**THE RESUREGENCE OF HEROIN:**

**BENEFITTING FROM THE CURRENT POLITICAL CLIMATE**

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I. Background on the Heroin/Opioid Crisis

 A. National Statistics (American Society of Addiction Medicine)

 1. Drug overdose is the leading cause of accidental death in the U.S., with 47,055 lethal drug overdoses in 2014

 2. Opioid addiction is driving this epidemic, with 18,893 overdose deaths related to prescription opioids, and 10,574 overdose deaths related to heroin in 2014

 3. Of the 21.5 million Americans 12 years or older with a substance use disorder in 2014, 1.9 million had a substance use disorder involving prescription pain medications and 586,000 had a substance use disorder involving heroin

 4. According to the CDC, 78 Americans die every day from an opioid overdose

 5. From 1999 to 2014, the amount of prescription opioids sold in the U.S. nearly quadrupled, with no overall change in the amount of pain that Americans report (CDC)

 6. In 2012, 259 million prescriptions were written for opioids, which is more than enough to give every American adult their own bottle of pills

 B. Virginia Statistics (Virginia Department of Health, Fatal Drug Overdose Quarterly Report, April 2016)

 1. From 2010 through 2015, the number of fatal drug overdoses rose from 690 to 1013, an increase of 68.4%.

 2. Primary drugs involved in fatal overdoses (2010 through 2015):

 a. Benzodiazepines: 183 to 171 (-6.5%)

 b. Cocaine: 93 to 167 (+79.5%)

 c. Heroin: 48 to 344 (+616.6%)

 d. Prescription Opioids: 427 to 560 (+31.1%)

 e. Fentanyl: 64 to 123 (+92.2%)

 3. In 2014, drug overdose deaths exceeded motor vehicle deaths for the first time

 C. The Biology of Opioid Addiction (National Institute on Drug Abuse)

 1. ADDICTION IS A DISEASE!!! The American Society of Addiction Medicine defines addiction as “a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.”

 2. Opioids act by attaching to specific proteins called opioid receptors found in the brain, spinal cord and other organs in the body

 3. When opioids attach to these receptors, they reduce the perception of pain and increase the sensation of euphoria in the reward center of the brain

 4. Opioids can also produce drowsiness, metal confusion, nausea, constipation, and can depress respiration

 5. Dependence vs. Addiction

 a. Physical dependence occurs because of normal adaptations to chronic exposure to the drug. Someone who is physically dependent will experience withdrawal symptoms when use of the drug is reduced or stopped. Dependence is often accompanied by tolerance, or the need to take higher doses of the drug to get the same effect

 b. Addiction can include dependence but is characterized by compulsive drug seeking and use despite adverse consequences

II. Legislative Reaction

 A. Historical

 1. Crack cocaine epidemic of the 1980’s lead to tougher sentencing laws, mandatory minimums, and mass incarceration

 2. Took 20 years to undo the harm of that approach

 3. Blakely, Booker and the current effort to re-sentence thousands of federal inmates

 B. Current reaction has been generally more treatment-oriented, with exceptions

 1. Federal Reaction

 a. Increased grant funding for treatment, Naloxone

 b. Administration proposal for additional $1.1 billion in funding for treatment, community health centers, naloxone, prevention and HIDTA

 2. State Reaction

 a. Safe Reporting

 i. 18.2-251.03 – Safe reporting of overdoses

 ii. Creates an affirmative defense for an individual charged with unlawful possession of alcohol, possession of a controlled substance, possession of marijuana, DIP, or possession of paraphernalia

 iii. Requirements: individual, in good faith, seek medical attention for himself or someone experiencing an overdose; remain on the scene until law enforcement responds; identify himself to law enforcement; if requested, substantially cooperate in any investigation; evidence was obtained as a result of the individual seeking medical attention

 b. PMP Requirements

 i. Section 54.1-2521 regarding the reporting requirements. Beginning January 1, 2017, the requirement for a dispenser to report to the PMP database will be within 24 hours or the next business day after the prescription is dispensed (instead of the current 7 days). Also, grants access to the PMP information by dispensers who are providing clinical consultation on the care and treatment to the recipient. Permits a copy of the PMP report to be included in the patient’s record (current law does not permit inclusion).

 ii. 54.1-2522.1 regarding the PMP querying requirements. Beginning July 1, 2016, the statute will require prescribers of opioids to query the PMP database if treatment is anticipated to last more than fourteen (14) consecutive days (current law requires querying if treatment is expected to last more than 90 days

 iii. Section 55.1-2523.1 authorizes the Director of the PMP to disclose certain information. Requires the Director to develop, in consultation with the Boards of Medicine and Pharmacy, criteria to detect unusual patterns of prescribing or dispensing covered substances by prescribers or dispensers and authorizes such information to be provided to the prescribers or dispensers as well as to the Enforcement Division of the Department of Health Professions, in addition to the Virginia State Police Drug Diversion Program or chief law enforcement officer in a county, city, town, or campus police department for the purposes of an investigation into issues surrounding drug diversion.

 c. Governor’s Task Force on Prescription Drug and Heroin Abuse

 i. Executive Order 29- Governor McAuliffe established the Governor’s Task Force on Prescription Drug and Heroin Abuse, a 32 member group of multi-disciplinary, bipartisan leaders from across Virginia.

 ii. Five Workgroups were defined in the Executive Order:

 • Education

 • Treatment

 • Data and Monitoring

 • Storage and Disposal

 • Enforcement

 iii. 51 recommendations were approved by the Task Force, including

 • Improve access to and availability of treatment services.

 • Foster best practices and adherence to standards for treatment of individuals addicted to opioids

 • Identify and promote evidence-based practices and strategies across the criminal justice system to address public safety risks and treatment needs of individuals with opioid addiction, training in the use of life saving interventions, expanded alternatives to incarceration, including drug courts, and cross-system collaboration to improve access and the availability of treatment.

 3. Legislative Proposals That Failed

 a. Distribution resulting in an overdose

 i. HB-284 would have made it a Class 5 felony to manufacture, sell, give, or distribute a Schedule I or II controlled substance where the use of such substance results in another person's overdose

 ii. Left in the House Courts of Justice Committee

 b. Felony Murder

 i. HB-102 would have made it felony murder if the underlying felonious act that resulted in the killing of another involved the manufacture, sale, gift, or distribution of a Schedule I or II controlled substance

 ii. Passed the House 94-5, Continued to 2017 in Senate Finance 15-0.

III. Commonwealth Attorney’s Reactions

 A. Felony Murder Prosecutions Persist

 1. Heacock v. Commonwealth, 228 Va. 397 (1984)

* Facts: Heacock was convicted of felony murder, distribution of cocaine, and conspiracy to distribute cocaine. Heacock supplied “very high quality cocaine” at a “drug party” held at the home of two other individuals. Heacock and another individual prepared a mixture of the cocaine in a spoon for injection. An indivudal at the party injected the cocaine mixture, experienced parazylzing convulsions, but revived. A short time later, the decedent injected cocaine that Heacock supplied. The evidence did not show who actually administered that injection. After injecting the cocaine, the decedent suffered convulsions and died 3 days later of “acute intravenous cocainism.” There was also evidence that Heacock left premises before the rescue quad arrived, took and hid the cocaine from the party, and tried to get witnesses to change their stories about who was present when the cocaine was injected.
* The Va. Supreme Court interpreted the felony murder statute (18.2-33) to apply to an accidental killing which occurs during the commission of any felonious act, including distribution of a controlled substance
* The court did not specifically rule on the question of whether felony murder requires a showing of “causal connection” or whether a showing of “mere nexus” will suffice because the evidence in Heacock’s case was “conclusive” in showing that “cause and effect were proximately interrelated”
* The Court reiterated the holding of Haskell v. Commonwealth, 218 Va. 1033, 1041 (1978):

“[W]hen the homicide is within the *res gestae* of the initial felony and is an emanation thereof, it is committed in the perpetration of that felony. Thus, the felony-murder statute applies where the initial felony and the homicide were parts of one continuous transaction, and were closely related in point of time, place and causal connection.” Heacock, 228 Va. at 405.

 2. Hylton v. Commonwealth, 60 Va. App. 50 (2012):

* Facts: Hylton illegally purchased methadone without a prescription, poured it into a cup which her son used to take his cold medicine, and left the cup unattended in the kitchen. Her son drank the methadone and subsequently died from an overdose. Hylton was convicted of felony murder in the commission of possession of a controlled substance
* The Court of Appeals affirmed the conviction holding that the son’s drinking of the methadone was closely related in time, place and causal connection to the mother’s possession of the drug.
* The Court specifically held that the possession of the methadone continued up until the point that the son drank it and therefore the killing occurred within the res gestae of the felonious possession

 3. Woodard v. Commonwealth, 61 Va. App. 567 (2013):

* Facts: Woodard sold ecstasy to the decedent in a store parking lot in Danville. Once the transaction was completed, they parted ways. The decedent went to dinner, stopped at a gas station for cigarettes, and went to a friend’s apartment. She did not inject the ecstasy until over two hours after the transaction with Woodard. She died 2 days later. Woodard admitted that he sold the ecstasy to the decedent, and he knew that ecstasy can kill a person. The trial court convicted Woodard of felony murder under 18.2-33
* The Va. Court of Appeals reversed the conviction finding that the killing did not occur during the prosecution of the sale of the ecstasy. The transaction was completed more than two hours before the substance was actually ingested. The Court held that “the killing must be ‘so closely related to the felony in time, place, and causal connection as to make it part of the same criminal enterprise.” Woodard, 61 Va. App. at 576.
* The Court specifically held that the killing did not occur during the prosecution of the sale of ecstasy because two of the elements were missing: time and place. The distribution was not a continuing transaction.
* The Court distinguished Heacock by stating that the facts in Heacock established the time, place and causal connection elements of the felony murder rule. The Court also distinguished Hylton finding that the distribution was completed in the store parking lot and was not continuing

 B. Drug Treatment Court Support Has Increased

 1. There are now 39 drug treatment court approved in Virginia

* 27 Adult Drug Treatment Courts
* 8 Juvenile Drug Treatment Courts
* 2 Family Drug Treatment Courts
* 2 DUI Drug Treatment Courts

 2. Most recent Courts were approved on April 28, 2016 – Northwest Regional, VA Beach, and Smyth County

 3. Most recent 2 year budget included an additional $1.2 million in new funding for drug treatment courts that have not previously received state funding and have significant drug- related caseloads

IV. Opportunities for Community Outreach

 A. Coalition Building

 1. Law Enforcement – Capitalize on feeling that “We cannot arrest our way out of this problem”

 2. Public Health – Reach out to local hospitals that experience the realities of the disease every day.

 3. Treatment Providers – both private and CSB’s

 4. Recovery Community – crucial element of the continuum of care

 5. Northern Shenandoah Valley Substance Abuse Coalition example

 B. Treatment Options

 1. Private Providers

 2. CSB’s

 3. De-Tox

 4. In-Patient

 5. Intensive Out-Patient

 6. NA/AA

 C. Medication Assisted Treatment

 1. Has been shown to be an effective treatment option for opioid addiction when coupled with proper counseling

 2. Federal grants currently have a requirement that drug treatment courts not deny participants who are using MAT’s

 3. Types of MAT’s:

 a. Methadone

 i. Synthetic opioid agonist that works by reducing or extinguishing cravings for opioids, allowing the patient to function without the major physiological components of opioid disorder.

 ii. When used as an addiction medication,

 methadone can only be dispensed in an opioid treatment program.

 iii. Typically dispensed in liquid form as a daily dose under observation

 b. Buprenorphine (Suboxone)

 i. Partial opioid agonist which functions similarly to methadone but has a lower maximal effect than a full agonist like methadone. Maintenance on methadone or buprenorphine produces no euphoria, intoxication, or withdrawal symptoms.

 ii. Buprenorphine is almost always combined with

 naloxone to deter abuse; the naloxone induces withdrawal symptoms if the medication is misused by being injected.

 iii. Buprenorphine can be dispensed in an opioid treatment program, or it can be provided by a physician who meets established qualifications to provide office-based treatment for opioid addiction.

 iv. Typically dispensed in sublingual film known as a “strip”

 c. Naltrexone (Vivitrol)

 i. Opioid antagonist which operates by blocking the effects of opioids so patients will not experience a high from using opioids.

 ii. People who are dependent on opioids must stop their drug use at least seven days prior to starting naltrexone.

 iii. Usually dispensed in the form of a monthly injection by a physician. Individuals can

 receive naltrexone in many settings, including doctors’ offices, opioid treatment programs, and other drug treatment settings

 d. Naloxone (Narcan)

 i. Immediately reverses effects of opioids and can bring overdose victims back to life

 ii. Dispensed in nasal spray or injectable form