

112TH CONGRESS
2D SESSION

H. R. 6311

To prevent deaths occurring from drug overdoses.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 2, 2012

Ms. EDWARDS (for herself, Mrs. BONO MACK, Ms. NORTON, Ms. LEE of California, Mr. GRIJALVA, Ms. SCHAKOWSKY, Mrs. NAPOLITANO, Mr. LYNCH, Ms. BROWN of Florida, Mr. BLUMENAUER, Mr. BUCHANAN, Mr. CARNAHAN, Mr. CARSON of Indiana, Mr. TOWNS, Mr. MORAN, Mr. KEATING, Ms. RICHARDSON, Ms. WILSON of Florida, Mr. OLVER, Mr. HINCHEY, Mr. CONYERS, Ms. WASSERMAN SCHULTZ, Mr. DAVIS of Illinois, Mr. TIERNEY, Mr. LEWIS of Georgia, Mrs. CAPITO, Ms. BASS of California, and Mr. RUSH) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To prevent deaths occurring from drug overdoses.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SECTION 1. SHORT TITLE.

4 This Act may be cited as the “Stop Overdose Stat
5 Act” or the “S.O.S Act”.

6 SEC. 2. FINDINGS.

7 The Congress finds the following:

1 (1) According to the Centers for Disease Con-
2 trol and Prevention, a drug overdose fatality occurs
3 in the United States every 14 minutes. More people
4 now die from drug-related deaths than traffic fatali-
5 ties in the United States.

6 (2) The Centers for Disease Control and Pre-
7 vention reports that nearly 36,500 people in the
8 United States died from a drug overdose in 2008
9 alone. More than 75 percent of these deaths were
10 due to unintentional drug overdoses, and many could
11 have been prevented.

12 (3) Deaths resulting from unintentional drug
13 overdoses increased more than 400 percent between
14 1980 and 1999, and more than doubled between
15 1999 and 2008.

16 (4) Ninety-one percent of all unintentional poi-
17 soning deaths are due to drugs. Poisoning deaths
18 cost society \$93,464,000 in direct medical costs and
19 \$28,142,598,000 in lost productivity costs in the
20 year 2005 alone.

21 (5) Both fatal and nonfatal overdoses place a
22 heavy burden on public health and public safety re-
23 sources, yet no Federal agency has been tasked with
24 stemming this crisis.

1 (6) Opioid pain medications such as oxycodone
2 and hydrocodone are involved in more than 40 per-
3 cent of all drug poisoning deaths. Six times as many
4 people died of an overdose from methadone pre-
5 scribed to treat pain in 2009 than a decade before.
6 Rural and suburban regions are disproportionately
7 affected by opioid prescription overdoses.

8 (7) Naloxone is a medication that rapidly re-
9 verses overdose from heroin and opioid pain medica-
10 tions.

11 (8) In April 2012, the Food and Drug Adminis-
12 tration (FDA) held a public workshop in collabora-
13 tion with the National Institute on Drug Abuse
14 (NIDA) and the Centers for Disease Control and
15 Prevention (CDC), and with participation from the
16 Substance Abuse and Mental Health Services Ad-
17 ministration (SAMHSA) and the Office of National
18 Drug Control Policy (ONDCP), to discuss making
19 naloxone more widely available outside of conven-
20 tional medical settings to reduce the incidence of
21 opioid overdose fatalities.

22 (9) Health practitioners often do not adequately
23 inform patients and caregivers on how to recognize
24 overdose symptoms and effectively respond by seek-

1 ing emergency assistance and providing naloxone
2 and other first aid in order to save a life.

3 (10) The American Medical Association (AMA),
4 the Nation's largest physician organization, supports
5 further implementation of community-based pro-
6 grams that offer naloxone and other opioid overdose
7 prevention services.

8 (11) Community-based overdose prevention pro-
9 grams have successfully prevented deaths from
10 opioid overdoses by making rescue trainings and
11 naloxone available to first responders, parents, and
12 other bystanders who may encounter an overdose. A
13 CDC report credits overdose prevention programs
14 with saving more than 10,000 lives since 1996.

15 (12) At least 188 local overdose prevention pro-
16 grams are operating in the United States, including
17 in major cities such as Baltimore, Chicago, Los An-
18 geles, New York City, Boston, San Francisco, and
19 Philadelphia, and statewide in New Mexico, Massa-
20 chusetts, and New York. In New Mexico, which has
21 one of the highest drug overdose death rates in the
22 country, health officials estimate the statewide
23 naloxone distribution program that began in 2001
24 has reversed 3,000 overdoses. Another program in

1 Wilkes County, North Carolina, reduced overdose
2 deaths 69 percent between 2009 and 2011.

3 (13) Overdose prevention programs are needed
4 in correctional facilities, addiction treatment pro-
5 grams, and other places where people are at higher
6 risk of overdosing after a period of abstinence.

7 (14) A real-time overdose surveillance and re-
8 porting database is needed to monitor fatal and
9 nonfatal drug overdoses, identify areas of the coun-
10 try in need of programmatic support, monitor the
11 outcomes of overdose occurrences, and enhance eval-
12 uation of community programs and interventions.

13 SEC. 3. OVERDOSE PREVENTION GRANT PROGRAM.

14 (a) PROGRAM AUTHORIZED.—The Director of the
15 Centers for Disease Control and Prevention shall award
16 grants or cooperative agreements to eligible entities to en-
17 able the eligible entities to reduce deaths occurring from
18 overdoses of drugs.

19 (b) APPLICATION.—

20 (1) IN GENERAL.—An eligible entity desiring a
21 grant or cooperative agreement under this section
22 shall submit to the Director an application at such
23 time, in such manner, and containing such informa-
24 tion as the Director may require.

1 (2) CONTENTS.—An application under para-
2 graph (1) shall include—

3 (A) a description of the activities to be
4 funded through the grant or cooperative agree-
5 ment; and

6 (B) a demonstration that the eligible entity
7 has the capacity to carry out such activities.

8 (c) PRIORITY.—In awarding grants and cooperative
9 agreements under subsection (a), the Director shall give
10 priority to eligible entities that—

11 (1) are a public health agency or community-
12 based organization; and

13 (2) have expertise in preventing deaths occur-
14 ring from overdoses of drugs in populations at high
15 risk of such deaths.

16 (d) ELIGIBLE ACTIVITIES.—As a condition on receipt
17 of a grant or cooperative agreement under this section,
18 an eligible entity shall agree to use the grant or coopera-
19 tive agreement to carry out one or more of the following
20 activities:

21 (1) Purchasing and distributing the drug
22 naloxone.

23 (2) Educating physicians and pharmacists
24 about overdose prevention and naloxone prescription.

(4) Implementing and enhancing programs to provide overdose prevention, recognition, treatment, and response to individuals in need of such services.

9 (5) Expanding a program described in para-
10 graph (1), (2), or (3).

11 (e) REPORT.—As a condition on receipt of a grant
12 or cooperative agreement under this section, an eligible en-
13 tity shall agree to prepare and submit, not later than 90
14 days after the end of the grant or cooperative agreement
15 period, a report to the Director describing the results of
16 the activities supported through the grant or cooperative
17 agreement.

18 (f) AUTHORIZATION OF APPROPRIATIONS.—There
19 are authorized to be appropriated such sums as may be
20 necessary to carry out this section for each of the fiscal
21 years 2013 through 2017.

22 SEC. 4. SENTINEL SURVEILLANCE SYSTEM.

23 (a) DATA COLLECTION.—The Director of the Centers
24 for Disease Control and Prevention shall annually compile
25 and publish data on both fatal and nonfatal overdoses of

1 drugs for the preceding year. To the extent possible, the
2 data shall be collected from all county, State, and tribal
3 governments, the Federal Government, and private
4 sources (such as the National Poison Data System), shall
5 be made available in the form of an Internet database that
6 is accessible to the public, and shall include—

7 (1) identification of the underlying drugs that
8 led to fatal overdose;

9 (2) identification of substance level specificity
10 where possible;

11 (3) analysis of trends in polydrug use in over-
12 dose victims, as well as identification of emerging
13 overdose patterns;

14 (4) results of toxicology screenings in fatal
15 overdoses routinely conducted by State medical ex-
16 aminers;

17 (5) identification of—

18 (A) drugs that were involved in both fatal
19 and nonfatal unintentional poisonings; and

20 (B) the number and percentage of such
21 poisonings by drug; and

22 (6) identification of the type of place where un-
23 intentional drug poisonings occur, as well as the age,
24 race, and gender of victims.

1 (b) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 such sums as may be necessary for each of the fiscal years
4 2013 through 2017.

5 **SEC. 5. SURVEILLANCE CAPACITY BUILDING.**

6 (a) PROGRAM AUTHORIZED.—The Director of the
7 Centers for Disease Control and Prevention shall award
8 grants or cooperative agreements to State, local, or tribal
9 governments, or the National Poison Data System, work-
10 ing in conjunction with the State, local, or tribal govern-
11 ments, to improve fatal and nonfatal drug overdose sur-
12 veillance and reporting capabilities, including the fol-
13 lowing:

14 (1) Implementing or enhancing the capacity of
15 a coroner or medical examiner's office to conduct
16 toxicological screenings where drug overdose is the
17 suspected cause of death.

18 (2) Providing training to improve identification
19 of drug overdose as the cause of death by coroners
20 and medical examiners.

21 (3) Establishing, in cooperation with the Na-
22 tional Poison Data System, coroners, and medical
23 examiners, a comprehensive national program for
24 surveillance of, and reporting to an electronic data-
25 base on, drug overdose deaths in the United States.

1 (4) Establishing, in cooperation with the Na-
2 tional Poison Data System, a comprehensive na-
3 tional program for surveillance of, and reporting to
4 an electronic database on, fatal and nonfatal drug
5 overdose occurrences, including epidemiological and
6 toxicologic analysis and trends.

7 (b) APPLICATION.—

8 (1) IN GENERAL.—A State, local, or tribal gov-
9 ernment or the National Poison Data System desir-
10 ing a grant or cooperative agreement under this sec-
11 tion shall submit to the Director an application at
12 such time, in such manner, and containing such in-
13 formation as the Director may require.

14 (2) CONTENTS.—The application described in
15 paragraph (1) shall include—

16 (A) a description of the activities to be
17 funded through the grant or cooperative agree-
18 ment; and

19 (B) a demonstration that the State, local,
20 or tribal government or the National Poison
21 Data System has the capacity to carry out such
22 activities.

23 (c) REPORT.—As a condition on receipt of a grant
24 or cooperative agreement under this section, a State, local,
25 or tribal government or the National Poison Data System

1 shall agree to prepare and submit, not later than 90 days
2 after the end of the grant or cooperative agreement period,
3 a report to the Director describing the results of the activi-
4 ties supported through the grant or cooperative agree-
5 ment.

6 (d) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated to carry out this section
8 such sums as may be necessary for each of the fiscal years
9 2013 through 2017.

10 **SEC. 6. REDUCING OVERDOSE DEATHS.**

11 (a) IN GENERAL.—Not later than 180 days after the
12 date of the enactment of this Act, the Secretary of Health
13 and Human Services shall develop a plan in consultation
14 with a task force comprised of stakeholders to reduce the
15 number of deaths occurring from overdoses of drugs and
16 shall submit the plan to Congress. The plan shall in-
17 clude—

18 (1) an identification of the barriers to obtaining
19 accurate data regarding the number of deaths occur-
20 ring from overdoses of drugs;

21 (2) an identification of the barriers to imple-
22 menting more effective overdose prevention strate-
23 gies and programs;

24 (3) an examination of overdose prevention best
25 practices;

1 (4) a plan for implementation of a public health
2 campaign to educate physicians and the public about
3 overdose prevention and naloxone prescription;

4 (5) recommendations for improving and ex-
5 panding overdose prevention programming; and

6 (6) recommendations for such legislative or ad-
7 ministrative action as the Director considers appro-
8 priate.

9 (b) **DEFINITION.**—In this section, the term “stake-
10 holder” means any individual directly impacted by drug
11 overdose, any direct service provider who engages individ-
12 uals at risk of a drug overdose, any drug overdose preven-
13 tion advocate, the National Institute on Drug Abuse, the
14 Center for Substance Abuse Treatment, the Centers for
15 Disease Control and Prevention, the Food and Drug Ad-
16 ministration, the American Association of Poison Control
17 Centers, and any other individual or entity with drug over-
18 dose expertise.

19 **SEC. 7. OVERDOSE PREVENTION RESEARCH.**

20 (a) **OVERDOSE RESEARCH.**—The Director of the Na-
21 tional Institute on Drug Abuse shall prioritize and conduct
22 or support research on drug overdose and overdose preven-
23 tion. The primary aims of this research shall include—

1 (1) examinations of circumstances that contrib-
2 uted to drug overdose and identification of drugs as-
3 sociated with fatal overdose;

4 (2) evaluations of existing overdose prevention
5 program intervention methods; and

6 (3) pilot programs or research trials on new
7 overdose prevention strategies or programs that have
8 not been studied in the United States.

9 (b) DOSAGE FORMS OF NALOXONE.—The Director
10 of the National Institute on Drug Abuse shall support re-
11 search on the development of dosage forms of naloxone
12 specifically intended to be used by lay persons or first re-
13 sponders for the prehospital treatment of unintentional
14 drug overdose.

15 (c) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated to carry out this section
17 such sums as may be necessary for each of the fiscal years
18 2013 through 2017.

19 **SEC. 8. DEFINITIONS.**

20 In this Act:

21 (1) DIRECTOR.—Unless otherwise specified, the
22 term “Director” means the Director of the Centers
23 for Disease Control and Prevention.

24 (2) DRUG.—The term “drug”—

1 (A) means a drug (as that term is defined
2 in section 201 of the Federal Food, Drug, and
3 Cosmetic Act (21 U.S.C. 321)); and

4 (B) includes any controlled substance (as
5 that term is defined in section 102 of the Con-
6 trolled Substances Act (21 U.S.C. 802)).

7 (3) ELIGIBLE ENTITY.—The term “eligible enti-
8 ty” means an entity that is a State, local, or tribal
9 government, a correctional institution, a law enforce-
10 ment agency, a community agency, a professional or-
11 ganization in the field of poison control and surveil-
12 lance, or a private nonprofit organization.

13 (4) NATIONAL POISON DATA SYSTEM.—The
14 term “National Poison Data System” means the
15 system operated by the American Association of Poi-
16 son Control Centers, in partnership with the Centers
17 for Disease Control and Prevention, for real-time
18 local, State, and national electronic reporting, and
19 the corresponding database network.

20 (5) STATE.—The term “State” means any of
21 the several States, the District of Columbia, Puerto
22 Rico, the Northern Mariana Islands, the Virgin Is-
23 lands, Guam, American Samoa, and any other terri-
24 tory or possession of the United States.

1 (6) TRAINING.—The term “training” means
2 any activity that is educational, instructional, or
3 consultative in nature, and may include volunteer
4 trainings, awareness building exercises, outreach to
5 individuals who are at-risk of a drug overdose, and
6 distribution of educational materials.

