United States Government Accountability Office

Report to Congressional Committees

March 2021

DRUG MISUSE

Most States Have Good Samaritan Laws and Research Indicates They May Have Positive Effects

GAO@100
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GAO-21-248

GAO@100 Highlights

Highlights of GAO-21-248, a report to Congressional Committees

March 2021

DRUG MISUSE

Most States Have Good Samaritan Laws and Research Indicates They May Have Positive Effects

Why GAO Did This Study

Since 1999, more than 800,000 people have died from a drug overdose in the United States, with over 86,000 occurring during the 12-month period ending in July 2020, according to the most recent provisional data available from the Centers for Disease Control and Prevention's National Center for Health Statistics. In recent years, some states have enacted Good Samaritan and Naloxone Access laws to help reduce overdose deaths and respond to opioid overdoses.

The Comprehensive Addiction and Recovery Act of 2016 included a provision for GAO to review these laws. This report addresses the following: (1) the efforts ONDCP has taken to collect and disseminate information on Good Samaritan and Naloxone Access laws, (2) the extent to which states, territories, and D.C. have these laws and the characteristics of them, and (3) what research indicates concerning the effects of Good Samaritan laws.

To answer these questions, GAO collected and reviewed ONDCP documents and interviewed agency officials. GAO also reviewed and analyzed selected characteristics of jurisdictions' Good Samaritan and Naloxone Access laws. Further, GAO conducted a literature review of empirical studies published from 2010 through May 2020 that examined the effects of Good Samaritan laws.

GAO provided a draft of this report to ONDCP for comments. ONDCP provided technical comments which we incorporated, as appropriate.

View GAO-21-248. For more information, contact Triana McNeil at (202) 512-8777 or mcneilt@gao.gov.

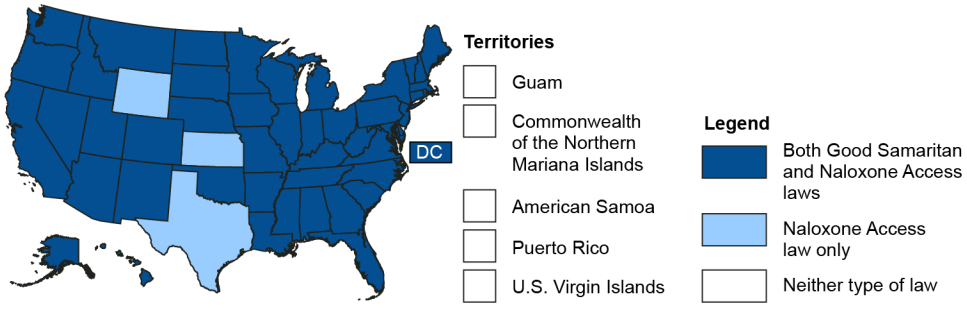
What GAO Found

The Office of National Drug Control Policy (ONDCP) has taken multiple actions to track, study, and share information about Good Samaritan laws, which protect individuals who call for medical assistance for an overdose victim, and Naloxone Access laws, which protect individuals who administer the opioid-reversal drug naloxone. For example:

- Since 2014, ONDCP conducted several reviews of states' Good Samaritan and Naloxone Access laws. It published a fact sheet in 2014 and conducted nationwide reviews in 2017 and 2020.
- ONDCP awarded grants to organizations that included support for efforts to track these laws and to develop a model law.

GAO found that 48 jurisdictions (47 states and D.C.) have enacted both Good Samaritan and Naloxone Access laws. Kansas, Texas and Wyoming do not have a Good Samaritan law for drug overdoses but have a Naloxone Access law. The five U.S. territories do not have either type of law. GAO also found that the laws vary. For example, Good Samaritan laws vary in the types of drug offenses that are exempt from prosecution and whether this immunity takes effect before an individual is arrested or charged, or after these events but before trial.

Figure: Jurisdictions with Good Samaritan and Naloxone Access Laws



Source: GAO analysis of jurisdiction laws. | GAO-21-248

GAO reviewed 17 studies that provide potential insights into the effectiveness of Good Samaritan laws in reducing overdose deaths or the factors that may contribute to a law's effectiveness. GAO found that, despite some limitations, the findings collectively suggest a pattern of lower rates of opioid-related overdose deaths among states that have enacted Good Samaritan laws, both compared to death rates prior to a law's enactment and death rates in states without such laws. In addition, studies found an increased likelihood of individuals calling 911 if they are aware of the laws. However, findings also suggest that awareness of Good Samaritan laws may vary substantially across jurisdictions among both law enforcement officers and the public, which could affect their willingness to call 911.

Contents

Abbreviations

CDC	Centers for Disease Control and Prevention
COVID-19	Coronavirus Disease 2019
FDA	Food and Drug Administration
HIDTA	High Intensity Drug Trafficking Areas
ONDCP	Office of National Drug Control Policy

441 G St. N.W.
Washington, DC 20548

March 29, 2021

Congressional Committees

Drug misuse—the use of illicit drugs and the misuse of prescription drugs—has been a long-standing and persistent problem in the United States. It represents a serious risk to public health and has resulted in significant loss of life and other harmful effects on society. From 1999-2019, more than 800,000 people have died from a drug overdose in the United States, with an estimated 86,000 deaths occurring during the 12-month period ending in July 2020, according to the most recent provisional data available from the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics.[1] Because of the devastating effects of the problem and the opportunities we found for federal agencies to help address it, we added this area—National Efforts to Prevent, Respond to, and Recover from Drug Misuse—to our high risk list in February 2021.[2]

In November 2020, we reported that the COVID-19 pandemic may increase the prevalence of risk factors related to overdose deaths, such as social isolation, stress, and unemployment.[3] In addition, we reported that access to treatment may be declining due to factors such as treatment providers closing or limiting hours and the loss of employer-based health insurance. We also reported that the expected increases in these risk factors due to COVID-19 are expected to exacerbate recent trends of increases in overdose deaths. In December 2020, CDC reported that, based on its analysis of National Center for Health Statistics provisional data, the largest recorded increase of drug overdose deaths occurred during the 12-month period ending in May 2020. In particular, CDC reported a concerning acceleration of the increase in drug overdose

[1]The CDC National Center for Health Statistics provisional counts are adjusted to account for reporting delays. Provisional data are underreported due to incomplete data.

[2]For more information on this work, see GAO, *High Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas,* GAO-21-119SP (Washington, D.C.: February 9, 2021) and *Drug Misuse: Sustained Efforts Are Necessary for Prevention, Response and Recovery,* GAO-20-474 (Washington, D.C.: March 26, 2020). For a complete list of our previous work in this area, see the Related GAO Products page at the end of this report.

[3]GAO, *COVID-19: Urgent Actions Needed to Better Ensure an Effective Federal Response*, GAO-21-191 (Washington, D.C.: November 30, 2020).

deaths from March 2020 to May 2020, coinciding with the implementation of widespread mitigation measures for the COVID-19 pandemic.

In recent years, federal, state, and local governments have taken efforts to reduce opioid overdose deaths. For example, states and the District of Columbia (D.C.) have enacted two types of laws to help reduce overdose deaths and respond to opioid overdoses, Good Samaritan laws and Naloxone Access laws.[4] Good Samaritan laws encourage individuals at the scene of an overdose to seek medical assistance for an overdose victim by protecting the individual from criminal penalties for certain drug offenses. For example, an individual who calls for medical assistance for an overdose victim might be exempt from prosecution for unlawfully possessing opioids under a Good Samaritan law, which may also extend these protections to the surviving victim. Naloxone Access laws aim to reduce overdose deaths by broadening the pool of people who are authorized to possess the opioid overdose-reversal drug naloxone, such as first responders and family members, friends, and others who interact with opioid users and may be in a position to assist during an opioid overdose. In addition, these laws can protect those who administer naloxone from civil, criminal, or professional penalties if they accidentally injure the overdose victim, such as by breaking the victim's nose when administering the naloxone nasal spray.

The Comprehensive Addiction and Recovery Act of 2016 (CARA) includes a provision for us to review the Office of National Drug Control Policy's (ONDCP) actions in support of Good Samaritan laws and to provide a compilation of laws in effect in the states, territories, and D.C.[5] This report addresses (1) the efforts ONDCP has taken to collect and disseminate information on Good Samaritan and Naloxone Access laws,

[4]The laws described in this report apply at the scene of a drug overdose, not other settings. For example, this report does not include Good Samaritan laws that protect bystanders who stop and give aid to strangers in other emergency situations, such as a car accident.

[5]See Pub. L. No. 114-198, tit. VII, § 703, 130 Stat. 695, 741-742 (2016). CARA defines a Good Samaritan law as a law of a state or local unit of government that exempts from criminal or civil liability (1) any individual who administers an opioid overdose reversal drug or device or (2) any individual who contacts emergency services providers in response to an overdose. Our report refers to the first type of law in the CARA definition as a "Naloxone Access law" and the second type as a "Good Samaritan law," which are the terms used by ONDCP and other experts, such as the Network for Public Health Law. In addition, although CARA refers to laws enacted by "a State or unit of local government," we confirmed with ONDCP and the experts we interviewed that exemptions from civil or criminal liability are enacted at the state, not the local, level.

(2) the extent to which states, territories and D.C. have Good Samaritan and Naloxone Access laws and selected characteristics of these laws, and (3) what research indicates concerning the effects of Good Samaritan laws.[6]

To describe the efforts ONDCP has taken to collect and disseminate information on Good Samaritan and Naloxone Access laws, we reviewed both current and prior documents that ONDCP officials have used to track the status of these laws in each of the 50 states and D.C. since 2014. We also reviewed documents and reports from two ONDCP grantees who have published material on the subject. In addition, we reviewed a model law that one grantee developed to assist jurisdictions in drafting legislation to expand access to naloxone. Further, we reviewed ONDCP strategy documents, such as the 2019 and 2020 National Drug Control Strategy, to identify ONDCP's priorities and how it engages with state and local stakeholders. We also interviewed officials from both grantees to understand how each conducted their research and discuss their respective findings. In addition, we interviewed officials who were responsible for conducting a study on behalf of ONDCP's High Intensity Drug Trafficking Areas (HIDTA) program that reviewed the effects of these laws on policing practices in selected states.[7] Finally, we interviewed ONDCP officials to understand how they collect and share information on these laws with interested stakeholders.

To determine the extent to which states, territories, and D.C. have Good Samaritan and Naloxone Access laws, and to identify characteristics of these laws, we conducted a review examining whether each jurisdiction had these laws and if so, we analyzed selected characteristics of them. To help identify laws, we reviewed an April 2020 ONDCP document that tracked these laws. We then conducted research on these laws in May 2020 using online legal databases, and our analysis is based on laws in

[6]We did not include studies that only examined the effectiveness of Naloxone Access laws in our scope because many of these studies examined behaviors outside of the scene of an overdose and therefore were not within the scope of our review.

[7]The HIDTA program was established in 1988 and coordinates and assists federal, state, local, and tribal law enforcement agencies to address regional drug threats with the purpose of reducing drug trafficking and drug production in the United States.

effect at that time.[8] For more information on the methodology we used to select the characteristics we reviewed, see appendix I.[9] Finally, we interviewed subject matter experts from six organizations to discuss general characteristics of Good Samaritan and Naloxone Access laws and any legislative trends they have observed.[10] We selected these organizations because of their expertise and prior research on these laws.

To determine what research indicates concerning the effects of Good Samaritan laws, we conducted a systematic review of empirical research from peer-reviewed academic publications that examined the various factors related to the effectiveness of the Good Samaritan laws published from 2010 through May 2020. We chose this time period because this is when most overdose-related Good Samaritan laws were enacted. Using a systematic process, further described in appendix I, we identified 17 studies that had empirical findings which assessed the effectiveness of these laws in reducing overdose deaths or examined one or more of the factors that may contribute to a law's effectiveness, such as a person's willingness to call 911.[11] In doing this, we not only reviewed the findings of the studies, but also the methodologies and any limitations. A bibliography of the 17 studies we reviewed are listed in appendix II. While we did not include articles that only examined the effects of Naloxone Access laws, we did identify and include in our analysis research that examined both Good Samaritan and Naloxone Access laws.[12] Further, while the results of our literature review provide potential insights into the

[8]In November 2020, we updated our analysis of Virginia's law to reflect a July 2020 amendment, which we identified based on our review of the Legislative Analysis and Public Policy Association's August 2020 report on Good Samaritan laws. The report can be found at http://legislativeanalysis.org/wp-content/uploads/2020/08/GSFOP-laws.8.10.2020-version.FINAL_.pdf (accessed October 21, 2020).

[9]Our analysis of the characteristics of the laws is limited to the 50 states and D.C. because we did not identify any Good Samaritan or Naloxone Access laws in the 5 U.S. territories.

[10]Two of the subject matter experts we interviewed were those who received grants from ONDCP.

[11]These studies also looked at other factors that are not detailed in this report because there was not enough evidence in the literature we reviewed to determine the effect of certain factors on the effectiveness of the Good Samaritan law.

[12]We did not include studies that only examined the effectiveness of Naloxone Access laws in the scope of our literature review because many of these studies examined behaviors outside of the scene of an overdose and therefore were not within the scope of our review.

effectiveness of these laws in reducing overdose deaths and the factors that may contribute to a law's effectiveness, our findings are generally limited. Specifically, because each study selected different combinations of factors and there are few studies conducted on each individual factor, we are limited in what we can report about the extent to which these factors contribute to the effectiveness of the laws.

We conducted this performance audit from March 2020 through March 2021 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Roles, Responsibilities, and Priorities of ONDCP

ONDCP, within the Executive Office of the President, is responsible for, among other things, working to reduce drug use and its consequences by leading and coordinating the development, implementation, and assessment of U.S. drug policy, including developing the National Drug Control Strategy. ONDCP also coordinates and assists with law enforcement and public health efforts related to drug threats at the state, local, and tribal levels. However, according to ONDCP officials, the agency is not in the position to advocate for specific state legislation, which reflects policy choices within a state's discretion, but can take steps to increase awareness of state laws.

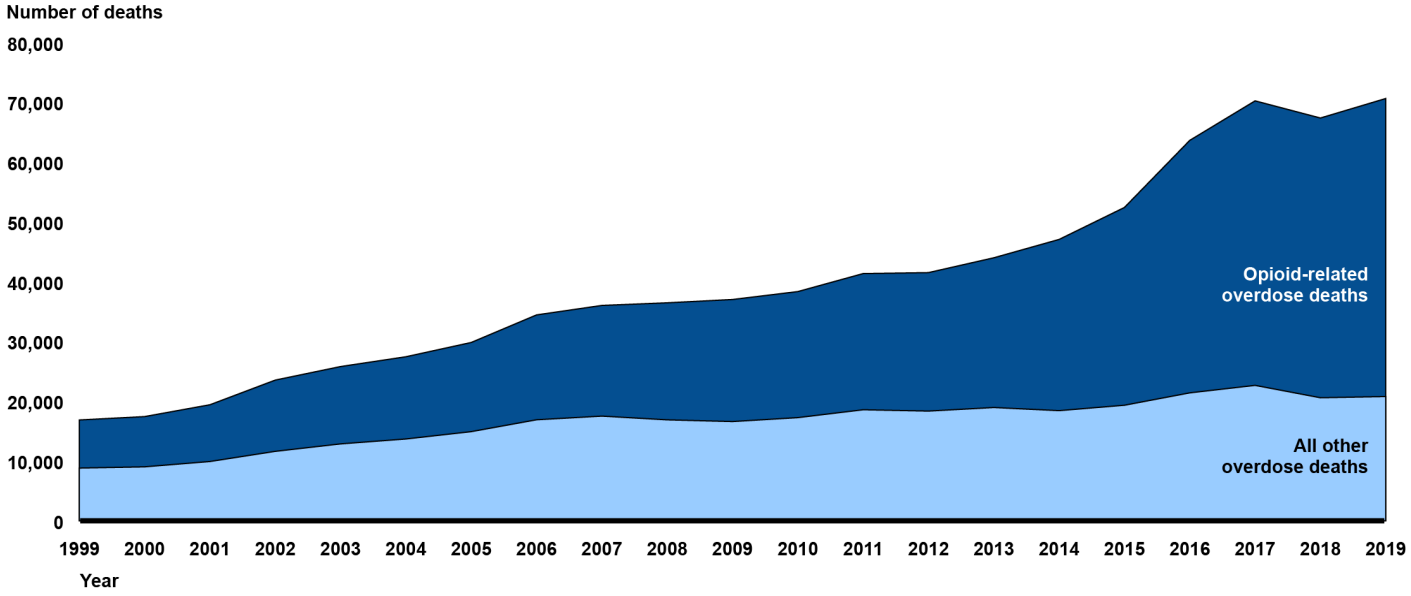
ONDCP's 2020 National Drug Control Strategy identified reducing drug overdose deaths as a top priority and specified improving the response to and monitoring of overdose as a strategic outcome of the strategy. ONDCP officials stated that one approach they have taken to achieve this outcome is to provide communities, organizations, and other stakeholders with information about the advantages of increasing access to naloxone. In addition, to achieve the goals in its strategy, ONDCP funds and coordinates the activities of law enforcement, community-based coalitions, and other stakeholders to combat drug misuse, including providing federal funds through grant programs.

National Trends in Overdose Deaths

According to the CDC, nearly 50,000 of the over 70,000 overdose deaths in 2019 involved an opioid—which includes both prescription opioids such as oxycodone as well as illicit opioids such as heroin—comprising nearly

70 percent of all drug overdose deaths. Figure 1 shows the trends in overdose deaths related to opioids in comparison with all other overdose deaths from 1999 through 2019.

Figure 1: United States Opioid-related Overdose Deaths and All Other Overdose Deaths from 1999 through 2019



Source: GAO analysis of U.S. Centers for Disease Control and Prevention/National Center for Health Statistics data. | GAO-21-248

Naloxone's Purpose and Administration

Naloxone is the generic name of a prescription drug, originally approved by the Food and Drug Administration (FDA) in 1971, to reverse the effects of an opioid overdose by displacing opioids from the receptors in the brain and blocking the effects on breathing and heart rates. The FDA has approved three ways to administer the drug: through an injection, auto-injector, and a nasal spray.[13] In 2019, the CDC reported substantial increases in the dispensing of naloxone prescriptions from 2012 through 2018, but also reported that the rate of naloxone prescriptions dispensed per high-dose opioid prescription remains low, and overall naloxone dispensing varies substantially across the country.[14] While naloxone is

[13]The FDA refers to auto injectors as complex drug-device combinations because they combine a medication and a device into a single product.

[14]Guy GP Jr., Haegerich TM, Evans ME, Losby JL, Young R, Jones, CM. *Vital Signs: Pharmacy-Based Naloxone Dispensing — United States, 2012–2018*, Morbidity and Mortality Weekly Report (MMWR), vol. 68, no. 31 (Atlanta, GA.: Centers for Disease Control and Prevention, August 9, 2019), p. 679-686.

currently available only as a prescription drug, the FDA is working to support the development of an over-the-counter version of naloxone by developing a model drug label that conveys what naloxone does, who can take it, and how to use it. By proactively developing a model drug label, FDA has enabled drug companies that wish to submit an over-the-counter version of naloxone for FDA approval to include this information as part of their application.[15]

ONDCP Tracks, Studies, and Shares Information on Good Samaritan and Naloxone Access Laws with Stakeholders

ONDCP has taken multiple actions to track and study Good Samaritan and Naloxone Access laws and share this information with stakeholders, such as federal, state, local, and tribal organizations and public health professionals. Specifically, ONDCP tracks existing laws, funds studies on the laws, and shares information with stakeholders.

Tracking laws. In August 2014, ONDCP published a fact sheet on its website that tracked whether states and D.C. had Good Samaritan and Naloxone Access laws, and reported certain characteristics of these laws, which it updated in December 2014. According to ONDCP officials, they began this initiative because the FDA was beginning to approve additional methods to administer naloxone, and expanding access to the antidote was a policy initiative at the time. After the initial review and revisions to the 2014 document, ONDCP conducted its review two additional times in January 2017 and April 2020 to capture information on newly enacted laws or amendments to existing laws.

In addition, ONDCP awarded grants to organizations that included efforts to track Good Samaritan and Naloxone Access laws. Specifically, in March 2016, the National Alliance for Model State Drug Laws summarized Good Samaritan laws across the states and D.C. Further, in August 2020, the Legislative Analysis and Public Policy Association issued a report that tracked the status of Good Samaritan laws in each of the states, D.C., and U.S. territories.[16] This report also included additional information on specific characteristics of the laws, including information on which individuals were eligible for protection under the various laws

[15]Food and Drug Administration. *Statement from FDA Commissioner Scott Gottlieb, M.D., on unprecedented new efforts to support development of over-the-counter naloxone to help reduce opioid overdose deaths* (Washington, D.C: January 17, 2019).

[16]The Legislative Analysis and Public Policy Association reported that the U.S. territories do not have laws pertaining to Good Samaritan fatal overdose prevention.

and what legal protections were available to them.[17] In September 2020, the Legislative Analysis and Public Policy Association released a similar report on Naloxone Access laws and their characteristics.[18] According to Legislative Analysis and Public Policy Association officials, their work is intended to be informative, not an evaluation of whether one legislative approach is better or more effective than another. In addition to these efforts to track the laws, in 2018, as part of an ONDCP grant, officials from the National Alliance for Model State Drug Laws told us they developed a model law that jurisdictions could use in developing their own law to expand access to naloxone.[19]

Studying laws. In 2017, ONDCP's HIDTA program conducted a study on Good Samaritan laws in the 20 states that participated in HIDTA's Opioid Response Strategy at that time.[20] This study resulted in 20 reports, one for each state, which addressed the laws' effects on policing practices, described officers' recent experiences responding to overdoses, and identified professional training opportunities to enhance officers' understanding of overdose response policies. Findings from this study were published in a peer-reviewed scholarly publication in December 2020 and included in our literature review discussed later in this report.[21] In addition, ONDCP officials stated that they regularly review the available

[17]The Legislative Analysis and Public Policy Association report can be found at http://legislativeanalysis.org/wp-content/uploads/2020/08/GSFOP-laws.8.10.2020-version.FINAL_.pdf (accessed October 21, 2020).

[18]Among the characteristics that the Legislative Analysis and Public Policy Association reported were details on who can prescribe, dispense, and administer naloxone and the various types of immunity provided to those persons. The report can be found at http://legislativeanalysis.org/wp-content/uploads/2020/10/Naloxone-summary-of-state-laws-FINAL-9.25.2020.pdf (accessed November 9, 2020).

[19]The model law can be found at https://namsdl.org/model-universal-access-to-naloxone-act-2/ (accessed October 21, 2020).

[20]In 2017, the HIDTA program oversaw 29 regional HIDTAs in 49 states, Puerto Rico, the United States Virgin Islands, and D.C. The Overdose Response Strategy is an initiative designed to enhance public health and public safety collaboration and to strengthen and improve efforts to reduce drug overdoses. In 2020, ONDCP awarded $5.4 million to HIDTA to expand the Overdose Response Strategy to all 50 states.

[21]Jennifer J. Carroll, Sasha Mital, Jessica Wolff, Rita K. Noonan, Pedro Martinez, Melissa C. Podolsky, John C. Killorin, Traci C. Green, "Knowledge, preparedness, and compassion fatigue among law enforcement officers who respond to opioid overdose," *Drug and Alcohol Dependence,* vol. 217 (2020): pp. 1-8.

research on these laws, including studies on what is known about their effectiveness, to inform their views.

Sharing information on laws. According to ONDCP officials, they generally view Good Samaritan and Naloxone Access laws as beneficial and share relevant information with interested stakeholders in various ways. One way they said they do this is by directing stakeholders to their grantees' reports, which are posted on their grantees' websites. In addition, ONDCP officials said that they present research on these laws through a variety of forums, including discussions at the agency's National Opioid and Synthetics Coordination Group's monthly webinars and presentations at conferences such as the Rx Drug Abuse & Heroin Summit.[22] According to ONDCP officials, the National Opioid and Synthetic Coordination Group monthly webinar is a very important mechanism the agency uses to achieve its goals and objectives, as it brings together participants from more than 300 federal, state, and local organizations and 700 professionals from public health, law enforcement, public policy, and professional organizations, as well as academia and research entities across the United States.

[22]The Rx Drug Abuse & Heroin Summit is a collaboration of professionals from local, state, and federal agencies, business, academia, treatment providers, and allied communities impacted by prescription drug abuse and heroin use.

Nearly All Jurisdictions Have Good Samaritan and Naloxone Access Laws and Their Characteristics Vary

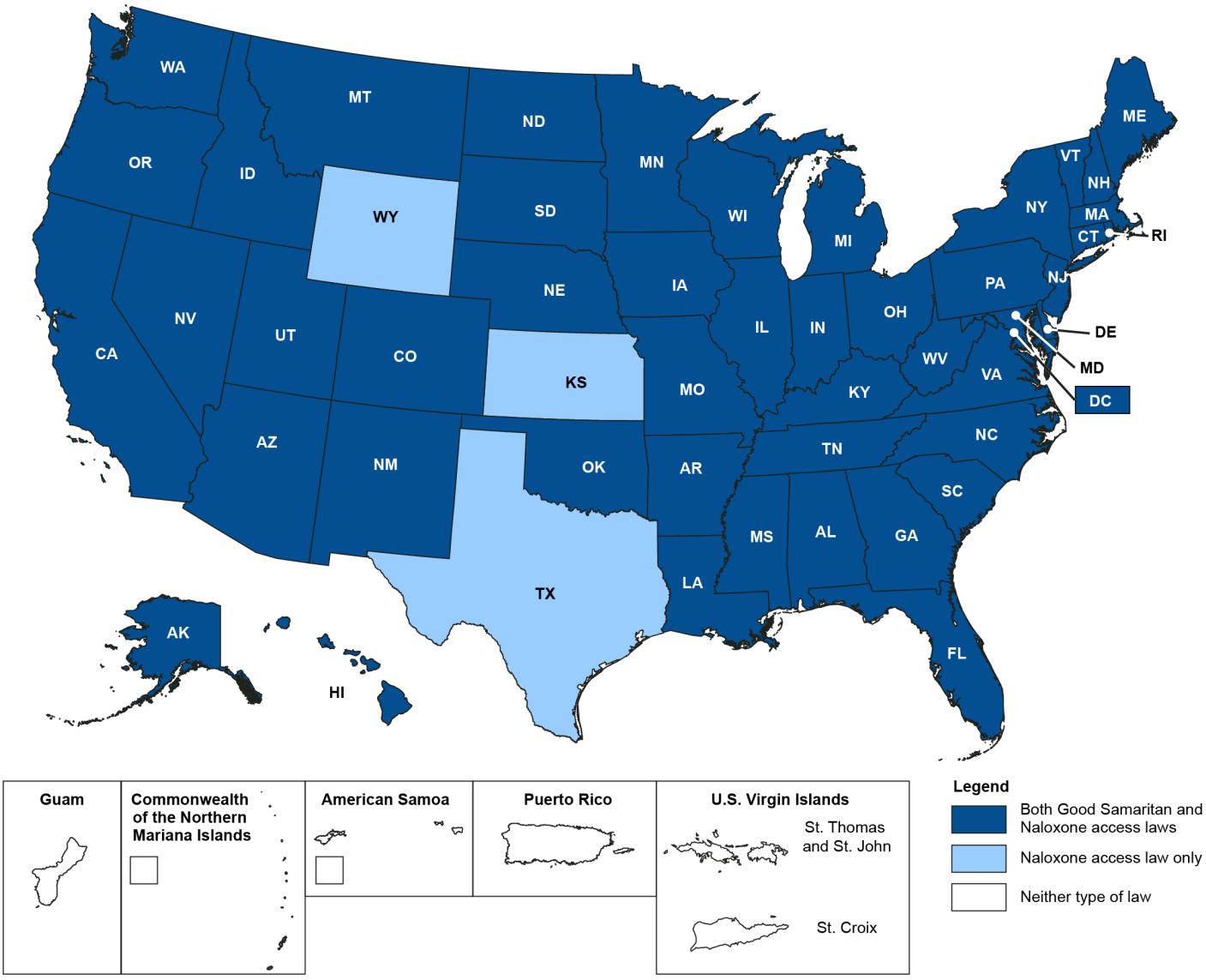
Forty-Eight Jurisdictions Have a Good Samaritan Law and Fifty-One Have a Naloxone Access Law

Our analysis found that 48 jurisdictions (47 states and D.C.) have enacted both Good Samaritan and Naloxone Access laws.[23] Three states—Kansas, Texas and Wyoming—do not have a Good Samaritan law, but do have a Naloxone Access law. None of the U.S. territories has either type of law. Figure 2 shows which jurisdictions have these laws.[24]

[23]Our analysis is based on laws we researched in May 2020 using online legal databases and is limited to laws that apply at the scene of a drug overdose, not other settings. For information on when each jurisdiction initially enacted their Good Samaritan law, see the August 2020 ONDCP grantee report from the Legislative Analysis and Public Policy Association at https://legislativeanalysis.org/wp-content/uploads/2020/08/GSFOP-laws.8.10.2020-version.FINAL_.pdf (accessed December 18, 2020). For information on when each jurisdiction initially enacted their Naloxone Access law, see the September 2020 ONDCP grantee report from the Legislative Analysis and Public Policy Association at https://legislativeanalysis.org/wp-content/uploads/2020/08/GSFOP-laws.8.10.2020-version.FINAL_.pdf (accessed December 18, 2020).

[24]We include citations to all statutory provisions relevant to our review—as well as one Rhode Island regulation that ONDCP identified as the basis for its Naloxone Access program—in Appendix III (Good Samaritan laws) and Appendix IV (Naloxone Access laws). Although we describe certain legal provisions in greater detail in this report, we did not repeat their citations. We did, however, include citations when describing another law of a jurisdiction that relates to a law cited in an appendix.

Figure 2: Jurisdictions with Good Samaritan and Naloxone Access Laws



Source: GAO analysis of jurisdiction laws. | GAO-21-248

Note: Our analysis is based on laws we researched in May 2020 using online legal databases.

In 2007, New Mexico became the first state to enact a Good Samaritan law specific to a drug overdose and through the years, many other jurisdictions have followed suit. According to experts we spoke with,

lawmakers have to strike a balance between enforcing drug laws and preventing overdose deaths when enacting or amending these laws. Several told us that the Good Samaritan laws enacted or amended in recent years offer more protections compared to the initial laws.

Good Samaritan Laws Vary in Their Protections

Our analysis of the characteristics of the 48 Good Samaritan laws found that they differ in the protections they offer to individuals who call for medical assistance for an overdose victim. First, there is variation in whether criminal immunity—an exemption from prosecution—is offered and, if so, for which type of drug offense, such as possessing or delivering drugs in violation of an otherwise applicable drug law. Second, there is variation in when criminal immunity takes effect—the timing can be before an individual would otherwise be arrested and charged as a criminal defendant or after these events but before an individual is prosecuted.

Finally, because a jurisdiction retains the power to prosecute individuals who do not have criminal immunity, some Good Samaritan laws offer either an affirmative defense at trial or a mitigating factor at sentencing, or both.

Figure 3 shows variations on these selected characteristics across the 48 Good Samaritan laws. In addition, Appendix III has additional information on these and other selected characteristics for each of the 48 Good Samaritan laws.

Understanding the Timing of Criminal Immunity

Immunity from arrest prevents law enforcement officers from arresting an individual, thereby eliminating the possibility of being prosecuted.

Immunity from charge does not prevent an individual from being arrested, but prevents a prosecutor from charging an individual as a criminal defendant, thereby eliminating the possibility of being prosecuted

Immunity from prosecution does not prevent an individual from being arrested and charged as a criminal defendant but prevents prosecution by providing for the dismissal of the charge before trial.

Source: GAO. | GAO-21-248

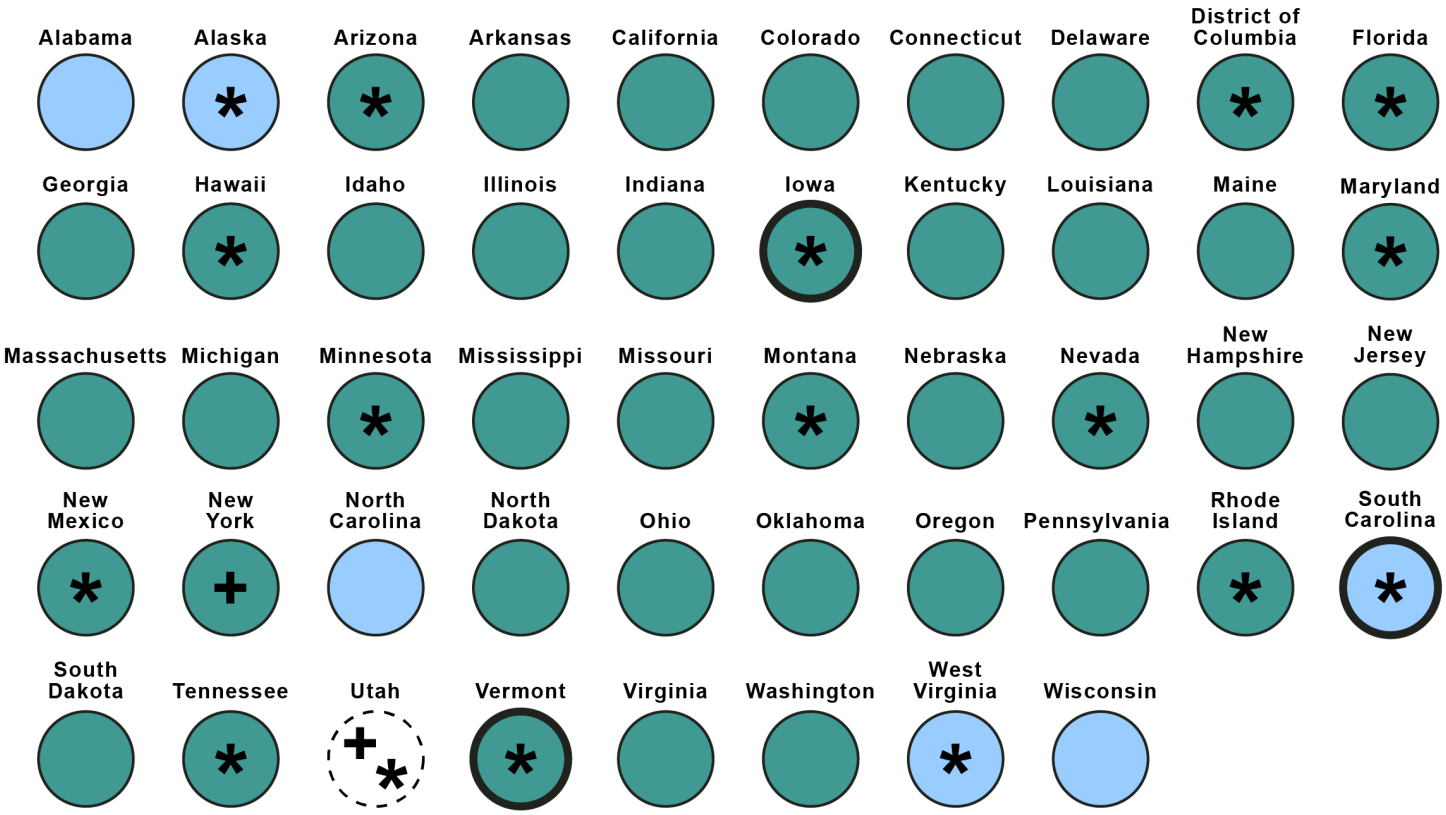
Understanding Trial and Sentencing Protections in Good Samaritan Laws

An affirmative defense at trial protects against conviction by allowing an individual who is prosecuted for an offense not specified for criminal immunity (non-immunized offense) to seek an acquittal by presenting evidence that the offense was discovered during a medical assistance request.

A mitigating factor at sentencing does not protect against conviction but allows an individual who has been convicted of a non-immunized offense to seek a reduced sentence by presenting evidence that the offense was discovered during a medical assistance request or that the individual provided medical aid to an overdose victim.

Source: GAO. | GAO-21-248

Figure 3: Selected Characteristics of Jurisdictions' Good Samaritan Laws



Source: GAO analysis of state and District of Columbia laws. | GAO-21-248

Notes: Kansas, Texas and Wyoming are not included in this figure because they do not have a Good Samaritan law specific to a drug overdose. Our analysis is based on laws we researched in May 2020 using online legal databases. However, in November 2020, we updated our analysis of Virginia's law to reflect a July 2020 amendment, which we identified based on our review of the Legislative Analysis and Public Policy Association's August 2020 report on Good Samaritan laws.

[a]Immunity from arrest, charge, and prosecution prevents an individual from being arrested and charged as a criminal defendant, thereby eliminating the possibility of being prosecuted.

[b]Immunity from prosecution only does not prevent an individual from being arrested and charged as a criminal defendant but prevents prosecution by providing for the dismissal of charges before trial.

[c]An affirmative defense at trial protects against conviction by allowing an individual who is prosecuted for an offense not specified for criminal immunity (non-immunized offense) to seek an acquittal by presenting evidence that the offense was discovered during a medical assistance request.

[d]A mitigating factor at sentencing does not protect against conviction, but allows an individual who has been convicted of a non-immunized offense to seek a reduced sentence by presenting evidence that the offense was discovered during a medical assistance request or that the individual provided medical aid to an overdose victim.

Types of drug offenses specified for criminal immunity. Of the 47 laws that provide criminal immunity to individuals who call for medical assistance, 44 cover drug possession offenses. The other three laws (Iowa's, South Carolina's, and Vermont's) cover both drug possession offenses as well as more serious drug delivery offenses, such as selling, dispensing, or possessing drugs with an intent to sell or dispense.[25] The 47 laws vary in the specific drug possession and drug delivery offenses covered by criminal immunity (immunized offenses). At the broadest level, Vermont's law provides immunity for any drug offense.[26] In comparison, the other 46 laws limit immunity to a subset of drug offenses. For example, in regards to immunized drug possession offenses, Alabama's law limits immunity to misdemeanor drug offenses, such as possession of marijuana for personal use, whereas Illinois's law includes some felonies, such as possession of less than 3 grams of heroin or morphine.[27] In regards to immunized drug delivery offenses, Iowa's law provides immunity if the drugs were delivered without profit, while South Carolina's law provides immunity if the drugs were delivered to the overdose victim.

Timing when criminal immunity takes effect. The 47 laws that offer criminal immunity also vary concerning when the immunity takes effect. We found that 41 of the 47 laws prevent an individual from being arrested or charged with an immunized offense—thereby eliminating the possibility

[25]To illustrate the difference in severity between drug possession and drug delivery offenses, the maximum sentence for a drug possession offense covered by Iowa's Good Samaritan law is 1 year for a first offense, as compared to 50 years for a drug delivery offense. See Iowa Code Ann. §§ 124.401(1)(a), (5), 903.1(1)(b).

[26]Although Vermont's law provides immunity for all drug offenses, an individual may be prosecuted for offenses that are not drug-related.

[27]Misdemeanors and felonies differ in severity. For example, possession of marijuana for personal use is a misdemeanor in Alabama and the maximum sentence is 1 year. See Ala. Code §§ 13A-5-7(a)(1), 13A-12-214. In comparison, felony possession of less than 3 grams of heroin or morphine has a maximum sentence of 3 years in Illinois. See 720 Ill. Comp. Stat. Ann. 570/414(c), (d)(1), (3), 730 § 5/5-4.5-45(a).

of prosecution.[28] Among the 41 laws, some, like Georgia's, offer immunity at the time of arrest, which is determined by law enforcement officers.[29] Others, like Idaho's, offer immunity after arrest but before an individual is charged as a criminal defendant, which is determined by prosecutors. Under the other six laws, an individual who calls for medical assistance does not have immunity from being arrested and charged as a criminal defendant, but is immune from prosecution and can have the charge dismissed prior to trial.[30]

Trial or sentencing protections. Some laws offer trial or sentencing protections to individuals who do not have criminal immunity.

- Of the 47 laws that offer criminal immunity, 17 also provide an affirmative defense at trial or a mitigating factor at sentencing if the individual is prosecuted for an offense not specified for immunity (non-immunized offense). One of the 17 laws—New York's—authorizes an affirmative defense at trial, while the other 16 authorize a mitigating factor at sentencing.[31] The 17 laws vary in whether they limit the protection to non-immunized drug offenses or if they also offer

[28]Some laws that we categorized as providing immunity from "arrest, charge, and prosecution" specifically state that an individual may not be arrested, charged, or prosecuted while others use different terminology that we also included in this category. For example, some laws state that the offense is not a crime or does not apply to the individual, or that a violation of the law did not occur or does not provide probable cause for arrest. This category also includes laws that state an individual may not be charged or prosecuted. While charge immunity does not prevent an individual from being arrested, we included it in the same category as arrest immunity because, like arrest immunity, charge immunity takes effect before the individual becomes a criminal defendant. In contrast, an individual with immunity from prosecution only can be charged as a criminal defendant but can have the charge dismissed prior to trial.

[29]To determine whether an individual has criminal immunity for a drug possession offense under Georgia's law, law enforcement officers would need to ascertain whether the drugs in an individual's possession weighed less than four grams in the case of a solid substance; less than one milliliter in the case of a liquid substance; less than four grams in combined weight if the substance is placed onto a secondary medium; or less than one ounce in the case of marijuana.

[30]A defendant could also choose to plead guilty instead of having the charge dismissed in the context of a plea bargain, if, for example, a prosecutor agreed to drop another charge against the defendant for a more serious offense that could not be dismissed under the Good Samaritan law, in exchange for the defendant's guilty plea to the one that could be dismissed. West Virginia's law expressly recognizes a defendant's right to plead guilty under these circumstances, provided the defendant consults with counsel.

[31]We did not consider Massachusetts' law as offering a mitigating factor at sentencing because it is based on violations of the federal Controlled Substances Act, which are prosecuted in the federal court system.

protection for offenses not related to drugs. For example, the affirmative defense under New York's law and the mitigating factor at sentencing under Nevada's law are available only for non-immunized drug offenses. In comparison, Florida's law allows a court to consider a defendant's assistance to an overdose victim as a mitigating factor at sentencing for any felony conviction (drug-related or non-drug related), except a capital offense. In addition, there is variation in the types of assistance a court may consider as a mitigating factor at sentencing. For example, Florida's law specifies two types of assistance a court may consider: the act of seeking medical assistance or the act of providing it. In comparison, other laws specify only one type. For example, Hawaii's law authorizes a court to consider the act of seeking medical assistance, while Tennessee's law authorizes a court to consider the act of providing medical assistance.

- One of the 48 Good Samaritan laws (Utah's) does not provide criminal immunity, but offers an affirmative defense at trial and a mitigating factor at sentencing. Utah's law is the only law that offers both of these protections. Utah's law limits both protections to drug offenses but they differ in which drug offenses they cover. For example, the affirmative defense at trial is not available for drug delivery offenses. However, an individual convicted of a drug delivery offense could present evidence of a medical assistance request as a mitigating factor at sentencing.

Other selected characteristics. Good Samaritan laws have other characteristics and these also vary. Examples include the following.

- Some laws protect individuals who call for medical assistance from penalties they may face in other judicial proceedings. For example, among the 47 laws that provide criminal immunity, 25 also protect against the use of an immunized offense to revoke a sentence of probation or a term of parole, which allows an individual sentenced in another criminal case to remain in the community rather than in detention.[32] Fifteen of these laws also protect the release status of an individual who has been permitted to remain in the community rather than in detention while awaiting trial in another criminal case.

[32]Some of the 25 laws protect against the revocation of probation, but not against the revocation of parole. In addition, we did not include Wisconsin's law among those that protect against revocation of probation or parole because the protection had a sunset date of August 1, 2020.

- Some Good Samaritan laws establish specific requirements that an individual must meet to be eligible for the law's protections. For example, in Minnesota, individuals qualify for immunity if they were the first person to seek medical assistance, provide their name and contact information, remain on the scene until assistance arrives, and cooperate with authorities. Iowa's law includes similar requirements but also limits eligibility to an individual who has not previously received immunity under the law.
- Some laws extend criminal immunity to overdose victims, but whether a victim is eligible may depend upon whether they call for medical assistance or someone else calls on their behalf. For example, victims in Arkansas have immunity if they seek assistance for themselves, while victims in Pennsylvania have immunity if someone else who has immunity calls for medical assistance on their behalf. Hawaii's law, in contrast, offers criminal immunity regardless of whether victims call for themselves or someone calls for them.

Naloxone Access Laws Use Various Methods to Expand Access

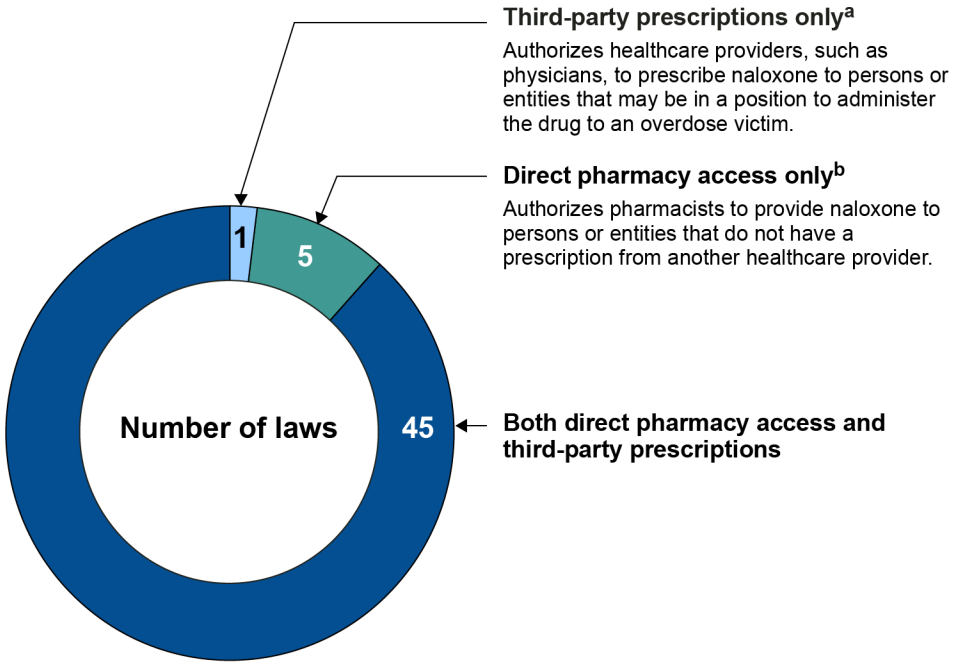
We found that all 51 Naloxone Access laws expand access to persons or entities that may be in a position to administer the drug to an overdose victim, such as first responders (including law enforcement entities), family members, and friends (collectively referred to as "naloxone administrators"). Because healthcare providers generally lack authority to prescribe drugs to persons other than a patient, and pharmacists generally lack authority to dispense drugs without a prescription from another healthcare provider, Naloxone Access laws expand access by authorizing the prescribing and dispensing of naloxone to persons other than a patient at risk of opioid overdose.

The two methods we identified to expand access in the laws are: (1) third-party prescriptions, which authorize healthcare providers, such as physicians, to prescribe naloxone to persons or entities that may be in a position to administer the drug to an overdose victim,[33] and (2) direct pharmacy access, which authorizes pharmacists to provide naloxone to persons or entities that do not have a prescription from another

[33]While Naloxone Access laws may also authorize a pharmacist to issue third-party prescriptions, we considered these a form of direct pharmacy access because they eliminate the need for a person or entity to obtain a third-party prescription from another healthcare provider, such as a physician.

healthcare provider, such as a physician.[34] Among the 51 laws, 45 expand access using both methods; five authorize direct pharmacy access but not third-party prescriptions; and one authorizes third-party prescriptions but not direct pharmacy access.[35] Figure 4 shows the number of laws that use one or both methods. Appendix IV has information on which of the methods each law uses to expand access and which types of immunities are available to naloxone administrators.

Figure 4: Number of Naloxone Access Laws by Method Used to Expand Access



Source: GAO analysis of state and District of Columbia laws. | GAO-21-248

[34]A Naloxone Access law may authorize a pharmacist to prescribe naloxone to these persons or entities, or dispense naloxone without the need for a prescription, either from the pharmacist or another healthcare provider, such as a physician. A Naloxone Access law may also authorize a pharmacist to dispense naloxone based on a standing order, protocol order, or collaborative practice agreement, which, for purposes of this report, are medication orders issued by entities such as state health officials, boards of pharmacy, or licensed healthcare providers that are not specific to a particular party but set forth the categories of persons or entities that are eligible to receive naloxone.

[35]The five states whose laws authorize direct pharmacy access but not third-party prescriptions are Idaho, Kansas, Missouri, Oregon and Virginia. Nebraska's law authorizes third-party prescriptions but not direct pharmacy access.

Note: Our analysis is based on laws we researched in May 2020 using online legal databases.

[a]While Naloxone Access laws may also authorize a pharmacist to issue third-party prescriptions, we considered these a form of direct pharmacy access because they eliminate the need for a person or entity to obtain a third-party prescription from another healthcare provider, such as a physician.

[b]A Naloxone Access law may authorize a pharmacist to prescribe naloxone to these persons or entities, or dispense naloxone without the need for a prescription, either from the pharmacist or another healthcare provider, such as a physician. A Naloxone Access law may also authorize a pharmacist to dispense naloxone based on a standing order, protocol order, or collaborative practice agreement, which, for purposes of this report, are medication orders issued by entities such as state health officials, boards of pharmacy, or licensed healthcare providers that are not specific to a particular party but set forth the categories of persons or entities that are eligible to receive naloxone.

Naloxone Access Laws Vary in the Types of Immunities They Offer

We found that all 51 Naloxone Access laws offer civil, criminal, or professional immunity to a person whose administration of naloxone results in injuries to the overdose victim.[36] Unlike Good Samaritan laws—which define immunity based on specific drug offenses—Naloxone Access laws generally define immunity based on the type of proceedings to which the immunity applies, which can be civil, criminal, or professional disciplinary proceedings.[37] The laws vary as to which of the three immunities they offer to naloxone administrators. Specifically, we found that all 51 laws offer civil immunity, 41 offer criminal immunity, and 28

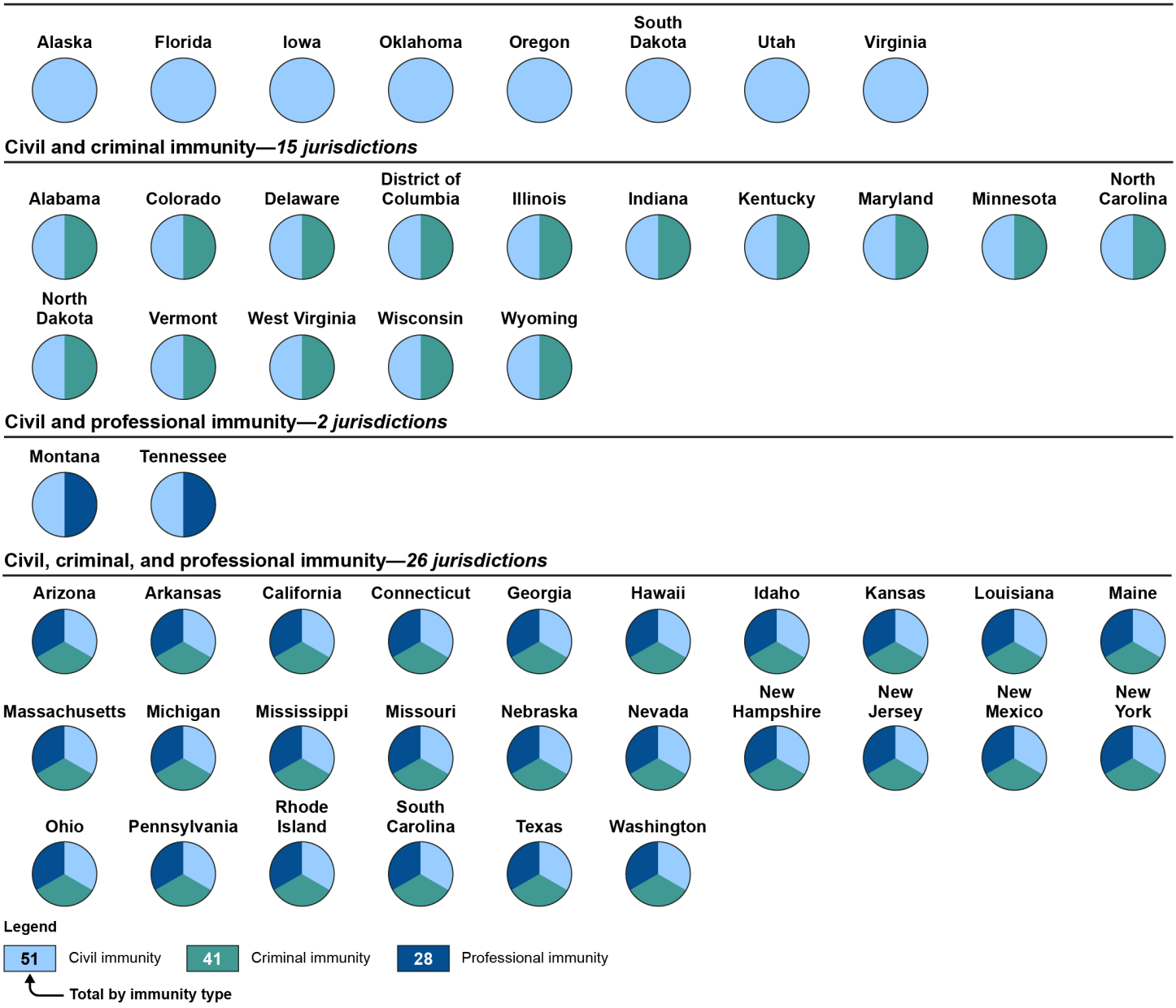
[36]Civil immunity means that a person is not liable for damages when sued by another party, such as a private individual; criminal immunity means that a person is not subject to prosecution by the government; and professional immunity means that a person will not face disciplinary action or administrative sanctions, such as by a professional licensing board. We considered laws that referred to violations of professional licensing statutes as offering professional immunity if they applied to naloxone administrators who were licensed healthcare professionals and criminal immunity if they applied to unlicensed individuals. This is because licensed individuals are subject to disciplinary action by a professional licensing board while unlicensed individuals are subject to prosecution by the government for offenses such as practicing medicine without a license.

[37]To illustrate the difference between the immunity provisions in the two types of laws, Missouri's Good Samaritan law designates the following offenses as exempt from prosecution if discovered during a medical assistance request: Mo. Code Ann. §§ 311.310, 311.320, 311.325, 579.015, 579.074, 579.078, or 579.105, which includes drug possession and other offenses. In contrast, Missouri's Naloxone Access law states that a naloxone administrator is immune from civil liability, criminal prosecution, or disciplinary actions from a professional licensing board, which provides protection depending on the type of proceedings initiated against the individual.

offer professional immunity.[38] Figure 5 shows how many of the 51 laws provide one, two, or all three types of immunity to an individual who administers naloxone.

[38]Our findings are based on immunities available to naloxone administrators, not immunities available to prescribers or dispensers under a law. For example, we did not consider Wisconsin's law to offer professional immunity because it is not available to naloxone administrators, only to health professionals for prescribing or dispensing the drug. In addition, we considered a law to offer an immunity if it applied to at least one group of specified naloxone administrators. For example, we considered Kansas's law to offer professional immunity because the immunity is available to first responders, even though it is not available to other specified administrators, such as family members, friends or school nurses.

Figure 5: Number of Jurisdictions' Naloxone Access Laws with Civil, Criminal and Professional Immunity for Individuals Who Administer the Drug



Source: GAO analysis of state and District of Columbia laws. | GAO-21-248

Notes: Civil immunity means that a person is not liable for damages when sued by another party, such as a private individual; criminal immunity means that a person is not subject to prosecution by the government; and professional immunity means that a person will not face disciplinary action or administrative sanctions, such as by a professional licensing board. We considered a law to offer an

immunity if it applied to at least one group of specified naloxone administrators. Our analysis is based on laws we researched in May 2020 using online legal databases.

Civil immunity. While all 51 Naloxone Access laws provide civil immunity, the circumstances in which immunity applies vary. For example, North Dakota's law does not provide immunity for actions by the naloxone administrator that constitute recklessness, gross negligence, or intentional misconduct. In contrast, Hawaii's law requires the naloxone administrator to use reasonable care to receive immunity. Although Hawaii's law does not specify what conduct demonstrates reasonable care, other laws do. For example, Tennessee's law states that evidence of reasonable care includes the receipt of basic instruction and information on how to administer naloxone, including the successful completion of an online program offered by the state's department of health.

Criminal immunity. Forty-one of the Naloxone Access laws offer criminal immunity to naloxone administrators. Unlike Good Samaritan laws, Naloxone Access laws generally do not specify the offenses that are exempt from prosecution for those who administer naloxone to an overdose victim. For example, Arizona's law provides criminal immunity for injuries resulting from the administration of naloxone but does not identify the particular offenses to which this immunity might apply. However, some laws are more specific. For example, Ohio's law provides naloxone administrators an exemption from prosecution for the offense of practicing medicine without a license.

Professional immunity. Twenty-eight of the Naloxone Access laws offer professional immunity to naloxone administrators, although they vary in which professional groups have immunity. For example, under Montana's law, the professional groups that have immunity include, among others, first responders and licensed physicians.[39] In comparison, under Georgia's law, professional immunity is not available to a licensed physician who administers naloxone, but is available to any other naloxone administrator, including a first responder.

Other selected characteristics. Naloxone Access laws have other characteristics and these also vary. Examples include the following.

[39]For naloxone administrators in professional groups that have immunity under Montana's law, see Mont. Code Ann. §§ 37-2-101(7), 50-32-603(5)-(9), -608(3).

- Some laws limit immunity to first responders and do not cover laypersons. For example, while family members, friends, and first responders all have access to naloxone under South Dakota's law, only first responders have immunity if injuries result from their administration of the drug. Other laws, such as Montana's, offer immunity to all eligible recipients who have access under the law, including family members, friends, and first responders.
- Some laws limit immunity based on whether the individual was in lawful possession of the naloxone they administered. For example, Indiana's law does not provide criminal immunity if the naloxone administrator did not obtain the drug by prescription or under a standing order issued by prescriber. In comparison, Vermont's law offers immunity regardless of whether the naloxone administrator had a prescription.
- Some laws require that naloxone administrators receive training or informational materials on the use of naloxone. For example, under Delaware's law, public safety personnel must complete an approved training course to receive immunity. Under New York's law, any distribution of naloxone must include an informational card that describes, among other things, how to recognize symptoms of an opioid overdose; steps to take before and after naloxone is administered, including calling first responders; and the protections available under the state's Good Samaritan law, if first responders find evidence of drug offenses at the scene of the overdose.

Limited Research Suggests Good Samaritan Laws Are Associated with Lower Rates of Overdose Deaths and Increased Lifesaving Behaviors

The 17 studies we examined (see appendix II for the list of studies) provided potential insights into the effectiveness of Good Samaritan laws in reducing overdose deaths or what factors may contribute to a law's effectiveness; however these findings have limitations.[40] For example, there have been few studies conducted on each factor, limiting our ability to draw conclusions about the extent to which these factors contribute to the effectiveness of the laws. Although additional research would be helpful to better understand the effect that Good Samaritan laws have when enacted, together these study findings suggest that there is a pattern of lower rates of opioid-related overdose deaths among states that have enacted Good Samaritan laws. Further the findings suggested that there is an increased likelihood of individuals calling 911 if they are

[40]Using a systematic process, described in appendix I, we identified studies that had empirical findings that assessed the effectiveness of the laws in reducing overdose deaths or one or more of the other factors that may contribute to a law's effectiveness. A bibliography of the studies we reviewed is in appendix II.

aware of the laws and, possibly as a result, greater hospitalization rates for accidental overdose. However, findings also suggest that awareness of Good Samaritan laws may vary substantially across jurisdictions among both law enforcement officers and the general public, which could affect their willingness to call 911.

Research Suggests Good Samaritan Laws Are Linked to Lower Opioid-Related Death Rates, but the Statistical Significance of Findings Is Mixed

We reviewed four studies (numbers 1, 2, 9, and 12 in appendix II) that examined the association between the enactment of a Good Samaritan law and rates of reported opioid-related overdose deaths across states. We found that across these four studies, the laws were associated with lower rates of opioid-related overdose deaths while controlling for some other variables that may affect these rates; however, not all findings were statistically significant.[41] Specifically, one study (number 9) showed a statistically significant decrease of 15 percent in opioid-related overdose deaths associated with enactment of a Good Samaritan law. Two other studies also showed a decrease in opioid-related deaths that were not statistically significant. One study (number 12) found a 14 percent decrease in the rate of opioid-related overdose deaths while the other study (number 2) showed 11 to 14 percent decreases. One other study (number 1) reported mixed findings of statistical significance within their analyses, with the decreases in overdose deaths ranging from 1 to 16 percent among the five states studied pre- and post-enactment of their Good Samaritan law.

The reasons for the lack of statistical significance for some of these findings are unclear. For example, the lack of statistical significance could indicate that there were no meaningful differences between states with and without Good Samaritan laws. However, based on the consistent pattern of findings we found in our review of these studies, it is also possible that there are meaningful differences in overdose death rates between states that do and do not have Good Samaritan laws, but the studies' methodologies may have reduced the ability to fully assess the overall effects of these laws across the country. Examples of these limitations include the following.

- The four studies all compared rates of overdose deaths for states with and without Good Samaritan laws over time. Although the same CDC

[41]Estimates where $p \leq 0.05$ are usually considered statistically significant. Study 9 had a p value of 0.050. Study 12 had a p value of 0.089. Study 2 had all p values > 0.100. Study 1 had mixed findings of statistical significance for the lower rates of opioid-related overdose deaths examined, specifically Illinois ($p \leq 0.010$), Kentucky ($p > 0.100$), Indiana ($p > 0.100$), and Michigan ($p > 0.100$).

data source was used in all studies, each used a different set of variables and a different analytic approach in their analysis. Three of the four studies included 50 states and D.C. (numbers 2, 9, and 12), while one study (number 1) included five Midwestern states in its analysis. The three studies that included all 50 states and D.C. used a study design that compared the changes in drug overdose death rates over time in states with a Good Samaritan law ("treatment group") versus states that had not enacted a Good Samaritan law ("control group").[42] This method assumes that the difference between the "treatment" group and "control" group is constant over time—an assumption that may not hold for states that enacted other harm mitigation policies during the study period. Specifically, because many other drug policies were being implemented during the same time period, it is possible these other policies may have also affected the rate of overdose deaths if they were not controlled for, making the effect of the Good Samaritan laws more difficult to detect.

- Although the amount of time since enactment of the laws varied across jurisdictions, many states had only recently enacted their laws at the time that these studies were conducted, which could affect the strength of the combined findings.
- There are some limitations related to the use of vital statistics data for this research. For instance, according to the authors of study number 2, substance-specific overdose deaths may be underreported as a result of differences in how the deaths are coded between, across, and within states over time, making policy evaluation more difficult.

Although Limited, Research Suggests Awareness of Good Samaritan Laws Is Generally Associated With Increased Lifesaving Behaviors, but Awareness Varies

Although the research discussed above found a consistent pattern between enactment of Good Samaritan laws and lower rates of overdose deaths, the effectiveness of these laws is likely to vary across jurisdictions based on several factors. For example, public awareness of the law may affect individuals' willingness to call 911 to provide overdose victims with emergency care on-scene and hospitalization, if necessary. Accordingly, hospitalization rates for accidental opioid overdoses may provide insight on whether an overdose victim received such emergency care, potentially saving their life. The studies we reviewed examined one or more of these factors. In addition, although not a lifesaving behavior, law enforcement

[42]Because it is not possible for researchers to randomly assign states to enact Good Samaritan laws for true experimental design, researchers instead compared states that enacted Good Samaritan laws as the "treatment group" and those that had not enacted the laws as a "control group" in a quasi-experimental design. The design is quasi-experimental because the treatment was not randomly assigned.

knowledge of the law may affect the extent to which the laws are carried out, and may subsequently influence individuals' willingness to call 911.

Public awareness of Good Samaritan laws. While the research on public awareness of Good Samaritan laws has limitations, seven studies (numbers 5, 6, 7, 8, 13, 14 and 15) suggest that public awareness of these laws varies widely. Specifically, the studies in our review assessed public awareness of Good Samaritan laws among different types of individuals who were at high risk of being at the scene of an overdose (e.g., individuals who use drugs or requested naloxone) and found that knowledge of the laws varied widely across samples, ranging from 15 to 77 percent. However, caution should be used when interpreting these percentages because studies varied in their sample types and size, making it difficult to determine if findings reflect differences in study methodology or in the extent of knowledge of Good Samaritan laws across jurisdictions and subpopulations.

Public willingness to call 911. Three studies we reviewed found a positive association between knowledge of the law and increased likelihood of calling 911.[43] In one qualitative study (number 8), some respondents with knowledge of their Good Samaritan law had reported a general sense that calling 911 had increased after enactment of the law, although others had expressed a more cautious view of its effect. Two studies (numbers 6 and 14) quantitatively examined the association between knowledge of the Good Samaritan law and the likelihood of making 911 calls and both found a significant positive association, suggesting that individuals who are aware of these laws are more likely to call 911 in the case of an overdose.

Hospitalization rates. While there are few studies on the effect of Good Samaritan laws on overdose hospitalization rates, the one study we reviewed (number 11) found a significant association between enactment of a law and an increase in hospitalization rates. Specifically, this study compared rates of hospitalizations before and after New York enacted its law to hospitalization rates in New Jersey, which had not yet enacted a Good Samaritan law during the study time period. The study found a significant association between enactment of New York's law and an overall increase in accidental opioid overdose emergency department

[43]None of the studies we reviewed directly compared overall rates of 911 calling before and after Good Samaritan law enactment in the same jurisdiction. However, they did examine the association between knowledge of Good Samaritan laws and likelihood of a call being made.

visits and inpatient hospital admissions, suggesting that more overdose victims may have received medical assistance at a hospital. However, given that this study only examined the effects in one state, the results cannot be generalized to other jurisdictions. Additional limitations that could impact these findings include whether the trends in overdose hospitalizations in New York and New Jersey would have remained constant over time in the absence of the Good Samaritan law, and how overdose-related hospitalizations were measured.

Law enforcement knowledge. While not directly a lifesaving behavior like calling 911, law enforcement knowledge of Good Samaritan laws can impact the extent to which the laws will be carried out and, consequently, may also influence individuals' willingness to call 911. While there are few studies on law enforcement knowledge of Good Samaritan laws, three studies (numbers 3, 16 and 17) suggest that law enforcement understanding of these laws may vary widely after passage and may be improved through targeted guidance and training. However, the findings should not be generalized to the entire population of officers within the sample location or to other jurisdictions.

Three studies in our review (numbers 3, 16 and 17) examined law enforcement officers' knowledge of Good Samaritan laws in their jurisdiction among a convenience sample of officers.[44] We found that understanding of these laws differed across studies. In one study (number 3), less than a quarter of officers surveyed reported being aware of the Good Samaritan law in their state over a year after its enactment. Of those officers who were aware of the law, many were unclear about the exact protections it afforded and almost none reported receiving clear guidance on the law from their department. Most officers in the second study (number 16), however, correctly answered an item assessing their knowledge of the Good Samaritan law enacted over 2 years previously in their state. Knowledge of the law increased to almost 100 percent accurate responses among this sample after receiving specific training on the topic. The third study (number 17) included a sample of officers from law enforcement agencies that participate in ONDCP's HIDTA program across 20 states, all of which had enacted Good Samaritan laws. Almost all of these officers (91 percent) were aware of their state's Good

[44]Convenience samples are used when participants are selected because they are easily accessible, rather than selected randomly. For example, one study we reviewed (number 17) surveyed officers from a convenience sample of law enforcement agencies that had established relationships with the HIDTA program that was conducting the study.

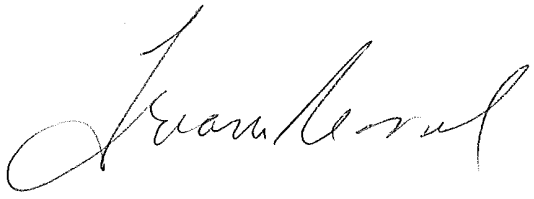
Samaritan law; however, many were not able to accurately describe the exact protections their state offered and to whom.[45] Officers who had responded to the scene of an overdose within the last 6 months were significantly more likely to be aware of the Good Samaritan law overall and to correctly describe these protections. While this study did not compare knowledge before and after training, officers did list their state's Good Samaritan laws as one of the most useful training topics related to responding to an overdose scene.

Agency Comments

We provided a copy of this report to ONDCP for review and comment. We received written comments from ONDCP stating that they had no objections to any of the factual information contained in the report. We have reprinted ONDCP's letter in appendix V. ONDCP also provided technical comments, which we incorporated, as appropriate.

We are sending this report to the appropriate congressional committees and to the Director of the Office of National Drug Control Policy. In addition, this report is available at no charge on the GAO website at http://gao.gov.

If you or your staff members have any questions about this report, please contact Triana McNeil at (202) 512-8777 or mcneilt@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VI.



Triana McNeil
Director, Homeland Security and Justice

[45]Inaccuracies included both over-estimates and under-estimates of the type of protections afforded by these laws. The high rate of knowledge overall from these officers may reflect their jurisdiction's participation in ONDCP's HIDTA program.

List of Committees

The Honorable Gary C. Peters
Chairman
The Honorable Rob Portman
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Dick Durbin
Chairman
The Honorable Chuck Grassley
Ranking Member
Committee on the Judiciary
United States Senate

The Honorable Jerrold Nadler
Chairman
The Honorable Jim Jordan
Ranking Member
Committee on the Judiciary
House of Representatives

The Honorable Carolyn B. Maloney
Chairwoman
The Honorable James Comer
Ranking Member
Committee on Oversight and Reform
House of Representatives

Appendix I: Methodology for Selecting Characteristics of Good Samaritan and Naloxone Access Laws and Literature

Methodology for Selecting Characteristics

For our review of Good Samaritan laws, we selected characteristics to analyze such as those pertaining to criminal immunity—an exemption from prosecution—and trial or sentencing protections for offenses that are not exempt from prosecution. For laws that offered criminal immunity, we analyzed whether the immunity was for a drug possession offense, a drug delivery offense, or both. We selected these two offense categories because each jurisdiction's controlled substances act includes drug possession and drug delivery offenses, which provided common attributes for comparing criminal immunity provisions across jurisdictions. For laws that offered criminal immunity, we also analyzed when the immunity took effect—either before an individual was arrested and charged as a criminal defendant or after these events but before the individual was prosecuted.[1]

We selected the timing of when an immunity goes into effect because, along with offense type, this characteristic defines the scope of criminal immunity. We also analyzed the laws to identify whether they permitted a defendant who did not have criminal immunity to present evidence of a medical assistance request to seek an acquittal at trial or a reduced sentence if convicted. We selected these characteristics because not all laws provide criminal immunity and for those that do, a trial or sentencing protection illustrates whether the law extends to offenses not specified for criminal immunity.

Finally, we selected a few examples of other characteristics we identified in some laws, such as whether they extend protections to overdose victims or protect against additional penalties individuals involved in other criminal proceedings may face, such as revocation of an individual's release into the community while awaiting trial on other charges or while serving a sentence of probation or a term of parole. The examples we selected are illustrative and not generalizable or representative of the requirements in any given law.

[1]Some laws that we categorized as providing immunity from "arrest, charge, and prosecution" specifically state that an individual may not be arrested, charged, or prosecuted while others use different terminology that we also included in this category. For example, some laws state that the offense is not a crime or does not apply to the individual, or that a violation of the law did not occur or does not provide probable cause for arrest. This category also includes laws that state an individual may not be charged or prosecuted. While charge immunity does not prevent an individual from being arrested, we included it in the same category as arrest immunity because, like arrest immunity, charge immunity takes effect before the individual becomes a criminal defendant. In contrast, an individual with immunity from prosecution only can be charged as a criminal defendant but can have the charge dismissed prior to trial.

For our review of Naloxone Access laws, we selected characteristics to analyze such as the methods used to expand access to the prescription drug naloxone and the forms of immunity offered to those who administer it. We selected the methods used to expand access because they provide context for the availability of the drug to individuals who administer it. The two methods we identified in the laws are: (1) third-party prescriptions, which authorize healthcare providers, such as physicians, to prescribe naloxone to persons or entities that may be in a position to administer the drug to an overdose victim; and (2) direct pharmacy access, which authorizes pharmacists to provide naloxone to persons or entities that do not have a prescription from another healthcare provider.[2] We also selected three forms of immunity that may be available under these laws to an individual who administers naloxone—civil, criminal or professional immunity.[3] We included professional immunity because some laws include this as an additional form of immunity for individuals who administer naloxone (naloxone administrators). As with our review of the Good Samaritan laws, we also selected a few examples of other characteristics we identified in some of the Naloxone Access laws, such as which groups of naloxone administrators are eligible for immunity and whether their immunity depends on having been prescribed the drug. The examples we selected are illustrative and not generalizable or representative of the requirements in any given law.

Literature Review

To determine what research indicates regarding the effects of Good Samaritan laws, we conducted a literature review of empirical studies that

[2]While Naloxone Access laws may also authorize a pharmacist to issue third-party prescriptions, we considered these a form of direct pharmacy access because they eliminate the need for a person or entity to obtain a third-party prescription from another healthcare provider. Pharmacists may also dispense naloxone without a prescription under the authority of a Naloxone Access law, which we also considered a form of direct pharmacy access. Direct pharmacy access also includes Naloxone Access laws that authorize pharmacists to dispense naloxone based on a standing order, protocol order, or collaborative practice agreement, which, for purposes of this report, are medication orders issued by entities such as state health officials, boards of pharmacy, or licensed healthcare providers that are not specific to a particular party but set forth the categories of persons or entities that are eligible to receive naloxone.

[3]Civil immunity means that a person is not liable for damages when sued by another party, such as a private individual; criminal immunity means that a person is not subject to prosecution by the government; and professional immunity means that a person will not face disciplinary action or administrative sanctions, such as by a professional licensing board.

examined various factors that may contribute to the law's effectiveness.[4] To identify and assess the appropriateness of these studies for our review, we took the following steps:

1. **Conducted a literature search**. A research librarian conducted searches of various databases including ProQuest, Scopus, Pubmed, EBSCO and Westlaw Edge to identify articles published in the United States from 2010 through May 2020. These dates were chosen because many of the Good Samaritan laws were enacted during this time. The following search terms were used to identify relevant articles: Good Samaritan law, drug overdose, naloxone, opioid, immunity, liability, and witness. The literature search identified 76 articles. In addition, during an interview with officials from the Office of National Drug Control Policy, we became aware of an article that had been accepted for publication and we received a pre-publication version to review. We added this article to our review outside of the literature search process, making it a total of 77 articles.
2. **Selected articles for relevance.** To select articles that were relevant to our research objective, two analysts independently assessed the abstracts for each of the 77 articles using the following criteria: 1) whether the article assessed effects specifically of Good Samaritan laws and 2) whether the article was based on original empirical research.[5] The two analysts discussed and reconciled the differences in the assessments. We identified 34 articles that met these criteria. Then, the two analysts independently conducted full-text reviews of the 34 articles using the same criteria to determine the final sample of articles to analyze. The two analysts discussed and reconciled the differences in the assessments. We identified 17 articles to include in our literature review.
3. **Collected data on articles.** One analyst and two methodologists then evaluated the 17 articles using a data collection instrument that we

[4]The Comprehensive Addiction and Recovery Act of 2016 (CARA) defines a Good Samaritan law as a law of a state or unit of local government that exempts from criminal or civil liability (1) any individual who administers an opioid overdose reversal drug or device or (2) any individual who contacts emergency services providers in response to an overdose. See Pub. L. No. 114-198, tit. VII, § 703(c)(1), 130 Stat. at 741. This analysis focuses on the second portion of the CARA definition. However "naloxone" was included as a search term. Articles that only examined Naloxone Access laws and did not examine broader Good Samaritan laws were excluded from our scope because many of these studies examined behaviors outside of the scene of an overdose and therefore were not within the scope of our review.

[5]We eliminated publications during the abstract review stage that were from news or trade organizations as they did not meet our criteria for empirical studies.

created. The data collection instrument collected various information from each study, such as the jurisdiction of focus, the population studied, methodologies used, data sources, factors examined related to the effect of the law, research findings, and strengths and limitations. The analyst and methodologist discussed and reconciled the differences in the assessments. Through this evaluation, we determined that all 17 articles should be included in our literature review. The citations for each article can be found in appendix II. We synthesized the findings from these 17 articles to identify common themes and trends.

4. **Synthesis of literature review findings.** A methodologist, in consultation with a statistician, synthesized findings captured in the data collection instrument from the 17 articles related to the following topics: 1) overdose death rates, 2) likelihood of calling 911 at the scene of an overdose, 3) overdose hospitalization rates, and 4) knowledge of the Good Samaritan law among law enforcement and the public.[6] The methodologist and statistician identified patterns among findings for each topic and discussed potential explanations for differences between studies (e.g., different methodological approaches and jurisdictions). In addition, the methodologist and statistician identified strengths and limitations from this body of research to provide context for interpreting the potential association between findings and Good Samaritan law enactment across the country (e.g., generalizability of study results).

[6]We selected these factors to report on because there was collectively sufficient evidence among the studies we included to draw conclusions on the law's possible effect. There were other factors we analyzed in the studies we included, however there was not sufficient evidence to draw discernable conclusions of their effect, and therefore we did not report on these factors.

Appendix II: Literature Review Bibliography

This bibliography contains citations for the 17 articles we reviewed that assessed the effect of Good Samaritan laws. See appendix I for more information on how we identified these studies. At the beginning of the citation, we include the study numbers that we used to reference the study earlier in the report.

Study number 1: Nicole Adams, Ellen Gundlach, Ching-Wei Cheng, “An analysis of state-level policies and opioid overdose deaths,” *Western Journal of Nursing Research*, vol. 42, no. 7 (2020): p. 535-542.

Study number 2: Danielle N. Atkins, Christins Piette Durrance, Yuna Kim, “Good Samaritan harm reduction policy and drug overdose deaths,” *Health Services Research*, vol. 54, no. 2 (2019): p. 407-417.

Study number 3: Caleb J. Banta-Green, Leo Beletsky, Jennifer A. Schoeppe, Phillip O. Coffin, Patricia C. Kuszler, “Police officers’ and paramedics’ experiences with overdose and their knowledge and opinions of Washington state’s drug overdose-naloxone-good Samaritan law,” *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, vol. 90, no. 6 (2013): p. 1102-1111.

Study number 4: Janice Blanchard, Audrey J. Weiss, Marguerite L. Barrett, Kimberly W. McDermott, Kevin C. Heslin. “State variation in opioid treatment policies and opioid-related hospital readmissions,” *BMC Health Services Research*, vol. 18, no. 971 (2018): p. 1-12.

Study number 5: Tristan I. Evans, Scott E. Hadland, Melissa A. Clark, Traci C. Green, Brandon D.L. Marshall, “Factors associated with knowledge of a Good Samaritan Law among young adults who use prescription opioids non-medically,” *Harm Reduction Journal*, vol. 13, no. 24 (2016): p. 1-6.

Study number 6: Andrea Jakubowski MD, Hillary V. Kunins MD, MPH, Zina Huxley-Reicher BA, Anne Siegler DrPH, “Knowledge of the 911 Good Samaritan law and 911-calling behavior of overdose witnesses,” *Substance Abuse*, vol. 39, no. 2 (2018): p. 233-238.

Study number 7: Stephen Koester, Shane R. Mueller, Lisa Raville, Sig Langegger, Ingrid A. Binswanger, “Why are some people who have received overdose education and naloxone reticent to call emergency medical services in the event of an overdose?” *International Journal of Drug Polic*y, vol. 48 (2017): p. 115-124.

Study number 8: Amanda D. Latimore, Rachel S. Bergstein, “Caught with a body yet protected by law? Calling 911 for opioid overdose in the context of the Good Samaritan Law,” *International Journal of Drug Policy,* vol. 50 (2017): p. 82-89.

Study number 9: Chandler McClellan, Barrot H. Lambdin, Mir M. Ali, Ryan Mutter, Corey S. Davis, Eliza Wheeler, Michael Pemberton, Alex H. Kral, “Opioid-overdose laws association with opioid use and overdose mortality” *Addictive Behaviors*, vol. 86 (2018): p. 90-95.

Study number 10: Katherine McLean, “Good Samaritans vs. predatory peddlers: problematizing the war on overdose in the United States,” *Journal of Crime and Justice*, vol. 41, no. 1 (2018): p. 1-13.

Study number 11: Holly Nguyen, Brandy R. Parker, “Assessing the effectiveness of New York’s 911 Good Samaritan Law – evidence from a natural experiment,” *International Journal of Drug Policy*, vol. 58 (2018): p. 149-156.

Study number 12: Daniel I. Reese, Joseph J. Sabia, Laura M. Argys, Dhaval Dave, Joshua Latshaw, “With a little help from my friends: The effects of Good Samaritan and Naloxone Access Laws on opioid-related deaths,” *Journal of Law and Economics*, vol. 62 (2019): p. 1-28.

Study number 13: Kristin E. Schneider PhD, Ju Nyeong Park PhD, Sean T. Allen DrPH, Brian W. Weir PhD, Susan G. Sherman PhD, “Knowledge of Good Samaritan Laws and beliefs about arrests among persons who inject drugs a year after policy change in Baltimore, Maryland,” *Public Health Reports*, vol. 0, no. 0 (2020): p. 1-7.

Study number 14: Dennis P. Watson, Bradley Ray, Lisa Robison, Philip Huynh, Emily Sightes, La Shea Walker, Krista Brucker, Joan Duwve, “Lay responder naloxone access and Good Samaritan law compliance: postcard survey results from 20 Indiana counties,” *Harm Reduction Journal*, vol. 15, no. 18 (2018): p. 1-8.

Study number 15: Cathy Zadoretsky, Courtney McKnight, Heidi Bramson, Don Des Jarlais, Maxine Phillips, Mark Hammer, Mary Ellen Cala, “The New York 911 Good Samaritan Law and opioid overdose prevention among people who inject drugs,” *World Medical and Health Policy*, vol. 9, no. 3 (2017): p. 318-340.

Study number 16: Cory D. Saucier, Nickolas Zaller, Alexandria MacMadu, Traci C. Green, "*An initial evaluation of Law Enforcement Overdose Training in Rhode Island" Drug and Alcohol Dependence*, vol. 162 (2016): p. 211-218.

Study number 17: Jennifer J. Carroll, Sasha Mital, Jessica Wolff, Rita K. Noonan, Pedro Martinez, Melissa C. Podolsky, John C. Killorin, Traci C. Green, "Knowledge, preparedness, and compassion fatigue among law enforcement officers who respond to opioid overdose," *Drug and Alcohol Dependence*, vol. 217 (2020): pp. 1-8.

Appendix III: GAO Analysis of Jurisdictions' Good Samaritan Laws

	Types of drug offenses specified for criminal immunity		Timing when criminal immunity takes effect		Trial or sentencing protection for non-immunized offenses		Protections for individuals already in the criminal system	
Jurisdiction and applicable legal citation	Immunity from drug possession offenses	Immunity from drug delivery offenses	Immunity from arrest, charge, and prosecution[a]	Immunity from prosecution only[b]	Affirmative defense at trial[c]	Mitigating factor at sentencing[d]	Pretrial release protections[e]	Probation or parole protections[f]
Alabama Ala. Code § 20-2-281	✓	—	—	✓	—	—	—	—
Alaska Alaska Stat. Ann. §§ 11.71.311, 12.55.155(d)(19)	✓	—	—	✓	—	✓	—	—
Arizona Ariz. Rev. Stat. Ann. § 13-3423	✓	—	✓	—	—	✓	—	—
Arkansas Ark. Code Ann. § 20-13-1704	✓	—	✓	—	—	—	✓	✓
California Cal. Health & Safety Code § 11376.5	✓	—	✓	—	—	—	—	—
Colorado Colo. Rev. Stat. Ann. § 18-1-711	✓	—	✓	—	—	—	—	—
Connecticut Conn. Gen. Stat. Ann. § 21a-279	✓	—	✓	—	—	—	—	—
Delaware Del. Code Ann. tit. 16, § 4769	✓	—	✓	—	—	—	—	✓
District of Columbia D.C. Code Ann. § 7-403	✓	—	✓	—	—	✓	✓	✓

	Types of drug offenses specified for criminal immunity		Timing when criminal immunity takes effect		Trial or sentencing protection for non-immunized offenses		Protections for individuals already in the criminal system	
Jurisdiction and applicable legal citation	Immunity from drug possession offenses	Immunity from drug delivery offenses	Immunity from arrest, charge, and prosecution[a]	Immunity from prosecution only[b]	Affirmative defense at trial[c]	Mitigating factor at sentencing[d]	Pretrial release protections[e]	Probation or parole protections[f]
Florida Fla. Stat. Ann. §§ 893.21, 921.0026(2)(n)	✓	—	✓	—	—	✓	✓	✓
Georgia Ga. Code Ann. § 16-13-5	✓	—	✓	—	—	—	✓	✓
Hawaii Haw. Rev. Stat. Ann. § 329-43.6	✓	—	✓	—	—	✓	—	✓
Idaho Idaho Code Ann. § 37-2739C	✓	—	✓	—	—	—	—	—
Illinois 720 Ill. Comp. Stat. Ann. 570/414	✓	—	✓	—	—	—	—	—
Indiana Ind. Code Ann. § 16-42-27-2	✓	—	✓	—	—	—	—	—
Iowa Iowa Code Ann. § 124.418	✓	✓	✓	—	—	✓	✓	✓
Kentucky Ky. Rev. Stat. Ann. § 218A.133	✓	—	✓	—	—	—	—	—
Louisiana La. Stat. Ann. § 14:403.10	✓	—	✓	—	—	—	—	—

	Types of drug offenses specified for criminal immunity		Timing when criminal immunity takes effect		Trial or sentencing protection for non-immunized offenses		Protections for individuals already in the criminal system	
Jurisdiction and applicable legal citation	Immunity from drug possession offenses	Immunity from drug delivery offenses	Immunity from arrest, charge, and prosecution[a]	Immunity from prosecution only[b]	Affirmative defense at trial[c]	Mitigating factor at sentencing[d]	Pretrial release protections[e]	Probation or parole protections[f]
Maine Me. Rev. Stat. Ann. tit. 17-A, § 1111-B	✓	—	✓	—	—	—	—	✓
Maryland Md. Code Ann., Crim. Proc. § 1-210	✓	—	✓	—	—	✓	✓	✓
Massachusetts Mass. Gen. Laws Ann. ch. 94C, § 34A	✓	—	✓	—	—	—	✓	✓
Michigan Mich. Comp. Laws Ann. §§ 333.7403, .7404	✓	—	✓	—	—	—	—	—
Minnesota Minn. Stat. Ann. § 604A.05	✓	—	✓	—	—	✓	✓	✓
Mississippi Miss. Code Ann. § 41-29-149.1	✓	—	✓	—	—	—	✓	✓
Missouri Mo. Ann. Stat. § 195.205	✓	—	✓	—	—	—	—	✓
Montana Mont. Code Ann. § 50-32-609	✓	—	✓	—	—	✓	✓	✓
Nebraska Neb. Rev. Stat. Ann. § 28-472	✓	—	✓	—	—	—	—	—

	Types of drug offenses specified for criminal immunity		Timing when criminal immunity takes effect		Trial or sentencing protection for non-immunized offenses		Protections for individuals already in the criminal system	
Jurisdiction and applicable legal citation	Immunity from drug possession offenses	Immunity from drug delivery offenses	Immunity from arrest, charge, and prosecution[a]	Immunity from prosecution only[b]	Affirmative defense at trial[c]	Mitigating factor at sentencing[d]	Pretrial release protections[e]	Probation or parole protections[f]
Nevada Nev. Rev. Stat. Ann. § 453C.150	✓	—	✓	—	—	✓	—	✓
New Hampshire N.H. Rev. Stat. Ann. § 318-B:28-b	✓	—	✓	—	—	—	—	—
New Jersey N.J. Stat. Ann. § 2C:35-30	✓	—	✓	—	—	—	—	✓
New Mexico N. M. Stat. Ann. § 30-31-27.1	✓	—	✓	—	—	✓	—	✓
New York N.Y. Penal Law § 220.78	✓	—	✓	—	✓	—	—	—
North Carolina N.C. Gen. Stat. Ann. § 90-96.2	✓	—	—	✓	—	—	✓	✓
North Dakota N.D. Cent. Code Ann. § 19-03.1-23.4	✓	—	✓	—	—	—	—	—
Ohio Ohio Rev. Code Ann. § 2925.11	✓	—	✓	—	—	—	—	✓
Oklahoma Okla. Stat. Ann. tit. 63, § 2-413.1	✓	—	✓	—	—	—	—	—

	Types of drug offenses specified for criminal immunity		Timing when criminal immunity takes effect		Trial or sentencing protection for non-immunized offenses		Protections for individuals already in the criminal system	
Jurisdiction and applicable legal citation	Immunity from drug possession offenses	Immunity from drug delivery offenses	Immunity from arrest, charge, and prosecution[a]	Immunity from prosecution only[b]	Affirmative defense at trial[c]	Mitigating factor at sentencing[d]	Pretrial release protections[e]	Probation or parole protections[f]
Oregon Or. Rev. Stat. Ann. § 475.898	✓	—	✓	—	—	—	✓	✓
Pennsylvania 35 Pa. Stat. and Cons. Stat. Ann. § 780-113.7	✓	—	✓	—	—	—	—	✓
Rhode Island 21 R.I. Gen. Laws Ann. § 21-28.9-4	✓	—	✓	—	—	✓	—	✓
South Carolina S.C. Code Ann. §§ 44-53-1920, -1940	✓	✓	—	✓	—	✓	—	—
South Dakota S.D. Codified Laws § 34-20A-110	✓	—	✓	—	—	—	—	—
Tennessee Tenn. Code Ann. § 63-1-156	✓	—	✓	—	—	✓	✓	✓
Utah Utah Code Ann. §§ 58-37-8(16), 76-3-203.11	—	—	—	—	✓	✓	—	—
Vermont Vt. Stat. Ann. tit. 18, § 4254	✓	✓	✓	—	—	✓	✓	✓
Virginia[g] Va. Code Ann. § 18.2-251.03	✓	—	✓	—	—	—	—	—

	Types of drug offenses specified for criminal immunity		Timing when criminal immunity takes effect		Trial or sentencing protection for non-immunized offenses		Protections for individuals already in the criminal system	
Jurisdiction and applicable legal citation	Immunity from drug possession offenses	Immunity from drug delivery offenses	Immunity from arrest, charge, and prosecution[a]	Immunity from prosecution only[b]	Affirmative defense at trial[c]	Mitigating factor at sentencing[d]	Pretrial release protections[e]	Probation or parole protections[f]
Washington Wash. Rev. Code Ann. § 69.50.315	✓	—	✓	—	—	—	—	—
West Virginia W. Va. Code Ann. § 16-47-4	✓	—	—	✓	—	✓	✓	✓
Wisconsin Wis. Stat. Ann. § 961.443	✓	—	—	✓	—	—	—	—

Legend:

✓ indicates present

— indicates not present

Source: GAO analysis of state and District of Columbia laws | GAO-21-248

Notes: Kansas, Texas, Wyoming and the five U.S. territories are not included because they do not have a Good Samaritan law. Our analysis is based on laws we researched in May 2020 using online legal databases, unless otherwise noted.

[a]Immunity from "arrest, charge, and prosecution" prevents an individual from being arrested and charged as a criminal defendant, thereby eliminating the possibility of being prosecuted. Some laws that we categorized as providing immunity from arrest, charge, and prosecution specifically state that an individual may not be arrested, charged, or prosecuted while others use different terminology that we also included in this category. For example, some laws state that the offense is not a crime or does not apply to the individual, or that a violation of the law did not occur or does not provide probable cause for arrest. This category also includes laws that state an individual may not be charged or prosecuted. While charge immunity does not prevent an individual from being arrested, we included it in the same category as arrest immunity because, like arrest immunity, charge immunity takes effect before the individual becomes a criminal defendant. In contrast, an individual with immunity from prosecution only can be charged as a criminal defendant but can have the charge dismissed prior to trial.

[b]Immunity from prosecution only does not prevent an individual from being arrested and charged as a criminal defendant, but prevents prosecution by providing for the dismissal of charges before trial.

[c]An affirmative defense at trial protects against conviction by allowing an individual to seek an acquittal by presenting evidence that the offense was discovered during a medical assistance request.

[d]A mitigating factor at sentencing does not protect against conviction but allows an individual who has been convicted to seek a reduced sentence by presenting evidence that the offense was discovered during a medical assistance request or that the individual provided medical aid to an overdose victim.

[e]Immunity from revocation of pretrial release protects the release status of an individual who has been permitted to remain in the community, rather than in detention, while awaiting trial in another criminal case.

[f]Immunity from revocation of probation or parole protects the release status of an individual who has been permitted to remain in the community, rather than in detention, while serving a sentence of probation or a term of parole in another criminal case. This category includes some laws that protect against the revocation of probation, but not against the revocation of parole.

[g]In November 2020, we updated our analysis of Virginia's law to reflect a July 2020 amendment, which we identified based on our review of the Legislative Analysis and Public Policy Association's August 2020 report on Good Samaritan laws. The report can be found at http://legislativeanalysis.org/wp-content/uploads/2020/08/GSFOP-laws.8.10.2020-version.FINAL_.pdf (accessed October 21, 2020).

Appendix IV: GAO Analysis of Jurisdictions' Naloxone Access Laws

	Methods to Access Naloxone		Types of Immunity for Administrators[a]		
Jurisdiction and applicable legal citation	Direct Pharmacy Access[b]	Third-Party Prescriptions[c]	Civil immunity[d]	Criminal Immunity[e]	Professional Immunity[f]
Alabama Ala. Code §§ 202-280, -283	✓	✓	✓	✓	—
Alaska Alaska Stat. Ann. §§ 08.80.030, .168, 09.65.340, 17.20.085	✓	✓	✓	—	—
Arizona Ariz. Rev. Stat. Ann. §§ 32-1979, 36-2228, -2266, -2267	✓	✓	✓	✓	✓
Arkansas Ark. Code Ann. § 20-13-1804	✓	✓	✓	✓	✓
California Cal. Civ. Code § 1714.22, Bus. & Prof. §§ 4052.01, 4119.9	✓	✓	✓	✓	✓
Colorado Colo. Rev. Stat. Ann. §§ 12-30-110, 12-280-123, 13-21-108.7, 18-1-712	✓	✓	✓	✓	—
Connecticut Conn. Gen. Stat. Ann. §§ 17a-714a, 20-633c, -633d	✓	✓	✓	✓	✓
Delaware Del. Code Ann. tit. 16, § 3001G	✓	✓	✓	✓	—
District of Columbia D.C. Code Ann. §§ 7-403, -404	✓	✓	✓	✓	—
Florida Fla. Stat. Ann. § 381.887	✓	✓	✓	—	—
Georgia Ga. Code Ann. §§ 26-4-116.2, 31-1-10, 31-11-55.1	✓	✓	✓	✓	✓
Hawaii Haw. Rev. Stat. Ann. §§ 329E-2, 461-11.8	✓	✓	✓	✓	✓
Idaho Idaho Code Ann. § 54-1733B	✓	—	✓	✓	✓
Illinois 20 Ill. Comp. Stat. Ann. 301/5-23, 225 § 85/19.1	✓	✓	✓	✓	—
Indiana Ind. Code Ann. §§ 16-31-3-23.5, 16-42-27-2, -3	✓	✓	✓	✓	—
Iowa Iowa Code Ann. §§ 135.190, 147A.18	✓	✓	✓	—	—
Kansas Kan. Stat. Ann. § 65-16,127	✓	—	✓	✓	✓

	Methods to Access Naloxone		Types of Immunity for Administrators[a]		
Jurisdiction and applicable legal citation	Direct Pharmacy Access[b]	Third-Party Prescriptions[c]	Civil immunity[d]	Criminal Immunity[e]	Professional Immunity[f]
Kentucky Ky. Rev. Stat. Ann. § 217.186	✓	✓	✓	✓	—
Louisiana La. Stat. Ann. §§ 40:978.1, .2	✓	✓	✓	✓	✓
Maine Me. Rev. Stat. Ann. tit. 22, § 2353	✓	✓	✓	✓	✓
Maryland Md. Code Ann., Health-Gen. §§ 13-3105 to -3108	✓	✓	✓	✓	—
Massachusetts Mass. Gen. Laws Ann. ch. 94C, §§ 19, 19B	✓	✓	✓	✓	✓
Michigan Mich. Comp. Laws Ann. §§ 333.17744b, .17744c, .17744e, 691.1503	✓	✓	✓	✓	✓
Minnesota Minn. Stat. Ann. §§ 151.37, 604A.04	✓	✓	✓	✓	—
Mississippi Miss. Code Ann. § 41-29-319	✓	✓	✓	✓	✓
Missouri Mo. Ann. Stat. § 195.206	✓	—	✓	✓	✓
Montana Mont. Code Ann. §§ 50-32-603 to -605, -608	✓	✓	✓	—	✓
Nebraska Neb. Rev. Stat. Ann. § 28-470	—	✓	✓	✓	✓
Nevada Nev. Rev. Stat. Ann. §§ 453C.100, .120	✓	✓	✓	✓	✓
New Hampshire N.H. Rev. Stat. Ann. § 318-B:15	✓	✓	✓	✓	✓
New Jersey N.J. Stat. Ann. §§ 24:6J-4, 45:14-67.2	✓	✓	✓	✓	✓
New Mexico N. M. Stat. Ann. § 24-23-1	✓	✓	✓	✓	✓
New York N.Y. Pub. Health Law § 3309	✓	✓	✓	✓	✓
North Carolina N.C. Gen. Stat. Ann. § 90-12.7	✓	✓	✓	✓	—

	Methods to Access Naloxone		Types of Immunity for Administrators[a]		
Jurisdiction and applicable legal citation	Direct Pharmacy Access[b]	Third-Party Prescriptions[c]	Civil immunity[d]	Criminal Immunity[e]	Professional Immunity[f]
North Dakota N.D. Cent. Code Ann. §§ 23-01-42, 43-15-10	✓	✓	✓	✓	—
Ohio Ohio Rev. Code Ann. §§ 2925.61, 3707.56, 4723.488, 4729.44, 4730.431, 4731.94, .942	✓	✓	✓	✓	✓
Oklahoma Okla. Stat. Ann. tit. 63, §§ 1-2506.1, .2, 2-312.2	✓	✓	✓	—	—
Oregon Or. Rev. Stat. Ann. §§ 689.681, .682	✓	—	✓	—	—
Pennsylvania 35 Pa. Stat. and Cons. Stat. Ann. § 780-113.8	✓	✓	✓	✓	✓
Rhode Island 21 R.I. Gen. Laws Ann. § 28.9-3, 216 R.I. Code R. § 20-20-5.4	✓	✓	✓	✓	✓
South Carolina S.C. Code Ann. §§ 44-130-30 to -60	✓	✓	✓	✓	✓
South Dakota S.D. Codified Laws §§ 34-20A-98, -103 to -105	✓	✓	✓	—	—
Tennessee Tenn. Code Ann. §§ 63-1-152, -157	✓	✓	✓	—	✓
Texas Tex. Health & Safety Code Ann. §§ 483.102, .103, .106	✓	✓	✓	✓	✓
Utah Utah Code Ann. §§ 26-55-104, -105	✓	✓	✓	—	—
Vermont Vt. Stat. Ann. tit. 18, § 4240, 26, § 2080	✓	✓	✓	✓	—
Virginia Va. Code Ann. §§ 8.01-225, 54.1-3408(X)-(Y)	✓	—	✓	—	—
Washington Wash. Rev. Code Ann. § 69.41.095	✓	✓	✓	✓	✓
West Virginia W. Va. Code Ann. §§ 16-46-3 to -5, -7	✓	✓	✓	✓	—
Wisconsin Wis. Stat. Ann. §§ 441.18, 448.037, 450.11	✓	✓	✓	✓	—
Wyoming Wyo. Stat. Ann. §§ 35-4-903, -904, -906	✓	✓	✓	✓	—

Legend:
✓ indicates present

— indicates not present

Source: GAO analysis of state and District of Columbia laws | GAO-21-248

Notes: The five U.S. territories are not included because they do not have a Naloxone Access law. Our analysis is based on laws we researched in May 2020 using online legal databases.

[a]An administrator refers to persons or entities that may be in a position to administer the opioid overdose reversal drug naloxone to an overdose victim, such as first responders (including law enforcement entities), family members, and friends.

[b]Direct pharmacy access authorizes pharmacists to provide naloxone to persons or entities that do not have a prescription from another healthcare provider. A Naloxone Access law may authorize a pharmacist to prescribe naloxone to these persons or entities or dispense naloxone without the need for a prescription, either from the pharmacist or another healthcare provider, such as a physician. A Naloxone Access law may also authorize a pharmacist to dispense naloxone based on a standing order, protocol order, or collaborative practice agreement, which, for purposes of this report, are medication orders issued by entities such as state health officials, boards of pharmacy, or licensed healthcare providers that are not specific to a particular party but set forth the categories of persons or entities that are eligible to receive naloxone.

[c]A third-party prescription authorizes healthcare providers, such as physicians, to prescribe naloxone to persons or entities that may be in a position to administer the drug to an overdose victim. While Naloxone Access laws may also authorize a pharmacist to issue third-party prescriptions, we considered these a form of direct pharmacy access because they eliminate the need for a person or entity to obtain a third-party prescription from another healthcare provider.

[d]Civil immunity means that a person is not liable for damages when sued by another party, such as a private individual.

[e]Criminal immunity means that a person is not subject to prosecution by the government.

[f]Professional immunity means that a person will not face disciplinary action or administrative sanctions, such as by a professional licensing board.

Appendix V: Comments from ONDCP

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

March 8, 2021

Triana McNeil
Director, Homeland Security and Justice
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Director McNeil:

The Office of National Drug Control Policy (ONDCP) hereby provides our response to the draft final report entitled, *Many States Have Good Samaritan Laws and Research Indicates They May Have Positive Effects*, GAO-21-248. Thank you for the opportunity to review and comment on the draft final report. We have no objections to any of the factual information contained in the report. Please find attached ONDCP's Technical Comments on the draft report which contains our recommended edits. Feel free to contact ONDCP General Counsel, Robert Kent at (202) 881-8815 or Robert.A.Kent@ondcp.eop.gov if you would like to further discuss this matter.

Sincerely,

Regina M. LaBelle
Acting Director

Appendix VI: GAO Contact and Staff Acknowledgements

GAO Contact

Triana McNeil, (202) 512-8777, mcneilt@gao.gov

Staff Acknowledgements

In addition to the contact named above, Tracey Cross (Assistant Director), Julia Vieweg (Analyst in Charge), James Cook, Christine Davis, Eric Hauswirth, Suzanne Kaasa, Amanda Miller, Jan Montgomery, Will Simerl, Mary Turgeon, Adam Vogt, and Sirin Yaemsiri, made key contributions to this report.

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