THE OVERDOSE PREVENTION ACT: A SMALL STEP WHEN NEW JERSEY NEEDS A GIANT LEAP

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I. INTRODUCTION

A. A NATIONWIDE EPIDEMIC

According to the Center for Disease Control (CDC), drug overdose death rates in the United States have increased three-fold since 1990.[1] In 2009, more Americans died from drug poisoning than from injuries sustained in a car accident.[2] Not surprisingly, the marked increase in fatal drug overdoses coincided with a rapid rise in the sale of prescription painkillers.[3]

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[1] DIV. OF UNINTENTIONAL INJURY PREVENTION, CTR. FOR DISEASE CONTROL, POLICY IMPACT: PRESCRIPTION PAINKILLER OVERDOSES 3 (Nov. 2011), *available at* http://www.cdc.gov/HomeandRecreationalSafety/pdf/PolicyImpact-PrescriptionPainkillerOD.pdf.

[2] JEFFREY LEVI ET AL., TRUST FOR AMERICA'S HEALTH, PRESCRIPTION DRUG ABUSE: STRATEGIES TO STOP THE EPIDEMIC 4 (Nov. 2013), *available at* http://healthyamericans.org/assets/files/TFAH2013RxDrugAbuseRptFINAL.pdf.

[3] *Id.* Both the sale of prescription painkillers and the number of fatal poisonings from these drugs quadrupled from 1999 to 2010. *Id.* Multiple factors have led to the increase in medical use of prescription painkillers,

The term "prescription painkiller" generally refers to a class of drugs known as opioids.[4] Commonly prescribed opioids include oxycodone (OxyContin, Percocet) and hydrocodone (Vicodin).[5] In 2011, 47 million people filled prescriptions for drugs containing hydrocodone and 15 million people filled prescriptions for oxycodone nationwide.[6]

Although the abuse potential of prescription painkillers has been well-documented, drug companies are still looking to manufacture and sell potent opioids. In March 2014, the prescription painkiller Zohydro, which is a form of hydrocodone, was released.[7] Zohydro is between five and ten times stronger than Vicodin, another painkiller that contains hydrocodone.[8] Experts posit that an adult could overdose on Zohydro by taking as little as two pills.[9] The abuse potential of Zohydro was so concerning that the Food and Drug Administration (FDA) Advisory Committee voted 11-to-2 against its approval; however, this decision was overruled by high-ranking FDA officials.[10] According to Dr. Michael Carome, director of Health Research for Public Citizen, "People are going to die from this drug. We are in the midst of a public health crisis. There is an epidemic of opioid addiction resulting in

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including aggressive marketing of the drug OxyContin and a push in the medical community to treat chronic pain more effectively. Susan Okie, Perspective, *A Flood of Opioids, a Rising Tide of Deaths*, 363;21 NEW ENG. J. MED. 1981, 1982 (2010); *see also All Things Considered: With Rise of Painkiller Abuse, a Closer Look at Heroin*, NPR (Nov. 2, 2013), http://www.npr.org/templates/transcript/transcript.php?storyId=242594489.

[4] LEVI ET AL., *supra* note 2, at 10.

[5] *Id.*

[6] Marie McCullough, *FDA Urges Tighter Controls for Prescribed Opioid Painkillers*, PHILA. INQUIRER, Nov. 11, 2013, http://articles.philly.com/2013-11-11/news/43889749_1_pain-medicine-opioid-pain-perception.

[7] *Morning Edition: Critics Question FDA's Approval of Zohydro*, NPR (Feb. 26, 2014), http://www.npr.org/2014/02/26/282836473/critics-question-fdas-approval-of-zohydro.

[8] *Id.*

[9] *Id.*

[10] *Id.*

thousands of deaths . . . Zohydro . . . will simply feed the epidemic."[11]

B. NEW JERSEY'S ON-GOING BATTLE AGAINST OPIATE ABUSE

The rising prevalence of prescription drug abuse is well established in New Jersey. Between 2006 and 2011, New Jersey drug treatment facilities saw a three-fold increase in patients admitted for opioid painkiller dependency.[12] In 2010, 244 of the 843 drug related deaths in New Jersey involved oxycodone and that figure jumped by 38 percent in 2011.[13] This epidemic has affected communities all over the state—rural, urban, suburban, rich, and poor.[14]

For many users, their addiction begins with a legitimate prescription for painkillers and ends in a full-blown heroin addiction.[15] Most prescription painkillers are, in essence, legal forms of heroin.[16] Some addicts begin their addiction after being prescribed opiates to treat a legitimate medical condition. Once the use turns into abuse and their legitimate supply is cut off, some addicts start "doctor shopping" to find a doctor willing to write them a prescription.[17] Throughout the state, there are

[11] *Id.*

[12] STATE OF N.J. COMM'N OF INVESTIGATION, SCENES FROM AN EPIDEMIC: A REPORT ON THE SCI'S INVESTIGATION OF PRESCRIPTION PILL AND HEROIN ABUSE 16 (July 2013), *available at* http://www.nj.gov/sci/pdf/PillsReport.pdf.

[13] *Id.* at 17-18. In 2011, there were 1,008 drug related deaths statewide, 337 of those involved oxycodone. *Id.* at 18.

[14] *Id.* at 17.

[15] *See* Andy McNeil, *Prescription Pain Pills Often Lead to Harder Drugs—and to Camden*, COURIER-POST, Sept. 21, 2013, http://www.courierpostonline.com/article/20130927/NEWS01/309220050/Prescription-pain-pills-often-lead-harder-drugs-Camden.

[16] Heroin is also a member of the opioid family of drugs. NPR, *supra* note 3. All opiates have a shared molecular structure and produce a similar effect on the brain's opiate receptors. *Id.*

[17] Scott Burris et al., *Stopping an Invisible Epidemic: Legal Issues in the Provision of Naloxone to Prevent Opioid Overdose*, 1 DREXEL L. REV. 273, 282 (2009); STATE OF N.J. COMM'N OF INVESTIGATION, *supra* note 12, at 33.

"pill mills" masquerading as legitimate medical clinics where unscrupulous doctors will provide prescriptions for opioid painkillers without examining the patient.[18]

For most, abusing prescription painkillers is only the first step in their drug addiction. Because prescription painkillers are relatively expensive (ranging from $25 to $50 dollars per pill), heroin is a cheap ($5 to $10 per bag) alternative.[19] Many addicts' descent into heroin use follows a familiar pattern. It begins with prescription painkiller abuse, but at some point, the pills become either too expensive or the users develop a tolerance to the drugs, so they switch to snorting or smoking heroin.[20] Inevitably, many users do not stop at snorting or smoking heroin but start injecting it intravenously, which, in addition to putting them at risk for an overdose, can expose them to HIV and Hepatitis C.[21]

The heroin available in New Jersey and the surrounding areas is some of the most potent in the country.[22] The City of Camden in particular is known for the purity of its heroin, which serves as a draw for suburban users who are in search of a good, cheap high.[23] Indeed, over 80 percent of people arrested in

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[18] STATE OF N.J. COMM'N OF INVESTIGATION, *supra* note 12, at 1. While beyond the scope of this note, New Jersey has attempted to crack down on "pill mills" through various regulatory programs. LEVI ET AL., *supra* note 2, at 18. New Jersey has implemented a prescription drug monitoring program which uses a statewide electronic database to monitor opiate prescriptions. *Id.*; *see also* STATE OF N.J. COMM'N OF INVESTIGATION, *supra* note 12, at 5.

[19] Dustin Racioppi, *Heroin's Death Rush at the Shore*, ASBURY PARK PRESS, Nov. 22, 2013, http://www.app.com/article/20131010/NJNEWS2003/111210001/0/SPECIAL/Heroin-s-death-rush-Shore.

[20] Russ Crespolini, *Ex-Heroin Addict Tells Task Force: I Was Killing Myself*, MENDHAM-CHESTER PATCH (July 11, 2012, 9:33 PM), http://mendham-chester.patch.com/groups/editors-picks/p/emotional-day-at-drug-hearing-in-mendham#photo-10627552.

[21] Bridget M. Kuehn, *SAMSHA: Pain Medication Abuse a Common Path to Heroin*, 310:14 J. AM. MED. ASS'N 1433, 1434 (2013); *see also* Racioppi, *supra* note 19; Crespolini, *supra* note 20.

[22] Dustin Racioppi & Andy McNeil, *South Jersey Faces an 'Epidemic' of Drug-Related Deaths*, COURIER-POST, Oct. 13, 2013 (on file with author).

[23] *Id.*

Camden for possessing or seeking narcotics are from the surrounding suburban communities.[24]

The danger of experiencing a heroin overdose increases when the heroin is either extremely pure or is "cut" with dangerous additives.[25] Cities often see clusters of overdose deaths in a very short period of time due to a particularly lethal batch of heroin.[26]

In order to address the opiate epidemic that has swept across New Jersey, Governor Chris Christie signed the Overdose Prevention Act (OPA) into law in May of 2013.[27] The OPA was a bipartisan effort, sponsored by State Senators Joseph F. Vitale and Richard Codey.[28]

The OPA takes a two-pronged approach to addressing the mounting opiate crisis. The first component of the OPA is the Good Samaritan provision, which grants immunity from some drug charges to individuals who seek emergency assistance for someone experiencing an overdose.[29] The second component of the OPA deals with access to the drug Naloxone.[30] Naloxone (sold under the brand name Narcan) is an opioid antagonist that can be administered to someone experiencing an overdose,

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[24] McNeil, *supra* note 15.

[25] Racioppi & McNeil, *supra* note 21.

[26] *See* Joe Green, *Camden Sees 5 Overdoses in 24 Hours from Dangerous Type of Heroin*, NJ.COM (Oct. 2, 2013), http://www.nj.com/camden/index.ssf/2013/10/camden_sees_five_overdoses_from_dangerous_type_of_heroin.html (detailing a crisis where Camden law enforcement officials saw five overdoses in a twenty-four hour period due to an "especially dangerous" batch of heroin); STATE OF N.J. COMM'N OF INVESTIGATION, *supra* note 12, at 17.

[27] Press Release, State of New Jersey, Governor Chris Christie Signs Bipartisan Overdose Prevention Act Into Law (May 2, 2013), *available at* http://www.state.nj.us/governor/news/news/552013/approved/20130502b.html.

[28] S.B. 2082, 215th Leg., Reg. Sess. (N.J. 2012).

[29] N.J. STAT. ANN. § 2C:35-30 (West 2013). The statute also gives the same protection for the overdose victim. *Id.* § 2C:35-31.

[30] N.J. S.B. 2082.

stopping the overdose before it becomes lethal.[31] Naloxone can be administered via injection or by nasal spray.[32] Its effects are temporary and there is no potential for abuse.[33] The OPA allows non-medical personnel to administer Naloxone or another opioid antagonist to someone experiencing an overdose without fear of being held either criminally or civilly liable for administering a controlled substance without a medical license.[34]

This note will discuss the various provisions of the OPA. Section II will compare the OPA to similar statutes that have been passed in other states, highlighting the advantages and pitfalls of New Jersey's version of this statute. Section III will examine the relationship between New Jersey's strict liability drug-induced death statute and the OPA. Finally, Section IV will argue that any state looking to save lives should implement overdose prevention legislation and that the OPA should be the first, not last step, in revamping New Jersey's drug policy.

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[31] LEVI ET AL., *supra* note 2, at 28. During an opiate overdose, the opiate receptors in the brain are overwhelmed by the high concentration of opiates. *Understanding Naloxone*, HARM REDUCTION COALITION, http://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/understanding-naloxone/ (last visited Oct. 1, 2014). This causes the person experiencing an overdose to stop breathing. *Id.* Naloxone essentially pushes out the opiates that are bound to the opiate receptors and allows the person to breathe normally again. *Id.*

[32] LEVI ET AL., *supra* note 2, at 28. The Food and Drug Administration recently approved EVIZO, which is an auto-injector form of Naloxone. *U.S. Food and Drug Administration Approves Kaleo's EVIZO™ for the Emergency Treatment of Opioid Overdose*, YAHOO FINANCE (Apr. 3, 2014, 10:42 AM), http://finance.yahoo.com/news/u-food-drug-administration-approves-144200984.html. This auto-injector method of administration will allow emergency personnel and laypersons to quickly administer Naloxone during an overdose. *Id.*

[33] YAHOO FINANCE, *supra* note 32.

[34] N.J. STAT. ANN. § 24:6J-4 (West 2013).

II. HOW DOES THE OVERDOSE PREVENTION ACT STACK UP TO OTHER SIMILAR LEGISLATION?

New Jersey is not the first state to pass a bill targeted to prevent overdoses. Indeed, as of June 2014,[35] seventeen states and the District of Columbia have a Good Samaritan overdose law on the books and twenty-five other states and the District of Columbia have passed statutes increasing access to Naloxone.[36]

A. LEGISLATIVE HISTORY OF THE OVERDOSE PREVENTION ACT

The original version of the Overdose Prevention Act was titled the "Opioid Antidote and Overdose Prevention Act," and did not contain the Good Samaritan provision.[37] After passing in both the New Jersey Senate and House, the "Opioid Antidote and Overdose Prevention Act" was conditionally vetoed by Governor Chris Christie.[38] The Governor's conditional veto suggested combining the "Opioid Antidote and Overdose

[35] This number will undoubtedly continue to increase as awareness of the efficacy and value of these types of laws spreads.

[36] NAT'L CONF. OF STATE LEGIS., PREVENTION OF PRESCRIPTION DRUG OVERDOSE AND ABUSE (last updated June 2, 2014), *available at* http://www.ncsl.org/research/health/prevention-of-prescription-drug-overdose-and-abuse.aspx [hereinafter PREVENTION]; *see also* THE NETWORK FOR PUB. HEALTH LAW, LEGAL INTERVENTIONS TO REDUCE OVERDOSE MORTALITY: NALOXONE ACCESS AND OVERDOSE GOOD SAMARITAN LAWS 2 (May 2014), *available at* https://www.networkforphl.org/_asset/qz5pvn/network-naloxone-10-4.pdf [hereinafter LEGAL INTERVENTIONS]. The eighteen states that have a Good Samaritan law are WA, NY, CT, IL, CO, RI, FL, MA, CA, NC, VT, DE, MN, GA, LA, UT and NM. PREVENTION, *supra*; LEGAL INTERVENTIONS, *supra*. For purposes of this note, Oklahoma's law pertaining to reporting alcohol overdoses is not considered a "Good Samaritan" law because it does not pertain to heroin overdoses. *See* PREVENTION, *supra*. The twenty-five states that have expanded Naloxone access are NY, IL, WA, CA, RI, CT, MA, NC, OR, CO, VA, KY, MD, UT, TN, ME, GA, WI, MN, OK, OH, IN, LA, ME and VT. PREVENTION, *supra*; LEGAL INTERVENTIONS, *supra*.

[37] S.B. 2082, 215th Leg., Reg. Sess. (N.J. 2012).

[38] *Id.*; Conditional Veto from Governor Chris Christie, Opioid Antidote and Overdose Prevention Act, *available at* http://www.njleg.state.nj.us/2012/Bills/S2500/2082_V1.PDF (last visited Oct. 1, 2014).

Prevention Act" with the "Good Samaritan Emergency Response Act," which had been passed the legislature as Assembly Bill No. 578.[39] The legislature made the Governor's recommended changes, and the Overdose Prevention Act was signed into law on May 2, 2013.[40]

B. AN EVALUATION AND COMPARISON OF NEW JERSEY'S GOOD SAMARITAN PROVISION

New Jersey's Good Samaritan immunity provision provides a broad grant of immunity for various drug-related crimes. Compared to the sixteen other similar statutes nationwide, the OPA grants immunity for the greatest number of crimes. However, all of the Good Samaritan statutes, including New Jersey's, should expand the protections afforded to individuals who report overdoses.

1. An Evaluation of the Protections Provided by the Good Samaritan Provision

In general, New Jersey's Good Samaritan overdose law provides broad immunity from prosecution of drug crimes to people who seek medical assistance for individuals experiencing an overdose. The statute provides immunity from being "arrested, charged, prosecuted, or convicted for possessing, using, being under the influence of, or failing to make lawful disposition of, a controlled dangerous substance . . . pursuant to subsection a., b., c. of N.J.S.2C:35-10."[41] The statute also gives

[39] N.J. S.B. 2082.

[40] N.J. STAT. ANN. § 24:6J-1 (West 2013). Governor Christie was joined at the signing by New Jersey native Jon Bon Jovi, whose daughter had been protected by a similar New York law after she overdosed on heroin in 2012. Julia Talanova, *New Jersey Law Protects Overdose Patient from Prosecution*, CNN.COM (May 2, 2013), http://www.cnn.com/2013/05/02/justice/new-jersey-overdose-law/.

[41] N.J. STAT. ANN. § 2C:35-30 (West 2013). N.J. STAT. ANN. § 2C:35-10 states:

> a. It is unlawful for any person, knowingly or purposely, to obtain, or to possess, actually or constructively, a controlled dangerous substance or controlled substance analog, unless the substance was obtained directly, or pursuant to a valid

protection for paraphernalia charges and a host of other drug-related crimes, such as "huffing."[42]

In order for a "Good Samaritan," to be protected by this law they must (1) act in "good faith," (2) be seeking medical assistance for someone experiencing an overdose, and (3) "the evidence for an arrest . . . [must be] obtained as a result of seeking medical assistance."[43] Stated differently, someone is not protected by this statute just by virtue of the fact that they were present when someone was experiencing an overdose and medical assistance or law enforcement happened to arrive, such as during the execution of an arrest or search warrant.[44]

Many of the provisions in the statute are specifically targeted to opiate use. For example, the section of the statute granting immunity from paraphernalia charges specifies that hypodermic needles or syringes are covered.[45] Furthermore, the statute grants immunity to individuals who obtain controlled

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> prescription or order form from a practitioner, while acting in the course of his professional practice, or except as otherwise authorized by P.L.1970, c. 226 (C.24:21-1 et seq.) . . . .
>
> b. Any person who uses or who is under the influence of any controlled dangerous substance, or its analog, for a purpose other than the treatment of sickness or injury as lawfully prescribed or administered by a physician is a disorderly person . . . .
>
> c. Any person who knowingly obtains or possesses a controlled dangerous substance or controlled substance analog in violation of subsection a. of this section and who fails to voluntarily deliver the substance to the nearest law enforcement officer is guilty of a disorderly persons offense . . . .

N.J. STAT. ANN. § 2C:35-10 (West 2014).

[42] § 2C:35-30.

[43] *Id.*

[44] Some Good Samaritan statutes explicitly note that the protections provided by the statute do not apply if the medical assistance is sought during the execution of a search warrant. *See* MINN. STAT. ANN. § 604A.05 (West 2014).

[45] *Id.*

substances by fraud.[46] Considering that many prescription painkiller abusers obtain their drugs through "doctor shopping" and fraudulent Medicaid transactions,[47] this provision is targeted towards protecting prescription painkiller addicts.

2. Comparing New Jersey's Good Samaritan Immunity Provision to Similar Statutes Nationwide

As previously mentioned, seventeen other states and the District of Columbia[48] currently[49] have a Good Samaritan law.[50] In terms of the number of crimes covered by the Good Samaritan immunity provisions of the OPA, the New Jersey statute provides broader immunity than many other states. For example, many states do not include a provision protecting people from paraphernalia charges.[51] In fact, only nine of the nineteen Good Samaritan statutes include immunity from being arrested for possessing drug paraphernalia.[52]

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[46] *Id.*

[47] *See* LEVI ET AL., *supra* note 2, at 4; STATE OF N.J. COMM'N OF INVESTIGATION, *supra* note 12, at 15.

[48] PREVENTION, *supra* note 36; LEGAL INTERVENTIONS, *supra* note 36.

[49] Again, this statement is based off of data available as of June 2014. Most likely, this number will continue to increase.

[50] LEGAL INTERVENTIONS, *supra* note 36, at 31-34.

[51] Id.

[52] *Id.* The Colorado statute gives immunity from prosecution, not arrest, for all the offenses covered in its Good Samaritan Act. COLO. REV. STAT. ANN. § 18-1-711 (West 2013). Additionally, the portion of the New York statute regarding paraphernalia charges is rather poorly constructed. It provides immunity for paraphernalia offenses listed in article thirty-nine of the general business law, which deals only with the purchase and sale of drug paraphernalia. LEGAL INTERVENTIONS, *supra* note 36, at 31 n.95; *see* N.Y. GEN. BUS. LAW § 851 (West 2013). Considering the intent of the law, it only seems logical that possession of drug paraphernalia would be covered as well. LEGAL INTERVENTIONS, *supra* note 36, at 31 n.95. Utah's Good Samaritan law does not provide immunity from prosecution in its Good Samaritan law. Instead, the act of reporting a drug-overdose is an affirmative defense for drug possession and paraphernalia charges. H.B. 11, 2014 Leg., Gen. Sess. (Ut. 2014).

Further, some states do not include protection for any crimes other than drug possession.[53] New Mexico, Connecticut, Illinois, Massachusetts, Louisiana, and Florida only provide protection for possession of a controlled substance.[54] The remaining twelve statutes provide protection for other crimes such as being under the influence of a controlled substance or providing alcohol to a minor,[55] but only New Jersey's statute[56] includes a provision that grants immunity to those who obtain a prescription by fraud. As previously discussed, this type of immunity is essential to encourage prescription drug users to seek medical assistance for an overdose victim.

Although the OPA gives broad protection for various drug possession offenses, in order to be as effective as possible, the immunity provision should be even broader. The OPA does not grant immunity for any distribution or intent to distribute charges.[57] By enacting the OPA without any protection for small-scale distribution crimes, the legislature has made it very

[53] *See generally* LEGAL INTERVENTIONS, *supra* note 36.

[54] *Id.* at 31-34.; S.B. 422, 2014 Leg., Reg. Sess. (La. 2014).

[55] *See, e.g.*, CAL. HEALTH & SAFETY CODE § 11376.5 (West 2013); VT. STAT. ANN. tit. 18 § 4252 (West 2013).

[56] There is a possibility that the Minnesota statue could also be read to provide immunity for drug users who obtain prescriptions through fraud. The Minnesota statute states: "A person acting in good faith who seeks medical assistance for another person who is experiencing a drug-related overdose may not be charged or prosecuted for the **possession, sharing, or use of a controlled substance** under sections . . . 152.025." MINN. STAT. § 640A.05 (2014) (emphasis added). Section 152.025 makes possession of a Schedule I-IV substance a fifth degree crime, but it in the same subdivision, it also makes it a fifth degree crime when someone "procures, attempts to procure, **possesses,** or has control over a controlled substance by any of the following means . . . fraud, deceit, misrepresentation, or subterfuge . . . ." *Id.* § 152.025 (2014) (emphasis added). While a narrow reading of Minnesota's Good Samaritan statute would indicate that the legislature only intended to give immunity for a typical possession charge, Minnesota's statute could be interpreted as covering all forms of possession that are prohibited by Section 152.025.

[57] This is not surprising considering that none of the other Good Samaritan laws provide protection for drug distribution crimes. The only state statute that provides any protection for individuals who distribute drugs is Minnesota, which gives immunity to persons who share controlled substances. *Id.* § 604A.05 (2014).

clear that drug addicts need protection; drug dealers need to go to jail. However, the line between drug addict and drug dealer tends to blur. It is not uncommon for a drug user to do drugs with their drug dealer because many drug dealers are themselves addicts.[58] While the idea of protecting drug dealers may seem reprehensible to many, the type of drug dealers who would be present during an overdose would most likely not be the large-scale drug kingpins that the state seeks to incarcerate.[59] Realistically, the arrest of a low-level drug dealer will not stop drugs from being sold. The state should not value the arrest of an inconsequential drug trafficker over a human life. If the legislature truly seeks to save as many lives as possible, then the OPA should grant immunity for some drug distribution crimes.

A less extreme alternative to granting immunity to drug dealers would be to revise the OPA to allow the act of seeking medical assistance for someone experiencing an overdose to serve as a mitigating factor for distribution-related crimes. Many other states already include such a provision in their Good Samaritan statutes.[60] Two states, Alaska and Maryland, that do not have a Good Samaritan provision allow reporting a drug overdose to serve as a mitigating factor in criminal prosecutions.[61] New York's mitigation provision goes further and states:

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[58] *See, e.g.,* STATE OF N.J. COMM'N OF INVESTIGATION, *supra* note 12, at 14-15; Erin Rose, *The True Lives of Low-Level Drug Dealers: "What's the Point of Surviving if You Can't Live?",* SALON (Mar. 9, 2014), http://www.salon.com/2014/03/09/the_true_lives_of_low_level_drug_dealers_whats_the_point_of_surviving_if_you_cant_live/.

[59] One of the major problems with prosecuting the heads of drug organizations is that they are rarely present around the drugs. *See* James H. Knight, Note, *The First Hit's Free . . . Or Is It? Criminal Liability for Drug-Induced Death in New Jersey*, 34 SETON HALL L. REV. 1327, 1346-47 (2004) (discussing of New Jersey's attempts to prosecute the elusive upper-echelon drug dealers).

[60] LEGAL INTERVENTIONS, *supra* note 36, at 15-18. Illinois, Washington, Rhode Island, Massachusetts, Vermont, Delaware, Minnesota, and DC's statues all include reporting as a mitigating factor in criminal sentencing for drug related crimes. *Id.*

[61] *Id.* at 15.

> It shall be an affirmative defense to a criminal sale controlled substance offense under this article or a criminal sale of marihuana offense under article two hundred twenty-one of this title, not covered by subdivision one or two of this section, with respect to any controlled substance or marihuana which was obtained as a result of such seeking or receiving of health care, that:
>
> (a) the defendant, in good faith, seeks health care for someone or for him or herself who is experiencing a drug or alcohol overdose or other life threatening medical emergency; and
>
> (b) the defendant has no prior conviction for the commission or attempted commission of a class A-I, A-II or B felony under this article.[62]

However, New York's affirmative defense approach to immunity is probably not the right approach for New Jersey because it wastes judicial resources and does not provide the necessary incentive for drug dealers to seek medical assistance for overdose victims. Under New York law, if someone calls 911 for an overdose victim, he will still be arrested and charged with a criminal sale controlled substances offense even though he ultimately will be acquitted. This approach produces the same final result as giving full immunity for criminal sale controlled substances offense while unnecessarily wasting the resources of law enforcement agencies, prison systems, and the judiciary.

Additionally, New York's affirmative defense provision discourages individuals from seeking medical assistance for overdose victims because they will still be arrested and charged with a crime, potentially landing them in jail prior to trial or, at the very least, forcing them to spend money on an attorney. It makes more sense for the legislature to either provide full immunity for drug sale charges or implement a traditional mitigation provision. Nevertheless, if New Jersey were to give immunity for distribution related offenses, the legislature could include a provision that limits the protection to individuals who

[62] N.Y. PENAL LAW § 220.78(4) (McKinney 2014).

have not been previously convicted of distribution related offenses, similar to section (b) of New York's affirmative defense provision.

Arguably, mitigation provisions do not provide the necessary incentives for drug dealers to seek medical assistance for someone having an overdose; however, even if this is true, there is little downside to including a mitigation provision. Drug dealers would still be arrested, charged, and prosecuted, but their sentences would be minimized in exchange for saving someone's life. The mitigation provision from District of Columbia's Good Samaritan provision serves as a good model for a mitigation provision that could be added to the OPA. It states in relevant part:

> (c) The seeking of health care under subsection (a) of this section, whether or not presented by the parties, may be considered by the court as a mitigating factor in any criminal prosecution or sentencing for a drug or alcohol related offense that is not an offense listed in subsection (b) of this section.[63]

The addition of "in any criminal prosecution" gives the courts discretion to not prosecute at all. Many of the other existing mitigation provisions only consider the act of reporting in sentencing.[64]

Again, the OPA does an adequate job of providing broad grants of immunity for various crimes to people who seek medical assistance for an overdose victim. However, another "blind spot" in the OPA is that it does not provide immunity for people on all forms of supervised status. The OPA states:

> a. A person who . . . seeks medical assistance for someone experiencing a drug overdose shall not be: . . . (7) subject to revocation of parole or probation based only upon a violation of offenses described in subsection a. (1) through (6) of this

[63] D.C. CODE § 7-403 (West 2013).

[64] *See, e.g.,* ILL. COMP. STAT. ANN. § 5/5-5-3.1 (West 2013).

> section, provided, however, this circumstance may be considered in establishing or modifying the conditions of parole or supervision.[65]

Unlike the District of Columbia, Vermont, and Minnesota statutes,[66] the New Jersey statute does not protect people on pretrial release or who are participating in a furlough program. People on pretrial release or furlough are strongly disincentived to report overdoses to the police because violating conditions of supervised status can immediately put an individual in or back in a correctional facility. People on supervised release may actually be the most reluctant to report overdoses to the police because the consequences of dealing with the authorities for someone on supervised release are more immediate than someone who is being arrested for the first time. Thus, New Jersey should expand its immunity provision to include all forms of supervised status.

One of the most advantageous aspects of New Jersey's Good Samaritan provision is that a "Good Samaritan" only needs to seek medical assistance for someone who legitimately needs medical assistance and act in "good faith" in order to be covered by the immunity.[67] Some other states will only grant someone

[65] N.J. STAT. ANN. § 2C:35-30 (West 2013).

[66] The District of Columbia statute protects individuals on any form of supervised status. D.C. CODE § 7-403 (West 2013). The Vermont statute states, "A person who seeks medical assistance for a drug overdose pursuant to subsection (b) or (c) of this section shall not be subject to any sanction for violation of a condition of pretrial release, probation, furlough, or parole for a violation of this chapter . . . ." VT. STAT. ANN. tit. 18, § 4254 (West 2013). The Minnesota statute states, "A person's pretrial release, probation, furlough, supervised release, or parole shall not be revoked . . . ." MINN. STAT. ANN. § 604A.05 (West 2014). Georgia also provides broad protection for persons on supervised release except for persons on furlough. *See* GA. CODE ANN. § 16-13-5 (2014). The Florida statute may provide protection for people on all forms of supervised status because it provides that "[a] person acting in good faith who seeks medical assistance for an individual experiencing a drug-related overdose may not be charged, prosecuted, or **penalized** . . . for possession of a controlled substance . . . ." FLA. STAT. ANN. § 893.21 (West 2013) (emphasis added). Depending on the court's interpretation, penalization could encompass revoking an individual's supervised status.

[67] N.J. STAT. ANN. § 2C:35-30 (West 2013).

immunity if they take very specific acts in conjunction with reporting an overdose. For example, someone is a "Good Samaritan" under the Minnesota legislation if he (1) is "the first person to seek [medical assistance];" (2) "provides a name and contact information;" (3) "remains on the scene until assistance arrives or is provided;" and (4) "cooperates with the authorities."[68]

Presumably, most people calling for medical assistance would do all of the things that the Minnesota statute requires, but the specificity of the statute may provide law enforcement officials and prosecutors with enough "wiggle room" to deny a "Good Samaritan" the immunity they should be granted for seeking medical assistance. The most troubling aspect of Minnesota's law is that the "Good Samaritan" has to be the first person to seek medical assistance. It is relatively easy to envision a scenario where the "first person" requirement could deprive assistance-seekers of immunity. Although New Jersey's statute does not explicitly cover situations where there are multiple assistance-seekers, the guidelines issued by the New Jersey Attorney General in conjunction with the OPA adopted an enforcement policy where any "individuals who were aware of and collaborated in the request for medical assistance" should be granted immunity.[69] Any state looking to enact a Good Samaritan law should ensure that the statute is drafted in a manner that would protect multiple "Good Samaritans" who seek assistance for an overdose victim.

Overall, the goal of any Good Samaritan act should be to encourage as many people as possible to seek assistance for someone who experiences an overdose. New Jersey's Good Samaritan provision does an adequate job of providing immunity for a broad range of drug-related offenses, but could be further improved by granting immunity for some drug distribution crimes. Additionally, the "ideal" Good Samaritan Act would grant immunity to persons who are on all forms of supervised release. Although the OPA protects assistance-

[68] MINN. STAT. ANN. § 604A.05 (West 2014).

[69] Memorandum from the State of New Jersey, Office of the Attorney Gen., Directive to Ensure Uniform Statewide Enforcement of the "Overdose Prevention Act" (June 25, 2013), *available at* http://www.state.nj.us/oag/dcj/agguide/directives/dir-2013-1-overdose-prev-act.pdf.

seekers who are on some form of supervised release, the provisions of the OPA should be expanded to include every possible form of release.

C. EVALUATION AND COMPARISON OF NEW JERSEY'S NALOXONE ACCESS LAWS

As previously discussed, the OPA takes a two-pronged approach in fighting New Jersey's opiate epidemic. The second section of the OPA is drafted to ensure access to Naloxone, an opioid antidote that can reverse an overdose.[70] An effective Naloxone access law removes civil and criminal barriers for laypersons and medical professionals. Additionally, it is important that any Naloxone law enables emergency responders to carry and administer Naloxone. New Jersey's Naloxone access laws provide broad grants of civil and criminal immunity for laypersons and medical professionals and, in that sense, should serve as a model for any other state looking to enact Naloxone access laws.

1. An evaluation of New Jersey's Naloxone access laws

The goal of state-based[71] Naloxone access laws is to remove barriers preventing the establishment of take-home programs. Take-home programs allow anyone at risk of having or

[70] N.J. STAT. ANN. § 24:6J-4 (West 2013).

[71] The federal government could also play a large role in facilitating access to Naloxone. In 2012, Congress considered the Stop Overdose Stat Act (S.O.S.), which sought to provide funding for the expansion of community programs that provide Naloxone to people at little or no cost. LEVI ET AL., *supra* note 2, at 49; S.O.S. Act, H.R. 6311, 112th Cong. (2012). Unfortunately, this bill was introduced but not enacted. The FDA also plays a significant role in limiting access to Naloxone. The most effective way of providing Naloxone to a large portion of the population is to make it available over-the-counter. Although the FDA is considering this idea, as of now, Naloxone is not yet approved for over-the-counter sale. *See generally* FDA, ROLE OF NALOXONE IN OPIOID OVERDOSE FATALITY PREVENTION (Apr. 12, 2012), *available at* http://www.fda.gov/downloads/Drugs/NewsEvents/UCM304621.pdf (discussing the legal barriers preventing reclassification of Naloxone by the FDA); *see also* Burris et al., *supra* note 17.

witnessing an overdose to obtain a prescription for Naloxone.[72] In terms of removing civil and criminal liability for Naloxone administration, the New Jersey statute is the broadest of any of the similar statutes and should be viewed as the model for any state looking to enact a similar law. Enabling access to Naloxone should be a "no-brainer" for any state legitimately interested in preventing overdoses. As previously mentioned, the effects of Naloxone are short-lived, and unlike many other drugs used in the treatment of opiate addiction, such as Suboxone and Methadone,[73] Naloxone cannot be abused.[74] Furthermore, as long as it is administered promptly, Naloxone has an extremely high success rate.[75] For any legislature that would not be swayed to enact a Naloxone access law based solely on public health concerns, research has also showed that Naloxone is a cost-effective tool.[76]

The Naloxone access provision of the OPA contains three main components. The first component deals with immunity from civil and criminal repercussions resulting from the administration of Naloxone to someone experiencing an overdose. The OPA states:

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[72] *See generally* Eliza Wheeler et al., The Harm Reduction Coal., Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects (FALL 2012), *available at* http://harmreduction.org/wp-content/uploads/2012/11/od-manual-final-links.pdf.

[73] Suboxone is a combination of buprenorphine and Naloxone that is used in opioid replacement therapy. Deborah Sontag, *The Double-Edged Drug: Addiction Treatment with a Dark Side*, N.Y. TIMES, Nov. 16, 2013, http://www.nytimes.com/2013/11/17/health/in-demand-in-clinics-and-on-the-street-bupe-can-be-savior-or-menace.html?_r=0. While Suboxone was initially developed to treat opiate addicts, many people are also becoming addicted to Suboxone itself. *Id.* Methadone, one of the first drugs used to treat opiate addiction, can also be abused by addicts and can lead to fatal overdoses. Donna Leinwand, *Deadly Abuse of Methadone Tops Other Prescription Drugs*, USA TODAY, Feb. 13, 2013, http://usatoday30.usatoday.com/news/nation/2007-02-12-methadone_x.htm.

[74] *See supra* notes 31-33 and accompanying text.

[75] Burris et al., *supra* note 17, at 287.

[76] *See generally* Phillip O. Coffin & Sean D. Sullivan, *Cost-Effectiveness of Distributing Naloxone to Heroin Users for Lay Overdose Reversal*, 158 ANNALS INTERNAL MED. 1 (2013).

> a. A health care professional or pharmacist who, acting in good faith, directly or through a standing order, prescribes or dispenses an opioid antidote to a patient capable, in the judgment of the health care professional, of administering the opioid antidote in an emergency, shall not, as a result of the professional's acts or omissions, be subject to any criminal or civil liability, or any professional disciplinary action . . . for prescribing or dispensing an opioid antidote in accordance with this act.
>
> b. A person, other than a health care professional, may in an emergency administer, without fee, an opioid antidote, if the person has received patient overdose information pursuant to section 5 of this act and believes in good faith that another person is experiencing an opioid overdose. The person shall not, as a result of the person's acts or omissions, be subject to any criminal or civil liability for administering an opioid antidote in accordance with this act . . . .[77]

This provision removes many of the legal barriers to Naloxone access. First of all, it ensures the Naloxone prescriber will not be subject to civil or criminal penalties or professional disciplinary action. It should be noted that there was little substantiated fear that medical personnel would be subject to civil action for administering Naloxone prior to the passage of the OPA;[78] however, studies have shown that doctors may have been reluctant to prescribe Naloxone due to fear of professional

[77] N.J. STAT. ANN. § 24:6J-4 (West 2013).

[78] Burris et al., *supra* note 17, at 314. Administering Naloxone during an overdose is within the standard of care for medical professionals. *Id.* Consequently, it would be difficult, if not impossible, to establish negligence in a suit for malpractice. *See id.* at 318-19 (discussing the practical difficulties of establishing a malpractice suit related to the administration of Naloxone).

disapproval.[79] While such fear might be deep-rooted and based on a negative perception of treating drug users,[80] knowing that Naloxone access is sanctioned by the legislature could shift the attitudes of some medical professionals. In that same vein, the OPA's immunity from professional discipline could also help shift attitudes about treating drug addicts with Naloxone.

A medical professional would not have been subject to criminal penalties for prescribing Naloxone to an addict under the legal regime that existed before the OPA as long as the professional was legally authorized to prescribe Naloxone.[81] Prior to the OPA, the legality of a Naloxone prescription would have only been implicated when the prescription was not for someone who was personally at risk for an overdose, such as the friends and family of an addict.[82] Those prescriptions would have technically contravened pharmacy laws.[83] However, the only sanctions that realistically would have resulted from these third-party prescriptions would have been professional, not criminal.[84]

The most important provision of the Naloxone access portion of the OPA is the protection afforded to laypersons. Before the OPA, volunteers who worked with programs that administered or gave out Naloxone were protected a New Jersey statute that granted tort immunity to volunteers working with non-profits;[85] however, this immunity did not protect anyone other than

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[79] Leo Beletsky et al., *Physicians' Knowledge of and Willingness to Prescribe Naloxone to Reverse Accidental Opiate Overdose*: *Challenges and Opportunities*, 84 J. URB. HEALTH 126, 132 (2007).

[80] *See id.* (providing evidence regarding physician attitudes towards Naloxone).

[81] Burris et al., *supra* note 17, at 290-91.

[82] *Id.* at 310-12.

[83] *Id.* at 312.

[84] *Id.*

[85] *See* N.J. STAT. ANN. § 2A:53A-7.1 (West 2013). Volunteer immunity, however, does not apply to "willful, wanton, or grossly negligent act[s] . . . ." *Id.*

volunteers associated with a non-profit. It also did not protect employees of the non-profit.[86]

Most significantly, there was no protection for addicts and their families and friends who would be the most likely to actually need to administer Naloxone. Naloxone is only effective if it is available during an overdose.[87] Timing is critical. Obviously, the people who need to have access to Naloxone are either addicts themselves or those who are closest to an addict. Hence, the most effective Naloxone access laws are those that remove the barriers for layperson administration.

The OPA removes both the civil and criminal repercussions associated with administering Naloxone for laypersons. In terms of the criminal repercussions, Naloxone is not a controlled substance, so the only crime that could have resulted from its possession would have been possession of a prescription drug without a prescription.[88] These types of criminal sanctions could also have been imposed on clinics that

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[86] *See id.* Only those who work without compensation are protected by this statute. *Id.*

[87] *See supra* notes 31-33 and accompanying text.

[88] Burris et al., *supra* note 17, at 312; *see* N.J. STAT. ANN. §§ 2C:35-10.5(a)(1)-(3) (West 2013) which states:

> a. A person who knowingly:
>
> (1) distributes a prescription legend drug . . . in an amount of four or fewer dosage units unless lawfully prescribed or administered by a licensed physician . . . is a disorderly person;
>
> (2) distributes for pecuniary gain or possesses or has under his control with intent to distribute for pecuniary gain a prescription legend drug . . . in an amount of four or fewer dosage units unless lawfully prescribed or administered by a licensed physician . . . is guilty of a crime of the fourth degree;
>
> (3) distributes or possesses or has under his control with intent to distribute a prescription legend drug . . . in an amount of at least five but fewer than 100 dosage units unless lawfully prescribed or administered by a licensed physician . . . is guilty of a crime of the third degree.

§§ 2C:35-10.5(a)(1)-(3).

distributed take-home Naloxone kits.[89] Additionally, before the OPA, a layperson who administered Naloxone could have been charged with unlicensed practice of medicine.[90] The same criminal penalties also could have been applied to an organization giving out Naloxone.[91] While, prior to the OPA, laypersons could have been charged with either possession of a prescription drug without a prescription or the unlicensed practice of medicine, it was unlikely that a prosecutor would bring such charges.[92]

Notwithstanding the unlikelihood of criminal penalties associated with Naloxone, removing any possibility of criminal prosecution is necessary to allow private organizations, municipalities, and potentially states themselves to establish take-home Naloxone programs. By eliminating criminal liability, New Jersey has removed many of the barriers to creating large-scale Naloxone access programs.

The Naloxone access component of the OPA requires that the health care professional or organization that is prescribing or distributing Naloxone provide information about overdoses to those receiving Naloxone, such as how to properly administer Naloxone and perform CPR.[93] The statute states:

> a. A health care professional prescribing or dispensing an opioid antidote to a patient shall ensure that the patient receives patient overdose information. This information shall include, but is not limited to: opioid overdose prevention and recognition; how to perform rescue breathing and resuscitation; opioid antidote dosage and administration; the importance of calling 911 emergency telephone service for assistance with an opioid overdose; and care for an overdose victim after administration of the opioid antidote.

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[89] *See* Burris et al., *supra* note 17, at 312.

[90] *Id.* at 311-12; *see* N.J. STAT. ANN. § 45:9-22 (West 2013).

[91] Burris et al., *supra* note 17, at 312.

[92] *Id.* at 313.

[93] N.J. STAT. ANN. § 24:6J-5 (West 2013).

> b. In order to fulfill the distribution of patient overdose information required by subsection a. of this section, the information may be provided by the health care professional, or a community-based organization, substance abuse organization, or other organization which addresses medical or social issues related to drug addiction that the health care professional maintains a written agreement with, and that includes: procedures for providing patient overdose information; information as to how employees or volunteers providing the information will be trained; and standards for documenting the provision of patient overdose information to patients.[94]

Section b enables community organizations to create Naloxone take-home programs without having to employ a full-time medical professional. The statute further allows the Commissioner of Human Services to award grants for the creation of overdose prevention programs.[95]

2. A Comparison of New Jersey's Naloxone Access Laws to Similar Statutes

As mentioned above, twenty-five other states and the District of Columbia,[96] all have Naloxone access laws.[97] However, not all

[94] *Id.*

[95] *Id.* § 24:6J-6.

[96] *See supra* note 36.

[97] LEGAL INTERVENTIONS, *supra* note 36, at 2; PREVENTION, *supra* note 36. The Swinomish Tribe also has a provision in their criminal code that allows for someone to "receive a [N]aloxone prescription, possess [N]aloxone, and administer [N]aloxone to an individual suffering from an apparent opiate-related overdose." SWINOMISH TRIBAL CODE § 4-10.045(C), *available at* http://www.narf.org/nill/Codes/swinomishcode/4_10.pdf. Considering there has been a 3,695 percent increase in opiate abuse among Native Americans, any native tribe that has not done so should seriously consider enacting Good Samaritan and Naloxone access laws. Gail Rosenblum, *Skyrocketing Abuse Among Indians Needs Attention*, STAR TRIBUNE, June 22, 2013, http://www.startribune.com/local/212640681.html.

of these laws adequately facilitate access to Naloxone by removing existing legal barriers. To illustrate, there are some states that provide immunity for laypersons but not for medical professionals. For example, the equivalent provisions in Rhode Island, New York, Illinois, Virginia, Washington, Oregon and the District of Columbia[98] do not include civil and criminal immunity for medical personnel.[99] The Rhode Island access provision states:

> (a) A person may administer an opioid antagonist to another person if:
>
> (1) He or she, in good faith, believes the other person is experiencing a drug overdose; and
>
> (2) He or she acts with reasonable care in administering the drug to the other person.
>
> (b) A person who administers an opioid antagonist to another person pursuant to this section shall not be subject to civil liability or criminal prosecution as a result of the administration of the drug.[100]

Some states, such as Kentucky, include immunity from professional disciplinary actions, but not civil immunity or explicit criminal immunity for medical professionals.[101]

Even though the risk of civil and criminal penalties resulting from prescribing and administering Naloxone is lower for medical professionals versus laypersons, the risk still does exist. The risk would be amplified when medical professionals worked

[98] This is not intended to be an exhaustive list of all of the states that do not provide immunity for medical professionals.

[99] *See* LEGAL INTERVENTIONS, *supra* note 36, at 3-8 tbl.1.

[100] R.I. GEN. LAWS § 21-28.8-3 (West 2013).

[101] KY. REV. STAT. ANN. § 217.186(1) (West 2013). A licensed health-care provider who . . . prescribes or dispenses the drug [N]aloxone to a patient . . . shall not . . . be subject to disciplinary or other adverse action under [licensing statutes] or any other professional licensing statute. *Id.*

with large scale Naloxone access programs and were prescribing and distributing Naloxone to many individuals. As mentioned above, there can also be professional consequences for medical professionals who prescribe Naloxone without explicit authorization. Consequently, all Naloxone access laws should include explicit immunity for both laypersons and medical professionals.[102]

Naloxone access laws should also enable emergency responders to carry and administer Naloxone. In Kentucky, State Senator John Schickel recently attempted to amend the Kentucky Naloxone access statute to allow "peace officer[s], firefighters[s], paramedic[s], and emergency medical technician[s]" to carry and administer Naloxone.[103] Again, Naloxone can only be effective when it is administered quickly after an overdose. On average in New Jersey, it can take up to fifteen minutes for an overdose victim to be treated by a hospital employee.[104] In contrast, it takes a police officer about two to four minutes to arrive at the scene.[105] Equipping emergency first responders is a logical way to help prevent fatal overdoses.

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[102] Naloxone Overdose Prevention Education Working Group (NOPE) created a legislation-drafting guide for an "ideal" Naloxone access law. The language NOPE suggests for removing civil, criminal, and professional penalties for medical professionals is:

> A health care professional who, acting in good faith and with reasonable care, prescribes or dispenses an opioid antagonist shall not be subject to any criminal or civil liability or any professional disciplinary action for (1) such prescribing or dispensing; and (2) any outcomes resulting from the eventual administration of the opioid antagonist.

NALOXONE OVERDOSE PREVENTION EDUC. WORKING GROUP, NALOXONE LEGISLATION DRAFTING GUIDE 4, *available at* http://harmreduction.org/wp-content/uploads/2013/10/NOPE-Model-Naloxone-Legislation-with-NOPE-Description-and-Exhibits.pdf.

[103] S.B. 12, Reg. Sess. (Ky. 2014).

[104] James Queally, *Police Get New Life-saving Tool in Battle Against N.J. Heroin Epidemic*, THE STAR-LEDGER, Dec. 27, 2013, http://www.nj.com/news/index.ssf/2013/12/police_get_new_life-saving_tool_in_battle_against_nj_heroin_epidemic.html.

[105] *Id.*

New Jersey's statute does not explicitly authorize emergency responders to carry and administer Naloxone, which created confusion for local governments attempting to create Naloxone access programs.[106] In Asbury Park, New Jersey, local officials delayed equipping their police, fire, and EMT departments with Naloxone until they received guidance from the Attorney General as to potential civil liability.[107]

In response to this confusion, the Christie Administration issued a waiver, allowing all of the state's 28,000 certified EMTs to carry Naloxone after completing a training course.[108] After an initial pilot program in Ocean and Hunterdon Counties,[109] the Christie Administration announced the statewide expansion of a program to train police officers and first responders in all twenty-one counties.[110] State troopers are also being trained and equipped with Naloxone.[111]

Even though the OPA is adequately drafted to remove the civil and criminal penalties related to Naloxone, the statute could still be improved. The major failing of the Naloxone access provision of the OPA is the absence of a state-created Naloxone access and education program. Although § 24:6J-6 allows the Commissioner of Human Service to award grants to local overdose prevention programs,[112] there is still no state-

[106] Niquel Terry, *Asbury Park Holds Back on Opiate Antidote*, ASBURY PARK PRESS, Mar. 9, 2014 (available through LexisNexis).

[107] *Id.*

[108] Susan K. Livio, *Christie Allows EMTs to Provide Heroin Antidote to Prevent Overdoses*, NJ.COM (Mar. 21, 2014, 6:15 PM), http://www.nj.com/politics/index.ssf/2014/03/christie_allows_emts_to_provide_heroin_antidote_to_prevent_heroin_overdoses.html.

[109] Queally, *supra* note 104.

[110] Press Release, State of New Jersey, Department of Law and Public Safety, Office of the Governor, Governor Christie Announces Statewide Expansion of Narcan Pilot (June 17, 2014), *available at* http://nj.gov/governor/news/news/552014/pdf/20140617a.pdf.

[111] *Id.*

[112] "The Commissioner of Human Services may award grants, based upon any monies appropriated by the Legislature, to create or support local opioid overdose prevention, recognition, and response projects." N.J. STAT. ANN. § 24:6J-6 (West 2013).

mandated education program regarding overdose prevention through the use of opioid antagonists.

Virginia, Vermont, Washington, California, Massachusetts,[113] New Mexico, New York, and Illinois all have statewide Naloxone access and education programs.[114] Vermont's statute states:

> (b) For the purpose of addressing prescription and nonprescription opioid overdoses in Vermont, the Department shall develop and implement a prevention, intervention, and response strategy, depending on available resources, that shall:
>
> (1) provide educational materials on opioid overdose prevention to the public free of charge, including to substance abuse treatment providers, health care providers, opioid users, and family members of opioid users; (2) increase community-based prevention programs aimed at reducing risk factors that lead to opioid overdoses; (3) increase timely access to treatment services for opioid users, including medication-assisted treatment; (4)(A) educate substance abuse treatment providers on methods to prevent opioid overdoses; (B) provide education and training on overdose prevention, intervention, and response to individuals living with addiction and participating in opioid treatment programs, syringe exchange programs, residential drug treatment programs, or correctional services . . . (6) develop a statewide opioid antagonist pilot program that emphasizes access to opioid antagonists to and for the benefit of individuals with a history of opioid use.[115]

[113] A Massachusetts program that trained 2,900 people on how to properly use opioid antagonists in case of an overdose resulted in significantly reduced death rates for communities where the program was implemented. LEGAL INTERVENTIONS, *supra* note 36, at 2.

[114] *Id.* at 3-4.

[115] VT. STAT. ANN. tit. 18 § 4240 (West 2013) (emphasis added).

Currently, the only Naloxone access programs that have been enacted in New Jersey have been started by private, non-profit organizations.[116] Community-based Naloxone access programs have been extremely effective. For example, in North Carolina, a non-profit organization created a Naloxone access program called Project Lazarus.[117] Project Lazarus is based on the ideas that "drug overdose deaths are preventable and that all communities are ultimately responsible for their own health."[118] In western North Carolina, Project Lazarus helps distribute Naloxone by encouraging physicians to prescribe it to their high-risk patients and distributing it for free to drug addicts.[119] Additionally, Project Lazarus uses North Carolina's prescription drug monitoring program to guide its interventions.[120] Its success is indisputable. There was not a single overdose from opioid painkillers just three years after Project Lazarus was implemented in western North Carolina.[121] While private projects, such as Project Lazarus, are extremely effective, the New Jersey Legislature should not rely on non-profit organizations to fund such projects. Instead, the State should be at the forefront of Naloxone access projects.

3. The Interplay Between Good Samaritan and Naloxone Laws

Although New Jersey passed its Good Samaritan and Naloxone access laws together in the OPA, not every state that has an overdose prevention statute has recognized the benefit of having these two laws work in tandem. Indeed, as of June

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[116] Press Release, Drug Policy Alliance, First-Ever New Jersey Naloxone Distribution Overdose Prevention Program Opened by South Jersey AIDS Alliance in Atlantic City (Nov. 26, 2013), *available at* http://www.drugpolicy.org/news/2013/11/first-ever-new-jersey-naloxone-distribution-overdose-prevention-program-opened-south-je.

[117] LEVI ET AL., *supra* note 2, at 49.

[118] *Id.*

[119] *Id.*

[120] *Id.*

[121] *Id.*

2014,[122] there are eight states[123] that have passed a Naloxone access law without passing a Good Samaritan law and two states that have done the converse.[124] Passing a Naloxone access law without a Good Samaritan law hampers the utility of Naloxone. To illustrate, suppose someone has an overdose and the only bystander does not have Naloxone available. In other states where the legislature have passed both a Naloxone access and a Good Samaritan law, the bystander could call 911 knowing that he would not be arrested for possession and knowing that the first responders could administer Naloxone. In the state without a Good Samaritan law, medical assistance is never called because the bystander is fearful of criminal repercussions. Additionally, even though Naloxone is extremely effective, it is still important to call 911 after administering it to someone who experienced an overdose because that person could be experiencing another medical problem, such as cardiac arrest, in addition to the overdose.[125] The opposite situation is true as well—a Good Samaritan law encouraging someone to call 911 is not as useful as it could be if the emergency responder is not able to carry Naloxone. Any legislature that passes one law without the other is not taking advantage of all the tools available to help prevent overdoses.

III. RECONCILING THE OVERDOSE PREVENTION ACT WITH NEW JERSEY'S STRICT LIABILITY DRUG-INDUCED DEATH STATUTE

In 1987, the New Jersey State Legislature passed the Comprehensive Drug Reform Act (CDRA).[126] In addition to

[122] As mentioned previously, the number of states with Good Samaritan and Naloxone access laws is predicted to increase.

[123] OR, KY, MD, TN, ME, WI, IN, VA, OH, UT, OK. LEGAL INTERVENTIONS, *supra* note 36, at 49.

[124] FL and DE. *Id.*

[125] NJ DEP'T OF HEALTH, NEW JERSEY EMS RESPONSE TO AN OPIATE OVERDOSE NALOXONE (NARCAN) PROGRAM, *available at* http://www.state.nj.us/health/ems/documents/narcan/narcan_administration_edu_material.pdf.

[126] Blair Talty, Note, *New Jersey's Strict Liability for Drug-Induced Deaths: The Leap from Drug Dealer to Murderer*, 30 RUTGERS L.J. 513, 516 n.13 (1999).

revamping sentencing guidelines and creating drug-free school zones,[127] the CDRA includes N.J.S. § 2C:35-9, which provides that anyone who "manufactures, distributes, or dispenses . . . [a] controlled dangerous substance classified in Schedules I or II" that causes someone else's death can be found guilty of a first-degree crime.[128] N.J.S. § 2C:35-9 states that no specific *mens rea* is needed to violate the statute.[129] Additionally, the statute specifies that the victim's voluntary decision to take the drugs cannot be used as a defense.[130] In other words, if *X* sells or gives drugs to *Y* and voluntarily taking those drugs kills *Y*, *X* is held strictly liable for *Y*'s death regardless if *X* intended for *Y* to die. Many other states also have strict liability drug-induced death statutes, but very few treat it as a first-degree crime.[131]

Recently, there has been an increased push to prosecute people under § 2C:35-9.[132] The original intent of the law was to

[127] *See* W. Cary Edwards, *An Overview of the Comprehensive Drug Reform Act of 1987*, 13 SETON HALL LEGIS. J. 5 (1989) (discussing the CDRA in-depth).

[128] N.J. STAT. ANN. § 2C:35-9 (West 2013). In New Jersey, crimes, other than disorderly persons offenses, are separated into four classes, with first-degree crimes carrying a potential penalty of ten to twenty years imprisonment. *The Criminal Justice Process*, N.J. CTS., http://www.judiciary.state.nj.us/criminal/crproc.htm (last visited Oct. 1, 2014).

[129] § 2C:35-9. "The provisions of N.J.S. 2C:2-3 (governing the causal relationship between conduct and result) shall not apply in a prosecution under this section." *Id.*

[130] *Id.* "It shall not be a defense . . . that the decedent contributed to his own death by his . . . injection, inhalation or ingestion of the substance, or by his consenting to the administration of the substance by another." *Id.*

[131] Talty, *supra* note 126, at 520-21. While the statutes in Florida, Connecticut, Louisiana, and Wisconsin do not all treat strict liability drug-induced death as a first-degree crime, the statutes provide for similar punishment as the New Jersey statute. *Id.*

[132] Lorenzo Ferrigno, *New Jersey Prosecutor Hit Dealers with Homicide Charges in Overdose Deaths*, CNN.COM (Mar. 11, 2014), http://www.cnn.com/2014/03/11/justice/new-jersey-overdose-laws/; *see also N.J. Man Sentenced in Ex-Girlfriend's Overdose Death*, NEWSWORKS (Sep. 28, 2013), http://www.newsworks.org/index.php/local/the-latest/60346-nj-man-sentenced-in-ex-girlfriends-overdose-death-; Rebecca O'Brien, *Analysis: Long-standing Strict N.J. Law on Overdose Death Still Debated*, NORTHJERSEY.COM (June 13, 2013), http://www.northjersey.com/news/crime-and-courts/analysis-long-standing-strict-n-j-law-on-overdose-deaths-still-debated-1.702866.

give prosecutors a means to prosecute upper-level drug dealers who could rarely be physically connected to the drugs.[133] However, this statute has not been used in its intended manner. From 1987 until 2004, prosecutors in New Jersey used § 2C:35-9 thirty-two times, but in only three of those cases was the statute used to prosecute someone who regularly sold drugs.[134] In the majority of the cases, prosecutors used the statute to prosecute friends of the deceased, not high-echelon drug dealers.[135] In *State v. Maldonado*, where the Supreme Court of New Jersey upheld the constitutionality of § 2C:35-9, the appellant had obtained heroin for a friend as a favor.[136] The appellant's friend was found dead the next day from an apparent overdose.[137] The appellant plead guilty under § 2C:35-9 and was sentenced to fifteen years in prison.[138]

Suppose that, instead of someone finding the friend the next day, the appellant witnessed the friend's overdose and called 911 to get emergency assistance. In this case, if the emergency response arrives in a timely manner and administers Naloxone, the appellant would be shielded from arrest and prosecution under the OPA. If the scenario is changed, however, and the emergency response does not arrive in time to save the drug user, then the appellant would be charged with strict liability drug-induced death. In these two scenarios, the appellant has taken the exact same actions but, due to forces outside of her control, would be facing either (1) no jail time or (2) a felony

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[133] Knight, *supra* note 59, at 1346-47.

[134] Ferrigno, *supra* note 132.

[135] *Id.*

[136] 645 A.2d 1165, 1169 (N.J. 1994). While the constitutionality of § 2C:35-9 is beyond the scope of this note, the New Jersey Supreme Court upheld the statute's constitutionality on the basis that (1) in general, strict liability statutes do not infringe on Due Process rights, (2) the penalties imposed by the statute do not constitute cruel and unusual punishment, (3) the "not too remote" element of § 2C:35-9 was neither vague nor unfair in the context of a Due Process analysis. *See generally id.*

[137] *Id.*

[138] *Id.*

conviction and fifteen years in prison.[139] The only thing that has changed in these two scenarios is the result.

What these scenarios illustrate is the tension between strict liability drug-induced death prosecutions and the OPA. New Jersey is moving towards a more progressive drug policy with the implementation of the OPA and Governor Chris Christie's promotion of drug courts.[140] Governor Christie stated, "We will no longer simply warehouse individuals in prison who are not a threat to society while the underlying cause of their criminality goes unaddressed."[141] However, New Jersey still has "tough on crime" laws such as the strict liability drug-induced death statute on the books. Not only is the strict liability drug-induced death statute still a valid law, but after twenty-seven years of relatively minimal use, county prosecutors are beginning to use it more frequently as a tool in their prosecutions.[142] The individuals who are being prosecuted are not who the Legislature originally intended to incarcerate.[143] Instead, this statute is being used to prosecute the people who Governor Christie stated that he wanted to protect.[144]

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[139] *See supra* note 138 and accompanying text.

[140] *See* Press Release, State of N.J., Office of the Governor, Governor Chris Christie Follows Through on Commitment to Reclaim Lives with Landmark, Bipartisan Mandatory Drug Court Law (Jul. 19, 2012), *available at* http://nj.gov/governor/news/news/552012/approved/20120719c.html [hereinafter Drug Court Law]. New Jersey's drug courts exist as a specialization in the Superior Court. *Drug Courts*, N.J. CTS., http://www.judiciary.state.nj.us/drugcourt/ (last visited Oct. 1, 2014). The goal of drug court is to support and monitor the recovery of drug-addicted criminals through frequent drug testing, court appearances, and therapeutic treatment. *Id.* Governor Christie promoted S-881, which expanded New Jersey's drug court program to make treatment mandatory for all eligible drug users. Drug Court Law, *supra*. Previously, the drug court program was entirely voluntary. *Id.* Governor Christie also dedicated $2.5 million dollars to expanding drug court in New Jersey's 2013 fiscal year budget. *Id.*

[141] *Id.*

[142] *See supra* notes 134-35 and accompanying text.

[143] *See supra* note 133 and accompanying text.

[144] S*ee supra* note 141 and accompanying text.

If the Legislature is serious about creating a more progressive drug policy, then it must either: (1) repeal the strict liability drug-induced death statute; or (2) include strict liability drug-induced death in the immunity provisions of the OPA. If the Legislature wants to use §2C:35-9 to prosecute high-level drug dealers, then the second option—including strict liability drug-induced death in the Good Samaritan provision of the OPA—would not impede that goal. The purpose of §2C:35-9 was to give prosecutors a means to prosecute high-level drug dealers who cannot be physically connected to the drugs.[145] Because these drug dealers are not physically present when the drugs are being distributed and used, then it is unlikely that they would be present during an overdose. Consequently, providing immunity for strict liability drug-induced death when someone calls 911 to report an overdose would not protect the drug dealers who the Legislature seeks to incarcerate.

IV. THE NEXT STEPS FOR OVERDOSE PREVENTION

The passage of the OPA is clearly a step in the right direction for New Jersey's drug policy. In a two-day span in March 2014, Camden County reported twenty emergency calls for overdoses—none of these overdoses were fatal.[146] The Camden County Police Chief credited the lack of fatalities to the OPA.[147] Because the legislation is relatively new, it is impossible to determine its exact impact, but there is anecdotal evidence that it is helping to prevent fatal overdoses in New Jersey.

Any state looking to save lives should implement both a Good Samaritan immunity law and a Naloxone access law. Any legislation that is enacted should provide broad grants of immunity that specifically target heroin and prescription pill related crimes, such as obtaining a prescription by fraud. Additionally, if states are serious about overdose prevention,

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[145] *See supra* note 133 and accompanying text.

[146] *Spate of Heroin ODs in Camden*, COURIER-POST, Mar. 24, 2014, http://www.courierpostonline.com/story/news/local/south-jersey/2014/03/24/spate-of-heroin-ods-in-camden/6812127/.

[147] *Id.*

then their Naloxone access laws should enable third-party prescriptions and allow all emergency responders to carry and administer the drug.

There is also overdose prevention legislation currently pending on the federal level. In March 2014, the Opioid Overdose Reduction Act of 2014 was introduced in the United States Senate.[148] The bill focuses solely on Naloxone access, providing civil immunity to health professionals who prescribe third-party prescriptions, volunteers who work at "opioid overdose programs," and laypersons who administer opioid antagonists after properly obtaining the antagonist and being trained in its use.[149] The statute would not apply in civil actions that involve non-diverse parties or if a state uses the authority of the statute to create its own opioid antagonist access statute.[150] However, it is intended to preempt any state law that does not provide equal or greater protections.[151] Considering that this statute does not apply when the parties in the civil action are from the same state, the usefulness of such a statute is questionable.

Furthermore, enacting the OPA is not enough to address this public health crisis. Both the Good Samaritan and Naloxone access provisions are useless if the public is not well-

[148] S. 2092, 113th Cong. (2014).

[149] *Id.* § 5(a). Regarding the immunity provisions for health care professionals, the statute states:

> (a) IN GENERAL.- Notwithstanding any other provision of law, a health care professional who prescribes or provides an opioid overdose drug to an individual at risk of experiencing an opioid overdose, or who prescribed or provided an opioid overdose drug to a family member, friend, or other individual in a position to assist an individual at risk of experiencing an opioid overdose, shall not be liable for harm caused by the use of the opioid overdose drug if the individual to whom such drug is prescribed or provided has been educated about opioid overdose prevention and treatment by the health care professional or as part of an opioid overdose program.

Id.

[150] *Id.* § 4(b).

[151] *Id.* § 4(a).

educated about the benefits these laws provide.[152] New Jersey must take all of the necessary steps to ensure that the public is informed about these laws. Some steps have already been taken, such as the erection of educational billboards.[153] These billboards, however, have been funded by donations from private advertising companies.[154] Similarly, the first Naloxone training program in New Jersey was established by a private non-profit organization.[155] New Jersey should not and cannot depend on private organizations to take the steps that the State itself should be taking to educate the public about these laws. Simply put, the State must put its money where its mouth is. A very practical place to start an educational campaign would be in New Jersey's public schools. It would be very easy, and potentially inexpensive, to incorporate a small unit on overdose prevention in the health curriculum of New Jersey's secondary schools.[156]

V. CONCLUSION

It is well established that opioid addiction is a public health crisis in this country.[157] As pharmaceutical companies

[152] In Washington D.C., a study showed that drug addicts were 88% more likely to report an overdose after learning about D.C.'s Good Samaritan law. UNIV. OF WASH., ALCOHOL & DRUG ABUSE INS., WASHINGTON'S 911 GOOD SAMARITAN DRUG OVERDOSE LAW: INITIAL EVALUATION RESULTS (Nov. 2011), *available at* http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2011-05.pdf.

[153] Press Release, Drug Policy Alliance, Billboards Supporting New Jersey's Overdose Prevention Act Erected Across State (Feb. 18, 2014), *available at* http://www.drugpolicy.org/news/2014/02/billboards-supporting-new-jerseys-overdose-prevention-act-erected-across-state.

[154] *Id.*

[155] *Id.*

[156] New Jersey high school students will soon be required to learn CPR in their health classes. Michael Phillis, *Lt. Gov. Guadagno Signs Bill Requiring Public High School Students to Learn CPR*, NORTHJERSEY.COM (Aug. 20, 2014, 3:23 PM), http://www.northjersey.com/news/lt-gov-guadagno-signs-bill-requiring-public-high-school-students-to-learn-cpr-1.1070198; *see* A.B. 2072, 216th Leg., Reg. Sess. (2014). Incorporating Naloxone training to the new CPR curriculum would further improve the efficacy of the CPR training.

[157] *See supra* notes 1-6 and accompanying text.

continue to produce more potent[158] and more lethal prescription painkillers, the high overdose rates in this country show no signs of slowing. New Jersey, in particular, is fighting an up-hill battle against the mounting opiate crisis.

New Jersey's latest countermeasure to help fight this battle, the OPA, is a landmark piece of progressive legislation that establishes a two-pronged approach to preventing overdoses. The Good Samaritan provisions of the OPA provide some forms of criminal immunity for overdose bystanders who call 911 when they witness an overdose. Of the many other similar statutes in the country, New Jersey provides some of the broadest and most pointedly targeted criminal protections. However, the efficacy of the OPA could be maximized by providing immunity for drug distribution charges, protecting individuals on all forms of supervised release, and including provisions which allowed the act of seeking emergency assistance to serve as a mitigating factor in sentencing for crimes that are not protected by the OPA.

The second portion of the OPA helps remove the legal barrier that prevented people from accessing an opioid antidote called Naloxone. New Jersey's statute provides a broad grant of civil and criminal immunity for both medical professionals and laypersons who administer or prescribe Naloxone. In that respect, New Jersey's statute should serve as a model for any state looking to enact similar legislation. However, New Jersey's Naloxone access could be further improved by incorporating a provision that establishes a statewide Naloxone access program.

New Jersey's approach to drug crimes and treating drug addiction is shifting from a hardline "tough on crime" approach to a more progressive recovery-based approach; however, there are still statutes in effect that conflict with the state's new goals. In particular, New Jersey has a strict liability drug-induced death statute does not help avoid overdoses, and as such, should be either repealed or included in the immunity provisions of the OPA.

Enacting the OPA should be the first step, but not the last step, in revamping New Jersey's drug policy. Both the Good Samaritan and Naloxone access provisions are only effective if the public is educated about the benefits these laws provide.

[158] *See supra* notes 7-11 and accompanying text.

Currently, the State has not dedicated the resources necessary to educating New Jersey's citizens about overdose prevention. Fatal opioid overdoses in New Jersey are, indeed, preventable, but only if New Jersey continues to treat this public health crisis as exactly that—a public health problem, not a criminal issue.