may have prescribed a medication that could have attributed to his suicidal thoughts and stressed that physicians must have a clear understanding as to what they are prescribing.

Jeremy Forgy

Mr. Forgy presented to the Task Force from the perspective of the opiate consumer in Indiana. At the age of ten, he began using marijuana and later his father introduced him to methamphetamine. His brother later introduced him to oral opiates and quickly became addicted at age 18. He expressed remorse for his actions and low points during his addiction. Mr. Forgy has spent time on probation, in a half-way house, drug court, work release, and prison. With three young children of his own, he desires to be a better father to them than he has been in the past. In order to manage his opiate addiction, Mr. Forgy now takes daily doses of methadone. Mr. Forgy recommended to the Task Force that Evansville designate friendly pharmacies that allow for the safe disposal of needles. He explained that an addict will use whether they have a clean needle or not. The unsafe and unhealthy behavior can attribute to the rise in HIV and hepatitis cases.

Representative Goodin asked how easy it would have been to get drugs while incarcerated. Mr. Forgy stated that drugs are very accessible in prison and are sometimes easier to get in prison than on the streets. Mr. Forgy added that prison also teaches inmates an easier way to break the law.

Discussions:

Dr. Mitcheff, Chief Medical Officer for the Department of Corrections, was asked by John Hill what the Task Force should know about MAT. He responded that they are looking for people who want to “walk the walk and stay clean.” He noted that it is critical that the patients receive the necessary wrap-around services and HIP 2.0 will make this more feasible. Without the wrap-around services, criminogenic behaviors often result. He noted that 85% of their patients are in the prison because of addiction. Dr. Mitcheff answered questions and noted that they will refer patients to many other programs, regardless of their use of Vivitrol.

Discussions continued with points related to MAT. Judge Davis noted that the national level is having a difficult time replacing a drug with a drug. She noted that it is important to make sure the addict is not manipulating the system. Judge Duvall followed by noting that we cannot incarcerate ourselves out of this problem. It is important that we are sending the right people to prison, but not all people. He offered the following recommendations:

- Teach doctors how to proscribe and track precursors.
- Have an approach that is bi-partisan with political backing that will transcend the political cycle.
- The plan must be multi-generational that will withstand the test of time.
- Raise taxes or enhance revenues.
- Support one another.

John Hill asked Dr. Adams if there is a way to properly educate physicians. Dr. Adams responded with the INSPECT usage numbers. Approximately 13,000 professionals are registered for INSPECT, but only half are doctors. Furthermore, 39% of professionals who are licensed to prescribe medications are registered with INSPECT. Dr. Adams recommended mandatory use of INSPECT for all professionals who are going to prescribe medications, physicians, nurse practitioners, veterinarians, podiatrist, dentist, etc. Adams later noted that doctors are prescribing multiple opiate and benzodiazepine cocktails. There is no limit on how many benzodiazepine patients a doctor may treat, but there are limits placed on the amount of buprenorphine patients a physician may treat. There are currently prescribing guidelines for chronic pain, but not for acute pain.

Dr. Duvwe recommended a universal prescribing guideline for Indiana physicians to adhere to in order to prevent over-prescribing.

Representative Goodin noted that there are no longer state hospitals and Indiana has turned the prison system into the rehabilitation and treatment centers. Judge Duvall noted that as a judge, he has felt the consequences of losing the state institutions.

Representative McNamara recommended to the Task Force that everyone get on the same page with the different task forces around the state. The end result is to do what is best for Hoosiers. Those involved should bear in mind that they are trying to find a solution to a pervasive problem.

Action Items:

John Hill requested feedback related to INSPECT work group, the Children’s Commission, and prescribing guidelines. Mr. Hill asked if it would be of benefit to hear a presentation on the Evidence-

Based Decision Making Initiative at the next Task Force. Judge Davis agreed that it would be of benefit and suggested a representative from the Indiana Judicial Center or Mary Kay Hudson.

Recommendations to the Governor:

- Direct the Indiana State Department of Health (ISDH) to convene a working group to send recommendations of improvements and best practices related to INSPECT, to the INSPECT Oversight Committee (For more information on INSPECT, visit: <http://www.in.gov/pla/inspect/>).
- Request the Commission for Improving the Status of Children make recommendations through its Educational Outcomes Task Force and Substance Abuse and Child Safety Task Force on the following:
 - Developing age-appropriate substance abuse curriculum for students.
 - Finding ways to better connect affected youth with substance abuse services.
- Direct the Indiana State Department of Health (ISDH) to work with appropriate entities including those that represent physicians, nurses, dentists, physician assistants, podiatrists, and veterinarians to develop guidelines for prescribing acute pain medications.
- Direct appropriate entities to promulgate with all expediency chronic pain prescribing rules for all prescribers.

Direct the Indiana Department of Homeland Security (IDHS) to identify gaps in Naloxone availability compared with overdose demographics.



Meeting Agenda

Governor's Task Force on Drug Enforcement, Treatment, and Prevention

October 15, 2015 | 12:30 p.m. - 4:30 p.m. | University of Southern Indiana | Evansville

- 12:30 p.m. – 12:40 p.m. Welcome & Task Force Recommendation Update**
John Hill, Co-Chair, Governor's Task Force on Drug Enforcement, Treatment, and Prevention
- 12:40 p.m. – 1:25 p.m. Enforcement – Enforcement Strategies in Vanderburgh County**
Nicholas Hermann, Vanderburgh County Prosecuting Attorney
Task Force Discussion
- 1:25 p.m. – 2:05 p.m. Treatment – Nalaxone Deployment and Training**
Donna Purviance, DNP, FNP-BC, Goodman Campbell Brain & Spine
First Sergeant Jeff Bell, Vigo County Sheriff's Office
Task Force Discussion
- 2:05 p.m. – 2:45 p.m. Treatment – Project ECHO**
Dr. Miriam Komaromy, ECHO Institute
Task Force Discussion
- 2:45 p.m. – 3:30 p.m. Prevention – Southwest Indiana Youth Assistance Programming**
Parri Black, Youth First, Inc.
Task Force Discussion
- 3:30 p.m. – 4:00 p.m. Public Comment**
- 4:00 p.m. – 4:30 p.m. Task Force Discussion on Recommendations**



Speaker Bios

Governor's Task Force on Drug Enforcement, Treatment, and Prevention

► Nicholas Hermann, Vanderburgh County Prosecuting Attorney

Since January 1, 2011, an Evansville native, Nicholas Hermann, has been the prosecuting attorney for Vanderburgh County.

Nick, who oversees 22 deputy prosecutors in his office, received his Bachelor of Science in chemistry from Ball State University. He later earned his law degree from the Indiana University School of Law in Indianapolis before he practiced family and criminal law.

► Donna Purviance, DNP, FNP-BC, Goodman Campbell Brain & Spine

Donna Purviance DNP, FNP-BC is a spine triage NP with Goodman Campbell Brain & Spine. She has worked tirelessly to identify and disseminate high-quality research on pain management practices to advocate for the holistic treatment of patients suffering from chronic pain and other comorbidities. She recognized with opiate medication management for chronic pain, substance abuse and addiction co-exist often leaving destruction and destitution as byproducts. Her experience is vast, having worked in a variety of inpatient and outpatient settings.

Educational experiences include a Bachelor of Arts in education, a Bachelor of Science in Nursing, and a Master's of Science in Nursing, Family Practice and Doctor of Nursing Practice. She has utilized her education and experience to teach and has been a guest lecturer in a variety of educational venues, including the Indiana State University's Family Nurse Practitioner Program. She is a member of Sigma Theta Tau's Lambda Sigma Chapter, and the Indiana Attorney General's Task Force on Prescription Drug Abuse. She participates on two working groups for the Task Force including naloxone training for law enforcement and first responders, as well as the education committee. She will be presenting at this year's BitterPill symposium on October 28, 2015. In June, she presented at the Indiana Rural Health Association annual conference on her research on law enforcement's attitude and knowledge as it relates to naloxone training for opiate and heroin overdoses.

► First Sergeant Jeff Bell, Vigo County Sheriff's Office

Jeff Bell was hired by the Vigo County Sheriff's Office in 1999 for the position of jailer. In 2001 he was promoted to a fulltime deputy position, attending ILEA in October of 2001. While serving the Sheriff's Office, he served in the Criminal Investigations Division fulltime for a year and has continued to be involved as needed to augment the division's manpower typically during major case investigations. In 2011 he was promoted to Sergeant and then promoted to First Sergeant. He has been assigned, at various times, to all the patrol shifts both as a merit deputy and later as a promoted supervisor. He has been a certified instructor through the ILTB for over 4 yrs. First Sergeant Bell has had the additional responsibilities of field training of the new hire fulltime and reserve deputies for the last 5 years. He assists in departmental training as needed, whether it be yearly in-service, firearms, emergency vehicle operations or instructing the 40 hour pre-basic course several times a year. He also holds certifications as a firearms armorer.



GOVERNOR'S TASK FORCE ON DRUG ENFORCEMENT
OCTOBER 15, 2015

WHERE ARE WE TODAY?

Indiana:

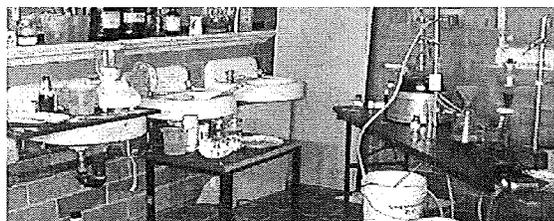
- Consistently one of the states that leads the nation in meth lab seizures.
- One of the leading states in pharmaceutical robberies.
- Has seen a sharp rise in heroin and prescription drug overdoses.
- Recently instituted a criminal code rewrite that drastically decreases the penalties for drug possession and dealing crimes.



METHAMPHETAMINE IN 2011

- In 2011, Indiana Law Enforcement seized methamphetamine labs from 1,437 locations.
- 116 of those locations were in Vanderburgh County.
- This means that more than 8 percent of all labs found in Indiana's 92 counties were found here.

BIRCH REDUCTION METHOD



ONE POT METH LABS





PRESCRIPTION DRUG ABUSE



TREAT ADDICTS, PUNISH DEALERS

Efforts in Vanderburgh County:

- Make every attempt to incarcerate dealers, particularly frequent flyers
- Offer alternatives to incarceration:
 - Drug Court
 - Forensic Diversion
 - Probation
 - Home Detention
 - Work Release
 - In-home drug testing

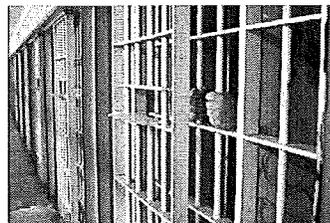


- WeTip was founded in 1972.
- June 2013, Vanderburgh County Prosecutor's Office implemented WeTip
- WeTip is a completely anonymous tip line
- WeTip has NEVER given up a caller
- Bilingual operators available 24/7

PROGRESS OF VANDERBURGH COUNTY WETIP PROGRAM

- WeTip is designed to be a multiplier of law enforcement resources.
- Since its inception in 2013, Vanderburgh County WeTip has consistently led the country in the quality and quantity of anonymous tips.
- We were recognized with a National Safety Award in 2014.
- Our WeTip program is now considered the model program for anonymous tip lines across the country.

JAIL OVERCROWDING



EFFECTS OF JAIL OVERCROWDING

- Lower bonds
- Difficulty in getting bonds revoked
- Lack of misdemeanants that ever see the inside of the jail
- Lack of incarceration of low-level offenders
- Returning drug users to the streets
- Law enforcement diverting resources

We must be careful not to create an environment where drug violence and property crimes increase.

CRIMINAL CODE REWRITE

Prior to July 1, 2014

- Murder 45-65 years
- A Felony 20-50 years
- B Felony 6-20 years
- C Felony 2-8 years
- D Felony 1/2 - 3 years

After July 1, 2014

- Murder 45-65 years
- Level 1 Felony 20-40 years
- Level 2 Felony 10-30 years
- Level 3 Felony 3-16 years
- Level 4 Felony 2-12 years
- Level 5 Felony 1-6 years
- Level 6 Felony 1/4 - 2 1/4 years

DEALING IN NARCOTIC DRUGS

- Prior to July 1, 2014
 - Class B Felony
 - Face 6-20 years (3-10 years actual time served)
- After Criminal Code Rewrite
 - Level 5 Felony
 - Face 1-6 years (.75 to 4.5 years actual time served)

DEALING TO A MINOR

- Prior to July 1, 2014
 - Class A Felony
 - Face 20-50 years (10-25 years actual time served)
- After Criminal Code Rewrite
 - Level 4 Felony
 - Face 2-12 years (1.5-9 years actual time served)
 - Sentence may be fully suspended

DEALING WITHIN 500 FEET

- Prior to July 1, 2014
 - Class A Felony within 1000 feet of a school, family housing complex and Youth Program Center
 - Face 20-50 years (10-25 years actual time served)
 - Minimum sentence could not be suspended
- After Criminal Code Rewrite
 - Level 4 Felony within 500 feet of a school
 - Face 2-12 years (1.5-9 years actual time served)
 - Entire sentence may be suspended

PROPOSAL 1

- Amend IC 35-48-4-1 and IC 35-48-4-1.1 to enhance the Dealing Offense by two levels if the defendant has more than one enhancing circumstance.

PROPOSAL 2

- Amend IC 35-50-2-2.2 to restore mandatory minimum sentences if an enhancing circumstance applies or if the amount of the drug is over 10 grams.

PROPOSAL 3

- Add Family Housing Complex (IC 35-31.5-2-127) and Youth Program Center (IC 35-31.4-2-357) to the locations covered by the 500 foot rule in the definition of Enhancing Circumstances (IC 35-48-1-16.5)

PROPOSAL 4

- Eliminate language in IC 35-48-4-1 and IC 35-48-4-1.1 that requires evidence in addition to the weight of the drug to prove intent to deal the drug.

★ GOVERNOR'S ★
TASK FORCE
 on Drug Enforcement,
 Treatment & Prevention



Training Law Enforcement
 The Research Conclusions

DEVELOPED BY
 JAMES L. CAMPBELL, JAMES A. STINE,
 AND ALEXANDER G. BROWN
 UNIVERSITY OF INDIANA

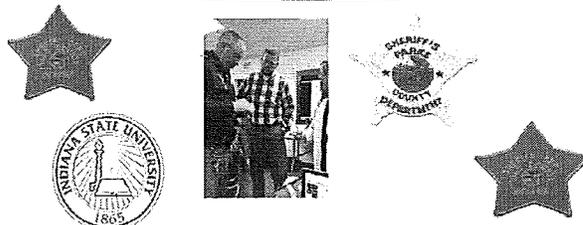
CYCLES 15, 2011
 UNIVERSITY OF MARYLAND
 EVANVILLE, INDIANA

OBJECTIVE

Understand

How the perception of naloxone administration by law enforcement changed before and after training

Law Enforcement Districts



The Question

- ▶ **Purpose:** to teach and assess knowledge deficits & to decipher law enforcement attitudes associated with saving a life from an opiate OD, be it intentional or accidental, be it from legally prescribed medications or illicit use.
- ▶ **Hypothesis:** Training would be associated with improved knowledge & have a POSITIVE impact on attitudes.

Research Tool

Development of opioid overdose knowledge (OOKA) and attitudes (OOAS) scales for take-home naloxone

training evaluation

Short Title: Development of OOKA & OOAS

Anna V. Williams, John Strang, & John Marsden
King's College, London: Addictions Department, Institute of Psychiatry
London, United Kingdom

Results

Domains	Significance (2-tailed)
Knowledge	.000
Competency	.000
Concerns	.000
Readiness	.000

Vigo County Attitudes

- ▶ Table 4 Officers attitude responses to an opioid overdose situation
 - ▶ Pre and post scores
 - ▶ Agree, Unsure, Disagree
 - ▶ Competency, Concerns, Readiness

OUTCOMES from Indianapolis PD 1 year later

- ▶ From Indianapolis South District Current Stats:
 - ▶ 129 uses of naloxone
 - ▶ 3 deaths despite officers using naloxone appropriately
 - ▶ No legal issues
 - ▶ 1 victim was combative
 - ▶ Overall, > 80% of the victims went to the hospital after resuscitation
 - ▶ All myths associated with LE using naloxone dispelled
 - Personal Communication, B. Ray, October 9, 2015

Senate Enrolled Act 227

- ▶ Section 7. IC 16-31-2-9, As amended by P.L.77-2012, Section 18, is amended to read as follows [effective upon passage]: Sec 9. The commission shall establish the following:
 - (5) Standard for distribution, administration, use, and training in the use of an overdose intervention drug.
- ▶ Section 8. IC 16-31-3-23.5
 - The following may administer an overdose intervention drug to an individual who is suffering from an overdose:
 - (5) A law enforcement officer.

Senate Enrolled Act No. 406 Aaron's Law

- ▶ Indiana Code § 16-42-27 *et seq.*

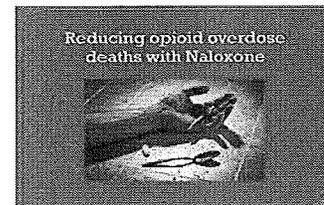
A prescriber may write a standing order to authorize an entity to receive naloxone and distribute it to those individuals that may be in a position to assist a person experiencing an opioid-related overdose.

The prescriber's standing order must contain 3 things:

 - ❖ Instructions to summons emergency services immediately
 - ❖ Education & training on OD response & treatment, including administration of naloxone
 - ❖ Information & referrals to drug addiction treatment & programs, including medical assisted treatment

Standardized Available Educational Program*

Training power point available
Composed by
Joan Duwve, MD, MPH
Indiana State Department
Of Health



Educational Requirements

- ▶ What is an opioid and how does it work?
- ▶ What is naloxone and how does it work?
- ▶ What does an opioid overdose look like?
- ▶ How to resuscitate the patient.
- ▶ How to administer the naloxone.
- ▶ Recovery of the victim.
- ▶ Reporting requirements.

References

- ▶ Williams, Strang, & Marsden. [2013]. OOFIS & OoAS. *Drug & Alcohol Dependence*, 132, 383-386. doi:10.1016/j.drugalcdep.2013.02.007
- ▶ Indiana Senate Bill 227. (2014). Second Regular Session 118th General Assembly. Retrieved from <http://www.in.gov/legislative/bills/2104/28/Sb0227.html>
- ▶ Indiana Senate Bill 406. (2015). First Regular Session 119th General Assembly. Retrieved from <http://www.in.gov/legislative/bills/2015/SB/590406.html>
- ▶ Duwve, J. (2015). *Naloxone: Reducing opioid overdose deaths*. Personal communication.



**VIGO COUNTY SHERIFF'S
OFFICE
NARCAN FOR PATROL USE**

F/Sgt. Jeffrey Bell

Introduction

F/Sgt. Jeffrey Bell:

- 14 yrs as a deputy
- 5 yrs as a promoted supervisor
- 5 yrs as an Field Training Officer
- 4 yrs as an ILTB certified instructor
- 5 yrs as a member of the departmental hiring review board
- 8 yrs. as a dept. firearms range safety officer/armorer

Narcan for patrol use

Conception (fall of 2013)

- Sheriff Ewing was approached about having his patrol cars issued Narcan
- First of the hurdles



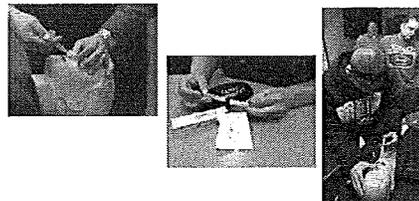
Narcan for patrol use (con't)

Training- (fall of 2014)

1. Explained who, what, when, why and where
 - a. What is Narcan
 - b. What is an Opioid
2. IC 16-31-6-2.5
 - a. Provides civil immunity when used in accordance with agency standards
 - b. No immunity for gross negligence

Narcan for patrol use (con't)

3. Practiced the assembling and administering of the agent



Narcan for patrol use (con't)

Policy- (2015)

Last major hurdle to its deployment to patrol units

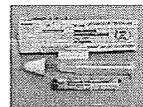
- 1. Legal- County Attorney
- 2. Medical- Medical Director



Narcan for patrol use (con't)

Policy

- 1. Implemented April 1, 2015
- 2. Approved policy was placed in to service
- 3. Kits issued after review of new policy by deputies



Narcan for patrol use (con't)

Event

June 13, 2015 accidental overdose

- Location
Residential neighborhood
- Response
Right place, right time

Narcan for patrol use (con't)

- Observations
Syringe, spoon, belt on the arm
Learned from witnesses he uses heroin
- Actions
Start CPR and prepare the Narcan
- Outcome
Victim is transported to local hospital
An hour later the victim is alert and talking on his cell phone

Narcan for patrol use (con't)

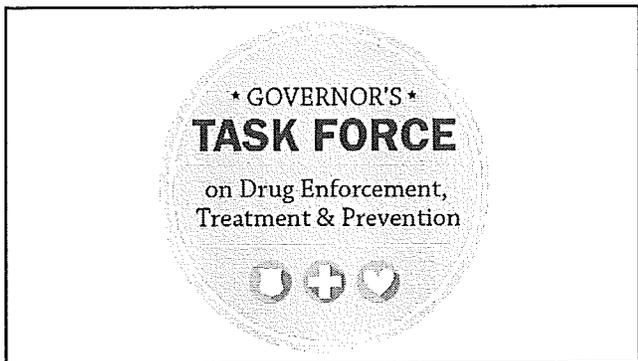
Questions?

Narcan for field use (con't)

Sheriff Greg Ewing
greg.ewing@vigocounty.in.gov

Training Sgt. John Davis
john.davis@vigocounty.in.gov

F/Sgt Jeff Bell
jeff.bell@vigocounty.in.gov



UNM HEALTH SCIENCES CENTER

Project ECHO

(Extension for Community Health Outcomes)

Miriam Komaromy, MD, FACP
 Associate Professor of Medicine
 Associate Director of Project ECHO
 Department of Medicine
 University of New Mexico Health Sciences Center

Tel: 505-272-7505
 miriamk1@salud.unm.edu

At ECHO, our mission is to democratize medical knowledge and get best practice care to underserved people all over the world.

Our goal is to touch the lives of 1 billion people by 2025.

Supported by New Mexico Department of Health, Agency for Health Research and Quality, New Mexico Legislature, the Robert Wood Johnson Foundation, the GE Foundation and Helmsley Trust



Methods

- Use Technology to leverage scarce resources
- Sharing "best practices"
- Case-based learning
- Web-based database to monitor outcomes

Arora S, Gessert CM, Kalishman S, et al: Acad Med. 2007 Feb;82(2):154-60.

Benefits to Rural Clinicians

- No-cost CMEs and Nursing CEUs
- Professional interaction with colleagues with similar interest
 - Less isolation with improved recruitment and retention
- A mix of work and learning
- Access to specialty consultation with GI, hepatology, psychiatry, infectious diseases, addiction specialist, pharmacist, patient educator

Project ECHO® Clinicians HCV Knowledge Skills and Abilities (self-Efficacy)

scale: 1 = none or no skill at all 7= expert-can teach others

Community Clinicians N=25	BEFORE Participation MEAN (SD)	TODAY MEAN (SD)	Paired Difference (p-value) MEAN (SD)	Effect Size for the change
1. Ability to identify suitable candidates for treatment for HCV.	2.8 (1.2)	5.6 (0.8)	2.8 (1.2) (<0.0001)	2.4
2. Ability to assess severity of liver disease in patients with HCV.	3.2 (1.2)	5.5 (0.9)	2.3 (1.1) (<0.0001)	2.1
3. Ability to treat HCV patients and manage side effects.	2.0 (1.1)	5.2 (0.8)	3.2 (1.2) (<0.0001)	2.6

Copyright 2013 Project ECHO® (continued)

Outcomes of Treatment for Hepatitis C Virus Infection by Primary Care Providers

Results of the HCV Outcomes Study

Arora S, Thornton K, et al. *BMJ Open* 2011;5:e001259-2017

Treatment Outcomes

Outcome	ECHO N=261	UNMH N=146	P-value
SVR* (Cure) Genotype 1	50%	46%	NS
SVR* (Cure) Genotype 2/3	70%	71%	NS
Minority	68%	49%	P<0.01

*SVR=sustained viral response
NEM : 364:23, June 9-2011, Arora S, Thornton K, Murata G

Disease Selection

- Common diseases
- Management is complex
- Evolving treatments and medicines
- High societal impact (health and economic)
- Serious outcomes of untreated disease
- Improved outcomes with disease management

Successful Expansion into Multiple Diseases

	Mon	Tue	Wed	Thurs	Fri
8-10 a.m.	Hepatitis C • Arora • Thornton	Diabetes & Endocrinology • Bouchonville		Geriatrics/ Dementia • Herman	Palliative Care • Neale
10-12 a.m.	Rheumatology • Bankhurst	Chronic Pain • Katzman	Integrated Addictions & Psychiatry • Komaromy		Complex Care • Neale • Komaromy
2-4 p.m.	HIV • Iandlorio • Thornton		Prison Peer Educator Training • Thornton	Women's Health & Genomics • Curet	

ECHO for Substance Use Disorders

- Addictions ECHO for 11 years
- Participation is free of charge
- 10,000 hours of no-cost CME credits
- Multidisciplinary team of experts including physicians, nurses, counselors, and CHWs
- Opioids were most common focus of SUD cases
- Network used to recruit for buprenorphine training

Specialty CHW Program

- Narrow Focus — Deep Knowledge
- Standardized Curriculum
 - 3 Day Onsite
 - Webcam/Weekly Video Based Clinics
 - Health coaching
 - Diet
 - Exercise
 - Smoking Cessation
 - Motivational Interviewing
 - Finger Stick
 - Foot Exam
- Ongoing support via CHW teleECHO clinics
- Part of Disease Management Team



Copyright 2013 Project ECHO®



Community Health Workers in Prison The New Mexico Peer Education Program

Pilot training cohort, CNMCF Level II, July 27-30, 2009



First day of peer educator training. Photo courtesy of the UNM Project ECHO® and CNMCF.

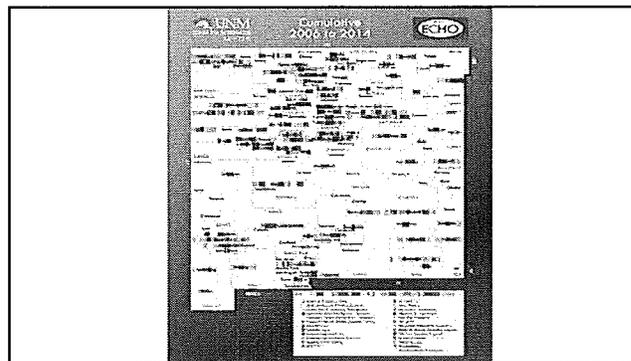
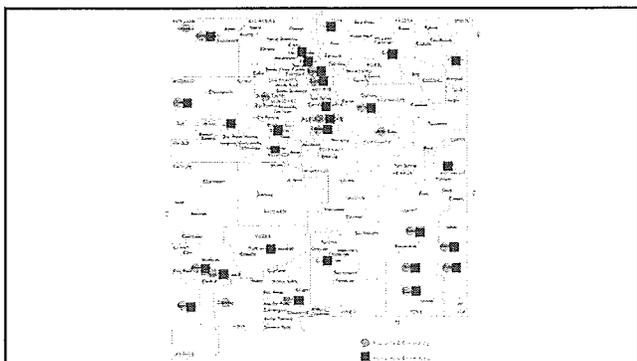
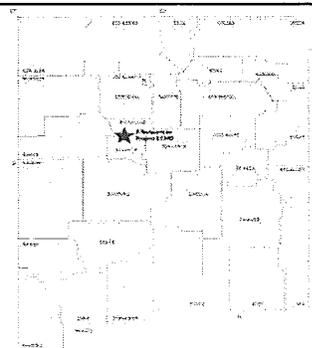
Copyright 2013 Project ECHO®

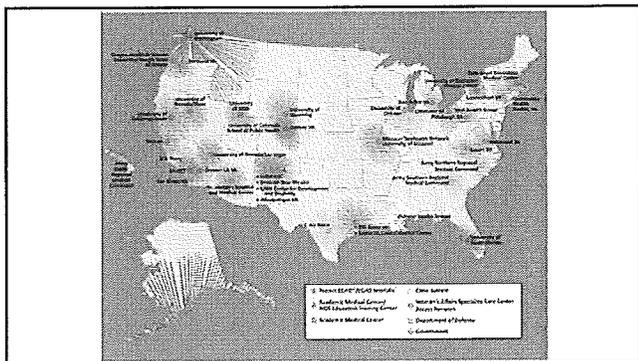
Potential Benefits of ECHO Model™ to Health System

- Quality and Safety
- Rapid Learning and best-practice dissemination
- Reduce variations in care
- Access for Rural and Underserved Patients, reduced disparities
- Workforce Training and Force Multiplier
- Democratize Knowledge
 - Improving Professional Satisfaction/Retention
 - Supporting the Medical Home Model
 - Cost Effective Care- Avoid Excessive Testing and Travel
 - Prevent Cost of Untreated Disease (e.g.: liver transplant or dialysis)
 - Integration of Public Health into treatment paradigm



Copyright 2013 Project ECHO®

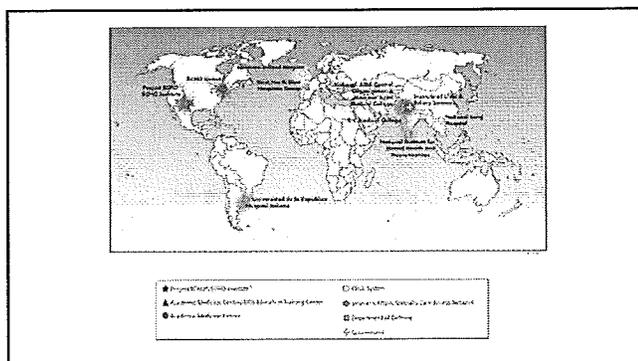




- ### ECHO Replication in US:
- University of Washington (HCV, Chronic Pain, HIV, Multiple Sclerosis) – Seattle, WA
 - University of Chicago (Hypertension, Breast Cancer Survivorship/Women's Health, Pediatric ADHD, Childhood Obesity, HIV) – Chicago, IL
 - University of Nevada (Endocrine Stewardship, Autism [closed group, by invitation only], Diabetes/General Endocrinology, Gastroenterology, Rheumatology, Sports Medicine, Mental Health, Professional Development Groups [closed groups, by invitation only], Mental Health Clinic Director's Group [closed groups, by invitation only], Marriage, & Family Therapy Intern Supervision Clinic [closed groups, by invitation only] – Reno, NV
 - University of Utah (HCV, Advanced Liver Care, Chronic Pain) – Salt Lake City, UT
 - Florida/Caribbean AIDS Education and Training Center/ University of South Florida (General HIV, Adolescents/Pediatrics HIV, HIV/HIV Co-infection, Psychiatry & HIV, Spanish Language HIV) – Tampa, FL
 - Harvard/Beth Israel Deaconess Medical Center (HCV, Gerontology – ECHO AIDS) – Boston, MA
 - St. Joseph's Hospital & Medical Center (HCV) – Phoenix, AZ
 - Community Health Center, Inc. (HIV, HCV, Chronic Pain, Opioid Addiction – Buprenorphine, Coaches International-supporting Quality Improvement and Satisfaction) – Middletown, CT
 - LA Net (ASPA Preventive Care, Nephrology, Adult Psychiatry) – Los Angeles, California
 - UNM Center for Development and Disability (Autism) – Albuquerque, NM
 - UNM Evidence-Based Childhood Overweight Medical Management, Pediatric Nutrition, Psychiatry, Asthma/Pulmonary) – Albuquerque, NM
 - Gill St. Luke's Health (HCV, HIV, Infectious Disease) – Houston, TX
 - University of California Davis (Pain Management) – Davis, CA
 - University of Wyoming, Wyoming Institute for Disabilities (Assistive Technologies) – Laramie, Wyoming
 - Odyssey Health Systems (Elder Care) – New Orleans, LA
 - University of Texas MD Anderson Cancer Center (Cervical Cancer Prevention) – Houston, TX
 - Oregon Health and Science University/Health Share of Oregon (Psychiatric Medication Management) – Portland, OR
 - University of Rochester Medical Center (Geriatric Mental Health) – Rochester, New York
 - Walking Horse Association Health Group (Care Transition) – Red Bank, New Jersey
 - Missouri Telehealth Network/University of Missouri (Autism) – Columbia, MS
 - University of Colorado School of Public Health (Children and Youth with Epilepsy) – Denver, CO



Copyright 2013 Project ECHO



ECHO provides a flexible model that can be adapted to expand access to high-quality care for a variety of common complex diseases in high-need communities

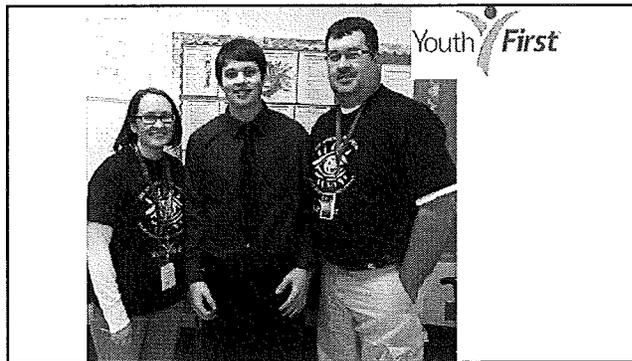


Copyright 2013 Project ECHO



★ GOVERNOR'S ★
TASK FORCE
 on Drug Enforcement,
 Treatment & Prevention

www.youthfirstinc.org
812-421-8336



Vision 

Create an effective and accessible preventive health system that saves lives and money

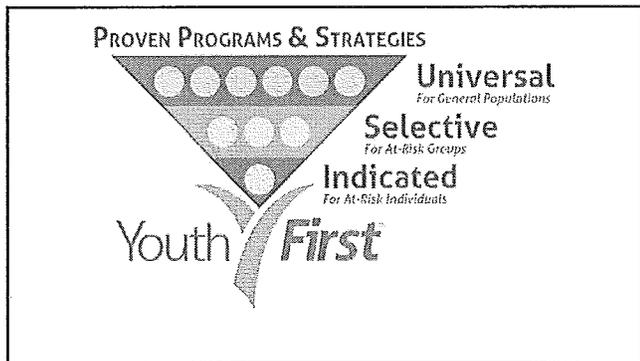
Approach 

System of Prevention

- Consistent & Comprehensive
- Accessible & Available
- Coordinated & Collaborative
- Accountable & Measurable
- Sustained Investment & Long-Term Commitment

Mission 

To strengthen youth and families by providing evidence-based programs that prevent substance abuse, promote healthy behaviors, and maximize student success.



Strategies 

Reduce Risk Factors
Remove Barriers to Learning

Increase Protective Factors
Boost Social Skills & Resiliency

Promote Positive Social Norms
Correct Misperceptions about Peers

Model 

- ✓ Skilled & Supervised Staff, primarily Master's Level Social Workers in Schools

Model 

- ✓ Skilled & Supervised Staff, primarily Master's Level Social Workers in Schools
- ✓ Comprehensive Menu of Proven Programs

Model 

- ✓ Skilled & Supervised Staff, primarily Master's Level Social Workers in Schools
- ✓ Comprehensive Menu of Proven Programs
- ✓ Continuous Evaluation & Improvement

Model 

- ✓ Skilled & Supervised Staff, primarily Master's Level Social Workers in Schools
- ✓ Comprehensive Menu of Proven Programs
- ✓ Continuous Evaluation & Improvement
- ✓ Strong Partnerships with Schools, Churches, and Other Agencies

Model 

- ✓ Skilled & Supervised Staff, primarily Master's Level Social Workers in Schools
- ✓ Comprehensive Menu of Proven Programs
- ✓ Continuous Evaluation & Improvement
- ✓ Strong Partnerships with Schools, Churches, and Other Agencies
- ✓ Passionate Volunteers & Supporters

Activities 

- ❖ **39 Master's Level Social Workers**
Accessible to 26,636 students
57 public, parochial & private schools
11 school systems in 6 counties
- ❖ **Toolkit of Evidence-Based Programs**
Targeting youth, families & communities during school and afterschool

By the Numbers 

17,090 Students Served in 2014-15

- ❖ 1,618 Received Intensive Support
- ❖ 32% Dealt with Abuse or Neglect Trauma
- ❖ 525 Crisis Interventions
- ❖ 397 Suicide Assessments
- ❖ 319 Self-Harm Assessments

By the Numbers 

School & Family Support

- ❖ 13,942 Faculty/Staff Consultations
- ❖ 6,047 Parent/Caregiver Consultations
- ❖ 4,772 Referrals to Community Resources
- ❖ 1,443 Educational Presentations
- ❖ 33 Family Programs with 669 Participants

Outcomes 

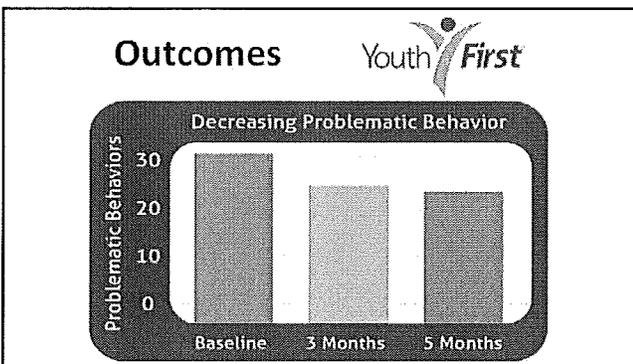
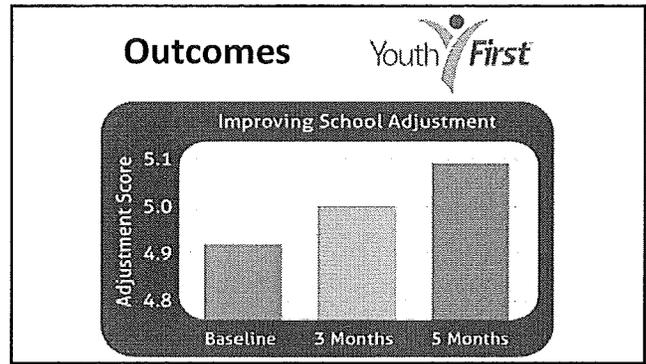
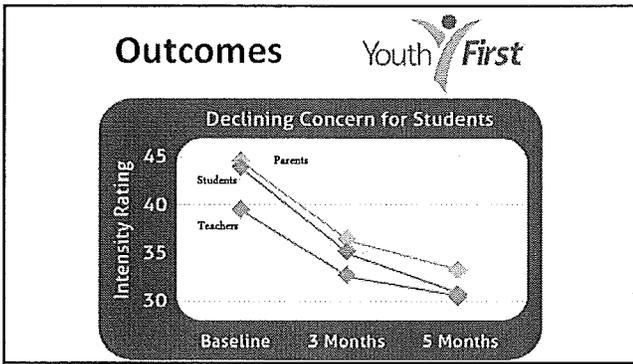
Evaluation:

- ❖ Protective Factors
- ❖ Individual Concerns
- ❖ School Adjustment
- ❖ Problem Behaviors
- ❖ Prevalence of Youth Substance Use

Outcomes 

Improving Protective Factors

- ❖ Resiliency & Coping Skills
- ❖ Children's Hope & Mood Management
- ❖ Communication & Decision-Making Skills
- ❖ Parent/Child Bonding & Family Attachment
- ❖ Peer Resistance & Assertiveness



Outcomes

Academic Impact

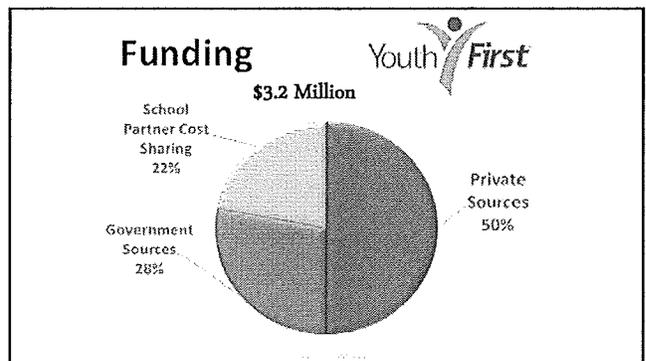
- ❖ 91% of the 3,024 at-risk students on the caseload the last two years were promoted to the next grade level or graduated.
- ❖ 89% of the graduating seniors had college or career plans.

Outcomes

Significantly Lower Youth Substance Use

(Local vs. State – 2014 IPRC Survey)

- Cigarettes and Other Tobacco
- Marijuana & Synthetic Marijuana
- Alcohol
- Cocaine, Crack, Inhalants, Ecstasy
- Prescription & Over-the-Counter Drugs



**Return on
Investment**



**\$18 in savings for every \$1
spent on effective prevention**

*- Substance Abuse & Mental Health Services Administration
US Dept. of Health & Human Services*

Value



\$7.3 Billion

**Indiana's FY08 costs for the
consequences of substance abuse**

- Indiana Center for Public Health Policy

Questions?



www.youthfirstinc.org



**111 SE 3rd Street, Suite 405
Evansville, IN 47708**

www.youthfirstinc.org

*** GOVERNOR'S *
TASK FORCE**

**on Drug Enforcement,
Treatment & Prevention**



GOVERNOR'S TASK FORCE ON DRUG ENFORCEMENT, TREATMENT & PREVENTION

FACT SHEET

There are many factors and stakeholders involved in combatting drug abuse, including the areas of law enforcement, prevention, and treatment. We must encourage conversation and information sharing to form the best solution to tackle this epidemic - for the sake of all Hoosiers.

TASK FORCE

Established by Executive Order, the Task Force will bring together Indiana experts from a variety of specialties to evaluate the growing national drug problem here in Indiana. Specifically, the Task Force is charged with:

- ▶ **STATEWIDE ASSESSMENT:** Evaluate the existing resources across all areas, identify gaps in enforcement treatment, prevention, and provide recommendations for improvement
- ▶ **ENFORCEMENT:** Identify effective strategies so federal, state, and local law enforcement can partner together to combat drug abuse
- ▶ **TREATMENT:** Analyze available resources for treatment and identify best practices for treating drug addiction
- ▶ **PREVENTION:** Identify programs and/or policies which are effective in preventing drug abuse, including early youth intervention programs

The Task Force will provide recommendations to the Governor throughout the process of meetings, and will prepare a final report of all findings and recommendations.

MEETINGS

Task Force members will meet monthly in the north, central, and southern areas of the state.

- ▶ **SEPTEMBER 16:** Indianapolis, 9:00 a.m. to 1 p.m.
Eskenazi Health Outpatient Center
- ▶ **OCTOBER 15:** Evansville, 12:30 p.m. to 4:30 p.m.
University of Southern Indiana
- ▶ **NOVEMBER 19:** South Bend, 12:30 p.m. to 4:30 p.m.
Specific location will be determined at a later date.

Updates to the meeting schedule, as well as resources to help those addicted to drugs, can be found here:

www.DrugTaskForce.in.gov

MEMBERS

Dr. Jerome Adams

Indiana State Department of Health

Senator Jim Arnold

Indiana State Senate

Judge Mary Beth Bonaventura

Indiana Department of Child Services

Superintendent Doug Carter

Indiana State Police

Bernie Carter

Lake County Prosecutor

Judge Wendy Davis

Allen County Superior Court

Chief Michael Diekhoff

Bloomington Police Department

Judge Roger Duvall

Scott County Circuit Court

Dr. Joan Duwve

Indiana State Department of Health

Joseph B. Fox, M.D.

Anthem, Inc.

Tony Gillespie

Indiana Minority Health Coalition

Representative Terry Goodin

Indiana House of Representatives

John Hill

Office of the Governor

Dr. Tim Kelly

Community Health

Sheriff John Layton

Marion County Sheriff's Department

Commissioner Bruce Lemmon

Indiana Department of Correction

Justice Mark Massa

Indiana Supreme Court

Representative Wendy McNamara

Indiana House of Representatives

Senator Jim Merritt

Indiana State Senate

Dan Miller

Indiana Prosecuting Attorneys Council

Dr. Charles Miramonti

IU Medicine/Indianapolis EMS

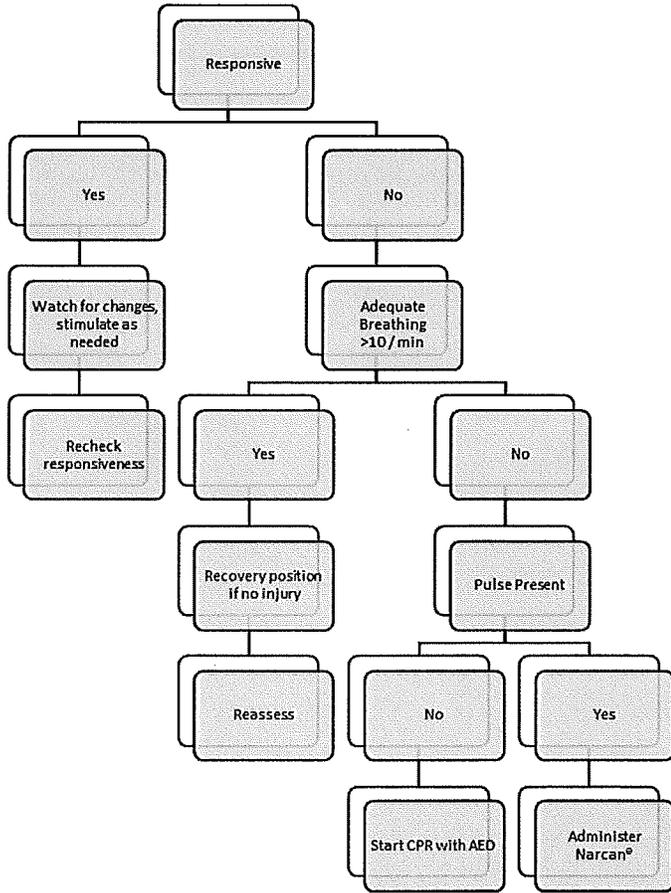
Rev. Rabon Turner, Sr.

New Hope Missionary Baptist Church

Dr. John Wernert

Indiana Family and Social Services Administration

VCSD Narcan® Administration

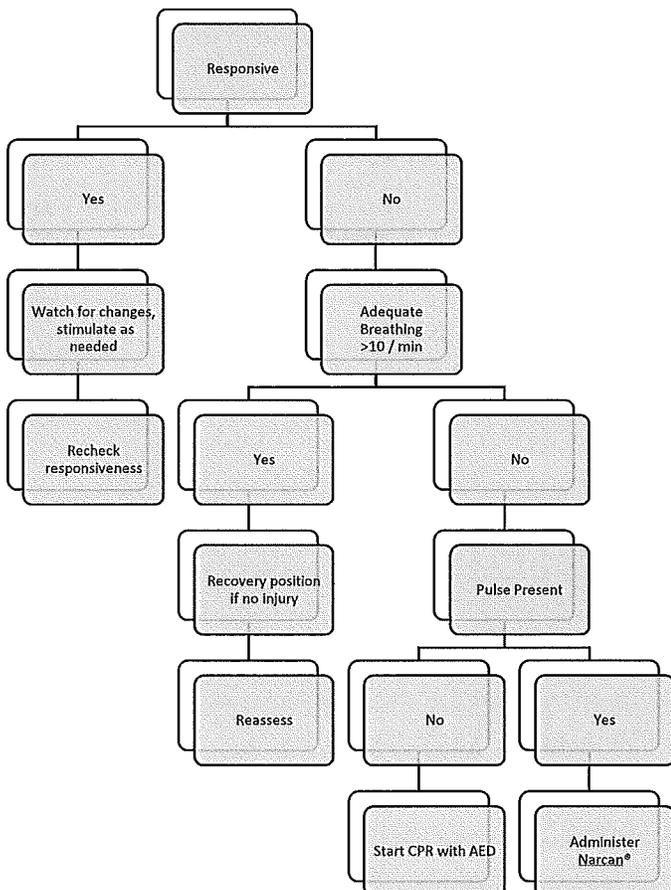


Report Number:	
Victim Name:	
<input type="checkbox"/> ___:___	1 mg Narcan® administered intranasally via nasal atomizer device
<input type="checkbox"/> ___:___	1 mg Narcan® administered intranasally via nasal atomizer device
Administered By:	
Signature:	Date:

Notes:

Issue Date:	Unit Number:
Issued By:	Received by:
Lot Number:	Expiration Date:

VCSD Narcan® Administration



Report Number:	
Victim Name:	
<input type="checkbox"/> ___:___	1 mg Narcan® administered intranasally via nasal atomizer device
<input type="checkbox"/> ___:___	1 mg Narcan® administered intranasally via nasal atomizer device
Administered By:	
Signature:	Date:

Notes:

Issue Date:	Unit Number:
Issued By:	Received by:
Lot Number:	Expiration Date:

Table 4 *Officers attitude responses to an opioid overdose situation*

<i>Competency Items</i>	Agree		Unsure		Disagree	
	<i>N(%)</i>		<i>N(%)</i>		<i>N(%)</i>	
	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>
1. I already have enough information about how to manage an overdose.	4 (13.3%)	18 (60%)	2(6.7%)	4 (13.3%)	24 (80%)	16 (53.3%)
2. I am already able to administer intra-nasal naloxone to someone who has overdosed.	2 (6.7%)	20 (66.7%)	Zero	4 (13.3%)	28 (93.3%)	16 (53.3%)
3. I would be able to check that someone who has overdosed was breathing properly.	20 (66.7%)	20 (96.7%)	7 (23.3%)	1 (3.33%)	3 (10%)	Zero
4. I am going to need more training before I would feel confident to help someone who has overdosed.	24 (80%)	8 (26.7%)	2 (6.7%)	4 (13.3%)	4 (13.3%)	18 (60%)
5. I would be able to perform mouth to mouth resuscitation to someone who has overdosed.	19 (63.3%)	24 (80%)	5 (16.7%)	4 (13.3%)	6 (20%)	2 (6.7%)
6. I would be able to perform chest compressions to someone who has overdosed.	30 (100%)	30 (100%)	Zero	Zero	Zero	Zero
7. If someone overdoses, I would know what to do to help them.	11 (36.7%)	28 (93.3%)	8 (26.7%)	1 (3.3%)	11 (36.7%)	1 (3.3%)
8. I would be able to place someone who has overdosed in the recovery position.	22 (73.3%)	28 (93.3%)	6 (20%)	1 (3.3%)	2 (6.7%)	1 (3.3%)
9. I know very little about how to help someone who has overdosed.	15 (50%)	4 (13.3%)	6 (20%)	2 (6.7%)	9 (30%)	24 (80%)
10. I would be able to deal effectively with an overdose.	11 (36.7%)	26 (86.7%)	8 (26.7%)	2 (6.7%)	11 (36.7%)	2 (6.7%)
Concerns Items						
1. I would be afraid of giving naloxone in the case the person becomes aggressive afterward.	3 (10%)	3 (10%)	7 (23.3%)	Zero	20 (66.7%)	27 (90%)
2. I would be afraid of doing something wrong in an overdose situation.	9 (30%)	1 (3.3%)	9 (30%)	5 (16.7%)	11 (36.7%)	24 (80%)
3. I would be reluctant to use naloxone for fear of precipitating withdrawal.	2 (6.7%)	2 (6.7%)	10 (33.3%)	Zero	18 (60%)	28 (93.3%)
4. If I tried to help someone who has overdosed, I might accidentally hurt them.	4 (13.3%)	Zero	11 (36.7%)	5 (16.7%)	15 (50%)	25 (83.3%)
5. I would feel safer if I knew that naloxone was around.	15 (50%)	13 (43.3%)	11 (36.7%)	5 (16.7%)	4 (13.3%)	2 (6.7%)
Readiness to Intervene						
1. Everyone at risk of witnessing an overdose should be given a naloxone supply.	5 (16.7%)	18 (60%)	15 (50%)	6 (20%)	10 (33.3%)	6 (20%)
2. I couldn't just watch someone overdose, I would have to do something to help.	27 (90%)	29 (96.7%)	3 (10%)	1 (3.3%)	Zero	Zero
3. If someone overdoses, I would call an ambulance but I wouldn't be willing to do anything else.	4 (13.3%)	4 (13.3%)	3 (10%)	2 (6.7%)	23 (76.7%)	24 (80%)
4. Family and friends of drug users should be prepared to deal with an overdose.	27 (90%)	26 (86.7%)	1 (3.3%)	3 (10%)	2 (6.7%)	9 (30%)
5. If I saw an overdose, I would panic and not be able to help.	Zero	2 (6.7%)	2 (6.7%)	1 (3.3%)	27 (90%)	27 (90%)
6. If I witnessed an overdose, I would call an ambulance immediately.	29 (96.7%)	29 (96.7%)	1 (3.3%)	1 (3.3%)	Zero	Zero

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2014 Regular Session and 2014 Second Regular Technical Session of the General Assembly.

SENATE ENROLLED ACT No. 406

AN ACT to amend the Indiana Code concerning health.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 16-18-2-263.9, AS ADDED BY P.L.156-2014, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 263.9. "Overdose intervention drug", for purposes of IC 16-31 and **IC 16-42-27**, means naloxone or any other drug that:

- (1) is an opioid, opiate, or morphine antagonist; and
- (2) prevents or reverses the effects of:
 - (A) opioids;
 - (B) opiates; or
 - (C) morphine;

including respiratory depression, sedation, and hypotension.

SECTION 2. IC 16-18-2-291.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 291.5. "**Prescriber**", for purposes of IC 16-42-27, has the meaning set forth in **IC 16-42-27-1**.

SECTION 3. IC 16-18-2-338.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 338.3. "**Standing order**", for purposes of IC 16-31 and IC 16-42-27, means:

- (1) a written order; or

SEA 406 — Concur



(2) is summoned immediately after administering the overdose intervention drug;
 shall report the number of times an overdose intervention drug is dispensed to the state department under the state trauma registry in compliance with rules adopted by the state department.

SECTION 6. IC 16-31-6-2.5, AS ADDED BY P.L.156-2014, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2.5. (a) Except for an act of gross negligence or willful misconduct, an advanced emergency medical technician, an emergency medical responder, an emergency medical technician, a firefighter or volunteer firefighter, a law enforcement officer, or a paramedic who administers an overdose intervention drug according to standards established by:

- (1) the department or agency that oversees the individual's employment in providing emergency medical services; or
- (2) the commission under IC 16-31-2-9;

to an individual suffering from an overdose is immune from civil liability for acts or omissions when administering the drug.

(b) If:

- (1) an advanced emergency medical technician;
- (2) an emergency medical responder;
- (3) an emergency medical technician;
- (4) a firefighter or volunteer firefighter;
- (5) a law enforcement officer; or
- (6) a paramedic;

is immune from civil liability for the individual's act or omission **when administering an overdose intervention drug**, a person who has only an agency relationship with the advanced emergency medical technician, emergency medical responder, emergency medical technician, firefighter or volunteer firefighter, law enforcement officer, or paramedic is also immune from civil liability for the act or omission.

SECTION 7. IC 16-42-27 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 27. Drugs: Overdose Intervention Drugs

Sec. 1. As used in this chapter, "prescriber" means any of the following:

- (1) A physician licensed under IC 25-22.5.
- (2) A physician assistant licensed under IC 25-27.5 and granted the authority to prescribe by the physician assistant's supervisory physician and in accordance with IC 25-27.5-5-4.
- (3) An advanced practice nurse licensed and granted the



immediately before or immediately after administering the overdose intervention drug.

(e) An entity acting under a standing order issued by a prescriber must do the following:

(1) Annually register with either the:

(A) state department; or

(B) local health department in the county where services will be provided by the entity;

in a manner prescribed by the state department.

(2) Provide education and training on drug overdose response and treatment, including the administration of an overdose intervention drug.

(3) Provide drug addiction treatment information and referrals to drug treatment programs, including programs in the local area and programs that offer medication assisted treatment that includes a federal Food and Drug Administration approved long acting, nonaddictive medication for the treatment of opioid or alcohol dependence.

Sec. 3. (a) Except for an act of gross negligence or willful misconduct, a prescriber who dispenses or prescribes an overdose intervention drug in compliance with this chapter is immune from civil liability arising from those actions.

(b) Except for an act of gross negligence or willful misconduct, a pharmacist who dispenses an overdose intervention drug in compliance with this chapter is immune from civil liability arising from those actions.

(c) Except for an act of gross negligence or willful misconduct, an individual or entity described in section 2(a)(1) of this chapter is immune from civil liability for the following actions:

(1) Obtaining an overdose intervention drug under this chapter.

(2) Administering an overdose intervention drug in good faith.

(3) Acting under a standing order under this chapter.

SECTION 8. IC 34-30-2-84.1 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 84.1. IC 16-42-27-3 (Concerning physicians, pharmacists, and other individuals or entities and the prescribing, dispensing, or administering of an overdose intervention drug).

SECTION 9. An emergency is declared for this act.

